



July 2015 Public Health Live Transcript *The Changing Face of Long Term Care in New York State*

Moderator: Hello. Welcome to Public Health Live! - the Third Thursday Breakfast Broadcast. I'm Rachel Breidster and I will be your moderator today. Before we get started, I would like to ask that you please fill out your online evaluation at the end of the webcast. Continuing education credits are available after you take our short post-test and fill out the feedback about planning for future programs. We will take your questions throughout the hour via phone at 1-518 -880-3516 or e-mail at phlive.ny@gmail.com. The planners and presenters do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity and no commercial funding has been accepted for this activity.

Today's program is *The Changing Face of Long-Term Care in New York State* and our guests are Ms. Rebecca Corso, Deputy Director of Long-Term Care at the New York State Department of Health, Dr. Lyn Hohmann, the DSRIP Medical Director in the Office of Health Insurance Programs at the New York State Department of Health; Director of Insurance Programs, and Ms. Debbie LeBarron, Director of Continuing Care at Healthcare Association of New York State (HANYS). Thank you all very much for joining us. We're excited to have this conversation. Becky, I'm hoping you can set the stage for us about why healthcare reform was necessary in new York State to begin with?

Becky Corso: Great. Sure. First, thank you very much for having me today, Rachel. So when Governor Cuomo took office in 2011, he looked at what was happening with healthcare in New York State and what he saw was concerning to him. He saw that costs were ballooning to unsustainable levels. We were spending \$46 billion in 2007 and that grew to \$53 billion in 2011 – a level that's just unsustainable. And he saw some other issues: there were quality concerns and disproportionate hospitalizations and other issues related to health debt related to socioeconomic disparities among the state, and he took a look at all those issues and implemented reforms as a result.

Moderator: It sounds like there was cause for concern and before we go into the details of what Medicare reform entails, can you tell us why this information is beneficial or necessary for discharge planners?

Becky: Absolutely. I really hope that discharge planners will get a lot out of this presentation because they are the gatekeepers for people receiving services in the community as they're planning to discharge someone from a hospital. Any time, you know, there's pressure to release someone to a nursing home and there may be viable community-based options available to them. But discharge planners are busy and they have a lot going on. So hopefully that they can learn some information from this presentation about what is available to them.

Moderator: Great. Now, let's talk a little bit about who exactly was involved in implementing reform and how they went about doing it?

Becky: Sure. Governor Cuomo created the Medicaid Redesign Team in 2011 and he invited people to be a part of that team from virtually every part of the healthcare sector. And what they did was – they were charged with recommending reforms to the system, and they took what's called the Triple Aim approach, which is to improve the quality of care by focusing on safety, effectiveness, patient-centeredness, timeliness, equity. And they were in charge of improving health by addressing root causes like physical activity, poor nutrition, those types of things and to reduce per capita costs in this system. So there are many recommendations that have been implemented and that're currently being implemented and will be implemented in the future as a result of this team and their efforts.

Moderator: Now of all of these different efforts and changes that are going to be taking place, what would you say are the most essential or most critical for discharge planners to know about?

Becky: Well, I think there are a lot of really good initiatives happening with MRT right now. But I think the most notable one that we want to talk about today is this concept of care management for all. So New York State is working toward bringing all Medicaid enrollees to have them served through a care management model by 2018 and essentially the goal is that care management will improve their quality of care, benefit coordination, their overall health and outcomes across the full range of healthcare, which includes behavioral health, developmental disabilities, as well as physical health. So there are a number of initiatives that are happening right now with care management and I'll just go through a few of those models.

The first one is managed long-term care. Essentially managed long-term care is available to anyone who needs long-term care services for more than 120 days and what they do is enroll with the healthcare plan that provides them with care management that helps them to obtain the services that they need, and we just went statewide with mandatory managed long-term care, so we're very excited about that.

Another program is the fully integrated advantage program (FIDA). I apologize to everyone because we have a lot of acronyms in New York State, and I will say a lot of acronyms but I will try to say what they are. The FIDA program is a demonstration program that's a partnership between New York State Department of Health and the Centers for Medicare and Medicaid Services, and it is a fully integrated model where somebody who is eligible for Medicaid *and* Medicare will get all of those benefits through one health plan. And what's unique about FIDA is they have a care management model through each disciplinary team and the interdisciplinary team brings together their physicians, their long-term care workers such as their home care provider, could be family members, the individual as well as their care manager, who all work together to create a care plan that meets the needs of that individual. So that is an interesting program that we have going on right now. OPWD, the Offices for Persons With Development Disabilities, is also going to be implementing their own FIDA for people with intellectual and developmental disabilities in 2016, and

that's something to look forward to.

Another initiative that people should be aware of is the health home. The health home is a plan or it's a service, not a plan, sorry. It's a service for people to be able to get health home care management and this is typically for people who have multiple dual diagnoses to help them to gain access to community services.

