ERIE COUNTY DEPARTMENT OF SENIOR SERVICES

Ready Set Home

Diane Oyler, Coordinator of Neighborhood Services
Dan Szewc, Long Term Care Coordinator
Karen Adamo, ADRC Representative

What's Ahead

I. The BIP Innovation Fund Opportunity
II. The Unmet Need
III. Our Concept—The Extroverted ADRC
IV. The Cooperative Agreement with DOH
V. The Pilot—Ready Set Home
    I. Setting Up Program Infrastructure
    II. Day to Day Reality (Partners and Clients)
VI. The Process
VII. The Future of Ready Set Home
VIII. Questions

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Background: The BIP Innovation Fund

Increase the number of individuals served in non-institutional settings and **improve access** to community-based LTSS services

Ensure **stakeholders** have a dynamic role in creating service solutions

Promote provider expertise by offering opportunities to "think differently" about how to best address barriers in transitioning from institutional to community-based settings, or assisting individuals to remain living within their communities.

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The Unmet Need

TARGET POPULATIONS:

Dual eligibles that are at high risk of not being able to make a 'safe discharge' from SNF within 100 day Medicare reimbursement window.

Low-acuity LTC with some informal caregiver support in the community, including those with SMI.

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The Unmet Need

- Calendar dynamics for MLTC plans can result in up to 6 weeks of non-coverage for people in need of in-home services.
- People trapped in a sub-acute because they cannot make a safe discharge.
- Long waits for MFP and waiver programs.

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How Can NY Connects Help?

LTSS Front Door Functions

- Options Counseling
- Assessment
- Service Planning
- Short-term Case Management
- Quality Assurance

Medicaid Federal Financial Participation (FFP)
Federal Medical Assistance Percentage (FMAP) for ADRC Functions

