Q1 Please provide your contact information below.

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

Visiting Nurse Service of New York (VNSNY) is the largest not-for-profit home- and community-based healthcare organization in the country, with over 48,500 patients and members under our care on any given day (30,750 patients receiving clinical care, and 35,000 members under coordinated care services through VNSNY CHOICE health plans, some of whom receive both). VNSNY serves the five boroughs of NYC as well as Westchester, Nassau, and Suffolk counties, allowing the organization to keep its finger on the pulse of changing community needs and provide the flexibility to shape service offerings.

Founded in 1893 by Lillian Wald, VNSNY's mission is to serve vulnerable, at-risk, and chronically-ill populations of all ages, social and economic means and promote the health and well-being of New Yorkers through high-quality, cost-effective healthcare in the home and community. As a pioneer of public health in America, VNSNY is a trusted leader in the development of innovative services and healthcare transformation, helping to shape healthcare policies that support beneficial home and community-based services and continue its tradition of charitable and compassionate care services critical to enabling people to function independently in their community.
Care is provided through a full continuum of high-quality, cost effective home and community-based services spanning the fields of skilled nursing, paraprofessional services, chronic and acute care management, rehabilitation therapies, behavioral healthcare, and hospice and palliative care.
In 2018, VNSNY went through a strategic planning process to guide the company to remain successful and flourish through the changing health care environment. The company's goal is to bring together the considerable expertise and capabilities from our payer and provider services in a paired, integrated platform, establishing the company as the leading payor and provider of integrated, cost-effective home and community-based healthcare in the region.

VNSNY's greatest strength is in its workforce. VNSNY manages over 13,00 employees across several affiliate corporations, each with providing innovative models of care, including bundled payment initiative, and community-based mental health services that target high-risk populations. These affiliates include:

- VNSNY Home Care II (VNSNY's Certified Home Health Agency, or CHHA).
- VNSNY CHOICE (managed care plans),
- VNSNY Hospice and Palliative Care, and
- Partners in Care, a Licensed Home Care Services Agency (LHCSA).

In addition to its direct services, VNSNY invests in technology, human resources and quality assurance at the management and frontline levels, providing a vital backbone for all programs and services. As an umbrella organization, VNSNY provides corporate administrative support services to its affiliate corporations that include legal, financial, facilities management, procurement, development and marketing, internal audit, performance improvement and research.

Q3 Please indicate which category your organization falls under.

Health Care Provider

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).

Summary:
Visiting Nurse Service of New York (VNSNY) proposes implementing a care management program to assist individuals who are in the process of transitioning from male to female or female to male. This population faces unique social, economic, medical and psychological challenges, social isolation, and difficulty finding providers sensitive to their specific concerns. By guiding them through the process, our goal is to enable these individuals to complete their transition healthfully in terms of mind and body and experience a better quality of life. The length of the intervention(s) will be driven by individual needs.

Describe the innovation and how it addresses social determinants of health:

Transitioning from female to male or male to female is a long and complicated process that is tremendously personal and involves a

great deal of time and touches many aspects of a person's life—gender identity, body image, personality, finances, and frequently the attitudes of others. Individuals in the process of transitioning face social and psychological, legal and medical and clinical challenges. It can be a long and emotionally charged journey with many moments of hope and times of despair. Transpeople face many of the challenges in their effort to create an identity that better reflects who they are as a person, including:

- Harassment and stigma
- Violence
- Poverty
- Discrimination –employment, housing
- Social isolation
- Lack of legal protection
- Housing discrimination
- Inadequate access to supportive health care—In a 2012 needs assessment by the Washington D.C. Trans Coalition, 44% of those who identified health as one of their top priorities said that access to transgender-sensitive healthcare was their most significant need.
- Need for identity documents—The widespread lack of accurate identity documents among transgender people can have an impact on every area of their lives, including access to emergency housing or other public services.

As a result, and not surprisingly, 36% of the transgender population reported attempting suicide at some point in their life, 22 times the rate of the general population of 1.6%.

