Lifespan of Greater Rochester - Annie Wells

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Organization Profile

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Mission/Vision 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. No one understands the new face of aging better than the professionals at Lifespan.

Lifespan helps older adults and caregivers take on the challenges and opportunities of longer life. As a regional nonprofit, 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. Annually we assist thousands of older adults and caregivers. All of our services are provided in Monroe County and several extend to the Pennsylvania border and over to Seneca and Genesee counties.

Receive County Funds? YES - (1) Monroe County Office for the Aging: Eldersource, Financial Management, Geriatric Addictions, Health Insurance Counseling, HEAP, Home Safe Home, NY Connects, Nutrition Sites, Ombudsman, Upstate Elder Abuse Center.

(2) Community Development Block Grant funding

Div. of Corp. N/A? no

Proposal Information

Project Name Improving Older Adults' Health, Safety and Economic Recovery Through Community-based Aging Services and Healthcare Integration

Summary The COVID19 pandemic exposed and increased the economic insecurity and barriers to healthcare access for older adults in Monroe County. In the early days of the pandemic, Lifespan quickly pivoted to respond to hundreds of requests from elders in Monroe County for help related to food insecurity needs, barriers to healthcare access, including vaccinations, telehealth, and medications. The long-lasting negative impact of the pandemic on older adults continues with rising prices for basic needs that exacerbate poverty and the resulting poor health outcomes.
11,000 (35%) of Rochester city residents 60 and older live below 150% of the Official Poverty Measure of 18,735.
Those with incomes under $20,000 are 105% more likely to lose their teeth, 154% more likely to have diabetes, and 224% more likely to be diagnosed with depression. (Overloaded, the Heavy Toll of Poverty on Our Region's Health, Common Ground Health, 2019).
ARPA funding will enable Lifespan to expand our existing and successful Community Care Connections program to improve safety and increase access to health care and financial benefits for vulnerable, medically complex, under served older adults, age 60 + in Monroe County.
Project Components:
LPNs will increase access to health care: coordinate transportation and attend medical appointments with older adults, facilitate telehealth, arrange pharmacy delivery, and schedule preventative health care screens and vaccinations.
Social Work Care Managers will increase household income through linkages to financial benefits such as SNAP and HEAP and improve safety at home through connections to minor home modifications and personal emergency response systems.

Workforce/Economic?	Health/Safety?	Infrastructure/Sustainability?
yes	yes	no

Description Lifespan's Community care Connections (CCC) program addresses public health, community wellness, behavioral health needs, and public safety for vulnerable, medically complex and under served older adults who experience health disparities, poverty, and barriers to healthcare access in Monroe County. CCC breaks down the barriers between community-based aging services and medical systems of care through partnerships with over 85 Primary Care Physician Practices.
The CCC program is well positioned to accomplish the Bring Back Monroe Goals in the areas of economic recovery, public health, and safety.
Project Components, A Team Approach:
1. Social work care managers conduct home visits, assessment, care planning and link patients to community-based services such as housing, caregiver supports and financial benefits. We visit patients referred by physicians and/or home care agencies in their homes to

assess the home environment, social supports, caregiver network and Activities of Daily Living. Patients are linked to supports such as meals, transportation, financial management assistance, chore services, fall prevention workshops, government benefits, etc. Social workers provide guidance for caregivers and help ease the stress of care giving.

2. LPN healthcare coordinators (nurses working as patient advocates and educators), schedule and attend appointments with the patient, coordinate transportation, ensure access to preventative health screens, conduct medication reconciliations, and provide health literacy training. “Attending appointments” now encompasses in-person, three-way phone call or full video telehealth appointments with physicians/physician assistants. When necessary, we facilitate the technology required for telehealth appointments.

3. A combination of the above interventions.

Each patient referred 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 patients’ health and social determinants of health. Each domain in the GWS results in an Older Americans Resources and Services (OARS) score which informs the development of a personal care plan to address health and social needs. Referrals are accepted from physician practices, and we provide a feedback loop to them about our action steps.

Assigned CCC care managers call the referral source to confirm connection with the patient. Following the Geriatric Wellness Screen completed by CCC staff, initial care plans that outline patient-driven goals are sent securely to the RN care manager/referral source. Most physician practices scan the care plan into the EMR. Upon case closure, the closing care plan that identifies goal accomplishment is shared with the referral source.

Health Literacy Activities:
LPN Healthcare Coordinators increase access to care for those experiencing health disparities due to technology, literacy, social determinant, and pandemic related barriers:

• Assist patients with registering with MyCare / My Chart to open access to telehealth.
• Assist patients with telehealth appointments and accompany to in-person appointments; ensure understanding and MD-directed follow up.
• Assist patients with healthcare proxy, advanced directives and generally all paperwork and application completion.
• Timely home visits to ensure follow up on discharge instructions post hospitalization.
• Provide health literacy education; increase ability to self-manage health concerns:
o Describe how to follow instructions.
o Explain what to do if illness gets worse.
o Ensure instructions are easy to understand.
o Address language barriers.

