Q1 Please provide your contact information below.

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

Longer life means that today's older adults have opportunities unknown to previous generations. Longer life also brings new challenges for both older adults and caregivers. Lifespan helps older adults and caregivers take on the challenges and opportunities of longer life. Lifespan is a trusted source of unbiased information, guidance and more than 30 services and advocacy for older adults and caregivers. We also provide training and education for allied professionals and the community.

Adults age 65 and older are the fastest growing demographic nationally and in the Finger Lakes region. Nationally, the older adult population is expected to increase by 30 million people between 2010 and 2030; regionally the senior population is projected to grow 38 percent from 2007 to 2025, at which point one in five people living in the region will be 65 or older.

Common Ground Health (formerly Finger Lakes Health Systems Agency) noted in the Community Needs Assessment, 2014, hospital "readmission happens at an alarming rate: Over 16% of hospital discharges (about one of six) result in a subsequent admission within 30 days, and nearly one of four discharges (22.65%) are followed by a readmission within 60 days. Readmission rates increase with increasing age, perhaps reflecting greater frailty of seniors". [1,2]
Recognizing these local and national trends, Lifespan has created an innovative approach by integrating our community-based services into healthcare, proactively assisting older adults to achieve improved health outcomes by addressing the social determinants of health resulting in significant decreases in emergency room visits and hospitalizations.

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).

Lifespan's Healthcare Navigation - Social Determinants of Health Innovation:
Lifespan has been providing multiple-source grant funded healthcare navigation services in partnership with physician's practices and certified home care agencies to assist older adults since May 2014, creating a replicable model of care that has improved health outcomes and decreased healthcare costs, proven through data analysis showing significant decreases in emergency room visits and hospitalizations after enrollment in the program. Additional measurable outcomes include an increase in the number of community-based service connections made, a decrease in caregiver stress and an increase in over-all quality of life post enrollment.

Lifespan uses a team approach that includes Social Work care navigators, LPN healthcare coordinators and community healthcare workers. A tiered service structure is utilized with LPN nurses supervised by an RN for a high need period, intervention with social work to address social needs and a pass-off to a community health care worker for a maintenance period. Participants are provided access to evidence based chronic disease and fall prevention classes. Participant progress is reviewed a minimum of every three months to update level of need and subsequent intervention. Please see the Appendix for the [3]Acuity Measures definitions. The navigation services provide bridge support until the patient has obtained access to preventive healthcare screens, achieved personal health and social goals and developed the confidence to manage his/her health.

Each person enrolled in Lifespan's Care Navigation Service is assessed via the Geriatric Wellness Screen (GWS), developed in partnership with the University of Rochester. The GWS is a tool for gathering information about the clients' health and needs in the area of the social determinants of health including social and community context, health and healthcare, neighborhood and environment, economic stability as well as education via health literacy training. Each domain results in an Older Adults Resource Services (OARS) score which informs the development of a personal care plan to address health and social needs.
In our New York State Department of Health funded project, Community Care Connections, we are currently partnered with 5 physician practices with embedded Social Work Care Navigators and have relationships with over 30 additional referring physician practices in the Finger Lakes area. Additionally, certified home care agencies make referrals to Lifespan Care Navigation when they must close service, but the older adult continues to need significant support to manage medical and social needs.
The patient population engaged is comprised of numerous groups including:

- Those with multiple chronic conditions
- Medicaid eligible, Medicare eligible, dually eligible
- Current Health Home members who need time-limited extra support and assistance.
- Individuals with low health literacy.
- Those from low-income, communities of color experiencing high health disparities.
- Individuals experiencing housing and financial instability.
- Individuals without family and/or caregiver support.
- Individuals with substance abuse and mental health issues.

Additional inclusion criteria are:

- A history of missed medical appointments.
- Aging or stressed caregivers/individuals without caregiver support/live alone.
- Two or more ED visits or hospitalizations in the previous year.
- History of non-adherence.
- Co-morbidities – especially those with limited Activity of Daily Living (ADL) capabilities.

Care Navigation Team Defined:
Social Work Care Navigators provide ongoing home visits, Geriatric Wellness Assessment, care plan development and connect patients to services such as:

- Housing
- Financial, Benefits and Entitlements, Nutrition
- Transportation
- Respite
- Socialization
- Mental health intervention
- Caregiver supports

- Home safety modification
- Chronic disease management workshops
- Geriatric addictions intervention
- Elder abuse intervention

The Healthcare Coordinator (HCC) role at Lifespan is staffed by LPNs and Community Health Workers who are supervised by an RN. Older adults are assisted in accessing preventive care and management including screening tests, counseling, immunizations or medications used to prevent disease, detect health problems early, and prevent disease progression and complications. Health literacy training is provided.

This service is unlike other efforts because our nurses and community health workers work across ALL health care settings as well as in patients' homes and provide the following services:

- Schedule primary care/specialist appointments and tests.
- Coordinate transportation for doctors' appointment and medical treatments.
- Accompany patients to medical appointments.
- Ensure the right questions are asked at appointments.
- Advocate for patients.
- Scribe at appointments.
- Communicate results of medical appointments with appropriate family members and other professional providers.
- Provide assistance with filling prescriptions.
- Complete prescription reconciliations in the home and at provider appointments.
- Ensure linkages are made with other supportive community-based services (home care, chore services, adult day care, minor home modifications to prevent falls, in-home financial management assistance for billing paying/budgeting, meals, durable medical equipment, chronic disease self-care management workshops, etc.).
- Employ health education/teach back methods that activate beneficiaries to take more active roles in their own health care.

