Evaluations

Nursing Contact Hours, CME and CHES credits are available.

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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%
- BIP Goal: 53.3%

BIP Goal
- Rebalancing must be 50%
- NYS surpassed goal: 58.8%

As of April 1, 2015
- NYS Rebalancing Percentage: 41.2%

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

- Medicaid Redesign Team (MRT)
- Discharge planning is one key component

DSRIP & Hospitals

- Changing how health care is delivered to Medicaid recipients in New York State
- Medicaid Redesign Team (MRT)
- Discharge planning is one key component

MRT Waiver Amendment

- Action Plan implemented by MRT in January 2011
- Over $17 billion in federal $ saved with 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

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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<th>New Model</th>
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Workforce Considerations

- 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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