



Main Contributor:

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The LeadingAge Center for Aging Services Technologies (CAST) is focused on accelerating the development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 6,000 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

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ROCHESTER **RHIO**

## Breaking Down Siloes Through Health Information Exchange

### *Mode of Interoperability*

Health Information Exchange (HIE)

### *Specific Use Case*

Care Coordination

### *LTPAC Organization Name*

Lifespan of Greater Rochester

### *LTPAC Organization Type*

Community Based Organization

### *LTPAC Organization Description*

Lifespan of Greater Rochester helps older adults and caregivers take on the challenges and opportunities of longer life. Lifespan is a trusted source of unbiased information, guidance and more. Lifespan provides over 30 services and advocacy for over 40,000 people in the Greater Rochester and Finger Lakes region annually, including older adults, people with disabilities, and caregivers.

Lifespan uses a cloud-based Care Management platform called Peer Place.

### *Trading Organization Name*

Rochester RHIO

### *Trading Organization Type*

Health Information Exchange Entity

### *Trading Organization Description*

Rochester RHIO (Regional Health Information Organization) is a secure, electronic health information exchange (HIE) serving authorized medical providers and over 1.4 million patients in Monroe, Allegany, Chemung, Genesee, Livingston, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates counties in upstate New York.

## Project Description

With support from the New York State Department of Health, Lifespan created Community Care Connections (CCC) because of an acute need for an integrated care approach for older adults referred by medical systems of care. A team approach is used that includes social workers as care navigators and LPN healthcare coordinators and community healthcare workers to address the social determinants of health. The program continues with demonstration project funding while we work to obtain sustainable payment model contracts.

## Implementation Approach

We contracted with the New York Academy of Medicine (NYAM) (<http://www.nyam.org/>) to evaluate the effectiveness and return on investment of the interventions. We also contracted with Rochester RHIO (Regional Health Information Organization) (<https://rochesterrhio.org/>) to provide emergency room and hospitalization encounter data for pre- and post-intervention comparisons. Accurate data collection was critical to the ongoing analysis of the project. Significant work was required with Peer Place, our cloud data management platform, to incorporate the data points of interest to the Advisory Committee and to the New York State Department of Health. RHIO, Lifespan and evaluator NYAM worked as a team to facilitate data analysis. Peer Place data extracts were sent to Rochester RHIO quarterly. RHIO isolated the patients with IRB consent and added dates of ED visits and hospitalizations occurring one year prior to and one year after enrollment in Community Care Connections. RHIO then de-identified the data and sent the file to NYAM for analysis.

## Outcomes

**1,667** patients through March 31, 2018 were included in data analysis.

**1,003** patients gave Independent review Board (IRB) consent.

The Community Care Connections pilot project successfully integrated with healthcare access points to breakdown the siloes between community-based aging services and medical systems of care. In doing so, Lifespan of Greater Rochester created a replicable model of integrated care for older adults.

The most successful access point integration was with physician practices and certified home care agencies. Ongoing outreach efforts with certified home healthcare agencies and more than 30 physician practices were critical to the successful establishment of relationships with those referral sources.

### Objective:

Increase medical professionals' understanding of how patients' previously unknown social determinants impact their health outcomes by the end of year three.

### Result:

100% of medical professionals surveyed were satisfied with the CCC program and have acknowledged the positive impact on patients' health of Lifespan's work to address social needs.

### Objective:

At case closure, 60% of caregivers were expected to report a decrease in stress as compared to a baseline measure.

### Result:

The Modified Caregiver Strain Index results shows that 87% of caregivers reported a decrease in stress as compared to baseline.

### Objective:

60% of patients/caregivers were expected to access at least one new community-based support service.

### Result:

94% of clients enrolled accessed at least one community-based service. 3,741 community-based services were accessed with an average of 3.78 services per client.

A measurement of the pre and post-effect of the intervention analyzed by service connection shows the following top six impactful services:

| Decreased Hospitalizations            |          | Decreased Emergency Room Visits       |          |
|---------------------------------------|----------|---------------------------------------|----------|
| Services                              | % Change | Services                              | % Change |
| Managed Long-Term Care                | 78%      | Home Meal & Grocery Delivery          | 61%      |
| Living Healthy with Diabetes Classes  | 77%      | Matter of Balance Classes             | 50%      |
| Bill Paying                           | 71%      | Minor Home Modification               | 47%      |
| Home Meal & Grocery Delivery          | 60%      | Financial Benefits Counseling         | 44%      |
| Matter of Balance Classes             | 57%      | Managed Long-Term Care                | 38%      |
| Transportation (non-Medicaid clients) | 44%      | Transportation (non-Medicaid clients) | 37%      |

The proven results of the Community Care Connections intervention have opened doors to further funding from various sources, which has enabled Lifespan to continue the program while we work to obtain sustainable funding through Value Based Payment and other payment model contracts.

We have been able to obtain demonstration contracts with an Accountable Health Partners, an Accountable Care Organization and with Rochester Primary Care Network, a FQHC and have a pending contract with an Insurer.

We have presented the Community Care Connections program and results at local and national conferences.

Community Care Connections recently won the American Public Health Association (APHA) and Archstone Foundation 2019 Excellence in Program Innovation Award Winner to be presented to Lifespan at the APHA annual meeting in November.

### *Challenges and Pitfalls to Avoid*

A challenge throughout the project related to the timing of data flow due to technical elements. All aspects took longer than anticipated starting with the Peer Place data platform, which was not live until June 2016. Prior to the go-live date, staff captured data on paper until and then had to enter it when the platform became available. Secure pathways had to be created for transfer of PHI. Much more coordination and communication were necessary to finalize the procedure for data flow. Initially, due to the labor-intensive work that included manual data verification on paper, matched digital files were not delivered timely. However, once digital pathways were established and some automation was developed, matched data files from Rochester RHIO became easier to obtain. Frequent phone meetings with Lifespan, NYAM and Rochester RHIO were of great benefit to the process.

It should be noted that the data analysis contained in this report would be strengthened by results from a control group. The work completed so far made it possible for New York Academy of Medicine to obtain a grant from the Robert Wood Johnson Foundation specifically to create a control group in partnership with Rochester RHIO and technical assistance from Lifespan. It is anticipated that this additional step will strengthen the results presented in this report.

The project title is Aligning Health Care and Social Services to Build a Culture of Health and the grant period is December 2017 through December 2019.

### *Lessons Learned/ Advice to Share with Others*

1. The initial workplan included our intent to partner with Brighton Emergency Medical Services (EMS) and Highland Hospital ED. EMS and Highland Hospital ultimately declined to participate due to various factors. The CCC Advisory Committee validated our successful partnerships with Home Care and Physician practices, directing us to focus the Community Care Connections intervention at the Primary Care level to assure coordination happens at the right “place.”
2. The service linkages, as noted above, made a significant impact on decreases in emergency room use and hospitalizations and subsequent return on investment.
3. A tiered approach to Healthcare Coordination based on defined level of need was developed and successfully employed to increase the patient’s ability to self-manage their health with a transfer from Licensed Nurse Practitioner (LPN) to Community Health Worker, to “graduation” from the service.
4. Consistent, structured communication among partners is critical to troubleshoot potential problems and issues, understand the full effects of the program, and identify areas of improvement.
5. Cost analyses broken down by population of interest is essential in making the case for sustainability.