VILLAGE CARE OF NEW YORK
The SeniorChoices Long-Term Care Demonstration
Update
June 2008

REFORM MARCHES ON

In 2005, the New York State legislature passed Public Health Law 2807-x, authorizing Village Center for Care (a corporate entity under Village Care of New York's umbrella) to operate a Long-Term Care Demonstration Project to *"develop, evaluate, and implement programs to test new models for the organization and delivery of long-term care services. . ."* To achieve the Demonstration goals, Village Care has worked to develop an integrated residential and community long-term care system called SeniorChoices. The Demonstration moves the nursing home from an end-point in long-term care to making it just one of a number of integrated care opportunities that offer the right service in the right place at the right time. A network of innovative and responsive services is dramatically broadening the scope and availability of community and at-home care and is recreating the role of skilled nursing, while at the same time making the most of service efficiencies.

SeniorChoices grew out of the vision of Village Care's board of directors, which seeks to make growing old in the community a better proposition by offering older adults access to services and supports that are affordable and safe, effectively combining medical and non-medical interventions. A hallmark of this pursuit is person-centered care and care management, buoyed by strong advocacy both for the individual and for the needs of seniors within larger public arenas.

In 2007, the SeniorChoices Demonstration accomplished a great deal on top of the successes achieved during its first 18 months (this report covers April through September, 2007), and anticipates the extension of this originally four-year initiative with an additional three years to complete implementation and evaluation. Key to the SeniorChoices Demonstration are two goals. The first is to assure that Medicaid savings are redirected and reinvested toward home and community-based services and, secondly, to maximize Medicare. The SeniorChoices Demonstration "rightsizing" process can be viewed as a reinvestment strategy, pointing the way for the State on how providers can be in the forefront of reform by effectively reallocating Medicaid dollars.

"MORE APPROPRIATE" USE OF RESIDENTIAL SETTINGS

Legislation: *Residential health care demonstration project. (A) the extent to which there is a reduction in the need for skilled nursing beds for a facility that is eligible to replace its existing skilled nursing facility;*

(B) the potential to design and develop more appropriate smaller residential health care facilities as an alternative to replacing an existing skilled nursing facility;

The SeniorChoices Demonstration is redefining the role of residential services in long-term care reform. SeniorChoices has moved steadily toward the reduction of traditional skilled nursing beds and creation of a new role for residential health care facilities that also supports transitions to less restrictive settings.

Currently, skilled residential nursing care is provided within the existing 200 bedVillage Nursing Home, but as the Demonstration progresses, this will be replaced by a new, smaller, state-of-the-art center of 105 beds. Even before the new nursing facility is built, however, the Demonstration is demonstrating a capacity to change the existing model of nursing home care:

- The use of nursing home beds for short-term, commercial insurance, private pay and Medicare-funded stays has increased by over 100 percent, from 34 to 80 beds.
- From 2005 to 2007, the number of discharges from the facility rose from 374 to 695. On a per-bed basis, the through-put of the facility – a key measure of efficiency – has increased nearly 200 percent in this time period.
- Village Nursing Home's short-term rehabilitation staff provided training, guidance, and eventually referrals to an outpatient day rehabilitation program offered by Village Adult Day Health Center. Day Rehab offers extension rehabilitation services to post-acute/subacute care patients in order to reduce hospital patient recidivism, improve physical functionality and treatment adherence.
- Village Nursing Home, working intensively with the organization's Certified Home Health Agency, improved the discharge/referral process for short-term rehabilitation patients requiring in-home skilled care. As a result of this effort, the nursing home referred over 150 patients for CHHA services during the Demonstration's second year. This represented a 55 percent increase from the previous year.
- The percentage of residents discharged to the community has also climbed – rising 11 percentage points in just two years. This is a result of the SeniorChoices Care Advocate intervention with at-risk individuals through the creation and implementation of a community transition plan upon admission. The way things used to work, as is typically in most traditional skilled nursing facility (SNF) settings with limited resources, most of these at-risk individuals – such as those with dementia or behavioral health issues – converted to permanent nursing home residency. Demonstration funds were used to facilitate the transition of long-term Village Nursing Home residents to community-based residential settings.
- From 2005 to 2007, the annual amount of Medicaid spending for the Village Nursing Home declined by $1.6 million, or 15 percent.
- Required work force competencies for the new model have been established, and training curriculum and competency assessments for direct care staff have been created. Assessment and training commenced during this period. Demonstration funds were used toward the staff costs associated with developing and implementing the training curriculum, work force competencies and assessments. This effort is