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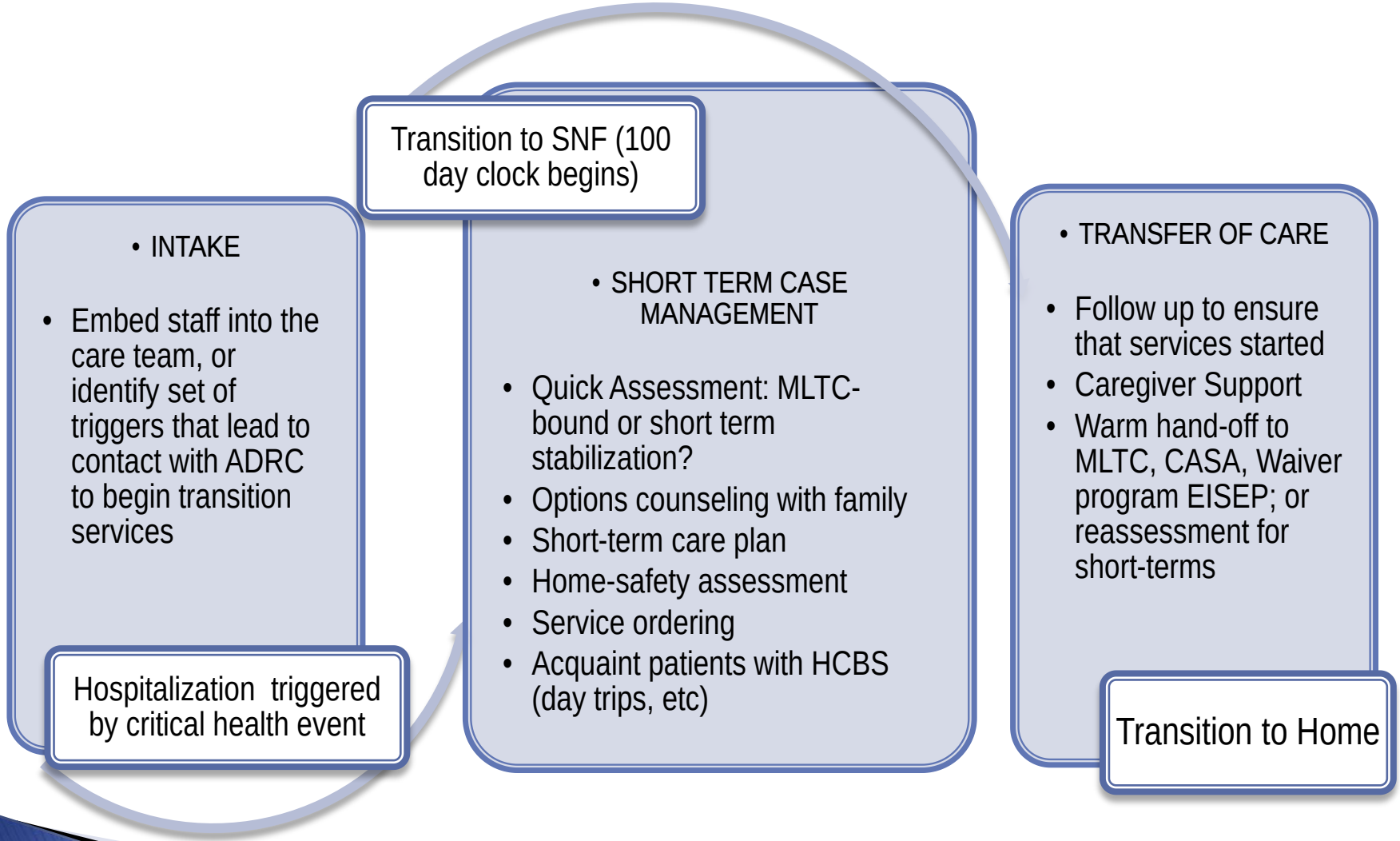
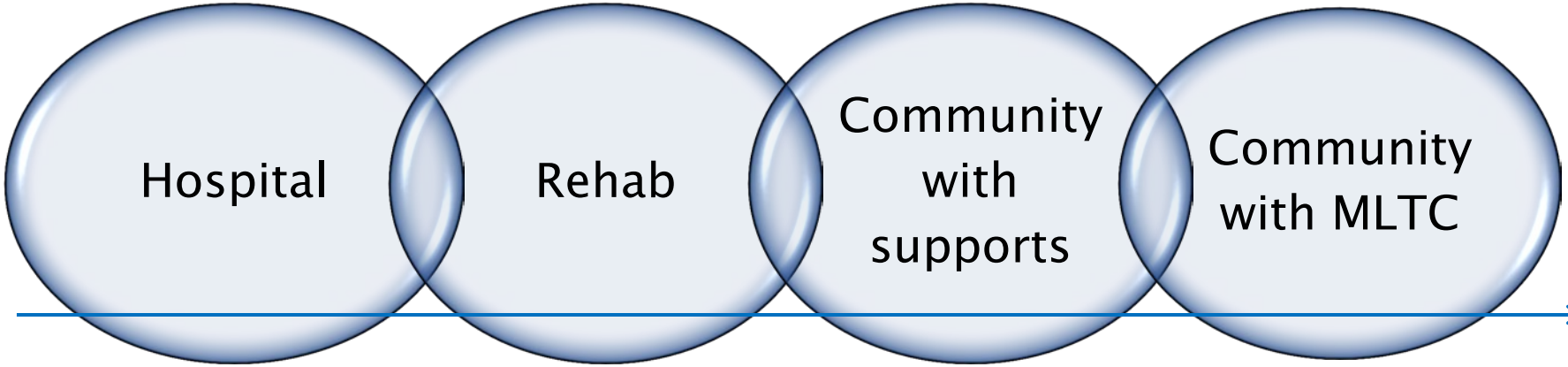
The Grant Model: The Extroverted ADRC



