CARE COMPASS NETWORK

Innovation Fund Program
Round 5

Capabilities – Ride-Sharing Program Capabilities, Inc. located in Elmira, NY will develop and pilot a ride sharing service to assist Medicaid members with transportation for work related activities and attend appointments with behavioral health/substance use providers. The current system of public transit operates on limited hours and routes, and, as a result, individuals who are seeking employment are forced to find jobs within the bus schedule. The timeliness of buses and cabs hinders being able to be on time for work and also appointments with providers. The ride share service will allow registered users the ability to access personalized transportation for the identified activities. This pilot program will also collect data about the transportation needs of Medicaid members and measure how effective a ride share service can be in increasing employability and compliance with appointments.

Catholic Charities of Chenango County – Emergency Shelter/ Roots & Wings Catholic Charities of Chenango County has been working on relocating its Roots & Wings division to an alternate available location that will allow Catholic Charities to enhance the safety, security, confidentiality, cost effectiveness and overall program and facility efficiency in order to enhance the provision of services to more than 10,000 unique individuals and more than 4,000 Medicaid members annually. This building will also allow Catholic Charities to provide the community with a safe space to go in case of an emergency. With access to the Roots & Wings division, this space would allow access to generated power and access to community support, access to resources related to healthcare and meals. This space will not only provide safety and protection but will simultaneously reduce the environmental impact on the community in emergent situations.

Catholic Charities of Tompkins/Tioga – Nichols Community Kitchen Catholic Charities of Tompkins/Tioga will use the former school site at 139 Roki Boulevard to create the Nichols Life Skills Café and Community Kitchen. The project will counteract the adverse effects of poverty that impact health through three main components: 1) Expanded options and availability of fresh, healthy food choices for low-income people; 2) a Life Skills Café training program to learn culinary skills and build essential job skills that apply to a wide range of employment situations; and 3) Community meals that will serve as a point of connection for all community members and to gain additional support and access to services that improve health and can reduce the use of emergency services. The former elementary school includes a commercial-grade kitchen and equipment, and space for community meals. The ability to store, prepare, and offer a broader range of foods will also help to address the need for additional healthy options for Nichols and the surrounding community in Tioga County.

Cayuga Health Partners – Suds 'N Such Healthcare starts at home. Supporting families where they are and, in the community, to meet the basic needs for food, shelter and clean clothing is the critical first step towards engaging with high-risk populations for sustainable health outcomes. Cayuga Health Partners (CHP), in collaboration with a number of community-based service organizations, will host the first Suds 'N Such program centered on a free laundry day event in efforts to bring services to where the people are, and incentivize additional participation in this community event. By bringing services to where people are, CHP will eliminate barriers associated with service access. People go to laundromats, so we will bring the services to support social determinants of health to where the people already are.

Many Medicaid members in our community struggle to make ends meet and are forced to make sacrifices to basic needs – like clean laundry – in order to afford food, medications, or provider co-pays. By eliminating the cost of laundry services, we hope to incentivize the Medicaid and uninsured/underinsured populations in our community to participate in a program designed to support optimal health outcomes. Community-based services to be highlighted throughout Suds 'N Such are uniquely designed to support early childhood literacy, food security, insurance navigation, mental health stability, medication management, oral health promotion, vocational advocacy, employment, and physical activity. This program will be a celebration of community and the power of coming together to support one another towards health.

Cayuga Health Partners – Mobile Integrated Care In early 2019 Cayuga Health Partners (CHP) began discussions with Bangs Ambulance on how the organizations might partner to support shared clients in the community towards sustainable health. The idea of Mobile Integrated Healthcare was born. Mobile Integrated Healthcare (MIH) involves targeted patient engagement in efforts to support some of the most medically and socially complex patients in the community towards optimal health outcomes. CHP has an established patient-centered care coordination program that seeks to identify patient/caregiver barriers to self-management in the community and work with community-based service agencies, in collaboration with their primary care provider. CHP Care Coordinators regularly work with patients and area service organizations to address social determinants of health including, but not limited to: housing needs/safety/security, access to medications, transportation, food insecurity, and navigating the complexity of the healthcare system. Bangs Ambulance serves the community with EMS and daily transport to the Emergency Department. Many of these transports are for non-emergent needs that may be better addressed in the outpatient setting with a primary care appointment. With greater transparency through information sharing and routine case conferencing, CHP and Bangs will provide wrap-around services to high utilizers of the emergency response system in the development of a more integrated care delivery system that is both highly accountable and value-driven. Prioritization of patients to receive services through MIH will include those who experience a high number of non-emergent Ambulatory Care Sensitive Conditions and who may not be engaged with, or have access to, a primary care provider.