discussed in detail in the section titled, "Preparing Today's Work Force for Tomorrow's Challenges."

The SeniorChoices Demonstration will be complete once the current 200-bed Village Nursing Home is transitioned into the 105-bed Village Center for Rehabilitation and Nursing, or VCRN, for which site preparation began early in 2008. Significant progress has been made on this front:

- A 105-bed facility with state-of-the-art care capabilities has been designed. Features include intimate and home-like areas that will function as neighborhoods, with bright, airy open spaces, a unique interior garden promoting healing and a roof deck and garden. VCRN design breaks dramatically from the traditional concept of a nursing home.
- There will be 84 beds for short-term rehabilitation and 21 beds for palliative and end-of-life care.
- Half of the rooms will be private.
- All dining and recreational experiences on the floors will be home-like, contributing to the functional abilities of residents receiving rehabilitation services and care, and to the comfort and dignity of those in palliative care.
- The facility will employ wireless technology for communication and information exchange. Electronic medical records (EMR) will promote efficiency and effectiveness of operations with an emphasis on improving quality of care and life. Much of 2007 and 2008 are being spent on designing this EMR, training staff in its use and implementation on the floors. In 2007, Village Nursing Home staff researched and later identified a portable communication device (like a small walkie-talkie worn around the neck), manufactured by Vocera Communications, which operates by voice recognition. The device expedites communication among staff – particularly those occupied on the units – and enhances staff ability to respond to patient needs and requests, and reduces the delays in response that otherwise would prevail. Demonstration funds will be used during the third year of the Demonstration to help support the cost of adaptation of this system.

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A major operational challenge now is the downsizing of the existing Village Nursing Home over the intervening months so the move to the new facility will be as seamless as possible. Reducing the census in the current Village Nursing Home operation in anticipation of the move to a smaller, specialized facility requires a significant investment. For example:

- To ensure residents safety, staff reductions must proceed more slowly than the census reductions, resulting in continued costs in excess of revenue. For example, a nursing team must exist around the clock, even if only a few residents are left on a unit; only once the unit is completely vacated can staff reductions occur.
- Even as nursing home staff positions are eliminated, costs will be incurred for early retirement or job transition assistance.
- The downsizing effort will also require additional management oversight, to ensure quality care for the residents at the same time that a specific bed- and staffing-

reduction plan must be adhered to. Moreover, it is anticipated that the Care Advocate will continue to collaborate with nursing management and discharge planning staff to make certain that clinical care needs do not "fall through the cracks" while residents are being discharged to other care settings.

CREATING AN INTEGRATED COLLECTION OF COMMUNITY CARE SERVICES

Legislation: *(C) the extent to which the quality, efficiency and continuity of care will be promoted and provided for by the development of integrated long-term care services in the community;*

The Demonstration fully recognizes that demands for services for SNF-eligible individuals will continue and will most likely grow… but those needs cannot be met by long term stays in a nursing home, but must rather be met in the community. A major goal of the SeniorChoices Demonstration is to create, in partnership with the State Health Department, an integrated array of community-based and at-home care with a sufficiently high level of quality services to meet the needs of persons who would otherwise be confronted with a nursing home placement. Progress in this area has been significant::

Long-Term Home Health Care Program

A 125-slot Long-Term Home Health Care Program was opened and filled. Since 2005, the LTHHCP successfully stabilized its frail and disabled clients, resulting in a hospital admission rate below 20 percent for fragile and largely depressed older adults (compared to the neighborhood average of 27 percent for all older adults, frail and non-frail). This is diverting persons from the nursing homes as well, and is part of the re-investment strategy called for in this Demo. Recognizing the value of this program to the community, an application to expand the LTHHCP by 100 slots will be submitted during 2008.