Another program is HARP, the Health and Recovery Plan - an integrated model for people with serious mental illness or substance use disorders. It is a care management model where people can get their Medicaid and behavior health services through one plan. And finally, there is the DISCOs, and that's a great acronym - Development Disability, Individual Support Care and Coordination Organizations, and this project is being implemented later in 2015 as well as the HARP, which is not implemented yet. That will be in later 2015 as well, but the DISCO is a model for individuals with intellectual and long-term care needs.

So all of these models are really focused on providing individualized coordinated care so that people can have better outcomes. It is really important for discharge planners to know about all these models because as they're working with someone, someone might be in one of these care management plans and they should really be working with those care managers to make sure that they're getting the services that they need after they leave the hospital.

Moderator: You weren't kidding about those acronyms! I'm going to introduce another one, and say many of us have heard of Delivery System Reform Incentive Payment (DSRIP) programs. Can you tell us about that, and how it's driving healthcare reform and how it interacts with these different models?

Becky: Absolutely. So the intent behind DSRIP is to change the healthcare, the state's healthcare delivery system and the goal of the program essentially is to take the savings earned and take some of those savings and reinvest them into back into the Medicaid program with the goal of reducing avoidable hospitalizations by 25%. It's an opportunity to create a system that's patient-centered, that's collaborative, that's transparent, that's value-based and then, of course, that's accountable. Dr. Hohmann will speak more about DSRIP. She will get into that soon.

Moderator: Sure. I understand that there's a Supreme Court decision known as the Olmsted Act and that pertains to service delivery systems. Can you talk to us about the key elements of the Olmstead ruling and how that fits in with the concept of care management for everyone?

Becky: Sure. Like you said, the Olmstead ruling came from a Supreme Court decision and essentially what the Supreme Court said was that people with disabilities have to get services and activities in the most integrated setting that's appropriate to their needs so what Governor Cuomo did is created the Olmstead Cabinet in New York State and charged them with coming up with recommendations to meet requirements for the Olmstead decision. They are helping to assist transitioning people from segregated settings back into the community-based settings to change the way we look at how we assess and evaluate

whether or not someone is, in fact, in an integrated setting and we're doing our job by getting them into integrated settings, and providing support for those integrated settings. And again, there's always the fact that you have to ensure accountability to make sure that we're actually achieving that goal to people and that we're allowing them to be more integrated settings if they need that.

So one of the goals set by the Olmstead plan was to reduce the number of people in long-stay nursing homes by 10% over 5 years. So we're working toward that goal and so these several initiatives at the New York Department Of Health will help us get there. The first one is the Money Follows the Person Program and through that program, we're helping to transition people who want to leave a nursing home and go back to the community. We have a transition team that helps them get back into the community. The second one is the Balancing Incentive Program, BIP, another acronym, and through the Balancing Incentive Program innovation fund, we're creating more community-based opportunities for people. And the third is the MRT, a really great initiative, MRT housing program where we're building infrastructure and supportive housing opportunities for people in the communities so that they can prevent going into a nursing home or they can leave.

Moderator: Now the second one you mentioned, the BIP or Balancing Incentive Program, can you tell us more about that?

Becky: Absolutely. So BIP, the Balancing Incentive Program, came out of the Affordable Care Act. It's a financial incentive for states to invest more on community-based services and get people into the community. So in New York State, we received nearly \$600 million in 2013 to do this but there are contingencies that go along with that funding. First, we have to tip the scales essentially so that we're spending at least 50% or more on community-based services as compared to institutional-based services. In addition to that, we have to have three structural changes on our system. The first structural change is a *No Wrong Door*, single-entry port system so people can access long term or get information about access to long-term care services through "one door." The second is an assessment, a CORE assessment, which is essentially allowing for a determination of what the level of care or uniform way of determining level of care for an individual. And the third is conflict-free case management. So when you have the evaluation determining whether someone's eligible for a program and then the actual service delivery has to be separated from that.

Moderator: I think many people involved in this work have heard of that *No Wrong Door* or *New York Connects*. Can you tell us how these relate to the reform efforts?

Becky: Sure. So, *No Wrong Door – New York Connects* is the *No Wrong Door* system for New York State. And *New York Connects* already exists. So essentially what we're doing through the Balancing Incentive Program is expanding *New York Connects* and we're making it and expanding what it can do for people. *New York Connects* is available to people in almost every county right now. By October 1, 2015, it will be available to everybody statewide so we're very excited about that.

Also, what we're doing is we're making it better coordinated so that it's going to have both

state agency level services as well as local services. People will be able to find information about all those. So, offices for persons with developmental disabilities services, offices of mental health, department of health and local agencies on aging, as well as local departments of social services. There's going to be a coordinated effort around people getting access to those services. There's going to be a screen that will allow people to screen for different types of services to see if it makes sense for them. It's going to provide coordination for applying for applications for public benefits and there will also be an updated resource directory which will list the different services that are available for people in the community.

I really see this as a great tool for discharge planners. They should be aware that this is available to them so that they can access this tool when they are getting ready to discharge someone into the community. They can go to *New York Connects* and find out what's available to them.

