CARE COMPASS NETWORK

Innovation Fund Program
Round 3

Community Health & Home Services – **Expanding and Enhancing the Nurse Case Manager Program at 5 Binghamton Low-Income Senior Housing Facilities** – Utilizing senior housing as a vehicle for delivering healthcare services to low-income residents, the Nurse Case Manager Program (NCMP) has achieved goal 1 in the Care Compass Network vision: Improving care and "reducing patient Emergency Department visits, readmissions, and preventable admissions, thereby reducing costs." Last year CHHC was provided funding through CCN's Innovation Fund Program to implement the Nurse Case manager Program at the Binghamton Housing Authority. This program has begun generating outcomes that have help achieve CCN objective. Additional funding from CCN will provide CHHC the opportunity to replicate this program and enhance their Nurse Case Manager Program at five Binghamton-area facilities that house approximately 289 low-income seniors and disabled adults. The Nurse Case Manager Program helps coordinate and navigate the residents to the appropriate level of services. Once this program is fully established, CHHC's ongoing work will be funded through Medicaid reimbursements.

Rural Health Network of SCNY – **Expand Fruit & Veggie Program** – The South-Central NY Fruit and Vegetable Prescription Program (FVRx) is a strategy to help prevent and manage chronic diet-related diseases in the adult Medicaid population. This program increases the knowledge, skills, and behavior change, thereby improving health outcomes for participants and their families. By providing a financial incentive and improving access to healthy food, the FVRx program enhances the effectiveness of existing clinical and community-based efforts to address social determinants of health and the barriers of transportation and income. The program is an expansion of a successful pilot initiated in 2017, and has the following three goals:

1. Prevent and manage chronic diet-related disease in the Medicaid population by increasing affordability and access to nutrient dense fresh fruits & vegetables through a prescription voucher program, and referral to nutrition and chronic disease education and support services in the community. Eligibility to participate will specifically target cardiovascular disease and associated risk factors.
2. Develop workflows that effectively screen and connect patients with community-based preventative and management services, and integrate into electronic medical records (EMR).
3. Evaluate the Return on Investment for nutrition-based preventative health care to determine replicability and sustainability.

ARC of Schuyler – **Supports-for-Health Regional Voucher Program** – CCN, Mobility Management in the Southern Tier, along with partnering Community-based Organizations from Cortland, Chemung, Schuyler, Steuben, and Tompkins counties are collaborating to replicate the successful voucher program developed by Rural Health Network of South Central NY that will increase transportation options for the regions Medicaid population. As Medicaid currently functions, the cost of transportation for enrollees to access specific medical and health related appointments are covered. However, costs for transportation to other services needed to stay healthy, such as access to pharmacies for prescriptions or grocery stores, are not covered. This program will help Medicaid enrollees learn about low cost options they can use to access those services which are designed to improve health and prevent costly hospital admissions and readmissions.

Cayuga Addiction Recovery Services – **Opioid Treatment Program (OTP) and Ancillary Withdrawal Service (AWS)** – Cayuga Addiction Recovery Services (CARS) Outpatient Services Unit is launching a comprehensive approach to treatment services in Tompkins and surrounding counties. CARS is developing an Opioid Treatment Program (OTP) which will help those in need receive comprehensive medical and behavioral healthcare in one setting. The OTP program will serve as a structured setting which will monitor and treat Opioid Use Disorder. As part of the Opioid Treatment Program, CARS will provide an Ancillary Withdrawal Services component which will help clients obtain rapid access to medications to mitigate withdrawal symptoms and provide for concurrent behavioral health services. A community outreach worker position will be created to help engage those in need and to reduce barriers to entering treatment. This program will help to significantly decrease overutilization of emergency departments and a meaningful treatment solution to those struggling with Opioid Use Disorder.