Adult Day Health Care

Village Care's Adult Day Health Care programs are designed to provide older adults with an optional way of receiving nursing, physical therapy, personal care, nutrition, recreational therapies and social work in a community setting. Alternatively, while in-home services as a stand-alone solution do provide skilled and supportive care, they often create situations whereby the older adult becomes isolated in his or her own home. The ADHC programs have become adept at collaborating with CHHA services in offering a comprehensive service plan that wraps in-home services around congregate services. This mixed-service approach helps ensure that older adults with functional or behavioral impairments are frequently being observed by clinicians who can more readily identify change in status and respond accordingly – this ability is key to reducing or preventing frequency of emergency room visits, hospitalizations and nursing home placements.

The ADHC programs have become specialized centers for specific needs. The Chelsea Adult Day Health Center now provides evidenced-based care to a cognitively impaired client base, largely as a result from the intensive person-centered care and dementia training staff undertook during 2007. All participants with dementia or cognitive impairments are registered with the Alzheimer's Association's "Safe Return" program, which provides an

immediate response infrastructure, including the local police precincts, to locate an individual who is at risk of wandering off. This added service has allowed many adults with dementia to remain living and engaged in their community because it provides families and caregivers with the confidence that their loved one will be safe.

The Village Adult Day Health Center staff received training in movement disorders and Parkinson's Disease care strategies and is now believed to be New York City's only ADHC program with staff skilled in working with this clientele. Furthermore, the program secured grant funding from the New York State Health Foundation to initiate a day rehabilitation program for older adults recovering from an acute or subacute cardiac, stroke or tertiary-care related event.

The day rehab program design is an 8-to-12 week intervention offering patients with: A comprehensive assessment; an individualized rehabilitation (PT/OT/SLP) service plan that includes individual and group modalities; nursing, dietary, social work, behavioral health, health education and caregiver support, and door-to-door transportation. Grant support pays for the daily costs for Medicare recipients who otherwise would not be eligible to participate in the Medicaid ADHC program. Referrals for the day rehab program come from acute, subacute and at-home care providers. Efforts are underway to offer this service to health plans as well.

Village Adult Day Health Center initially partnered with the NYU Health System/Rusk Institute for Rehabilitation on patient identification strategies, clinical interventions and care planning, and transitional care arrangements for post-day rehabilitation. [This relationship extended from a Village Nursing Home/Rusk partnership established in 2006 to link the acute and subacute settings to offer a continuous care intervention for patients requiring rehabilitation.] Preliminary outcomes from the initial panels of patients served showed improvement in physical functioning and depression, and a diminished hospital recidivism rate. The program is being evaluated by Lewin Associates, a nationally recognized organization in assessing the potential to achieve improved clinical outcomes under a cost-saving model of care when compared with traditional outpatient rehabilitation models. The program intervention extends through mid-December 2008 and the formal evaluation will be concluded in March 2009.

During this reporting period, an innovative and intensive educational program was designed and implemented for the staff of the ADHC programs, to reinforce the concept of "team," and care planning practices. Together, Village Care's vice-president for quality and the corporate nurse educator developed a 14-week curriculum and measured outcomes according to pre- and post-testing of knowledge and skill concepts. Over 20 staff were engaged in this educational program. The aim was enhance ADHC staff abilities to think and act more comprehensively in delivering patient-centric care, and their understanding that care does not begin and end with the daily arrival and departure of the participant at the ADHC program site. The ADHC programs will eventually serve as the platforms for the organization's new VC PACE (Program of All-inclusive Care for the Elderly) program, and as such, staff must have the competencies required to deliver holistic, interdisciplinary and integrated care in the congregate setting, while always keeping alert to care considerations and cost implications related to other environments as well, such as the home, hospital and outpatient settings.

