Q1 Please provide your contact information below.

Name	**Arielle Basch**
Title and Organization	**Director of Program Development at JASA**
Address	**247 West 37th Street, 9th Floor**
City/Town	**NYC**
State/Province	**NY**
ZIP/Postal Code	**10018**
Email Address	**abasch@jasa.org**
Phone Number	**917-862-6277**

Q2 Please describe your company or organizations overall goals and mission.

Founded in 1968, JASA seeks to enrich the lives of vulnerable and older adults so they can remain in the community with dignity and autonomy. JASA serves over 43,000 clients in the Bronx, Brooklyn, Manhattan, and Queens through the delivery of the following services: adult protective services, advocacy, community guardian, benefits and entitlements assistance, caregiver assistance, case management, community health navigation, elder abuse prevention and intervention, home care, housing, legal assistance, meals, mental health services, naturally occurring retirement communities (NORCs), and senior centers . JASA's mental health services include an Article 31 geriatric mental health clinic in the Bronx, psycho-social clubhouses in the Bronx and Brooklyn, BH-HCBS in the Bronx and Brooklyn, and PEARLS (Program to Encourage Active, Rewarding Lives for Seniors) in the Bronx. Additional information about JASA can be found at www.jasa.org.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

In 2016, JASA developed a home-based care transitions program targeting older adults to address the social determinants of health and reduce 30-day hospital readmissions. JASA's care transitions program provides critical services to support dual eligibles and the uninsured as well as hospital partners who have faced financial penalties for 30-day readmissions. Currently, the program is funded by Wyckoff Heights Medical Center (WHMC) as part of the Performing Provider System (PPS) Community Care of Brooklyn. However, additional partners are being sought to scale the initiative and enable longer-term program sustainability. Future partners could include both health care providers and payers.

The care transitions intervention is offered to patients free of charge, independent of insurance status and serves a population that includes a large number of immigrants with limited English proficiency (LEP), low levels of formal education, high rates of poverty and clinically complex conditions (e.g., comorbidities, behavioral health disorders) which exacerbates health status and compliance with recommended medical treatment. The care transitions project was initially developed by JASA, based on existing evidence-based models, as well as care transition programs implemented by JASA in the past that have been tailored to meet the needs of the target population.

Two years ago, JASA approached Wyckoff Heights Medical Center (WHMC) about the project, noting that it could help Wyckoff reduce its high 30-day readmission rates. Wyckoff staff do not do home visits, so the care transitions program fills an important gap for vulnerable, medically complex patients. The care transitions services through this project are available to individuals hospitalized at Wyckoff who speak English or Spanish, are over age 60, live in the target zip codes, and have no serious mental illness or substance abuse issues. JASA receives approximately 40 referrals per month. The program has successfully doubled its patient caseload in the two years since its launch and has capacity to scale further in the coming year.

The staffing model is both effective and cost-efficient. The care transitions teams are comprised of care transition specialists, discharge specialists, social workers and peer health coaches. The care transitions specialists coordinate services needed after patients are discharged, including access to community-based self-management and other social services. The discharge specialists help ensure patients understand discharge instructions, medication regiments as provided upon discharge, and other details surrounding the management of their conditions. The discharge specialists are typically international medical graduates who have not yet identified a residency or practice position in the U.S. While these team members do not provide clinical services, their medical education background allows them to recognize potential concerns, which they raise to either the inpatient care transitions team or to the patient's primary care provider. The peer health coaches are older adults from the targeted community, culturally similar to the clients served. Because project staff meet clients in the hospital, they are screened, registered, and trained as volunteers through the Wyckoff Human Resources Department.

A care team member meets the client in the hospital, providing an opportunity for a "warm handoff" and for initial identification of post-discharge needs. Access to the client while in the hospital is somewhat atypical, prohibited by some other facilities, possibly due to concerns about liability. JASA staff feel that this early access is a demonstration of Wyckoff's commitment to a productive partnership. It strengthens the program by facilitating patient engagement post-discharge and promotes effective collaboration and trust between staff of the two organizations who are in regular in-person contact with one another.

JASA project staff visit clients in their homes within 48 hours of discharge to complete a follow-up assessment. During this visit, staff check that the client understands his or her medical condition and its management, is living in a safe and clean environment, and has food and any needed durable medical equipment. In addition, project staff provide linkages to resources (e.g., Meals on Wheels), assistance with medications, and planning for follow-up physician visits. The peer health coaches serve as community health navigators and provide longer-term, targeted support, consistent with need. A licensed counselor is also available to visit patients who have difficulty leaving their homes. Although the project is focused on reduced 30-day hospital readmissions, services are provided for longer, if needed.

JASA and Wyckoff staff have open and frequent communications regarding individuals participating in the program. The partners have a standing bi-weekly call, but communicate often between scheduled meetings to discuss issues and concerns that come up.

JASA tracks referrals to and engagement in the program, care transition services provided, service referrals, and readmissions for their own records using and Electronic Health Record (EHR) and provides the information to Wyckoff. It is important to note that although results have been strong, a subset of the patients referred for—and needing—home-based services are so ill that re-hospitalization is likely, even with supportive services. According to JASA data, approximately 10% of program clients are readmitted. Since the start of the care transitions program, 30-day readmissions at Wyckoff have sharply declined. WHMC reported that JASA's Care Transitions program contributed to it decreasing its readmission penalty by 1.13 percentage points (from 2.45% to 1.32%) between 2017 and 2018. Another important result of this program is the new revenue stream for JASA from WHMC.

Furthermore, the project has not only assisted enrolled patients, but it has helped Wyckoff to identify systemic issues associated with high readmission rates. For example, discharge instructions being delivered in English to patients with Limited English Proficiency (LEP). Language issues have also been linked to readmissions, and bilingual JASA project staff have provided translation services and

helped Spanish-speaking patients understand their discharge instructions.

JASA and Wyckoff staff describe the care transitions partnership as an unqualified success.

I've been in healthcare a long time and I haven't seen anything so easy to implement and effective for our patients. And again, I think it's the smallness of the team that makes it work. JASA's a big organization, Wyckoff's a big organization, but the people that are dealing with this project aren't. It's a small group and if we could replicate that, and an organization like JASA just keeps growing and meeting the needs of our communities -- that could really help hospitals. (Wyckoff Discharge Nurse)

Ultimately, JASA leadership are confident that the care transitions program will reduce health care costs and prove to be a valuable service for hospitals. The next step is a rigorous evaluation of outcomes and service costs to ensure fair and appropriate contract conditions—and a financially viable program.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	Yes (please specify when and the estimated number of people impacted): JASA's Care Transitions intervention launched in April 2016.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Social and Community Context** , **Health and Health Care** , **Neighborhood and Environment** , **Economic Stability**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**