S^{2}AY Rural Health Network – **Regional Task Force on Opioid Overdose** – Whether it is a son or daughter, a friend, a co-worker, or a friendly neighbor, opioid overdose and mortality has affected so many of us personally. The problem has become an epidemic, and addressing it has become imperative. Based on their work within the Finger Lakes region, S2AY Rural Health Network is seeking additional diversified funding to support the creation of a Regional Task Force on Opioid Overdose for the Chemung, Schuyler, and Steuben counties. S2AY Rural Health Network will be using many of the same tools and the sustainability model from the Finger Lakes project. The Regional Task for Opioid Overdose will include representatives of existing county task forces, drug and alcohol agencies, law enforcement, probation, public health, primary care, district attorneys/judicial system, and elected officials. Members of the task force will be using evidence-based tools to ensure the most efficient use of resources to improve mortality and morbidity related to opioid overdoses. The task force will be building on existing efforts within the community to provide general education and to expand care to individuals suffering from Substance Use Disorders, including support services such as housing, transportation, day care, Certified Peer Counselors, and warm hand-offs to providers/community organizations.

Catholic Charities of Tompkins/ Tioga – **Health Outreach Coordination** – Catholic Charities of Tompkins/Tioga uses a philosophy and practice that helps people in poverty to make lasting changes and recognizes that health care seeking behavior does not occur in a vacuum. For many health and behavioral health conditions, poverty is a contributing factor, particularly concerning nutritional access and lack of resources to choose from. Catholic Charities of Tompkins/ Tioga will be providing two full-time health outreach coordinators, one serving each county, to provide outreach to rural, underserved areas. The health outreach coordinators will assist clients in reducing hospital and emergency room visits by helping Medicaid members access health care and make improvements in their own health outcomes. These services will include an exploration of current usage of emergency facilities and knowledge/understanding of viable alternatives for treatment.

Our Lady of Lourdes Memorial Hospital – **Community Health Support Program** – The Community Health Support program will provide a reliable resource person for individuals with chronic illness in the community that don't qualify for or consent to skilled services (such as CHHA or Hospice), or community-based Care Management services such as Health Homes. This intervention aims to address the social determinants that can have a significant impact on an individual's health outcomes, through the establishment of an ongoing trust relationship with the individual. Knowing a person's medical and non-medical history and experiences is key to pursuing options that work, while establishing trust is essential in engaging the patient in their own health care and building self-efficacy.

Our Lady of Lourdes Memorial Hospital – Adherence to Behavioral Health Treatment Planning – Estimates of patients receiving mental health services and being out of adherence of medication and/or counseling services has been estimated to reach 90%. This project will provide intense education services for patients treated for a mental health diagnosis at the Article 31 clinic and two primary care practices. The educator will use the recovery-focused method and work to empower patients to make their best decisions for their treatment. During these interactions, the educator will provide specific information to the individual on how adherence to treatment options and medications can increase their quality of life.

The educator will use a variety of techniques to interact with their patients, from social media to phone calls and texts to face-to-face interactions to encourage adherence to the agreed upon treatment plan while maintaining HIPAA compliance. Additionally, the educator will conduct group meetings with patients at multiple states of treatment allowing peed support at the earlier stages of treatment or relapse. The programs goal is to have a strong therapeutic relationship with each patient so they feel empowered to contact the educator. Through this relationship, they can work with a team of providers in order to adjust or discuss treatment versus non-adherence, which often results in emergency room or inpatient hospital admissions.

Our Lady of Lourdes Memorial Hospital – **Expansion of Lourdes Outpatient Nutrition Services** – Registered Dietitians are known to be experts in nutrition and are an integral part of the health care team. For those financial or physical barriers, transportation can be a burden. Many of our population that fall into this category could benefit from nutrition therapy services. Over the past six months, Registered Dietitians have established services in the Lourdes Primary Care sites. This integration has been a cost-effective, team-based approach to provide Medical Nutrition Therapy to the community. It removes barriers of time, distance, and provider scarcities. This model has proven to improve health outcomes of chronic disease, prevent chronic disease, and promote wellness. The Dietitians will expand their services to include Tele-nutrition, which would be utilized for those who cannot travel to an office for an initial or follow-up visit, but can utilize modern day technology.