The innovation we propose addresses the social determinants of Social, Family and Community context—isolation and lack of community support—and Health and Healthcare—Lack of access and/or engagement in community health and wellness programs among individuals in the process of gender transition as well as lack of health literacy including social context for providers and for patients.

Transition takes on many forms and includes the need for medical, legal, social, and other supports. Transition is a process during which there are three major touch points—pre-surgical, post-surgical, and transition to daily life. Each phase brings a unique set of social, medical, advocacy and other needs and requires assistance from various organizations to address those needs. Without proper and vital support during each transitional phase, clients can experience poor outcomes or even death.

A strong care management model that considers the distinct needs of this population can assist clients by providing the support, guidance and preparation for the future. Care managers can assess the client's needs, identify goals, develop a care plan and help bring together the providers and services needed to achieve the goals of care and increased quality of life.

Visiting Nurse Service of New York (VNSNY) has extensive experience providing both nurse-led and social work-led care management with support from an interdisciplinary team that includes professionals with expertise in nutrition, rehabilitation, pharmacy, along with health and wellness coaches. Services are grounded in a strengths-based and person-centered framework, utilizing skilled interdisciplinary engagement, patient advocacy, ongoing assessment and clinical understanding of the whole person to enable our patients to receive the best possible care and the highest quality of life. Our unique perspective and wide variety of services allows us to be sensitive to the multi-system needs of our patients. As with all other VNSNY services, these services are culturally competent and tailored to meet the individual's complex needs.

VNSNY Home Care proposes offering care management services for this population directly and through partnerships with organizations that currently serve this community and share our philosophy and approach.

- For those who are considering a transition: Often individuals considering a transition seek initial advice from peers and social circles rather than obtaining advice from medical professionals. They may use hormones and other treatments in a non-conforming method, which can lead to serious health problems. To ensure that those considering a transition access quality care and appropriate advice, VNSNY Home Care and its partners will promote their unique set of care management services to a broad array of providers— physicians, clinics, hospitals and community-based organizations (CBOs)—so that they can refer transitioning individuals to the support they need. The process should begin with a "…perioperative assessment that includes an overall assessment of psychosocial functioning and support, health literacy, capacity for self-care, and social support structure in place." The University of California at San Francisco Center of Excellence for Transgender Health has identified and/or established evidence-based guidelines for providers in various settings to direct these patients to a safe transition. Part of the VNSNY assessment process includes the use of depression and anxiety screens to identify individuals at risk and in need of support.

- The goal of care will be to assess individuals in the transition process to identify their social service and other needs and link them to appropriate care to ensure a safe and productive transition.

- For those who have opted for surgery and are post-operative patients: VNSNY Home Care is experienced in providing post-acute home services to this population and with funding, can add a care management component to extend its patient involvement for a period of time post-discharge from home care. To do this, VNSNY Home Care will utilize care managers to make in-person and remote visits with the patient based on need and risk. This model is identical to those VNSNY currently provides in bundled payment and risk sharing arrangements with Medicaid Managed Care, Medicare Advantage and commercial health plans.
- The focus of this intervention will be to provide clinical follow-up care and community linkages to supportive services to ensure they recover fully and safely.

- For those who have transitioned: This process entails providing legal and social adjustment interventions to ensure that clients can adjust to and thrive in everyday life. VNSNY and its partners can work with patients to address mental health issues that may arise due to post-operative complications or hormonal therapy or simply adjusting to a "new" self. The care management interventions will be both remote and in-person.
- The goal of this intervention is to ensure that the client is fully integrated, supported, engaged and independent in achieving identified next step activities and connections.

Objectives in the short term are that clients will:

- Be linked with community-based organizations that meet holistic and identified client needs;
- Follow-up on referrals in a timely fashion;
- Learn to access services on their own through coaching by the care managers; and
- Demonstrate quality of life improvement as measured by the Essen Transgender Quality of Life Inventory survey or similar tool. (This will be administered at the outset, midpoint and end of engagement.)