Project Metrics and Deliverables

Public Health and Safety Outputs:

(1) Increase Access to Healthcare
Preventative healthcare screens / interventions attended, including vaccinations
Medical appointments attended successfully
Connected to Mental Health services
Pre and decreased post enrollment hospitalizations and emergency room visits

(2) Increase Safety through connections to:
Personal Emergency Response Systems
Minor Home Modification for Fall Prevention

Public Health and Safety Measures:

Outcome: Older adults served will access a minimum of two preventative healthcare screens / interventions and / or a Mental Health service by 12/31/2026.

Outcome: Older Adults served and enrolled in LPN Healthcare Coordination will successfully attend medical appointments 85% of the time by 12/31/2026.

Outcome: Through Lifespan facilitated access to preventative healthcare, healthcare management, health literacy training and social service connections, older adults served will decrease potentially avoidable hospital admissions and emergency room visits 25% by 12/31/2026.

Economic Recovery Outputs:
(1) Increase access to Financial Benefits and associated increase in household income through connections to:
Medicaid enrollments
Utility Assistance provided (HEAP, weatherization, track cell phone, etc.)
Health Insurance Counseling
Financial Benefits Counseling
Bill paying / budgeting service
Connected to Legal Services

(2) Increase Food Security and associated increase in household income through connections to:
Community-based Food Program (SNAP)
Home Delivered Meals
Connected to Congregate Meals

Economic Recovery Measures:
Outcome: 70% of older adults served will access at least one new community-based support service by 12/31/2026.
Outcome: 70% of older adults served will increase household income by 12/31/2026.

Independent Evaluation:
We contract with the New York Academy of Medicine for ongoing independent evaluation of the effectiveness of the interventions that address the social determinants of health.

We contract with the Rochester Regional Health Information Organization (RRHIO) to provide emergency room and hospitalization encounter data for pre-and post-intervention comparisons.
Sustainability:
We anticipate approval of the 1115 Medicaid Wavier will offer Lifespan an opportunity for sustainable funds. Lifespan has also become certified to provide Health Home Care Management (HHCM) this year to support older adults who meet the criteria for HHCM and to utilize Medicaid as a sustainable funding source.

The Medicare beneficiary population, however, does not have access to the same level of care management services as those with Medicaid and subsequently experience a gap in healthcare and financial benefits navigation support.

ARPA funds will support continued measurement and evaluation activities in collaboration with the New York Academy of Medicine to demonstrate the positive impact of CCC as an integrated care model and inform value propositions to potential payers. Lifespan will develop a replicable road map for community-based organization and healthcare systems integration and subsequent development of a sustainable payment model.

Company Strengths Lifespan is the largest not-for-profit social agency in Monroe County, NY, with the exclusive mission of helping older adults and their caregivers take on the challenges and opportunities of longer life. Founded in 1971, the agency offers over 30 programs including the Upstate Elder Abuse Center , Eldersource, the Finger Lakes Caregiver Institute, Long Term Care Ombudsman programs, and evidence-based health promotion programs. The agency serves 26,000 unduplicated older adults and caregivers in the Finger Lakes region each year with a budget of $14.9 million (2022-2023). All programs are available in Monroe County.

Lifespan recognized the need to integrate community-based aging services with healthcare. We observed the disconnect between the two was causing gaps in care and contributing to multiple and often unnecessary hospitalizations for the people we serve. We sought to change the paradigm by breaking down the silos between community-based aging services and medical systems of care to help an increasing population of older adults improve health outcomes by addressing the social determinants of health that physicians' offices do not have the time or resources to manage.

Independent evaluation of CCC by the New York Academy of Medicine proved our hypothesis that an integrated care model positively affects the triple aim of cost, quality, and patient satisfaction. Pre-and post-program enrollment data analysis results have been published and showed a 30% decrease in hospitalizations and a 29% decrease in emergency room visits. . (Fisher, E. M., Akiya, K., Wells, A., Li, Y., Peck, C., & Pagán, J. A. (2021). Aligning social and health care services: The case of Community Care Connections. Preventive Medicine, 143, 106350.)

CCC won national recognition for innovation with awards from Mather Lifeways in 2017; Archstone Foundation in November 2019; Administration for Community Living - John A. Hartford Foundation 2020 Business Innovation Award.

Community Resources To better address the needs of medically complex older adults in our region, we formed a community advisory committee in 2016 including representatives from the two local health systems, the Monroe County Office for the Aging, health insurers, Monroe County Medical Society, Finger Lakes Performing Providers Systems / DSRIP, the Rochester Regional Health Information Organization and Accountable Care Organizations (ACOs). Guidance from the advisory committee was essential to the development of our integrated care model that became Community Care Connections (CCC).