Moderator: Well, certainly, it sounds like having this resource would be beneficial to discharge planners and the folks they serve. Can you tell us how people can access *New York Connects*?

Becky: Sure. On the screen, you see how you can access *New York Connects*. Like I said, it will be statewide in October, but it's available in most counties now. It can be accessed through the website. It can be accessed through the 1-800 hotline as well as in person. So people can go to the website or call the hotline to find out the address of where they need to go if they want to visit in person.

Moderator: So we've talked so far about a number of different policies and initiatives and acts. We got the BIP and Olmstead and MRT, so can you help us put all of those pieces together and understand the big picture?

Becky: Sure. It is kind of a puzzle and it's trying to figure out how do these all work together. Essentially they work together because they're going to help the state to provide a system that's coordinated, that provides higher quality, person-centered and improved overall care, of course, with the goal of reducing costs for taxpayers.

Moderator: Thank you so much for that overview. I think you set a great foundation for the rest of the show. Lyn, I'd love to welcome you to the show, first of all.

Lyn Hohmann: Thank you for inviting us here today.

Moderator: Sure, and Becky mentioned earlier that you're the one to talk to about DSRIP. Can you provide more details about it and how it relates to hospitals?

Lyn: Absolutely. DSRIP came out of the Medicaid Redesign Team and resulted in the implementation of the aspects of the MRT that were not yet implemented. It's focused on the Triple Aim, and I can't emphasize it enough - it's not just about saving money. It's about improving quality of care for Medicaid recipients. What's going to happen - well, what's actually happened already, is in communities across New York State, public hospitals and the safety net providers, are coming together as Performing Provider Systems and they will

be responsible for this fundamental change in our healthcare delivery system. We talked about the 25% reduction in hospital utilization - that's ER and outpatient. Discharge planners have a great role because it's not just the new inpatient admissions, but the readmissions where they can have a really significant impact on that reduction.

The other piece is this is an incentive program. We're not paying for widgets. We're paying for outcomes, both process measures and quality outcomes at the end of the project. But I want to say this is complicated. DSRIP is a complicated program and no one is going to understand it completely in the 20 minutes we'll be talking about it today, so I recommend people go to the Department of Health website under MRT and look at the DSRIP link and you'll find many articles about the program. Much like MRT, DSRIP was transparent process. We brought in a lot of input from the communities of providers throughout the state and citizens throughout the state to build this project. So, complicated but transparent. We've had a lot of input from the community on what they need.

Moderator: It does sound complicated and great that it has been so transparent, to at least make the details evident to the community. Now can you talk to us about how the Medicaid Reform Team waiver amendment will help?

Lyn: Yeah. We talked a little bit earlier about the MRT initiative starting in 2011. And those first initiatives that impacted our healthcare delivery system actually saved the federal government over \$17 billion in shared savings. That's a lot—a considerable amount of money. We asked them, could we have \$8 billion back to really finish what MRT had initiated and that's what DSRIP is about. It's \$6.42 billion of this amendment for implementing the DSRIP program. Again, it's aligned with the Triple Aim. We're looking at quality, not just cost savings.

Let me show you on the next slide what I think is that picture that you were talking about earlier about the cost savings. You see up on the screen here, the cross-rise of Medicaid over the last seven years until 2011 and you will see as we talked, those would could not be maintained in the state of New York. With the initiatives, you can see the change in the curve that's where those cost savings came. That's that \$17 billion that caught the attention of the federal government. We did save that money. But also part of the savings which is not shown on this graph is that the cost of the Medicaid recipients also decreased. From 2003 up till now, we had almost two million more Medicaid recipients join as a result of the ACA, and even though initially up until 2011, their costs per Medicaid recipient also increased, when MRT went into effect, their costs also decreased. So we did the right thing. Quality was not impacted and in fact, improved. So the cost per recipient even with two million extra folks coming into the system, actually went down to 2003 levels. That's a pretty significant impact.

Moderator: That's very impressive. Now that we have that background information, give me more details about the goals of the DSRIP program?

Lyn: We said we're trying to transform the healthcare safety net in New York State, and we're doing it by reducing – this is our elevator speech - we're reducing avoidable and it's not all emergency room and inpatient, it's the avoidable ones, by 25%. How we're doing that is really by focusing on the community. We're trying to increase the number of

primary preventative care services and community-based services that are available to the Medicaid recipients so they're not going to need to go to a hospital for things that could have been treated in the community-based setting.

So it's focused on the many Medicaid safety net providers and public hospitals out in the community that are already serving these Medicaid recipients. And, it's helping to bring this balance into the system so that the services are where they need to be for those folks. It's also going to be improving access to services not only just the preventative and primary care services, but really also looking at those other pieces that really affect people's healthcare and those are the community and social determinants of health, so housing, like you said earlier, you know, and assistance with language. Many of our New York State Medicaid recipients and New Yorkers do not have English as their primary language and they're going to need that assistance. If we can get that package together, we're going to change healthcare in New York State.

