Adirondacks ACO

Better Community Care Through Collaboration

Transforming Rural Health Care: Successful Community and Clinical Partnerships Addressing Social Determinants of Health

Katy Margison, Director of Communications & Partner Engagement
Jeremy Powers, Director Clinical Quality Improvement
Adirondack Health Institute & Adirondacks Accountable Care Organization

Lee Rivers, Chief Executive Officer
Community Connections of Franklin County

Deborah Beach, BSN, RN, Director of Education & Program Management
UVMHN – Alice Hyde Medical Center

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Learning Objectives

1. **Understand the Key Social Determinants of Health (SDOH) Domains:**
   - Learn about the five critical domains of social determinants of health, specifically in the context of rural communities and how they impact the health and well-being of high-risk patients in the Northern New York region.
2. **Examine the Collaborative Partnership Model:**
   - Explore the structure and dynamics of the partnership between the accountable care organization, the two regional community-based organizations, and the managed care organization.
3. **Assess the Impact and Success of the Initiative:**
   - Evaluate the measurable outcomes and success indicators of the partnership in reducing emergency room utilization in Northern New York.

How Did This Partnership Begin?

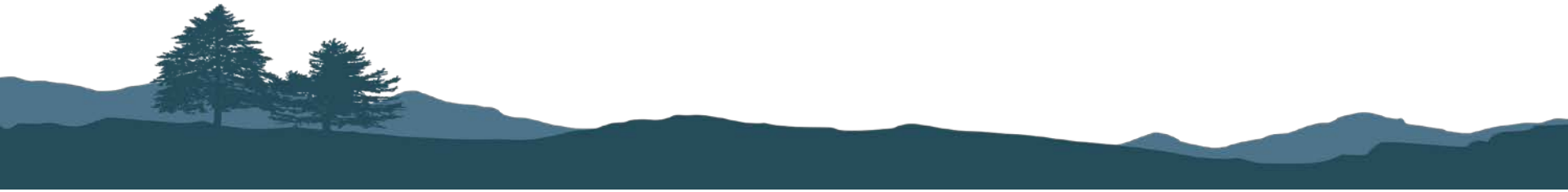
In 2020, the Adirondacks ACO contracted with the National Alliance on Mental Illness (NAMI) Champlain Valley to address the five key domains of social determinants of health (SDoH) including economic stability, education, social and community context, health and health care, and neighborhood and built environment for high-risk members. The program was built to address targeted populations in subgroups through timed phases. These phases include members who have frequent emergency department visits, members connected to NYS Health Home, members directly referred by providers, and members in need of supports to bridge successfully from primary care to psychiatric care. This support was made possible with funding provided by the ACOs relationship with the regions' largest Managed Care Organization.

How We Utilize ACO Data to Measure Success

Adirondacks ACO has access to Medicaid Managed Care claims data for ACO attributed lives. Initial review of claims data evidences that there were 45,721 Fidelis members (‘22-’23 performance year) attributed to the providers in the Adirondacks ACO.

NAMI Champlain Valley is tracking measures that indicate their engagement with the Medicaid Managed Care members. The engagement is vital to gaining trust and then determining how to best support the individual with specific assistance. The measures show how much time and what supports have been provided. The ACO measures track the traditional claims-based information that is available, looking at utilization including a number of process and outcome measures for the individuals being supported by NAMI Champlain Valley.

Engagement for some individuals consisted of an SDoH screening phone call, while for others consisted of a need for long term supports including crisis intervention, peer support, peer advocacy and other services. Due to the uniqueness of NAMI Champlain Valley’s services, individuals were able to be served based on their identified needs.