Children's Home of Wyoming Conference – Family Nutrition & Overall Wellness Children's Home is thrilled to announce that we have been awarded Care Compass Network funding to create an innovative pilot-program at our new Southern Tier Community Center (STCC). Family Nutrition and Overall Wellness (Family NOW) will provide 50 mothers on Medicaid with innovative wrap-around health services – including free physical fitness and nutrition opportunities, as well as transportation and health navigation services. By providing mothers and their small children with access to physical fitness, nutrition, transportation, and health navigation services, we will effectively address multiple social determinants of health (SDOH), increase health outcomes for underserved populations, and improve value-based care at the STCC. By investing in a multi-pronged, social service program that address SDOH, we will undoubtedly maximize health outcomes for mothers and their families, and we will minimize avoidable healthcare costs in Broome and Tioga counties.

CirCare – Gaps in Care Closing critical gaps in care for individuals is key to improving their health and wellbeing. Gaps, including lack of diabetes management for those diagnosed with the condition, lack of diabetes screening for those on antipsychotic medication, and absence of follow-up after mental health inpatient stays and emergency room visits can lead to recurring health problems, development of new issues and relapse, resulting in more hospital admissions and emergency room visits. Circare, as a Lead Health Home, proposes to dedicate staff to provide a targeted approach to closing these gaps. Working with Circare care management agencies in the Care Compass Network (CCN) area, the Gaps in Care team will train care managers to identify and address these issues, will connect with primary care physicians to provide education regarding the gaps and to link them with clients, and will work directly with clients to help reduce barriers keeping them from receiving the care they need. With CCN funds, the dedicated staff will reduce the number of individuals with these gaps by 50%. Evidence has shown that closure of these gaps will lead to improved health outcomes for individuals, resulting in fewer emergency room visits and hospital admissions. This will ultimately lower system costs by shifting from expensive emergency treatment to more stable and lower-cost management and medication maintenance.

Cornell Cooperative Extension of Delaware County – Seed to Supper About 12% of Delaware County residents are considered food insecure, which the USDA defines as "a lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods." The rural nature of the county makes access to nutritious food particularly challenging due to a lack of public transportation and the distance to fresh food outlets. Numerous studies have shown that gardening greatly reduces food insecurity. With funding from Care Compass Network, Cornell Cooperative Extension of Delaware County will offer gardening classes and provide ongoing assistance to participating gardeners. Seed to Supper is a comprehensive beginning vegetable gardening curriculum designed for adults gardening on a budget. The program has been adopted by Cornell Cooperative Extension of NYS as a shared program of Oregon Food Bank's Learning Gardens. Garden educators and Master Gardener Volunteers will teach the Seed to Supper curriculum to interested community members. The courses highlight practical, low-cost techniques for building, planning, planting, maintaining, and celebrating the harvest of a successful vegetable garden. The six-week course will be offered at three sites: UHS Delaware Valley in Walton, Downsville Central School in Colchester, and Sacred Heart Church in Stamford. Participants will receive the Seed to Supper text-booklet, plants, seeds, and

gardening tools for use in home or community gardens. The harvest will be celebrated with a pot-luck dinner at each location. The program will be expanded to an additional six sites in 2021.

Cornell Cooperative Extension of Tompkins County – Food Insecurity The Fruit and Vegetable Prescription Program in Tompkins County (FVRx-TC), a cross-sector collaboration between Cornell Cooperative Extension in Tompkins County, local farmers, healthcare providers, Cayuga Health Partners and Cornell's Master of Public Health Program, will provide 75 food-insecure Medicaid patients diagnosed with a diet-related disease (diabetes/hypertension) in 2020 with fresh produce weekly coupled with integrated medical, nutritional and educational services to promote health. This will result in immediate and long-lasting positive impacts on the health and quality of life of participants, while providing an expandable model to improve the health of thousands of low-income community members. FVRx-TC's innovative disease prevention and management strategy will change the landscape of wellness by creating a model for the intersection of local agriculture, nutrition and healthcare, and will transform the culture of the health care system by bringing nutrition incentives into the healthcare space and food to the center of promoting health.