From Hospital to Home



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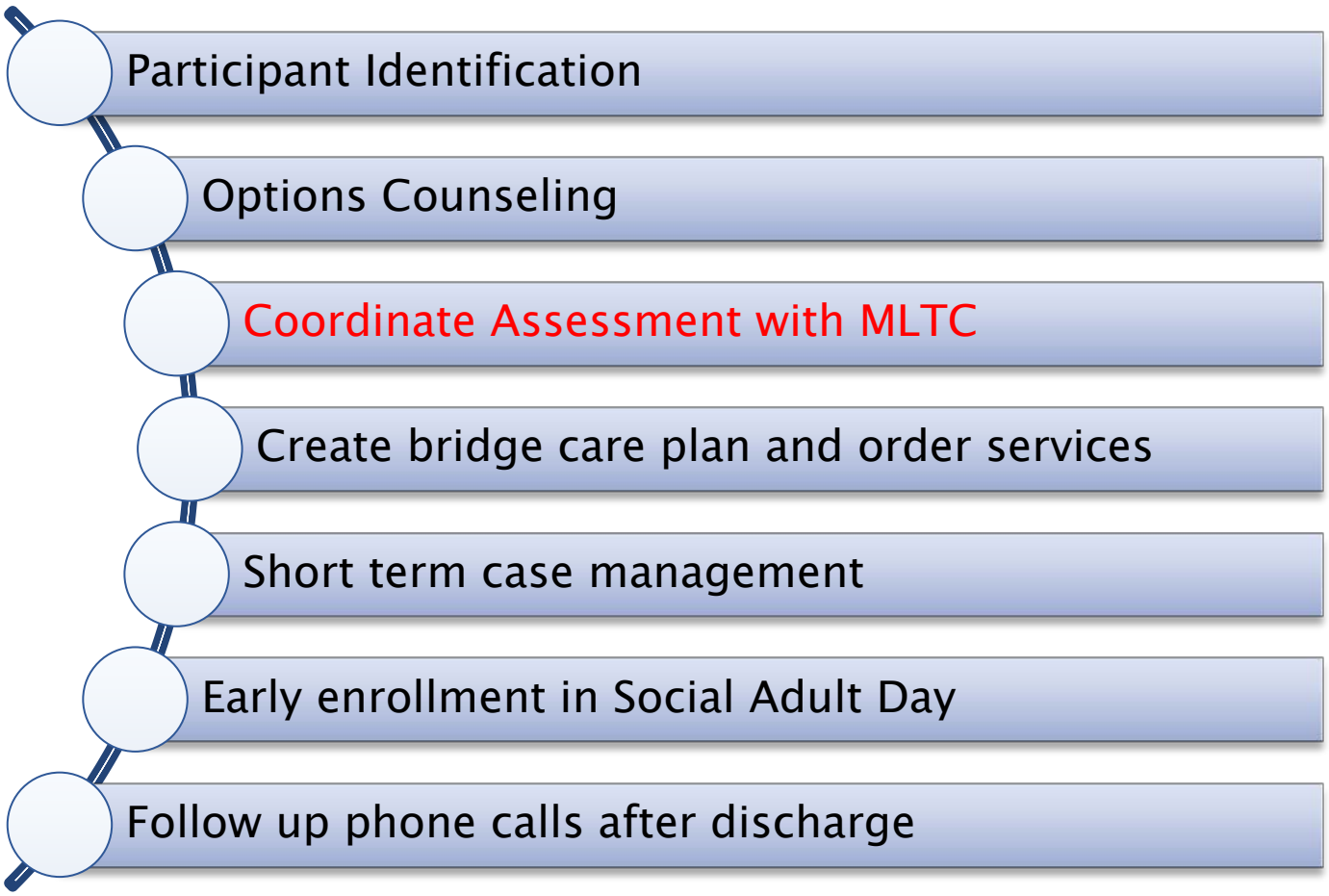
The Cooperative Agreement with NYDOH

- Medicaid-allowable expenses
- Avoiding duplication

DOH WORK PLAN ADJUSTMENTS: sub-acute



DOH WORK PLAN ADJUSTMENTS: Long term

Who we anticipated serving

Model Client

- Someone who had a critical health event (i.e., stroke, fall, heart attack)
- Will need rehab
- New functional impairments
- Medicaid beneficiary
- Appropriate for MLTC program
- Informal caregiver support in the community

Not Appropriate for Ready Set Home

- Not a Medicaid beneficiary
- No informal caregiver support in the community
- Not in need of ongoing long term care supports after discharge/transition

The Pilot: Ready Set Home

- Partners
- Clients
- Process

Our Partners

- Kaleida Health Systems- Highpointe and DeGraff
  - Acute, Sub-Acute, Long Term Care
    - Original focus on LTC
  - High need with Long Term Care patients
  - Fewer Medicaid patients in Rehab setting
  - Possible inter – county assistance,

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Our Partners

- Erie County Medical Center- Terraceview
  - Acute, Sub Acute and Long Term Care Facility
  - Very willing partner, high need
  - High patient turnover
  - Patients with Medicaid in Rehab setting
  - New Medical conditions- MLTC eligible
  - County wide pull

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Setting Up Program Infrastructure Legal Considerations

- Varying needs among partners
- MOU's
- Ready, Set, Home client record access

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Defining our Role

- Part of the team at the facilities
- Part of the discussion and decision making process
- Not waiting for the phone to ring
- Proving our worth

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Necessary Relationships

- Headway
  - TBI/NHTD waiver program
- MLTC's
- Independent Living
  - MFP
- Service Providers

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Greatest Service Needs

- Housing Assistance
- Home modifications
- Legal Assistance
- Personal Care

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Working With New Partners

- Discharge planners
- Social workers
- Fiscal Departments
- Therapists
- MLTC plans
- Maximus
- Provider agencies
- Contractors

Clients and Families

Mr. Perfect

- Active local Medicaid
- Linked to RSH early
- New health situation
- Secure housing
- Engaged caregivers
- Client wants to go home
- Can discharge from rehab as soon as supports are arranged, up to 6 weeks prior to MLTC coverage

Clients and Families

Mr. Thewayitis

- **Not always local Medicaid**(could be pending; Marketplace; waiting on 5year look backs, Medicaid in a different county)
- **Long standing health concerns**
- **Lack of housing- rehab stay**
- **Lack of caregiver supports**
- **Client trepidation**
- **Many roadblocks**

Client Profiles—Helping Those Who Are Hard to Help

Dorothy H

- 74 yr old hospitalized for severe weakness
- In rehab for 4 months; about to be transferred to a long term care bed
- Needed a ramp and linkage to an MLTC plan to make a safe discharge
- Her one request: "Get me home before Christmas."