Lourdes Dietitians will continue to partner with the Rural Health Network as providers for the Fruit and Vegetable Prescription Program, assuring locally-grown fresh fruits and vegetables are accessible and affordable for the Medicaid population.

Our Lady of Lourdes Memorial Hospital – Diabetes Prevention Project – The Lourdes Diabetes Prevention Project, working in conjunction with the Lourdes Primary Care Providers, will continue to develop and implement procedures and interventions to improve the health status for Medicaid members and the uninsured in Broome and Tioga counties. Lourdes proposes to decrease the risk of developing Diabetes in over 3,326 Medicaid patients who are identified as having prediabetes. These innovative interventions will lead to an improved glycemic control among patients with prediabetes whose hemoglobin A1C is between 5.8 and 6.4%. There will a focus on interventions that can be reasonable and affordably adapted to the resources of a functionary primary care medical practice. Through ongoing interaction with patients including the utilization of advanced technology and social media, the project will provide increased support to those patients at risk for diabetes. The health coach and LPN navigator will support additional patient engagement and lifestyle changes in individuals who are identified as having or at risk for prediabetes.

UHS Hospitals – **Phytel Live** – UHS will be implementing IBM's live-feed patient outreach system known as Phytel Live, which will be utilized to decrease the number of Gaps in Care of both Medicaid members and the general patient population. UHS defines Gaps in Care as a patient not meeting one or more of the UHS System Quality Measure Goals. These measures will include the following: childhood immunization combination 10, childhood immunization combination 8, fall screening, blood pressure within JNC8 guidelines, mammography, outpatient medication reconciliation, and hemoglobin A1C >9. Phytel Live is a bi-directional automated system that syncs between the UHS scheduling system and UHS electronic medical records (EMR) in real time to ensure the most accurate and up-to-date patient cancellation, reschedule, and no-show information is directed to a Wellness Coordinator for follow-up. This program will ensure that patients missing any visits pertaining to System Quality Measure Goals will be followed up with in real time versus waiting for a batch upload from the scheduling system to the EMR. Currently more than 45% of the Medicaid members have Gaps in Care and UHS aims to utilize the Phytel Live program as a means of having an immediate impact on closing Gaps in Care.

UHS Hospitals – **Promise Zone** – UHS Hospitals and Binghamton University's Promise Zone have collaborated to develop a comprehensive innovative telemedicine service line to children where they spend the most time – school. The BU Promise Zone, an evidence-based community school model, was developed specifically to enable students to succeed academically; however, this is not possible if children are not a school due to illness or have access to care, particularly in the rural areas of Broome County. This project entails deploying telehealth devises in all 17 Promise Zone school locations and three UHS Walk-Ins to connect students and school nurses with a licensed UHS Walk-In provider for an acute visit. UHS & Promise Zone schools will leverage MD live telehealth platforms as a means of having a virtual face-to-face visit. Since MD Live is a standalone application, this means all documenting will occur in the patient's existing medical record at UHS. School nurses will schedule a virtual visit through UHS' online schedule system, Clockwise MD. At the time of the visit, both parties will log into the cloud-based MD Live video interface and begin the visit. At the conclusion of the visit, the provider will be able to send any applicable prescriptions to the patient's pharmacy of choice. This unique approach enables UHS and Promise Zone schools to connect children with a health provider with the child remaining in school with their trusted school advocate while allowing the parent or legal guardian to remain in the workplace setting.
This project will enable children to receive timely high-quality care while allowing their parents or legal guardian to remain at work. UHS Hospitals and Binghamton University believe a strong partnership such as this is key to ensuring the student population in Broome County reaches their academic potential. The best way to help students achieve that goal is to keep them in school.