Patient Snapshot

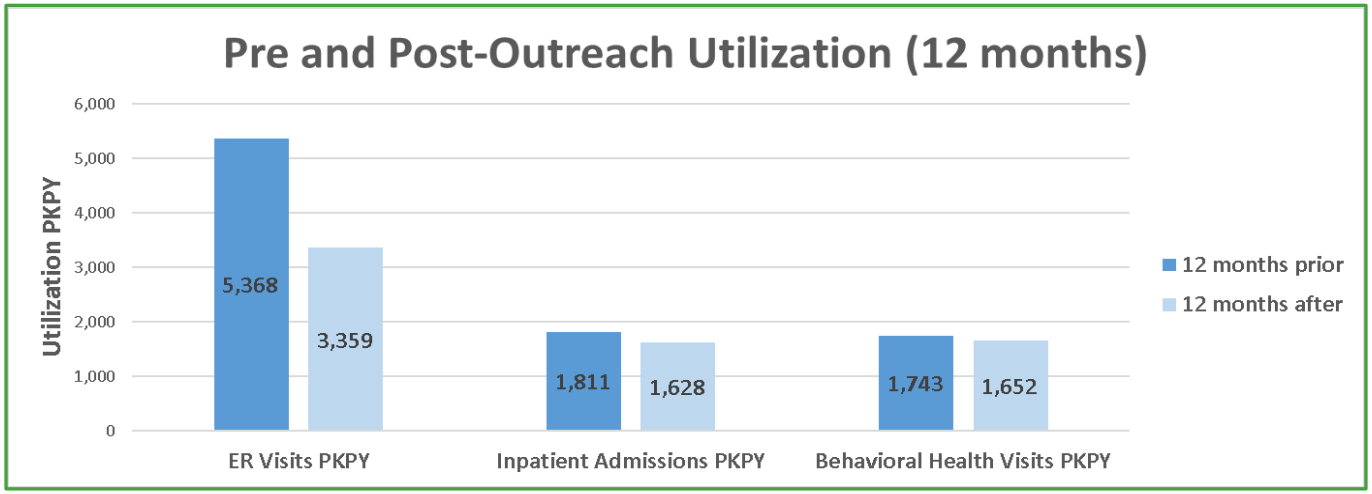
Snap Shot – Patient
50's Female

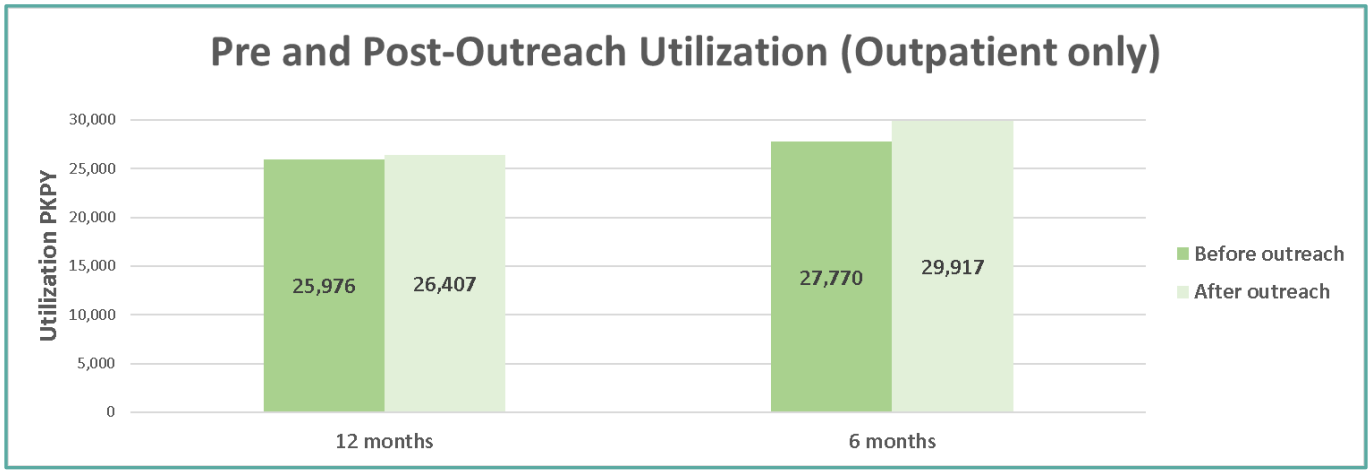
Medical History	Outpatient Services	ADLS	ER Visits/Hospitalizations
1.acute non-ST segment elevation myocardial infarction 2.paranoid schizophrenia 3.urinary incontinence 4.essential hypertension 5.osteoarthritis of left knee joint 6.renal calculus	1.NAMI – no other mental health services, patient declines. 2.HCR – discharged from services due to non-compliance, unsafe environment for staff. 3., Primary Care services. Last seen by PCP in 2021. Declining appointments, home visits by provider(s). Refusing to take medications. 4.Adult Protective Services – rep payee. 5.Fidelis – approved for home health aides (3hrs x 7 days per week), unable to secure LHCSA agency to provide aides. Patient is not self-directed, CDPAP not an option, patient does not have a designee to manage home health aides. Not a candidate for Adult Day Program.	1.Patient does not bathe or shower. 2.Patient remains in the same urine-soaked clothing and bedding for very long periods of time. 3.Patient does not wash clothing. 4.Patient has reported eating under-cooked or raw foods, including meat. 5.Patient does not let Care Manager into apartment to assess completely. There is an overwhelming smell of urine when patient opens her apartment door. Odor can be noticed when elevator doors open to patient's floor.	1.2/9/22 –ER VISIT MHL, UTI ruled out 2.10/26/21 – ER VISIT Caffeine overuse 3.10/15/21-10/18/21 ER VISIT MHL 4.10/06/21 – ER VISIT Flank pain (renal calculus) 5.8/24/21-9/8/21 MHU Admission 6.2/27/21 -3/1/21 Medical Admission for NSTEMI