Again, another piece of this is we're obviously changing. We're changing service distribution. There's going to be a need to keep our safety net providers stable during this period of time so there's funding to support that stability and then as always, this is an incentive program and it's not just a five-year program. Five years is the beginning ... we're paying for outcomes now, but we have committed to the federal government that 90% of Medicaid payments at the end of DSRIP are going to be value-based. So we're not just changing the face of healthcare. We're changing how we pay for healthcare in New York State.

Moderator: Certainly very comprehensive. Can you talk about the key themes of the reform incentive program?

Lyn: Collaboration, collaboration, collaboration. This is really bringing folks together who have never worked in the same way together. These performing provider systems, public hospitals, safety net hospitals, safety net clinics, all those components – discharge planning is clearly in it – health homes as you mentioned earlier, home services, skilled nursing facilities, all those people who are providing services to our Medicaid recipients, those are in the DSRIP program and will have to take down silos. They're going to have to work in a different way. They can't be in their silos doing what they do. They have to work collaboratively across the system.

There's going to be a need for integration not just face-to-face but also electronically. Really significant use of electronic health records, uses of things like the RHIO-Regional Health Information Organization, SHIN-NY-Statewide Health Information Network for New York and MOA- Memoranda of Agreements, to really share information so wherever that patient goes in this integrated system, his or her medical records are going to be available for their care, and that's going to make a big difference.

The other piece of this is payment. The projects— the value of the projects to the system really drive the dollars. So outcomes - you got to do what you said you're going to do. You've got to pick projects that are significant for your community; you want to take high-value projects for your community. You want to integrate your providers and as many providers as possible into those programs and impact as many Medicaid recipients as

possible. That's going to drive the value of the projects as well as meeting your goals. You got to meet the goals. It's an incentive program and talking about collaboration, we're all in this together.

The state has also committed to goals to CMS. If we don't make our goals and our goals are based upon Performing Provider System goals, we're going to lose money. So the value of DSRIP is going to go down. What happens in Buffalo affects Brooklyn, so we're all in this together truly.

We understand, and it became obvious as we were developing the projects for DSRIP, that there was going to need to be a look at so regulations in the state that impacted the types of projects we wanted to do. So we did put in place regulatory releases to address those integration projects, particularly around primary care and behavioral health care as well as providing some state funding for capital improvements and that's the bricks and mortars and HIT systems. DSRIP did not allow coverage for those types of services. Again, I'm going back to that lasting change, 90% of payments from Medicaid services will be value-based at the end of this program, and we're going to be working with our managed care plans so that that doesn't end at five years and continues on into the future.

Moderator: One of the things you mentioned was Performing Provider Systems as the structures for the action on DSRIP. Can you quickly talk more about the systems that are being developed what is it that they're charged with doing?

Lyn: Absolutely. These systems are really formal systems. These are-- have brought together folks who never probably never worked together in the same way before. So it's really hospitals. As I said, primary care physicians, specialists, nursing homes. It's all that would compose healthcare delivery programs throughout the community. In addition, it's bringing in the community-based organizations. Those who do the housing, who provide the food services and so forth. Those ancillary services which are so important in the social determinants of health. They're coming together very formally with a structure in place. They have had to do that and they commit to do this. They had to agree to do this. The first thing they had to do was called a community needs assessment. They had to go into the community, and this is not just, 'oh, what do we got to solve.' It's looking at what are the services we need to have? What are our problems and what is the service delivery system that we need to develop in five years that is going to change that healthcare delivery system so that we are, in fact, improving primary preventative care and reducing the avoidable hospital use. Once they did that community needs assessment, they got to choose up to 11 projects out of 44 projects in our project suite that would impact directly upon those problems they identified, so it was a very directed project so they had to come up with a project plan and then they have to implement it.

It's complicated. It's a very complicated process, but that's where they are now. They're in the process of developing these project plans and presenting to the state and a lot of work, wonderful work has been going on. It's very impressive, what the state has been doing and what these Performing Provider Systems have been doing in the state. We call them PPS – it's easier to say.

Moderator: Okay. What are the roles of hospital and discharge plans in DSRIP?

Lyn: As I said before, it's avoiding hospital use. That's getting people who don't need to be in the hospital out of the hospital, keeping them out of the hospital (ER, inpatient) and that's the readmission issue also. That's where this is really critical. And with the discharge planners, it's not just writing up a discharge planning and saying good-bye to the patient – 'here's what you need to do, go out and take care of it.' A lot of folks who go in the hospital, they may not understand their medication, they may not have English as a primary language, so they need that transitional service. They don't need the 'plan and out the door' – they need 30 days to get back out with their new health, whatever that is, their new medication and their new exercise program, a new doctor and so forth, and they need to transition out into the community with the support to embrace that and feel their own self-efficacy in handling those problems. That's where discharge planning is absolutely critical in reducing avoidable hospitalizations.

Moderator: Can you describe some the projects, just an overview of projects that might support those efforts?