Community Health Workers provide one-on-one support to adults age 60 and older residing within a community-based setting who have become stabilized and no longer need an intensive level of support from an LPN. Through health literacy training and telephonic support, the Community Healthcare Worker assist the client to increase the ability to self-manage health needs and become more independent. The Community Healthcare Worker is trained and supervised by the RN, Healthcare Coordination Project Leader.

Scalability, feasibility and speed to market:

Because the infrastructure, staffing, data collection system, policies and procedures are already in place and operational, Lifespan can immediately begin to increase the geographic reach and the number of clients served by the care navigation team as well as the necessary documentation upon obtaining new funding opportunities. The per person per month cost is $110.00, which is less than the lowest monthly Health Home Care Management rate ($200.00).

Evidence Based Support for Innovation:

Lifespan uses our existing data base, Peer Place to record all pertinent information including demographics, diagnoses, service connections, clinical outcomes, hospitalizations and emergency room visits. Lifespan utilizes the Rochester RHIO to receive real-time alerts, actual dates of ED visits and hospitalizations. An evidence-based tool (STAAR Initiative, Institute for Healthcare Improvement) is used to evaluate hospital readmissions for immediate process improvement. Lifespan utilizes New York Academy of Medicine to evaluate the project for effectiveness and return on investment.

5. RESULTS - Evidence Based Return on Investment Analysis:

May 2014 through March 2016:

In an initial one-hundred-person pilot for Medicaid beneficiaries funded by New York State DOH Balancing Incentive Program funds, Lifespan Healthcare Coordination was able to decrease hospitalizations 48% and emergency room visits 81% over the period of the project. Also of significance was the increase in medical appointment attendance to 89%. The total estimated cost savings of this project was 1.6 million dollars.

August 2015 to the Present:

Community Care Connections, funded by New York State DOH and New England Independent Review Board approved study; 1,596 clients have been served to date.

With support from the Rochester Regional Health Information Organization and New York Academy of Medicine, data evaluation to date shows a 59% decrease in hospitalizations and a 42 % decrease in emergency room visits. New York Academy of Medicine, project evaluator has determined an estimated return on investment of $4.02 for every dollar spent on delivering the intervention resulting from reduced hospitalizations and emergency department visits.

Appendix

[1] Regional Chart Book, 2014, Common Ground Health

[2] Regional Chart Book, 2014, Common Ground Health

[3]Lifespan Care Navigation Acuity Measures

HIGH NEED

(Lifespan LPN Care Coordination)

Anticipated surgery for acute illness.

Acute fall risk; injury from fall within < 3 months.

Number PCP visits REQUIRED is greater than once per quarter

Nutrition instability

One or more Emergency Room visits within the past 3 months for acute illness

Hospitalization within the past 3 months.

4 or more specialist visits within the past 6 months.

3 or more specialist visits scheduled in one month.

Has history of missed medical appointments over past 3 months.

Lacks understanding of diagnoses and treatment goals; not following treatment Plan

One or more of the following:

- Cancer (in treatment
- Dementia
- Uncontrolled diabetes
- End Stage Kidney Disease and on dialysis less than 6 months
- COPD diagnosis less than 6 months
- On oxygen less than 3 months
- Active substance abuse but accepts treatment

Does not recognize “red flags” or warning signs indicating call to doctor in advanced of a health crisis.

Lacking one or more up-to-date preventive health screens

Mental Health diagnosis or dementia with behaviors which significantly interfere with meeting goals, understanding directions, or adherence to medical treatment plan .

MODERATE NEED

(Transition to Community Health Worker)

Elective surgery anticipated.

Fall history but > 3 months ago; attending Matter of Balance class or PT.

Number PCP visits REQUIRED is no more than once per quarter

Nutritional needs are being addressed.

1- 3 emergency room visits for acute illness within the past 3-6 months.

>1 hospitalization for acute illness over the past 6 months.

< 4 specialist visits within the past 6 months.

1-2 specialist visits in one month.

Needs reminders to attend appointments but goes when they are scheduled.

Is aware of diagnoses; willing to participate with treatment plan/goal development; needs reminders to follow treatment plan.

- Cancer treatment complete

- Diabetes protocol being followed
- On dialysis more than 6 months and stable
- COPD diagnosis >19 than 6 months and following treatment plan.
- Oxygen use greater than 3 months and able to manage or has family member able to help manage.

Able to verbalize “red flags” or warning signs of SOME diagnoses, and when to call doctor in advance of a health crisis.
Preventive health screens scheduled.
Mental Health diagnosis or dementia, but only mildly interferes with meeting goals, understanding directions, or adherence to medical treatment plan.
ABLE TO SELF-MANAGE
Discharge
No surgery anticipated.
No current fall risk identified.
Number PCP visits REQUIRED is no more than once per quarter
Verbalizes or demonstrates nutritional knowledge.
No emergency room visits for acute illness in past 3-6 months.
0-1 hospitalizations over the past 12 months for acute illness.
Routine or annual specialist visits only.
Routine visits to specialists 1-2 times per quarter.
Needs no reminders to attend medical appointments.
Understands diagnoses and follows treatment plan.

Can identify “red flags” to prevent ED use and hospital admission. Knows when to take action and call doctor in advance of a health crisis.
Up-to-date with routine health screens
Either no mental health or dementia diagnosis, or present but strong family support and/or does not interfere with meeting goals, understanding directions, or adherence to medical treatment plan.

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):

May 2014 through March 2016: 100 Medicaid Beneficiaries - see #4 for results. August 2015 to the Present: Community Care Connections - 1596 particicapnts served to date. See #4 for results.

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)

Education,

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**