Patient hospitalized per NAMI request for MHL for inability to take care of self in September

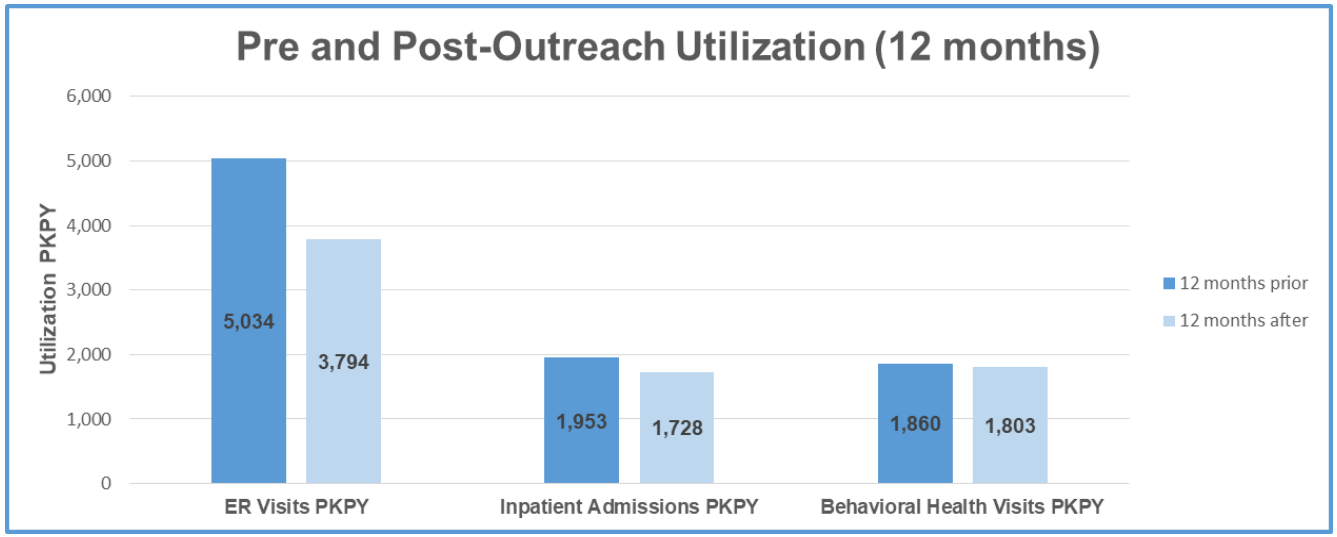
During a lengthy hospitalization, and with advocacy and supports from CBO, it was determined that patient needed a higher level of care. Patient agreed to higher level of care but still was not open to outpatient behavioral health services. CBO worked with a local primary care provider experienced in psychiatric medications was willing to see the patient on an out-patient basis and consult with psych when needed to support the patient's needs for medications to manage symptoms of schizophrenia. Patient is now successfully housed in assisted living facility; and has maintained medications.