Continuing collaborative partners include the Monroe County Office for the Aging, Finger Lakes Performing Provider System, Accountable Health Partners, Excellus Blue Cross Blue Shield, Adult Protective Services, Monroe Plan, Rochester RHIO, New York Academy of Medicine and more than 85 primary care practices in Monroe, Ontario, and Livingston Counties from both health systems: Rochester Regional Health and University of Rochester Medical Center.

Lifespan's CCC program has become a trusted resource for medical providers and their patients.

"I am so grateful for having Lifespan as a resource, especially during the pandemic. These unmet socioeconomic needs have become so overwhelming, and Lifespan does such a great job at addressing them."
~ Casey Hanaburg, PA, Westridge Primary Care

"We both were very pleased and overwhelmed with Karin's [LPN Healthcare Coordinator] professional knowledge, experience, with checking my meds, my upcoming appts. her extreme friendliness and calming, knowing I now have Afib. But I feel very assured that I know I have a Health team working for me. Thank You."
~ CCC Client

Lifespan supports and utilizes certified minority-owned and women-owned businesses based in Monroe County that are necessary for the day-to-day success of our programs. We contract with Midnight Janitorial, Panther Graphics, Christopher Communications and Initivity.

Financial Resources:
- Accountable Health Partners Contract: $ 125,857, 4/1/2022 to 12/31/2022 with option to renew.
- Administration for Community Living Grant: $488,749, 9/1/2021 – 8/31/2023.
- Excellus Grant: $125,000, 1/1/2023 – 12/31/2023.
- Rochester Area Community Foundation Grant: $60,000 7/1/2022 to 6/30/2024.

Audience A key aspect of Lifespan's mission is to address the needs of under served, low-income older adults, living in Monroe County and struggling to navigate healthcare and financial benefit systems. Through our well-established partnerships with more than 85 Primary Care Physician offices, we engage the target population through referrals from medical providers who recommend the CCC program to their patients. Medical providers make a referral when they recognize a social need and/or barrier to good health outcomes that they do not have the time to address.

A significant number of the elders Lifespan serves live just above the poverty line, do not have access to the same level of care management services as those with Medicaid and subsequently experience a gap in healthcare and financial benefits navigation support.

The racial/ethnic composition of older adults served by CCC in 2021 was Asian, < 1%, Black, 27%, Latino, 7%, Native American, < 1%, White, 66%.

The greatest number of individuals served by CCC in 2021 live in Monroe County (86%). In 2021 the program served a total of 730 clients: 21% under age 65; 30% between 65-74; 28% between 75-84; 21% over 85. 72% of individuals served in 2021 were considered Frail/Disabled.

The data collected in the CCC program analysis shows 41% of those served reported an income below $1000 per month. 52% of individuals served by CCC in 2021 had income below the federal poverty line. Since 2016, the number of Medicaid beneficiaries enrolled in the CCC program has increased from 19% to 31% of total population served.

There will be no associated costs, fees, financial requests, or other obligations to participate that will be asked of the targeted individuals.

Cost 1st Year	***Cost All Years***	***Residents 1st Year***	***Residents All Years***	***FT Employees***	***PT Employees***
$200,000.00	$800,000.00	625	2,500	21	0

Volunteers
0

Staffing Oversight and Management Team:
Annie Wells, BA Psychology, Division Leader for Healthcare Initiatives, awells@lifespan-roch.org
Ms. Wells has 30 + years of experience in the fields of Aging and Disability. She oversees the initiatives at Lifespan aimed at improving health outcomes of older adults and reducing hospital readmissions and emergency room use by addressing the social determinants of health.

Jodi Owen, RN, Program Director, jowen@lifespan-roch.org
Ms. Owen has 18 years' experience as a nurse, working with high risk, chronically ill adult and geriatric patients in a variety of settings including long term care facilities, hospitals and community-based care. She supervises the team of Lifespan's LPN Healthcare Coordinators.

Ellen Baker, LMSW, Program Director, ebaker@lifespan-roch.org
Ms. Baker has been working as a social worker and manager in the field of Aging Services for over 20 years in various health care settings including home care, long term care, outpatient care and for the National Caregiver Support Program within the Department of Veterans Affairs. She currently uses this broad range of experience to support the care management team of Community Care Connections at Lifespan.

Direct Service Team:
Program Coordinators (3 FTE): process and assign referrals; provide direct service to reduced caseload.
• Sandy Schencke, BSW, Program Coordinator
• LaTorya Robinson-Cooper, LPN, Program Coordinator
• Kayla Lewis, BSW, Project Coordinator
Social Work Care Managers (6 FTE): MSW, BSW: Role described above.
LPN Healthcare Coordinators (9 FTE): Role described above.