Family Planning of South Central New York – Transportation Family Planning of South Central New York's proposed project will address the issue of access to health care by providing transportation assistance as a service to Medicaid and Medicaid-eligible individuals. Funding from Care Compass Network, will expand the reach beyond the specific population of the Women's Health Cohort project with ultimate goals of reducing preventable ED visits and increasing access care. Those accessing this transportation assistance service will include:

- Patients who present with a transportation need at or prior to their appointment
- Patients who have three or more no-shows
- Cohort members who no longer meet cohort-specific criteria or have graduated to the program due to lack of panel space

Through this project, Family Planning of South Central New York will increase access to health care services for at least 400 individuals between April 1, 2020 and December 31, 2020 by reducing transportation barriers. By offering transportation assistance, Family Planning of South Central New York will ensure that patients have optimal personal health and wellness by accessing appropriate health care and health support services. The proposed project has beneficial byproducts, including the reduction of stress and anxiety, as well as decreased stigma during health care appointments. Family Planning of South Central New York expects to see behavior change in individuals accessing this transportation assistance service, reducing preventable Emergency Department visits for non-emergency care. Finally, this project will continue successful data tracking on the role that social determinants of health play in access to care.

Gadabout Transportation – Transportation Transit Management Technology System- Gadabout Transportation Services, Inc. is implementing a system wide project which will provide:

- New scheduling software which will increase efficiency and allow for same day service.
- GPS tracking on the buses for accurate arrival times.
- A Platform for medical and care providers to easily reserve a trip for their clients.
- A client notification system that will notify riders with their pickup times eliminating the need for them to call the office the day before to get their times. This will include an additional notification when the bus is 15 minutes away.

This project would address the need for same day, low cost, accessible transportation in Tompkins County and allow the service to be more responsive to rider needs. The addition of an easy to use booking platform will let care providers request trips on behalf of their clients. Discharge planners and medical providers would be able book a patient's transportation to follow up appointments ensuring they are seen within the 7-day post hospital release timeframe. The client notification system and reminder should decrease the number of no-shows or at the door. Cancels and "no shows" account for about 20% of all scheduled trips with Medicaid trips accounting for a staggering 55% cancelation rate. By increasing the ease in use of transportation we are able to address the social determinates of health ultimately decreasing ER use and hospital re-admittance.

Ithaca College – Trauma-Informed LTC This project employs a Trauma-Informed Care (TIC) Champion Team model to integrate trauma-informed behavioral health care into primary medical care for residents in ten skilled nursing facilities (SNFs) in the Care Compass Network region. For each organization, a full-time nursing or social work staff member will be paired with the SNF's licensed behavioral health (BH) provider to create a Champion Team (ten teams total). Teams will have the explicit support of their administration and will be trained to work together to promote trauma-informed organizational change that integrates behavioral health care into the existing patient medical care in their facility. Each Master Trainer trainee will be required to teach ten hours of trauma-informed care curricula to at least 25 staff in their home facility. Behavioral Health trainees will receive training in evidence-based strategies for trauma-specific intervention with patients who are seriously ill and/or have serious cognitive challenges. Champion Teams will also be trained to work with one another and with their entire SNF care team to establish and promote the integration of trauma- informed care and behavioral health care into medical care for all residents in their home organization.

Mothers and Babies Perinatal Network of South Central New York – Social/ Emotional Health Promoting social/emotional health for children and families at risk of separation through family court and the foster care system has been developed with the goal of transforming the way child protective services, family court and foster care systems address the trauma that children experience, and strive to re-unify children (when appropriate) in the most expeditious manner. Research shows that children in foster care have extensive trauma histories and frequently exhibit behavioral issues, attachment disorders, and a long list of indicators that suggest their wellbeing and overall development is threatened by the presence of

traumatic experiences. Left unaddressed, this trauma may result in lifelong complications that ultimately jeopardize their health and quality of life in adulthood. This project is a true community collaborative and one which is identified by the partners as critically needed "next steps – and "out of the box" strategies for ensuring the mental health and wellbeing of children and families. The program will incorporate a multi-pronged approach to work with families' w/ infants and toddlers (ages 0-3). We will address their needs by increasing the frequency of visitation for infant/toddlers and biological parents, improve parents' capacity by providing individualized mentoring, connection to primary and mental health services and connection to home visiting services through the expansion of 3 evidence-based programs: Binghamton School's Parents & Children Together (PACT)) program, Lourdes Hospital's ImPact program, & the Parents As Leaders (PAL) Family Resource Center (Mothers & Babies Perinatal Network). The new and innovative component is the implementation of a 4th EBP – the Safe Babies Court Team Model. The Safe Baby Court program uses the science of early childhood development and mental health support and connects babies and their families with services and support they need to promote health and optimal development, while ensuring speedier exits from the system.