Additionally, the ADHC staff worked collaboratively with the Quality staff and PACE administrator on the development of an integrated, comprehensive geriatric assessment tool, named Village Interdisciplinary Geriatric Assessment Tool (VIGAT). VIGAT integrates standardized and best practice assessment instruments with state-mandated eligibility tools, which ultimately will provide the data needed to develop a patient-centric plan of care. VIGAT will also be adopted into an electronic format in the EMR that is under development, and used either in its entirety or as individual discipline-specific modules such as nursing, physical therapy and nutrition. Data from VIGAT assessments will be extracted for benchmarking and quality improvement efforts. Much of the work finalizing VIGAT will be done in the Demonstrations third year.

Care Advocacy

The Care Advocacy Team (care advocate social worker, care advocate associations and director of community services) continues to facilitate integration of care across time, place and discipline through the use of the appropriate "system." During this reporting period, the Care Advocacy program underwent a transformation from solely carrying out individual-based "advocacy" work, to effecting "systems change." The shift took place largely as a result of the Care Advocate's ongoing relationship-building efforts with staff at Village Nursing Home, CHHA, the ADHC programs and acute care providers. This enabled these individual providers to think beyond traditional care and discharge approaches to develop those that are patient-centric and comprehensive and which creatively wrap-around supportive services that enable older adults to return to community life. The Care Advocate became a permanent participant in discharge planning meetings convened by both the nursing home and Village Care's CHHA, and was routinely referred cases.

Several key tools were developed by the Care Advocate during this reporting period to facilitate identification of clients, illustrate workflow among different provider settings and assess environmental settings for possible risks and hazards, and a comprehensive psychosocial tool. These resources enhanced the ability of the Care Advocate to respond more effectively and access other support services on a more timely basis to ensure clients received the right service at the right time in the right environment.

Significant efforts were taken during this reporting period to integrate assessment and tracking tools and resources into an electronic environment. Demonstration funds were used to support the further development of the EMR; this work will continue into the third year. Additionally, access to electronic clinical information was made available to the Care Advocate during this time period, which had mixed-results. Village Nursing Home receives PRIs (Patient Review Instruments) from acute-care providers through an electronic system named ESIN, and the Care Advocate was able to access this information in tandem with the nursing home's director of admissions, to identify "rejected" patients quickly and propose a community-based alternative to hospital discharge planning staff. Numerous meetings and outreach to the social work/case management staff at NYU Medical Center and St. Vincent's Medical Center were held to discuss this process; however, due to the hospital pressures to quickly discharge, combined with a "novel" approach to care that required more time to discuss/educate, ultimately few patient and their families were willing to consider a non-institutionalized care approach to post-acute care.

Notwithstanding the gains made by the Care Advocate, there are lingering challenges. Providing transitional care arrangements for clients continues to be greatly hampered by the lack of safe, affordable and supportive housing. Demonstration funds were made available to the Care Advocate to support transitional care arrangements. The Demonstration subsidized the rent-related costs for a nursing home resident who transitioned to Village Care's assisted living residence until his Social Security Income became available. Without this resource, it is unlikely this person would have returned to community-residency. Demonstration funds were also used by the Care Advocate to escort other clients touring potential residential housing locations.

Accomplishments of the Care Advocate include:
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- 53 patients were diverted from LTC
- Complex case load of 20 patients was maintained
- 6 transitional care cases, identified by the Senior Information centers, were accepted onto the case roster

Assisted Living

The state Public Health Council approved Village Care's application for licensing of an 80-bed Medicaid Assisted Living Program (ALP) and its corresponding Licensed Home Care Service Agency (LHCSA). Work was completed by the staff of The Village at 46 & 10 to prepare all policies, procedures and other documentation required by the Department of Health. This capacity is being integrated into Village Care's existing senior living facility and will meet the needs of people who might otherwise have gone to a nursing home.