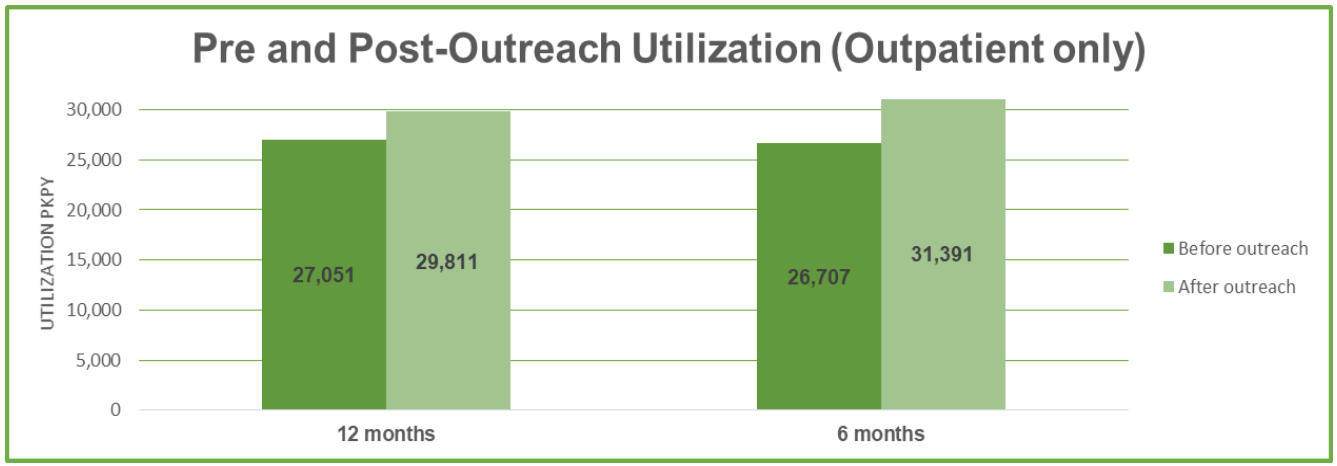
2022


Pre and Post-Outreach Utilization (12 months)
Utilization PKPY
6,000
5,000
4,000
3,000
2,000
1,000
0
5,368
3,359
1,811
1,628
1,743
1,652
ER Visits PKPY
Inpatient Admissions PKPY
Behavioral Health Visits PKPY
12 months prior
12 months after


Pre and Post-Outreach Utilization (Outpatient only)
Utilization PKPY
30,000
25,000
20,000
15,000
10,000
5,000
0
25,976
26,407
27,770
29,917
12 months
6 months
Before outreach
After outreach

2023


Pre and Post-Outreach Utilization (12 months)
Utilization PKPY
6,000
5,000
4,000
3,000
2,000
1,000
0
5,034
3,794
1,953
1,728
1,860
1,803
ER Visits PKPY
Inpatient Admissions PKPY
Behavioral Health Visits PKPY
12 months prior
12 months after


Pre and Post-Outreach Utilization (Outpatient only)
UTILIZATION PKPY
30,000
25,000
20,000
15,000
10,000
5,000
0
27,051
29,811
26,707
31,391
12 months
6 months
Before outreach
After outreach

Community Connections of Franklin County

In 2022, the Adirondacks ACO contracted with several additional North Country community-based organizations (CBOs) to address SDoH, connect high-utilizer members to appropriate resources, and enroll/engage patients in chronic disease self-management programs. Data highlights include:

- One CBO, Community Connections of Franklin County, placed a peer coordinator in the UVMHN - Alice Hyde Medical Center ED and worked with over 140 patients over a 6-month timeframe providing over 130 hours of direct service resulting in 29 referrals to housing support, 38 referrals to food support, and 33 individuals enrolled in health benefits.
- Another CBO, North Country Healthy Heart Network, offered 32 different workshops focused on chronic disease and diabetes self-management, with 234 patients referred to these workshops.

Last year, the Adirondacks ACO added 1 more CBO to support 4 total organizations focused on both peer support in the ED and addressing other health-related social needs. Community Connections of Franklin County for example, added a second peer to another hospital!

NAMI-Champlain Valley added an intervention focused on assisting individuals in need of psychiatric medications through transitional support by utilizing PCPs as a bridge to psychiatry.

Structure Variations

- One CBO partner provides peer services based on referrals from ED patients, Health Home clients, high-utilizer clients identified by providers, and clients following inpatient behavioral health services.
- One CBO partner provides peer services by maintaining in-person staffing for two ED's and seeing all patients. Most patients consent to an SDoH screening (only 2 declinations in 2024).
- One CBO partner has struggled to achieve a high-volume of referrals and we are in the process of transitioning from an all phone-call referral process to trialing 1-day/week in each of the two ED's they serve.

Funding

- Thanks in large part to the success of Adirondacks ACO's existing VBP arrangement with a payor partner, they have year after year continued to provide funding to support the expanding programs.
- We are now approaching commercial payers in an effort to acquire additional funding to support and expand the programs noting the significant reduction in ED utilization and potential cost savings, along with the benefits of investing in better addressing the SDoH needs of the North Country community.

