

HOSPITAL AND HOME CARE PARTNERSHIPS WITH AGING PROVIDERS COLLABORATION MODELS AND LESSONS LEARNED



Statewide Hospital-Home Care Collaborative
for COVID-19 and Beyond

PREPARED IN COLLABORATION WITH THE FOLLOWING PARTNERS



This collaboration was made possible through the generous support from the Mother Cabrini Health Foundation.



TABLE OF CONTENTS

01

INTRODUCTION

02

ASSOCIATION
PERSPECTIVES

03

MODELS OF COLLABORATION

04

AGING SERVICES COLLABORATIVE

06

COMMUNITY CARE CONNECTIONS

10

STEBEN COUNTY OFFICE FOR THE AGING
AND FULL CIRCLE AMERICA PARTNERSHIP

12

GERIATRIC HOME PROGRAM

13

COLLABORATION

14

COLLABORATION CHALLENGES

15

ESSENTIAL COMPONENTS OF
COLLABORATION

16

HOW TO COLLABORATE

17

BACKGROUND: AGING
IN NEW YORK STATE

24

NEXT STEPS
CONTACT INFORMATION
LEARN MORE

20

RELATED INITIATIVES

25

ACKNOWLEDGMENTS

INTRODUCTION

Hospitals and home care providers have long collaborated as essential partners in the care continuum. Hospital-home care collaboration is vital to primary/pre-acute care, post-acute care, and care transitions between hospitals and in-home services. On a broader level, hospital-home care collaboratives are critical to tackling major problems in the health care system.

Since 2020, the Home Care Association of New York State Education and Research (HCA E&R), Healthcare Association of New York State (HANYS), and Iroquois Healthcare Association (IHA) have worked together under a generous grant from the Mother Cabrini Health Foundation to develop and implement the *Statewide Hospital-Home Care Collaborative*. Initiated during COVID-19, the collaborative focused not only on emergency intervention, but on permanently strengthening and improving patient care and outcomes in the pre-acute, primary/ preventive; and the post-acute, transitional, and in-home recovery/continuing care healthcare settings.

As part of these efforts, HCA, HANYS, IHA, and leaders and providers of the aging network in New York State joined efforts to identify compelling prototypes for collaboration between hospitals, home care agencies, and aging services. To further this effort, HCA, HANYS, and IHA worked with the Association on Aging in New York State and several county offices for the aging to present collaborative models and lessons learned for hospital, home health, and aging services collaboration to stakeholders across the care continuum. These models can be replicated or used as a roadmap across the state to support and strengthen healthcare capabilities, services, and outcomes.

While the benefits of collaboration are clear, many barriers persist. Workforce shortages, the lasting impact of the COVID-19 pandemic, and regulations limit collaboration between these sectors. Despite these roadblocks, many organizations including those who have participated in this primer have found innovative ways to work together.

Broader change is necessary to meet the aging needs that are present in the system today, and the aging needs that are anticipated in the future. To improve health system delivery for those who are aging and for the population, we must commit to building a sustainable workforce through education and training, influence regulatory changes, and mobilize the consumer as a key partner in healthcare.

COLLABORATIVE MODELS

Essex County Office for the Aging, Lifespan of Greater Rochester, Steuben County Office for the Aging, and Broome County Area Agency on Aging shared their prototypes for hospital, home care, and aging services collaboration. The models highlighted in this primer provide a foundation for future collaborative work. These models demonstrate that successful hospital, home care, and aging services collaboration is multifaceted. This primer can serve as a catalyst for all stakeholders to begin or continue collaboration efforts.

Essex County Office for the Aging partnered with the University of Vermont Elizabethtown Community Hospital to develop the Aging Services Collaborative model. The Office for the Aging ensures that older adults use community services to decrease the number of unnecessary emergency room visits. Communication between the hospital and OFA allows both organizations to work together to better understand older adults' social determinants of health and medical needs, and how they impact each other.

Steuben County Office for the Aging, Steuben Senior Services Fund, and Full Circle America partnered to support aging in place. Technology, dedicated volunteers, and other professionals form a circle of support around the older individual. This program allows for peace of mind and continuous remote monitoring of the patient.

Lifespan of Greater Rochester developed Community Care Connections as a three-county pilot project after identifying the acute need for an integrated care approach for older adults. Lifespan sought to break down the silos between community-based aging services and medical systems to improve health outcomes by addressing the social determinants of health (SDOH) that physicians' offices do not have the time or resources to manage.