Lyn: Absolutely. The first project is the integrated delivery system and that's really what the PPS are all about. We talked about that project, if you are in our project book, we staff these things, and that is what I said. Bringing that whole system together so wherever that patient goes in the system, their record will be there, the providers know what's going on, they know what happened before. They know the trajectory the patient is on and how to help them get there. That's one, the integrated delivery system.

And the other, and this goes to discharge planning is our care transitions intervention model, which is that 30-day transition from the hospital out into the community. We also have a new project that is a 30-day transition from the hospital to the skilled nursing facility and I particularly really like this project because in the past, I've seen where a patient may go to a skilled nursing facility and the discharge plan may be two weeks out of date and someone forgot to update it. Something happens that could have been avoided because something happened in that last two weeks of the hospitalization. This is really going to allow the skilled nursing facility nurses to go into the hospital, meet with the care planners for that patient, smooth the transition, be able to talk back and forth and have the up-to-date records and just know where that patient is at that time. I really like that project and I think our discharge planners are going to like that as they're placing patients in the skilled nursing facilities.

Another one, one of the types of folks that bounce back to the hospitals very frequently are those people who are homeless. So transitional housing is another piece. We'll get somebody who doesn't have an identified residence, put him in supportive housing for 30 days so that we can get them again, used to their healthcare changes, their medications, allow them to heal and be sure they have food, that they're safe, and then help them get those community-based services that will continue them on that trajectory of health. That's a really solid one that should have significant impact.

Finally, the integration of palliative care and patient centered medical home care into the skilled medical facility. Palliative care can give so much support to our Medicaid recipients who need it, who have chronic health problems, and that will allow that comfort, additional

comfort, and it's something again that the discharge planner can put in place and ensure that the PCP, primary care physician, skilled nursing facility know these things are available.

So these are some of the great projects.

Moderator: Thank you for that overview of DSRIP. Now, to illustrate how partners collaborate toward prevent readmission, we went to the Adirondack Health Institute in Glen Falls, New York.

ROLLIN SEGMENT> Hi. A Performing Provider Systems expands upon the network of hospitals and primary care partners that have been convened, and we added substance abuse partners, mental health partners and long-term care facilities, who have come to the table to look at this broad expansion and transformation. So as we work with the managed care organizations, we are looking to achieve what is called the Triple Aim. We are looking to lower cost, get better outcomes as well as increase access to care. So our partners with the Medicaid managed care organization and insurance networks is to achieve that. We are the same mind set, philosophy, as we look to achieving the triple lane.

>>It's a program for Medicaid recipients to lower their cost of care by lowering their ER visits and improve their quality of life. It's for people with Medicaid and they need to have two or more chronic conditions or serious persistent mental health issues or AIDS. If someone is not already enrolled, this can be a great option to connect the person with the health home at that point in time. Some of our care management agencies have embedded care managers in the hospital so the person can be there to work with them at that moment in time. Others that are community-based and can come to the hospital and meet with the person and make the connection and that way, they'll have that face-to-face contact already before after leaving the hospital. Health forums can be a viable option to ensure that people don't end up back in the hospital.

>>Hospitals and nursing homes are central to PPS networks and they have been involved since we started the PPS. The hospitals and nursing homes in particular are key players in the hospital-to-home collaborative solutions project. Under that project, we're working with discharge planners and others to set up better processes and support so that people have an option to live in the community instead of a long-term care facility wherever possible. You know what discharge planners need to know is that through Medicaid redesign, there are many opportunities to better support patients at points of transition. So when it comes to leaving a hospital or leaving one setting of care and moving into another, that's a place where discharge planners will definitely be involved, and it's a very important point in care to manage well in order to reduce unavoidable visits down the road.

>> The other thing that's really pushing some of the changes and transitions in care is reform. As you know, Medicare is really cutting back on paying for what they consider to be avoidable readmission and they're looking at length of stay and there's a push to get patients out of the hospital sooner. Our program is based upon

the work of Dr. Eric Coleman, a physician out of Denver, Colorado, who actually worked with Medicare and the Centers for Medicaid and Medicare Services to show that with his particular intervention you can go into the patient's home within 24 hours post-discharge and you assess their transition of care needs. So with our program, because we're going into the house within 24 hours of discharge, we're able to identify those patients who might be at 0 more risk of having a readmission and get them to call the doctor and move those post-discharge visits up and we worked out a system with our kind of record, they're flagged as a priority patient. If they call, the receptionist sees they're priority and gets them back to the nursing staff to triage and assess if they need to see the doctor.

>>As healthcare reform takes place and we transition ourselves through the DSRIP program, we are the hub. We are the convener and we are the catalyst for change within the region.

Moderator: I think that really helps give us a sense of the work it takes to streamline services and make all of this come together. Debbie, I'd like to welcome you to the show and thank you for joining us.

Debbie LeBarron: Thank you I'm pleased to be here.

Moderator: Can you give us more detail about the provider perspective, and what kinds of incentives are there for providers to reduce these avoidable readmissions to the hospitals?