Our Lady of Lourdes Memorial Hospital – Health Home Medication Management Data analyzed from the Centers for Medicare and Medicaid Services (CMS) show that overall 68.4% of beneficiaries have 2 or more chronic conditions and 36.4% have 4 or more chronic conditions. According to CMS patients with multiple chronic conditions take more prescriptions and OTC medicines, are often seen by different prescribers resulting in concurrent use of multiple medications to manage coexisting chronic conditions and struggle with regimen complexity. Many studies have shown a direct link between the numbers of medications a patient is taking and the risk of adverse drug reactions. According to the Agency for Healthcare Research and Quality (AHRQ), nearly one-third of adults in the United States takes 5 or more medications. Adverse drug events, defined as harm experienced by a patient as a result of improper medication management/use result in nearly 700,000 emergency department visits each year and 100,000 hospitalizations. Other barriers to medication adherence include health literacy, high copayments, transportation, and access to care, forgetfulness, and cognitive function. The Syn Med automated packaging system offers an accurate and efficient way for the pharmacy to prepare multiple medications in a sealed blister card. Packages are clearly labeled with medication names and time of day for ease of administration. Automating this process will allow the Health Home Medication Management Program to expand its reach to many more patients in our community and surrounding areas. The med boards ease medication adherence and therefore improve patient outcomes. Lourdes Medication Management Program, assists patients with applying for financial assistance to provide prescriptions free of charge to the patient. The Med Boards are complete with med list and then delivered to the patient's home from the Lourdes Pharmacy, to improve provider communication along the continuum of care. The patient has a community care plan established in the patient electronic medical record to describe the program in place. A Nurse Care Manager visits with the patient once a month for medication reconciliation.

Our Lady of Lourdes Memorial Hospital – Population Health Improvements

- A health and wellness program, offered every Monday and Wednesday, May 4 thru October 16.
- Four – Six-week sessions with a maximum of sixty people per session to allow for personal instruction.
- Program leader organizes, gathers participants and leads a stretch. Health care staff provide a brief health and wellness talk.
- At the first session, each member receives a program t-shirt and pedometer. At each session, participants log-in and log-out with staff member when finished. Staff will assist in tracking mileage and time. Participants can walk, jog, or run, depending on the "prescription" provided by a medical professional.
- Healthy refreshments are provided after exercise. Participants will be allowed time to relax and socialize.
- Goal is to improve health in wellness in the community. Additional goal is to motivate participants to run or walk in a 5K.
- Group leader will assist in motivating individuals to make exercise a daily routing.

Rural Health Network of South Central New York – Expanding Rural Cultural Competency Expanding Rural Health Network of SCNY's Rural Cultural Competence Professional Development Training to a Clinical Workforce **–** The Rural Cultural Competence professional development training curriculum is a comprehensive overview and discussion of rural cultural characteristics and the social determinants of health and health disparities uniquely impacting rural individuals, families, and communities. This program enhances the knowledge, skills, and cultural sensitivity of providers serving rural populations. The expansion project will create the opportunity for the clinical workforce to participate in the training, as well as supporting an opportunity for rural patients on Medicaid to voice their experiences and recommendations toward a more culturally competent clinical experience.

Steuben Senior Services Fund – Long-Term Care Alternative Steuben Senior Services Fund is working on expanding its care network to additional people wanting to age in place within Steuben County. Steuben Senior Services Fund is committed to empowering seniors to age at home. We believe that through the use of technology and communication, we can build a circle of care centered around the aging individual who will effectively be able to remain in their home instead of needing the services of long-term care facilities such as a nursing home or assisted living. We use cameras, and other smart technology to partner with Full Circle America, who offers monitoring by a board-certified Gerontologist Dr. Teel. Dr. Teel works alongside each member's primary care physician to help patients remain in their homes. Our goal is to allow seniors to age in place and prevent frequent hospitalizations and emergency room visits.

United Health Services Hospitals – Bridge Program for Immigrants The ***Bridge*** Program for Immigrants is a collaboration between UHS Hospitals, American Civic Association, SUNY Broome and the Greater Binghamton Chamber of Commerce. ***Bridge is a mentoring, education and language training program*** that accelerates the process by which immigrant job seekers reach their highest potential for cultural and social assimilation into the community while also achieving financial independence with skills that will lead to participation in the region's workforce. **Bridge** is designed to provide education and training for immigrants who lack job readiness skills such as the need to learn to speak English at the level necessary to be a productive member of the work force. **Bridge** will also partner each participant with a skilled and experienced local mentor who will prepare them to be job ready by gaining an understanding of local workforce dynamics and integration in the community and workforce group cultures. The program will empower immigrant job seekers to reach their full potential while also filling critical gaps in the Broome County Workforce, particularly in the health care industry. Program participants also will be job ready with the ability to address their own social determinants (e.g., transportation, unemployment, childcare issues, and health insurance) and enter the workforce with the ability to reach their highest potential as the result of education, integration and preparedness. Employers seeking qualified employees will be better able to address the workforce shortages in Broome County due to recruitment and retention challenges, particularly in the healthcare industry sector.