The Broome County Area Agency on Aging and Lourdes Hospital collaborated to form the Geriatric Home Program. The program aims to prevent unnecessary hospital emergency department visits by serving older adults who are homebound and have limited mobility, as well as identifying and helping those who are not attending their regular primary care visits.

ASSOCIATION PERSPECTIVES ON HOSPITAL, HOME CARE, AND AGING SERVICES COLLABORATION

HOME CARE ASSOCIATION OF NEW YORK STATE

“Collaborative models offer an approach that integrates core providers and practitioners for comprehensive, coordinated and patient-centered care. It’s an approach that optimizes care and efficiency, and solves major system gaps especially in access and quality. The fragmentation of coverages and service criteria for complex, older populations further increases their care challenges across the entire continuum. Including aging services providers in core collaboratives with hospitals and home care agencies expands the capacity to address these challenges. This report is a roadmap to these hospital-home care-aging services partnerships and how they can be applied to benefit the patients and communities in transformative ways. We are committed to supporting providers, communities and state-local officials in these efforts.” – HCA President Al Cardillo

IROQUOIS HEALTHCARE ASSOCIATION

“In Upstate New York, in particular, the aging population is growing rapidly. This means the majority of hospital patients are older, generally sicker and in need of greater resources. Our Upstate New York providers are also faced with labor shortages that are exacerbated by an aging workforce. Now more than ever, the need for collaboration across the continuum of care is critical,” according to Gary J. Fitzgerald, CEO of the Iroquois Healthcare Association. “Continued evolution of innovative programs like the models identified to date will be critical to forming policies that will help keep the elderly ‘aging in place’ in the future.”

HEALTHCARE ASSOCIATION OF NEW YORK STATE

“HANYS members understand that older adults must have the opportunity to meaningfully participate in their own care, said HANYS President Bea Grause RN, JD. “Our hospitals, health systems and providers across the continuum have embraced evidence based approaches to healthy aging that have demonstrably improved care for older adults. These models provide further proof that we can and must partner across the continuum to deliver care that honors the preferences for older adults and their loved ones.”

ASSOCIATION ON AGING IN NEW YORK STATE

“The collaboration between facility-based care and Offices for the Aging is paramount to support older New Yorkers, caregivers, and families, and allow individuals to age in place. The Association on Aging in New York is thrilled to partner with the Home Care Association, HANYS, and IHA to highlight best practice models for holistic care,” said Becky Preve, Executive Director, Association on Aging in New York.

NEW YORK STATE OFFICE FOR THE AGING

“Partnerships and coordination are not just critical, they are necessary: to help bridge health care with social determinants of health and other support needs that have a direct bearing on healthy aging. This is very much the focus of our work under Governor Hochul’s leadership to develop the state’s first-ever Master Plan for Aging. New York’s offices for the aging work closely with over 1,200 community-based partners to provide holistic, person-centered assistance to older adults. We applaud their dedicated and focused effort to work with hospitals and home care providers in ways that are meeting the needs of the whole person across disciplines, and the outcomes speak for themselves.” -New York State Office for the Aging Director Greg Olsen

MODELS OF COLLABORATION

The following section of the primer details four collaborative models that are currently being used, have been used in the past or will be used in the future. HCA, HANYS, and IHA thank the Association on Aging in New York and the participating county offices for the aging for supporting the *Statewide Hospital-Home Care Collaborative* and for sharing their perspectives and collaborative models.



AGING SERVICES COLLABORATIVE WITH ESSEX COUNTY OFFICE FOR THE AGING AND UNIVERSITY OF VERMONT ELIZABETHTOWN HOSPITAL

Summary and Goals: This partnership ensures that the “whole person” is served. The OFA ensures that older adults use community services to decrease the number of unnecessary ER visits. Communication between the hospital and OFA allows both to work together to better understand the SDOH needs and medical needs. Communication between the OFA and Essex County Health Department enables ongoing coordination as the patient moves through the system.

Key Takeaways: The program has helped decrease ER visits, reduced hospital length of stay and enabled seamless transitions from the hospital to the home. Successful communications between healthcare providers and community-based organizations were key in supporting these efforts.

PROGRAM OVERVIEW

The Aging Services Collaborative with Essex County Office for the Aging and the University of Vermont Elizabethtown Community Hospital serves patients 60 years of age and older. The Essex County Office for the Aging and Elizabethtown Community Hospital have a great working history that enables both entities to collaborate to serve people while in the hospital setting and allow for a smooth transition back into the community.