The Impact of a Peer Support Person in the ED

2023:

Monthly average of Medicaid individuals the peer connected with: 19
Monthly average of Social Determinants of Health screenings provided: 12
Monthly average of Medicaid individuals connected to a PCP that maintained their appointment: 3

Beginning last year, the peer at UVMHN - Alice Hyde Medical Center ED began seeing ALL patients regardless of insurance to ensure every individual received that warm hand-off and wrap around care. The peer receives a list each week that identifies high-utilizers and super high-utilizers of the ED (identified as having 3 or more visits in a 6-month period). The list initially had 103 total patients, 15 of which had greater than 20 visits in 2023 and the other 88 had 8 or more visits in 2023.

Once the peer began seeing every patient that came through, in a nine-month timeframe, only **TWO** of those high-utilizers have returned to the ED!

The Impact of a Peer Support Person in the ED

2024 (Through July 31st):

Monthly average of individuals the peer connected with: **72**
Monthly average of Social Determinants of Health screenings provided: **71**

- Individuals connected with peer advocacy services YTD: **18**
- Individuals connected with housing assistance services YTD: **9**
- Individuals assisted with food insecurity services YTD: **17**
- Individuals connected with counseling services YTD: **12**
- Individuals assisted with establishing health insurance coverage YTD: **8**
- Individuals established or re-established with PCP: **46**
- Individuals connected with transportation services YTD: **22**
- Individuals seen who attempted suicide or experienced suicidal ideation: **11**

Member Success Story – Community Connections

I would describe myself as an individual who copes with ADHD and severe seizures pretty much all the time now. This has created severe anxiety for me and sometimes anger because no one understands. I just want to get on the right medications to straighten myself out. I was beginning to feel anxious and unsettled and decided to go to the Crisis Center.

I got really angry because the Crisis Center would not keep me because of my severe seizure disorder. I was brought to the ER from the Crisis Center, they stuck me in room and left for a while, I was getting scared and then angry. No one was coming in so I got up yelled "I am going to go hang myself" and walked out of the ED/ ER.

I was brought back to the ER by the police department, I was even angrier and crying by this time, then a woman walked and introduced herself as Karin; a Care Coordinator with Community Connections who has an office here at AHMC. Karin asked me what happened to me, I just unloaded what was happening and she just listened. It was nice to talk to someone who understood what I cope with daily, she made suggestions and even helped me find a new primary care provider. Before I got discharged, Karin came back to see me and helped get an appointment for a neurologist. It was nice to know I wasn't completely alone.