Darleen B

- 74 yr old diabetic with amputated toes; prone to chronic infection in the wound sites.
- In long term care for 3 years
- Needed help finding an apartment and linkage to an MLTC plan.

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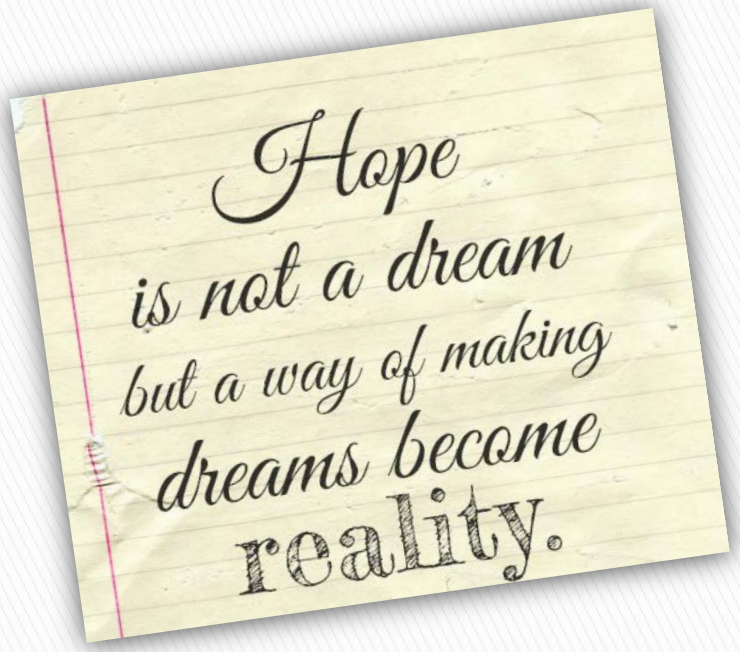
Client Profiles—Helping Those Who Are Hard to Help



Mr. B

- 20 yr old crime victim. Shot 5 times in the back, leaving him paralyzed.
- Had been in hospital and rehab for a year
- Needed assistance transitioning from Marketplace to LTC Medicaid
- Needed family re-engagement, a ramp, and linkage to MLTC

The Process—Success Factors

- Early Involvement with Ready Set Home
- Good communication with waiver, MFP, and MLTC
- Timely assessment and enrollment in MLTC or waiver program
- Timely start in of in-home services
- Client and family able and willing to comply with documentation needs, etc.