Programmatic modifications took place during this reporting period as well – staff incorporated a frailty assessment into initial and annual resident assessment instruments, and exercise, intergenerational recreational and nutritional programs were offered for residents who showing signs of isolation and frailty. These ongoing efforts are designed to support continued residency in assisted living and reduce the transfer rate to nursing homes.

PACE

Village Care has received designation for a Manhattan-based Program of All-inclusive Care for the Elderly (PACE) and has been working aggressively to develop this dually capitated program for community-dwelling, nursing home-eligible persons. Numerous key activities were undertaken:

- Key personnel have been hired including the medical director and director of network development/provider relations.
- PACE was incorporated
- Approval was received from the NYS DOH to file for a certificate of incorporation;
- A strategic marketing plan was prepared;
- The provider network is in formation:

- Working with DOH on improving the clarity of the rate-setting methodology, and,
- A quality assurance and performance improvement plan was developed.

Demonstration funds supported the consultation and vital technical assistance services provided to develop the PACE application, supporting documentation and the financial *pro forma*.

NNORC

The community infrastructure is also strengthened by SeniorChoices' implementation of a State Office For the Aging Neighborhood Naturally Occurring Retirement Community (NNORC) supportive service program, and a state Office of Mental Health Gatekeeper Program. Both of these undertakings work to find and intervene with at-risk older adults before a crisis and hospitalization occur (thus diverting nursing home demand and reducing SNF utilization). The "Heart of Greenwich Village NNORC" also provided exercise classes designed to reduce the risk of falls and promote wellness, along with concrete social work service coordination and entitlement planning. Plans include providing home visits and health education and screening by a nurse. NNORC staff received training by the United Hospital Fund on implementation of screening tools with NNORC participants. Outreach was conducted to over 185 older adults living within the NNORC catchment area (located within central Greenwich Village).

The Gatekeeper Program is collaborative project with St. Vincent's Medical Center's Behavioral Health Services designed to work with natural community contacts (such as health care providers, merchants, doormen, pharmacies, managing agents and community agencies) to identify community-dwelling older adults in need of behavioral health services; refer these individuals to proper health care providers; and assist with any coordination of care-related issues, accordingly. These natural community contacts, or "gatekeepers" as they are known, are trained by Village Care and St. Vincent's program coordinators to identify and refer seniors in need. The gatekeepers become the "eyes and ears" for the behavioral health providers who can then ultimately intervene earlier, rather than when a need becomes acute. The Gatekeeper Program focused on development of its infrastructure and outreach/training materials during this reporting period and will begin the intervention phase in the Demonstration's third year.

PREPARING TODAY'S WORK FORCE FOR TOMORROW'S CHALLENGES

Legislation: *(D) the extent to which the project will provide training to health care workers to appropriately staff new community based models of long term care; (E) demonstrate the involvement and support of workforce in the program redesign;*

There has been substantial progress using a joint labor-management workgroup called "The Building the Future Committee," made up of senior executives from both labor and management and front-line nursing home workers and nurses who have done the following:

- Determined the skills required to work on a short-stay, rehabilitation-focused unit and on palliative care units as well as skills required to provide care using technology-

supported communication systems and electronic medical records (EMR). Based on these required competencies, a staff training program has been developed and delivered, and competency-testing is now being developed. The empowerment of "bedside workers" to better assist in the healing process is one of the most important and exciting aspects of the Demonstration and will have statewide implications.

- Redesigned the job descriptions for certified nursing assistants, housekeepers, maintenance and food service personnel, and laundry and linen supply workers.
- Developed a transition plan to reduce the SNF work force while maintaining full employment for those who wish to continue working with frail and disabled individuals. This includes the creation of an early retirement option, and job opportunity provisions throughout SeniorChoices.