Deb: Absolutely, Rachel. Thank you. Becky and Lyn have done a great job talking about state side and there are incentives from the federal side, and we have heard that Medicare plays a part in this as well. So certainly I just want to mention a couple of different things. There is out there what they call the Impact Act. That was a law that was signed by President Obama in October of 2014 that really strives to align post-acute care settings, four of them specifically: long-term hospitals, nursing homes, home care as well as inpatient rehab facilities. And what the Impact Act is looking to do is really to do some of that coordination and collaboration for the post-acute settings and be able to have them aligned and come together in terms of the expectations about quality performance as well as payment.

Another couple of different things going on that Medicare is doing is they're looking to create quality reporting programs as well as value-based purchasing. And what these kinds of things do is kind of repackage, if you will, into a total program, not only the quality performance expectations of providers but also what the payment systems are going to be. So that – we'll talk a little bit later about this, but it's going to be paid on an episode-of-care basis rather than a setting specific fee for service basis. They're trying to draw together the different settings of providers across the continuum to really get working together and coordinating their efforts to improve outcome.

Moderator: So now, there are pretty dramatic federal and state changes in the way that healthcare is delivered. It doesn't come without challenges. Can you talk to us about what some of the challenges are that providers are facing?

Deb: Absolutely there are various challenges that they're looking at. It has to do with the provider's approach to dealing with the populations and the expectations of performance that these reform issues are looking to achieve. Certainly, the complexity of the chronic illness population. Medicare has identified that approximately 48% of Medicare beneficiaries have at least three chronic illnesses.

Of those folks, 21% of those beneficiaries have five or more chronic conditions, so in terms of coordination of care and being able to address all of those needs that those patients have takes a lot of communication, a lot of collaboration and a lot of coordination of all of those services. Also, the breadth of the long term care services that these folks need in order to remain in the community and to remain healthy are overwhelming people as we learn more about the population. You heard Lyn talk about social needs as well and housing and some of the ADL additional support services, the activities of daily living. That's also a component. New reforms call for new roles for people, and I think many in the provider community are still trying to figure out what shared accountability is, and in terms of people working together, coordinating their care efforts for patients and having those feed into the long-term, positive outcomes for patients.

And certainly, new payment paradigms are another opportunity here for learning, as well as for achieving the Triple Aim. The episode of care, I already talked about. This is where all of the care needs, services that patients need for whatever the event is, for example, a fractured hip. They go to the acute care hospital for the surgery. Then they go to post-acute care in some shape, manner or form for rehab. So the episode of care now is not just about setting specific services but it's about the whole complement of services that are following the patient through the continuum as they recuperate and rehab from whatever acute illness they have and certainly what the other issue is is lack of data especially on the post-acute care side. Many of the things that we've already talked about depend on the data that is available. So that people can see the progress, can measure the metrics and in post-acute care settings, we're not that sophisticated yet for data collection. We're just now collecting data and being able to establish the baseline.

Moderator: So certainly there's a lot of information that you've covered so far and that's been covered thought the program and it almost sounds like there's a need for new infrastructure; as if the old rules don't apply anymore. I wonder from even your perspective at the state level, would you agree with the statement that we're really kind of changing the rules of the game?

Lyn: Absolutely. That's what DSRIP is all about is changing the rules. Building systems that weren't there anymore and supporting quality metrics, you're right on top of that. That's exactly what DSRIP is also about is outcomes.

Moderator: Excellent. Now can you talk about how that situation of changing the rules of the game, how that's manifesting itself in the issue of long-term care, Debbie?

Deb: Certainly. Again, we've talked about the old model as being focused on setting specific issues. Payment is part of that. The quality, the accountability. What we're now looking to do is to shift the whole approach, if you will, in state healthcare delivery to this new model to be patient-specific, across the continuum. So all of the existing regulations and rules that

we had that governed that old model, we are now discovering that there is an entire web of intricate rules that are starting to conflict with what the outcomes and what the goals are of this new model. Even to the point where as we progress through this process of transitioning, we're finding that we're peeling the onion, if you will, and finding those intricate barriers from a regulatory standpoint that need to be corrected.

Moderator: I imagine with so many of these dramatic changes, there will be new demands on the work force. Can you talk about what you see as some of the changes that they'll be facing?

Deb: Absolutely. In the provider community, there needs to be a refocusing, if you will, on patient assessment, on prevention and on many of the settings of care outside of the acute setting looking to treat the patient where they're at, and preventing those acute episodes and crises before they ever get to the point where they need hospital care. That comes with enhanced skill sets. It comes with engaging advanced practitioners in the long-term setting, both home care, nursing homes across the board and certainly a component of physician leadership. These advanced practitioners and physicians are the ones that really have the advanced knowledge and the skills and are able to be wonderful teachers in terms of the rest of the staff and the facility.