OFA ensures that services are utilized while older adults are in the community to decrease the number of unnecessary ER visits. A social worker/case manager communicates constantly with OFA to ensure that the hospital is aware of the patient’s needs and that the community services are already in place for the patient. Healthcare providers share their requests with the social worker/case manager, which are relayed to/ordered with appropriate providers. OFA works with the social worker/case manager to address needs upon discharge and communicate concerns and services being provided in the community to the social worker/case manager while the older adult is in inpatient.

Essex County has two certified home health agencies: Essex County Home Health Unit and HCR Home Care. The Essex County home health unit operates under the Essex County Health Department, allowing for collaboration and daily meetings. Clients are shared between the aging and health offices upon every initial start of care. The health department gives each patient an information release form that covers resources provided by the office for the aging. The county health department uses an electronic record system for its patient data.

Krissy Leerkes, Director of the Essex County Office for Aging, accesses this data and refers her staff to patients. Ongoing communication is key. For example, if a patient needs general home health services initially and these visits prompt the need for home-delivered meals, communication between home health and the office for aging will occur to best serve the patient.

AGING SERVICES COLLABORATIVE

PATIENT SUCCESS STORY

A 67-year-old female residing with her husband who works during the day had limited mobility and did not use a walking device consistently, causing multiple falls each day. Each fall meant a call to local emergency medical services for a lift assist. Often, these falls warranted an ER visit that could have been avoided by her using a walking device. This older adult was phoning 911 at least three to four times a day for assistance. Eventually, the hospital contacted OFA and they assessed her for services. A personal emergency response system was installed, home-delivered meals began, and a personal care aide was authorized daily while the husband worked. The 911 calls drastically decreased, and the ER services were not needed unless medically necessary for other health impairments.

OUTCOMES

The program decreased ER visits, reduced hospital length of stay, and allowed for seamless transitions from the hospital to the home. Successful communication between healthcare providers and community-based organizations (CBOs) allowed for this seamless transition from hospital to home and from home to hospital. Patients who refuse services that would allow them to become healthier and age in place can be a challenge. Another challenge is when eligibility and criteria for community services become a barrier to accessing services.

IMPORTANCE OF COLLABORATION

Communication between multiple healthcare providers and the aging network enables holistic care. Often, providers look at a patient with a “medical lens” and are not fully aware of the services that are already being provided in the community or could be offered to help the patient better address SDOH. The model enables all stakeholders to work together as a care team to ensure that all needs, social and health, etc., are being addressed.

NEXT STEPS

The hospital and OFA are working to communicate via the Health Information Exchange of New York. This communication will become a part of the patient's electronic medical record and allow providers to better understand the supports and services that are in place, and the concerns that need to be addressed. This collaboration can easily be replicated in any hospital/healthcare setting with the local OFA.



COMMUNITY CARE CONNECTIONS: IMPROVING OLDER ADULTS' HEALTH THROUGH COMMUNITY-BASED AGING SERVICES AND HEALTHCARE INTEGRATION

Summary and Goals: Lifespan of Greater Rochester is a regional nonprofit serving Monroe and surrounding Finger Lakes counties. It provides information, advocacy, guidance, and more than 30 services for older adults and caregivers. Lifespan is funded, in part, by New York State and the Monroe County Offices for the Aging, New York State Department of Health, US Administration on Aging, United Way of Greater Rochester, and donations. Recognizing the need to integrate community-based aging services with healthcare, Lifespan sought to break down the silos between community-based aging services and medical systems to help improve health outcomes for older adults. Lifespan was able to achieve this by addressing SDOH that physicians' offices do not have the time or resources to manage.

Key Takeaways: Integrating the Community Care Connections intervention with healthcare systems results in a positive impact on the quadruple aim of lowering costs, improving health outcomes, and increasing patient and healthcare staff satisfaction.

PROGRAM OVERVIEW

Lifespan recognized the need to integrate community-based aging services with healthcare after observing that the disconnect between the two was causing gaps in care and contributing to multiple and often unnecessary hospitalizations.

To better address the needs of medically complex older adults in the region, Lifespan formed a community advisory committee in 2016 that included representatives from two local health systems, the Monroe County Office for the Aging, health insurers, Monroe County Medical Society, Finger Lakes Performing Providers System, the Rochester Regional Health Information Organization, and accountable care organizations.