SeniorChoices must now integrate its monitoring and communication technology to enable the least-restrictive care environment possible, while at the same time ensuring the safety of residents, staff and visitors. Nurse call, resident wandering and video surveillance will all interact. EMR will enable the efficient flow of information across settings, also helping to ensure safety and quality-of-care. Demonstration funds were used during this reporting period to support the development of EMR. As these technology solutions are determined and implemented, the work force competencies must be concurrently expanded to include abilities to work within a technology-enhanced environment

EVALUATING THE PROGRESS – WHAT THE SENIORCHOICES DEMO WILL ACHIEVE

Over three decades Village Care has engaged a strategy of building systems of care that look to offer services in the least restrictive and most appropriate settings. Village Care, responding to consumer needs and demands for more and better choices for long-term care, has been building the framework for SeniorChoices since the mid-1990s.

The Demonstration moves the nursing home from an end-point in long-term care to making it just one of a number of integrated care opportunities that offer the right service in the right place at the right time. With the replacement of the traditional-style Village Nursing Home with the Village Center for Rehabilitation and Nursing, SeniorChoices will offer the community a state-of-the-art, short-stay rehabilitation facility focusing on restoration and recovery, along with a palliative care, end-of-life residential program where skilled nursing care is provided in an environment that is pleasant, comfortable and caring.

Moreover, the Demonstration will shift and expand capacity to community settings with the establishment of PACE, Medicaid Assisted Living Program, Care Advocate services functioning as point-of-entry and an expanded Long-Term Home Health Care Program. Village Care's two adult day health centers, primary care clinic, senior walk-in storefronts for information and referral, Certified Home Health Agency and licensed home care program will collectively continue to help older adults living with frailties, remain in the community.

Village Care will provide a formal evaluation that documents change processes and determines the impact of SeniorChoices on staff, clients and the community served. The

evaluation will be conducted by Brookdale Center on Aging of Hunter College, and Demonstration funds are being used to support this essential work.

The evaluation plan will focus on transformations in the long-term care work force. SeniorChoices is breaking ground by incorporating 1199SEIU in long-term care work force transition planning and implementation. SeniorChoices represents a major shift in roles among union certified nursing assistants with competencies serving as the basis for job placements rather than seniority. Through this Demonstration project, Village Care and 1199SEIU plan to establish a model for work force transitions that can be adopted within other long-term care systems.

The evaluation plan will use validated standardized measures wherever possible to understand changes in the SeniorChoices work force – both in terms of skills/competencies and more intrinsic transformations relative to worker empowerment, worker/client relationships and "connectedness" to the organization. Goals include benchmarking where possible, evaluating the effect of training and new practices on employees, learning more about employee values and attitudes, determining how to make the best use of resources, achieving quality and increasing marketability.

SENIORCHOICES
CURRENT AND FUTURE
People Served

Today		**Proposed Future** (2013)	
Program (Existing Village Nursing Home – 200 SNF beds)	Older Adults Served Annually	Program (With 105 SNF beds – Village Center for Rehabilitation and Nursing)	Older Adults Served Annually
SNF Level Need		**SNF Level Need**	
• SNF Facility (VNH)	758	• SNF Facility (VCRN)	798
Community Services		**Community Services**	
• CHHA	199	• CHHA	421
• LTHHC	99	• LTHHC	198
• ADHC/PACE	271	• ADHC/PACE	300
• Information Centers	595	• Information Centers	1,500
• 46 & Ten	97	• 46 & Ten	97
• Medicaid ALP	--	• Medicaid ALP	152
• Targeted Case Management	--	• Targeted Case Management	500
Total Older Adults	**2,019**	**Total Older Adults**	**3,966**

SNF- Skilled Nursing Facility; PACE - Program of All Inclusive Care for the Elderly; LTHHC- Long Term Home Health Care Program,; ALP - Assisted Living Program; ADHC - Adult Day Health Care; CHHA - Certified Home Health Care Agency.