This kind of education and also the communication that happens between these providers across the continuum needs to be very effective communication. Patient information exchange at the time of transition is a very important thing. Everybody has this shared accountability now and the information that's being exchanged both by the sender and the receiver is very important so everybody is focused on pushing the cart, if you will, in the positive direction for patient outcomes.

Certainly also, this new paradigm is going to call for new collaborators in the plan of care. Managed long-term care is a new player in the long-term care world. So learning what their roles are and how people can collaborate and partner for the positive outcomes for the patient is something that we're going to have to learn along the way. And most importantly, and something that in many ways has been ignored for a long time because the healthcare system is so focused on healing, is looking at end-of-life and having conversations with patients and their family about their goals of care at the end of life, and incorporating palliative care and other interventions into that so acute care hospital stays are not the only option that people can consider.

Moderator: So clearly, discharge planning and planning transitions, these are complex processes and we're talking about shortened stays in hospitals and new challenges facing the work force. So what are some helpful tools or strategies to get this process accomplished, given the challenges that might exist?

Deb: Certainly, there is a wealth of information out there that discharge planners, care and case managers, need to incorporate into their learning and update on a periodic basis so they're aware of all of the different options that are out there. They should not feel like they're the only ones in the world now that are responsible for this. This new paradigm has created a whole host of new partners in this.

So certainly knowing what the regulatory requirements are for discharge planning, looking at the comprehensive care at home histories and the dialogue that they have with patients and family about what were you doing at home before you came to the hospital? What kinds of needs did you have? What kind of supports? What kinds of resources were you already tapped into? That is something that needs to be considered and incorporated into the planning for the future.

Certainly identifying who's at top risk, that not only applies to the patient in terms of the risk for readmission to the hospital but a big component of that is also caregiver risk because if there was a dependency at whatever level about a caregiver in the community, then that is an important consideration for moving forward with any kind of discharge planning. Also as we've heard talked about before, community-based resources and with *New York Connects* and the new enhancements that are planned for October, this is going to offer a wealth of new information certainly about community-based services. Because now as we move patients and transition patients back into the community rather than institutions, it's those community-based services that are going to be a big part of the web of supports that is going to the patients. And then, everybody gains professional experience and they develop networking and information resources on their own so those are all important pieces.

Moderator: Now throughout the program, we've shared quite a bit of information. Are there places or specific resources that you would recommend where you viewers can get more information about all of the different topics, programs and incentives that have been mentioned today during our show?

Deb: Absolutely. What we've done here is just given people a taste of the resources that there are. Again, top of the list is *New York Connects*. When the enhancements and the new and improved version of *New York Connects* is out there, that's going to be a very important resource that discharge planners need to go to. There are other consumer-based groups like the Center for Independent Living and government resources and programs. There are a whole host of resources out there that will be available to our listeners later from the website that refer to patient and family education, supports for them in terms of preparing for what their role is in terms of hospitalizations as well as their role in discharge planning. Patients and families and other supports are critical component to really supporting folks that want to go back to the community.

Moderator: Excellent. Well, thank you so much for sharing all of that with us. We have a few minutes to take some questions from the audience. So let's see, we got a few that have come in. The first one, Becky, is for you. Do all Medicaid recipients who need long-term care services need to enroll in managed long-term care?

Becky: That's a really good question. So managed long-term care is a statewide program. We recently received approval from CMS to go into the last few counties that hadn't had mandatory managed long-term care. If there's an individual over 21 years old who is in need of long-term care services for more than 120 days and duly eligible for Medicare and Medicaid, if they want to receive those services, they need to enroll in the managed care program.

Moderator: Thank you. Another question is housing is a major barrier, and I think we would all agree with that statement. Housing is a major barrier. So what housing resources are available, or are there housing resources available?

Becky: I'll take that one.

Lyn: I can add to it when you're done.

Becky: Ok, great. So, that's a great question as well because housing is a tremendous barrier to some people to be able to remain in the community. There are different places that people can go. We've been talking about *New York Connects* and we think that *New York Connects* will be an invaluable resource to people to find out what housing resources are available to them in their community and there are things such as the local departments of social services. There are the local housing authorities that people can reach out to as well as the local department of health, division of home and community renewal, if I got that acronym correct. And in addition...

Lyn: Yeah. A new program we also are working on the health home project. This is for those complex Medicaid recipients who have either HIV/AIDS, a persistent mental illness or two or more chronic conditions or medical conditions or a mix, and for those folks there is a new program out in support of housing for folks who are in health home. The health home is care management structured for these patients to help them be able to manage their healthcare and become able to manage it in a more productive way.

Moderator: So, so there are some option available?

Lyn: There are options, yes.

Moderator: Is there information available on any of the website that we mentioned for people to find out about the housing options, or is there a place that people can go?

Becky: *New York Connects* is the first place to go.

Moderator: Excellent. Another question, what is considered an avoidable hospitalization? I know we said throughout the show that we're not looking to prevent hospitalization, but avoidable hospitalization, or avoidable readmissions?