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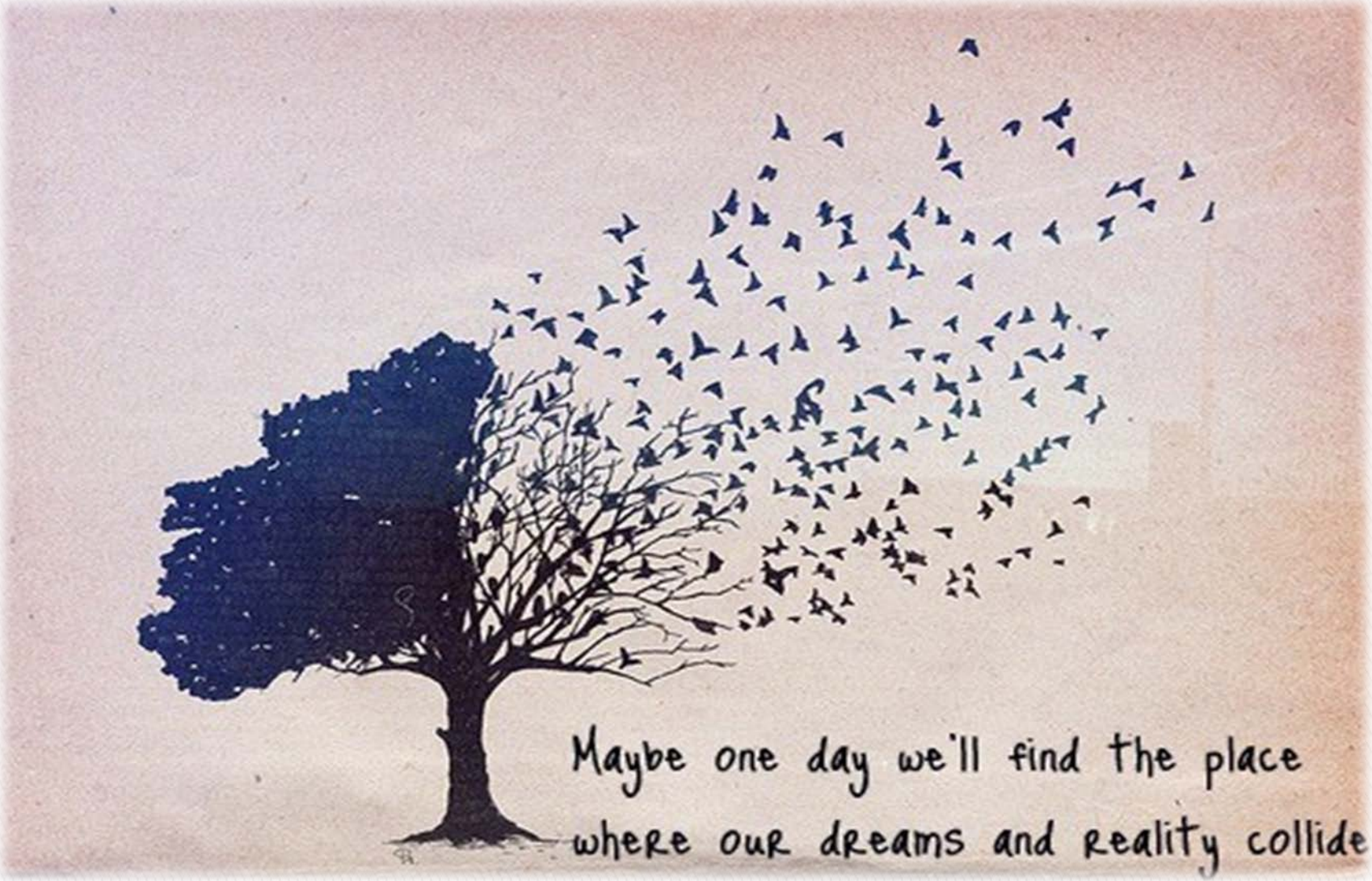
The Process—Delay Factors

- "Referred" to Ready Set Home after significant time spent in rehab
- Conflict-free process
- Appropriate Medicaid not in place
- Logistics of completing timely home modifications
- Bottlenecks due to lack of appropriate documentation at RSH, MFP, and waiver.
- Client trepidation and reluctant caregivers

The Future of Ready Set Home



Program Performance to Date

65% of pilot period completed

Sub-Acute

- 84 people received options counseling (109% of grant goal)
- 63 clients receiving short term case management (93% of grant goal)
- 36 clients transitioned back to community (63% of grant goal)

Long-Term

- 35 people have received options counseling (61% of grant goal)
- 26 clients receiving short term case management (53% of grant goal)
- 5 people transitioned back to the community (14% of grant goal)

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Return on Investment

TOTAL TRANSITIONS	41	
TOTAL EXPENDITURES TO DATE	$299,195	
	PARTICIPANTS	SAVINGS
FIRST 30 DAYS OUT ($9,000 30 day savings over LTC)	35	$315,000
90 DAYS OUT ($6,000 additional 60 day savings over LTC)	18	$108,000
180 DAYS OUT ($9,000 additional 90 days savings over LTC)	6	$54,000
TOTAL SAVINGS		**$477,000**
TOTAL SAVINGS		$477,000
TOTAL EXPENDITURES TO DATE		$299,195
NET SAVINGS TO THE SYSTEM		$177,805
RETURN ON INVESTMENT (SAVINGS REALIZED PER INVESTED DOLLAR)		**$1.59**

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After the Pilot Ends

What can continue:

- Through Enhanced Connects:
  - Options Counseling
  - Benefits Assistance
  - Facilitated Referrals
- Through AAA funding
  - Caregiver Support
  - Short-term services

What's needed:

- Funding for home modifications
- Funding for short-term case management
- Funding for follow up calls (quality assurance)

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Long Term Policy Dialogue

- Stand alone funding for short-term services
- Reimbursement mechanism for HCBS
- Medicaid reimbursement for front door activities

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Questions & Answers

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Want to talk some more?

Policy/planning questions:
diane.oyler@erie.gov
Implementation questions:
daniel.szewc@erie.gov
Case management questions:
karen.adamo@erie.gov
Hard questions? Ask our boss!
randall.hoak@erie.gov