Evaluations

Nursing Contact Hours, CME and CHES credits are available.

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Thank You to Our Sponsors:

- University at Albany School of Public Health
- New York State Department of Health
The Changing Face of Long Term Care In New York State

July 16, 2015

Speakers

- Rebecca Corso, Deputy Director, Division of Long Term Care, Office of Health Insurance Programs, New York State Department of Health
- Lynda Hohmann, Medical Director, DSRIP, Office of Health Insurance Programs, New York State Department of Health
- Debora LeBarron, RN, BS, Senior Director, Continuing Care, Healthcare Association of New York State
Training Objectives

By the end of the program, viewers will be able to:

- Recognize at least two of New York State’s reform efforts supporting individuals in the community
- Identify the DSRIP goal that pertains to hospitals
- Describe two benefits of collaborating with New York Connects to improve hospital discharge planning processes

Health Care Reform

Why Should Discharge Planners Care?

- Gatekeepers of community resource information
- Key to meeting reform goals for providing community and home-based services when possible
Medicaid Redesign Team

Lower Costs

Better Health

Better Care

Care Management & Person Centered Planning
Delivery System Reform Incentive Payment (DSRIP) Program

Program Principles

- Patient Centered
- Collaborative
- Value Driven
- Transparent
- Accountable

Olmstead in New York State

- Community Transition
- Common Assessment & Outcome Measures
- Community Integration Reforms
- Accountability
Balancing Incentive Program

- **Federal Fiscal Year 2009**
  - NYS eligible for BIP: 46.7%
  - NYS Rebalancing Percentage: 53.3%

- **BIP Goal**
  - Rebalancing must be 50%
  - 50%

- **As of April 1, 2015**
  - NYS surpassed goal
  - 58.8%
  - NYS Rebalancing Percentage: 41.2%

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NY Connects & No Wrong Door

- Statewide system of partners & state & local agency collaboration
- Information, assistance & referrals to local social service systems
- Linkage to community resources, regardless of payment source, disability or diagnosis
- Assistance & coordination of application for public benefits, and/or linkage to the comprehensive assessment process for all populations as appropriate
NY Connects & Discharge Planning

www.nyconnects.ny.gov

NY Connects hotline: 1-800-342-9871

In-person - NY Connects in each county

Program Coordination

MRT  BIP  Olmstead  DSRIP
Changing how health care is delivered to Medicaid recipients in New York State

Medicaid Redesign Team (MRT)

Discharge planning is one key component

Action Plan implemented by MRT in January 2011
Over $17 billion in federal $ saved w/Medicaid match
MRT waiver allows reinvestment of $8 billion into further Medicaid reform
$6.42 billion for DSRIP
Alignment with the Triple Aim: better care, better health, reduced cost
NYS Total Medicaid Spending

Projected Spending Absent MRT Initiatives *

System & State DSRIP Goals

- Transforming health care safety net
- Reducing avoidable hospital use (inpatient & ED) by 25%
- Improving other health and public health measures
- Continuing delivery system transformation beyond waiver period through leveraging managed care payment reform
- Providing near-term financial support for vital safety net providers at immediate risk of closure
Key Themes of DSRIP

- Collaboration through Performing Provider Systems
- Project-value drives dollars & performance-based payments via process & outcome measures
- Overall poor state performance will reduce funding
- Regulatory relief and capital funding available
- Lasting change: 90% of Medicaid payments will be performance-based in 5 years

Performing Provider Systems

Steps:
1. Community Needs Assessment (CAN) focused on system change principles
2. Development of a project plan of up to 11 projects that address the findings of the CAN
3. Planning and implementing these projects
Role of Discharge Planning

- Reducing avoidable hospital & ED use by 25%
- Reducing avoidable readmissions to hospitals and emergency departments

Types of DSRIP Projects

- An integrated delivery system
- Care transitions intervention model
- Care transitions intervention model for Skilled Nursing Facility (SNF) residents
- Transitional supportive housing services
- Integration of palliative care into Patient Centered Medical Homes (PCMH) and SNF
Decreasing Readmissions

- **State**
  - DSRIP
  - State Medicaid Transition to Managed Care and Managed Long Term Care (MLTC)
- **Federal**
  - Improving Medicare Post Acute Care Transformation (IMPACT) Act
  - Medicare Quality Reporting Programs (QRPs)
  - Value-based Purchasing Programs (VBPs)

Challenges

- Complexity of chronic illness population management
- Breadth of LTC Services needed in the community
- Defining shared accountability/shared savings
- New payment paradigms:
  - “Episode of Care"
  - Per member/per month
- Lack of post-acute care readmissions metrics
Reevaluate Regulations

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Assessment/prevention/intervention in place?
- Enhanced staff skills/advanced practitioners
- Physician leadership

Effective communication
New collaborators in Plans of Care
End of Life Goals of Care
Information Gathering

- Comprehensive Care at Home histories
- Risk assessments (i.e., patient readmission risk, caregiver risk)
- Community-based service resources
- Professional-experiential directory/networks

Resources

- NY Connects
- Centers for Independent Living
- Government resources/programs-State Agencies’ sites
  - State Department of Health
  - State Office for the Aging
  - Office for People with Developmental Disabilities
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