Lyn: Lets think about the ER or inpatient. With ER, somebody should not go to the emergency room for a cold. It's avoidable if they have primary care physician. For people with chronic illnesses like diabetes or hypertension, if they're well managed in the community, they've got a doctor, they get their testing done on a regular basis, they have what they need to be able to self-manage their diabetes, then they shouldn't need go to the hospital for the chronic complications of diabetes and acute insult related to the diabetes. It's where primary preventative care in the community can avoid that use of those services because they don't need them, they're not there. For readmissions, it's when somebody maybe has an infection in a hospital that wasn't identified or they were sent home with medication they didn't understand and so they take – for example, this is so common, unfortunately, in the past, where someone has two different, say, beta blockers. They look

different, they do the same thing. They were told one thing in the hospital and they have another one at home, but the hospital didn't tell them to stop the one at home. They come back because they took two of the same drug - that's avoidable readmission. It's those things that we can do something about out of the hospital to help that patient do the right thing for their health and get the right services in place for them.

Deb: That's where those other settings of care and the things that I talked about in terms of advanced practitioners and physician involvement and really stepping up their game, if you will, in terms of prevention and treating in place. They're important to be able to identify early on where the complications are beginning to show up, and intervening immediately and being able to prevent the need to go to the hospital.

Moderator: Absolutely. we have another question for each speaker what is one thing you hope that people take away from today's program? from each of your different perspectives?

Becky: From my perspective, I hope that, you know, discharge planners who are the main audience for this webinar, I hope that what you take away from it is that there are resources available to get information about services that people can access in the community and that it's not—you know, the nursing homes discharging to a nursing home, as you already know, but it's not always the answer and in fact, there are a lot of reasons to keep people out of the nursing home. So information is available and that's what I'm hoping people will get out of it.

Lyn: For me, I want people to be excited about this change in the healthcare delivery system. Things are going to be better at the end. It's a little maybe unsteady right now because people—this is something that is changing and change is always hard, let's face it. I think at the end, I want people to be excited that this change is happening. that we're really looking at getting the services in place to keep people healthy and healthy is where we want to be. And I want them to also go to the resources, learn about these programs and participate as much as they can, find out what's going on in your community and what you are going to add to it. There's a lot that the community is going to be able to do and I want them to be excited about it and not be scared - it's going to be good.

Deb: I think I would agree with both of my colleagues' points here. The other thing I would add is that I would hope that discharge planners and care case managers recognize not only the resources that are out there but the partners that they now have in the discharge planning process. Do not be afraid to contact those folks that are now the new collaborators in this process because they have a wealth of information out there they have news about new resources. There is history about what the patient has needed to do in terms of the community and the services they already tapped into before they ever had to come to the hospital. I think to be able to recognize that now they have a community of partners that they can tap into and not have to feel like the whole burden is on their shoulder, that's my important whole take away.

Moderator: Excellent. Another question is the *New York Connects* expansion going to include services for people with Medicare?

Becky: It will include a wide range of services and I would say the answer to that is yes.

Moderator: Okay, and how will these programs affect those who are not on Medicare and Medicaid and the improvement of healthcare in general?

Lyn: Well, as a physician, I can tell you we never, or I've never treated, and I'm sure most colleagues did not treat people differently based on their insurance. So I think as we see the changes in the system and there are other changes that are happening to the – on the other side called SHIP - State Health Improvement Plan, and I think the whole system is changing. So what we do now when these see these changes and see the improvements in them and other areas of the healthcare system are to adopt them. We're not just changing Medicaid and Medicare, we're going to change in total how the practice of medicine and how health care occurs in new York State. I think it's going to catch on.

Deb: I would agree with that. I would also say that what is – what we are hoping that these reforms develop is the resources so that these kinds of interventions and resources can be tapped into a lot earlier before patients may even ever get to needing Medicare or Medicaid, and that these are going to be available. And the planning really should happen early on. So, you know, setting up a new system here where we're only focused on this particular population right now because this is the high cost population, but these resources apply to all patients across the continuum of and should be apply eventually to those as well.

Lyn: I'd like to add one more piece to that because as you mentioned regulations and I mentioned regulations, these programs that we're doing are changing regulations. we're looking at what's not needed anymore, so that I think and in our area, it's particularly integration and primary care and behavioral health because people shouldn't have to go to two different places to have their healthcare treated and I think those regulation changes are going to impact everybody. So we're going to find a more integrated system just because we're not standing in the way of integrating that system.

Moderator: Sure. Well, Becky, Lyn, Debbie, thank you very much for joining us today. I'm afraid we're out of time. I think you did a great job answering the questions and thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain those continuing education hours, go to www.phlive.org and complete an evaluation and the post-test for today's offering. Additional information on upcoming webcasts and relevant public health topics can be found on our Facebook page. Don't forget to like us on Facebook to stay up to date. This webcast will be available on demand within two weeks of today's show. Join us for our next webcast on August 6th, our annual Breastfeeding Grand Rounds - Breastfeeding in the Workplace, Success Takes a Team. I'm Rachel. Thanks for joining us on Public Health Live!