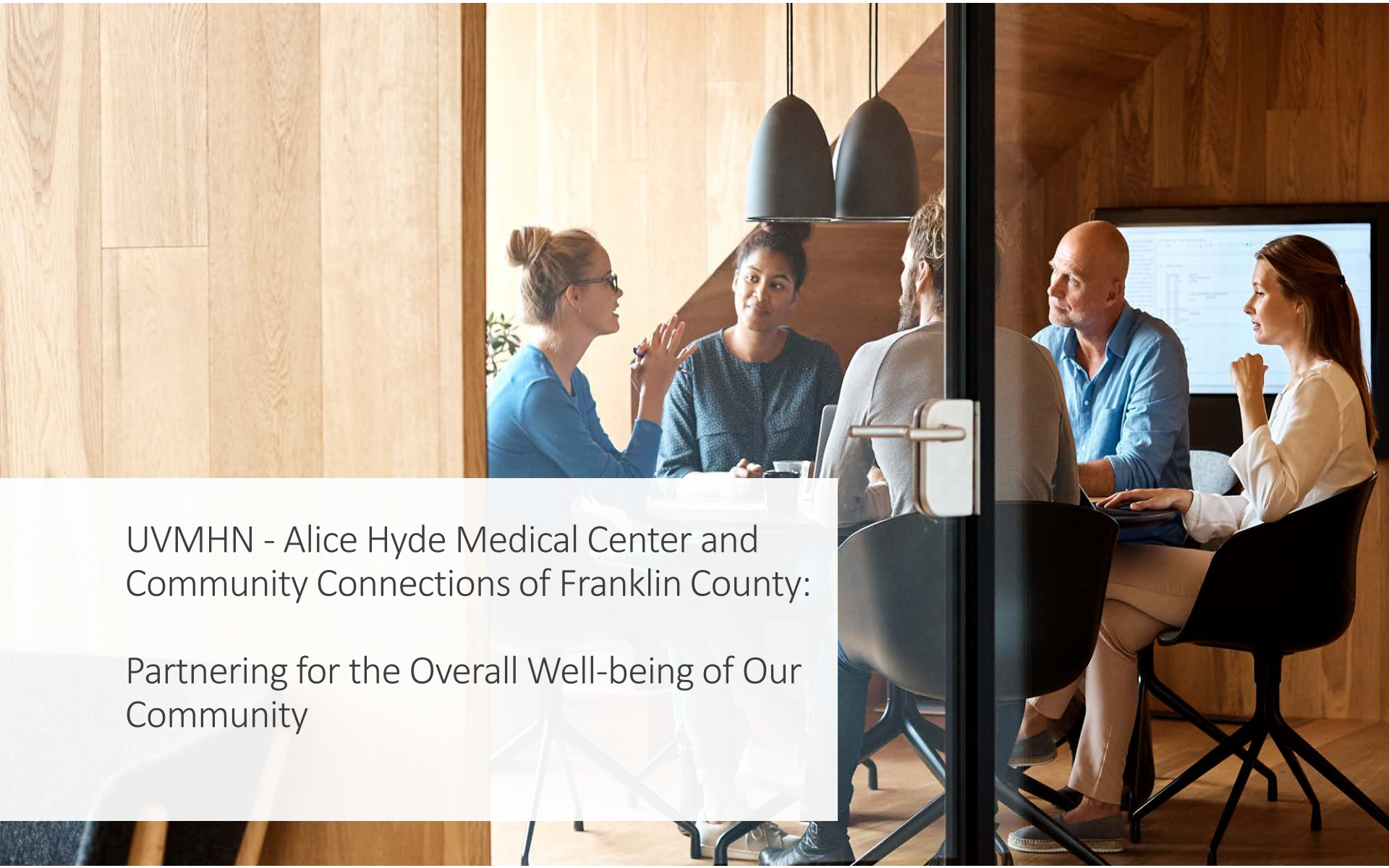
Challenges/Barriers

- Recruitment and Retention
- In the absence of existing buy-in/collaboration with the health system partners, an in-person model has been more effective
- Availability of physical space within ED's
- Logistics of onboarding processes with a partner organization and a staff member working on-site in another facility

Questions?

Katy Margison
Director of Partner Engagement & Communications
kmargison@ahihealth.org
518.480.0111 x.329

Jeremy Powers
Director of Clinical Quality Improvement
jpowers@ahihealth.org
518.480.0111 x.379



UVMHN - Alice Hyde Medical Center and Community Connections of Franklin County:

Partnering for the Overall Well-being of Our Community

Agenda

- Introduction
- Building confidence
- Engaging the audience
- Final tips & takeaways

The Power of Communication



Building partner engagement at all levels

Engaging employees at every level

1. In 2017, we had multiple meetings with clear communication on the hospital's expectations and our expectations for the partnership.
2. Gathering knowledge of how the emergency department operates, regulations and policies. Determining how our service can help medical staff, help their patients.
3. Engaging emergency department staff by presenting the additional service, allowing them to ask questions and offer feedback.
4. Implementing some of the employee's ideas on how the process would flow smoother for the employees and the patient.

Engaging employees at every level

5. Developing and entering into a business agreement.

6. Sharing information for high utilizers.

7. Determining a plan to conduct outreach prior to a high utilizer entering the emergency department again.

8. Developed a plan of meeting with high utilizers in the emergency department.

9. Continued meetings to discuss the program and how best to assist the patients.

Engaging employees at every level

10. COVID hit, we had to temporarily halt the partnership.

11. In 2022, we contracted with the ACO to reengage our partnership.

Evolution of the Initiative

- Initially only Fidelis members were seen.
- Recognizing the broader need, an all patient approach was adopted.
- Peers have even been providing support in the waiting room.
  - Transportation delays for discharged patients were identified.
  - As a result, in partnership with the host facility, meals and transportation assistance have been provided and improved, respectively.
- More recently, one of the peers recognized the need for personal hygiene products and was aware of a school-based program where packs were being provided.
  - CCFC has elected to support the provision of the first 100 care packages with the ACO prepared to provide additional supplies to support the initiative going forward.

Program Feedback

1. One patient told our Peer Care Coordinator, “nobody has ever asked her these questions before, thank you.”
2. One patient shared they did not know all the resources available to them until the Peer Care Coordinator informed them.
3. A Physician’s Assistant stated, “I think what you are doing for our patients is great, you can see all of my patients.”

Thank You

Lee Rivers – CEO

lrivers@communityconnectionsfcny.org

Debbie Beach – Director of Education & Program Management

dbeach@alicehyde.com