

Greater Access to Integrated Supports and Care: Leveraging Provider-CCO Collaboration to Improve Outcomes for People

with

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ACCESS:
SUPPORTS FOR LIVING





ABOUT CARE DESIGN NEW YORK



MISSION:

to assist individuals with intellectual and/or developmental disabilities (IDD) to get the supports and services they need to live a quality life.

120 AFFILIATED AGENCIES

750+ CARE MANAGERS

29,000 MEMBERS SERVED

30 NEW YORK COUNTIES



ABOUT THE ACCESS: NETWORK

MISSION:

To help people live the healthiest and fullest lives possible. We work toward a world where no one is marginalized.

4 AGENCIES WITH SHARED VALUES, CULTURE

\$183M ANNUAL BUDGET

2,400+ STAFF

\$183M HUDSON VALLEY, NYC, LONG ISLAND

20,000+ PEOPLE SERVED ANNUALLY

THE PILOT: BACKGROUND AND RATIONALE



JOINT LEADERSHIP ALIGNMENT

Access and Care Design Leadership Teams aligned to improve outcomes



PARTNERSHIPS IN CARE COORDINATION

CCO/Health Homes (HHs) and providers can work collaboratively to meet the needs of individuals and address system-level challenges



SHARED VALUES

Increasing independence, respecting the person's dignity of risk, supporting families, data driven



SHARED QUALITY GOALS

Reducing preventable hospital utilization, improving clinical outcomes, and supporting individuals to remain in their home of choice

DATA-DRIVEN APPROACH

Performance Measures:
Use of population-level performance metrics and quality indicators.

Clinical Detail: Review of clinical cases and risk factors; behavioral health clinical reviews with care managers.

Impact: Review of recent improvements in health outcomes and individual independence. Measurement examples include:



ER VISITS
(medical and psych)



INPATIENT ADMISSIONS
(medical and psych)



LAW ENFORCEMENT INTERACTIONS AND ARRESTS



DAYS UNHOUSED



OVERALL HEALTHCARE OUTCOMES

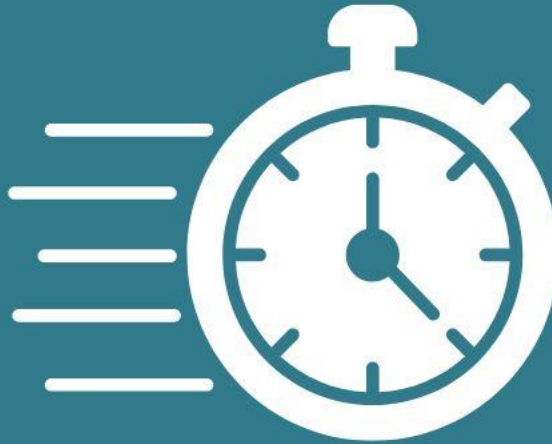


COLLABORATIVE STRATEGIES



SHARED VALUES

Strong CCO/HH and provider alignment supports innovative, “out-of-the-box” approaches through interdisciplinary teams that bring together diverse perspectives from Care Management, DD provider agencies, clinical, behavioral, and forensic disciplines.



TIMELY PROBLEM SOLVING

Enhance identification and resolution of issues through regular leadership meetings.



SHARING INTERVENTIONS

Exchange strategies for quality improvement and early intervention.

METHODOLOGY



Jointly identify people served by both Access and CDNY



Use collaborative processes to review data from health related social needs screening and preventative care measures



Implement person-centered, proactive interventions to maintain independence and support community living



RHIO alerts for hospital utilization data



WEBCRIM and VINKELINK for forensic data

THE DETAILS



Initial plan to identify people by RHIO report alone



Hospitalization alone does not give a full picture; not all people in crisis use the hospital



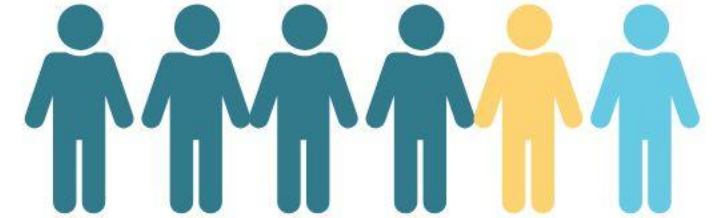
Pivoted to add housing insecurity and forensic involvement