Objectives in the longer term are that clients will:

- Complete their transition healthfully in terms of mind and body; and
- Experience an improved quality of life as measured by the Essen Transgender Quality of Life Inventory survey or similar tool.

Scalability, Feasibility and Speed to Market:

VNSNY has a long history of providing community-based care coordination and care management services for patients at need as well as experience serving the LBGTQ+ population. It is our hope to work with Medicaid managed care payors to create and test the viability of risk sharing arrangements that will cover these services across the transitioning continuum. With financial support, scaling up to meet demand could be achieved within a reasonable period of time.

- This program model will fit smoothly into existing workflows within VNSNY: VNSNY operates nurse-led and social work-led interdisciplinary care management for its patients and clients—both those receiving traditional home care services and those served through its Community Mental Health Services programs and already uses a care management platform for these programs. VNSNY also has care liaisons who can assist with the transition from inpatient setting to the community.
- VNSNY's workforce is culturally sensitive, resourceful and already committed to serving this community. In 2016, VNSNY made the commitment to work with SAGE (Advocacy and Services to LGBTQ+ Elders) to assure that all staff are culturally competent as they work with LGBTQ+ patients. That training is held annually. That same year, VNSNY began providing post-acute care for patients who have received gender affirmation surgery and is now the leading provider of these services in New York City. VNSNY has developed a training specific to the needs of those patients who have undergone gender affirmation surgery and, to date, has trained over 150 clinicians (nurses, physical therapists and social workers) throughout the VNSNY Home Care service area.
- VNSNY has strong contacts within the social service community to help meet the social, psychological, medical, entitlement benefits and other needs of individuals in the transition process.
- This program model is sufficiently flexible to enable CBOs that already serve the LGBTQ+ population to implement a program such as this.

Evidence-based Support for Innovation and Return on Investment:

Calculating return on investment requires "…the existence of various economic-based (i.e., monetized) social program studies and evaluations as part of the templates for generating cost-benefit calculations." It is difficult to put a price tag on most of the outcomes we are expecting this program to deliver. However, VNSNY can state that post-operative gender affirmation patients receiving home care have lower rehospitalization rates (estimated 4.9%) than the CMS benchmark (15.6%) .

What we can say with confidence is individuals who transitioned have demonstrated improvements in quality of life. Scientists in Essen, Germany "…have developed (and validated) a transgender-specific questionnaire, which confirms for the first time that gender surgery significantly improves quality of life for the majority of patients. It is called the Essen Transgender Quality of Life Essen Inventory which is administered at two different points in the transition. A survey of 156 people who transitioned from male to female showed about 75% of patients showed a better quality of life after surgery. We expect the combination of gender affirmation surgery along with support accessing services in the community will lead to a better quality of life and overall well-being.

Relevance to the Medicaid population
According to the National Transgender Discrimination Survey (2010), the LGBTQ+ population in New York State has experienced poverty and unemployment at higher rates than the general population:

- 19% of respondents had a household income of $10,000 or less, compared to 4% of the general population, which is almost 5 times the rate of poverty.
- 12% were unemployed compared to 7% in the nation at the time of the survey.

In 2015, New York became the ninth state to allow its Medicaid program to cover gender affirmation surgery. This move vastly expanded access to this life-affirming and altering procedure, including to patients who are disproportionately low-income. In 2015 alone, Medicaid paid for 115 procedures in New York. In 2016, the number more than doubled to 257. A support system equipped to address the complex needs of these patients has failed to keep pace with provision of this service or is fragmented and difficult for an individual to navigate. This services provided through this innovation will help bring together the existing services and fill a void in the coordination of care to best support individuals in transition.
The relevance and importance of this initiative to the transgender Medicaid population is very high.

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): In part--VNSNY Home Care has provided in-home services to approximately 170 post-operative transgender patients since March 2016. We have not implemented the full care management program.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Social and Community Context** , **Health and Health Care**
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**