Recency of hospitalization and CDNY HCM risk stratification model cross referenced against Access data/risk stratification



THE WORK SO FAR



IDENTIFICATION

Identified 6 people living throughout the Hudson Valley

CONCERNS

4 frequent hospital utilization
2 housing concerns

SERVICES RECEIVED

4 in IRAs, most also receiving day services with Access
1 receiving traditional community habilitation and housing subsidy
1 in self-directed services served by different teams at both agencies

KEY STAKEHOLDERS



- Initially clinical and program leaders from both agencies met to set up project
- Internal meetings at each agency to discuss each person
- Worked toward joint, multi-disciplinary meetings for each person identified
- Needed a combination of people who work directly with the person and people with “fresh eyes” to think of new strategies
- Still tweaking frequency and invites to see what adds the most value
- Importance of frequent communication between teams outside of meetings
- Access providers from each service and clinical leadership, CDNY Clinical (Medical, BH/MH, Forensic, and Care Management)

INITIAL OUTCOMES FOR FIRST 6 PEOPLE



3 months prior
to project

First 3 months
of project



**ER
VISITS**

3

4



**INPATIENT
ADMISSIONS**

3

0



**LAW
ENFORCEMENT
INTERACTIONS**

7

3



**DAYS
UNHOUSED**

21

90



CLINICAL PROGRESS

- Connect and refer people to clinical providers
- Create strategies to engage individuals and/or families around these goals and build trust with the teams
- Develop strategies to ensure better appointment attendance and medication compliance

WORK IN PROGRESS

#1



BACKGROUND:

- IRA individual with frequent ED visits, law enforcement involvement due to aggression and other high risk behaviors
- Mother who is legal guardian is understandably untrusting after an unexplained neurological event 2022 that led to a long hospitalization

ACCOMPLISHMENTS:

- Relationship building-CDNY HCM/CM meeting with member's mother to build relationship and trust with Access/CDNY

PLANS FOR FUTURE WORK:

- Goal to improve treatment adherence and engagement with MH/BH resources

WORK IN PROGRESS

#2



BACKGROUND

- Person receiving tradition community habilitation and housing subsidy.
- Poorly optimized diabetes management and hesitation to see endocrinology as it is an unfamiliar provider, schedule constraints due to work and caring for child
- Insulin pump beeping

PLANS FOR FUTURE WORK:

- Consider connecting with endo nurse for pump and diet education
- Ask if endo offers telehealth visits during off hours
- Get consent to contact insulin pump rep to troubleshoot beeping



WORK IN PROGRESS

#3



BACKGROUND:

- Person with a history of homelessness and maladaptive survival skills
- Current home of choice to live more independently (current resides in IRA)
- Complicated romantic and familial relationships
- Difficulty managing money

PLANS FOR FUTURE WORK:

- Consider self-direction
- Encourage living close by partner and minimize intermingling of funds
- Medication reminders applications, pill boxes, phone alarms.
- Determine IADL/ADL supports needed in the form of DME or DSP support
- Consider telehealth visits when appropriate to maintain treatment adherence and access to care

WORK IN PROGRESS

#4



BACKGROUND:

- IRA individual with frequent ED visits, law enforcement involvement due to aggression and other high risk behaviors.
- Mother who is legal guardian is understandably untrusting after an unexplained neurological event 2022 that led to a long hospitalization

ACCOMPLISHMENTS:

- Relationship building-CDNY HCM/CM meeting with member's mother to build relationship and trust with Access/CDNY

PLANS FOR FUTURE WORK:

- Goal to improve treatment adherence and engagement with MH/BH resources



CHALLENGES



- Choosing the right people for the project
- Anecdotal reported concern by team vs what the data shows
- Missing RHIO data
- How to measure acuity
- Frequent changes in status
- Staff time as we scale up work
- Larger meetings with a lot of thinkers are hard to pull together timely
- Staff turnover/leave/role changes
- Timeliness of data
- Limited ability to impact change on people receiving self-directed services

PLANS FOR FUTURE FOCUS



Help people move from 24-hour care to more independent settings

Increase focus on the systemic issues that contribute to common concerns

Consider additional opportunities for streamlined communication, such as a portal

Help people to stay in more independent settings as health or ADL needs arise

More work is needed before expanding to other partners

Identify goals through POMs process

Greater Access to Integrated Supports and Care

Questions?

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