Guidance from the advisory committee was essential in developing the integrated care model that became Community Care Connections (CCC). With initial support from DOH, Lifespan developed CCC as a three-county pilot project in 2015 because of the acute need for an integrated care approach for older adults.

A key aspect of Lifespan's mission is to address the needs of underserved, low-income older adults, living in the Greater Rochester and Finger Lakes region, who are struggling to navigate healthcare and financial benefit systems. Through well-established partnerships with more than 85 Primary Care Physician offices, Lifespan engages the target population through referrals from medical providers who recommend the CCC program to their patients. Medical providers make a referral when they recognize a social need and/or barrier to positive health outcomes that they are unable to address.

A significant number of the older adults Lifespan serves live just above the poverty line, do not have access to the same level of care management services as those with Medicaid, and therefore experience a gap in their ability to navigate the healthcare system and financial benefits.

“I AM SO GRATEFUL FOR HAVING LIFESPAN AS A RESOURCE, ESPECIALLY DURING THE PANDEMIC. THESE UNMET SOCIOECONOMIC NEEDS HAVE BECOME SO OVERWHELMING, AND LIFESPAN DOES SUCH A GREAT JOB AT ADDRESSING THEM,” SAID CASEY HANABURG, PA, WESTRIDGE PRIMARY CARE.

COMMUNITY CARE CONNECTIONS

HOW IT WORKS

Social work care managers conduct home visits, assessments, and care planning and link patients to community-based services such as housing, caregiver support, and financial benefits. Patients are visited in their homes and referred by physicians and/or home care agencies to assess the home environment, social support, caregiver network, and Activities of Daily Living. Patients are linked to supports such as meals, transportation, financial management assistance, chore services, fall prevention workshops, government benefits, etc. Social workers guide caregivers and help ease the stress of caregiving.

Assigned CCC care managers call the referral source to confirm a connection with the patient. After CCC staff complete the GWS, initial care plans outlining patient-driven goals are sent securely to the registered nurse care manager/referral source. Most physician practices scan the care plan into the electronic medical record. Upon case closure, the closing care plan that identifies goal accomplishment is shared with the referral source.

Licensed practical nurse health-care coordinators (licensed practical nurses working as patient advocates and educators), schedule and attend appointments with the patient, coordinate transportation, ensure access to preventive health screens, conduct medication reconciliations, and provide health literacy training. “Attending appointments” can now encompass in-person, three-way phone calls or full video telehealth appointments with physicians/physician assistants. When necessary, technology is facilitated for required telehealth appointments.

Each referred patient is assessed via the **Geriatric Wellness Screen** developed in partnership with the University of Rochester. The GWS gathers information about patients' health and SDOH. Each domain in the GWS results in an Older Americans Resources and Services score, which informs the development of a personal care plan to address health and social needs. Referrals are accepted from physician practices and a feedback loop is provided to these practices about action steps.

PATIENT SUCCESS STORY

CASE STUDY: MARGARET

- Margaret was regularly drinking sugary soft drinks, adding large amounts of sugar to coffee and other beverages, and most meals consisted of processed frozen and pre-prepared or fried foods. Her A1c was 13.
 - She was inconsistent with attending medical and podiatry appointments.
 - She was experiencing anxiety due to financial difficulties; her sister-in-law who owned the home she lived in passed away and the house was in foreclosure; her power bill was unpaid, and she was receiving minimal family support.
 - Margaret had five ER visits in the year before enrollment in the program.
- CCC team interventions contributed to the below successful outcomes.
- The LPN healthcare coordinator attended medical appointments with Margaret, helping her ask questions and understand the provider's instructions.
 - The team helped reinforce prescribed dietary and lifestyle changes.
 - The social work care manager worked with Margaret to address housing needs, and finances, and establish communication with her daughter who has since moved in with the client and helps with meal preparation and daily activities.
 - Currently, Margaret's A1c has been reduced from 13 to 7. She is eating a diabetic-friendly diet, attending medical appointments regularly, has had no ER visits or hospitalizations, and continues to call the coordinator for advice and support.

COMMUNITY CARE CONNECTIONS

OUTCOMES

Independent evaluation by the New York Academy of Medicine confirmed that integrating the CCC intervention with healthcare systems would positively impact the quadruple aim of lowering costs, improving health outcomes, and increasing patient and healthcare staff satisfaction.

Post-program enrollment results:

- Between June 10, 2016, and April 4, 2022, a total of 2,103 clients joined CCC and provided consent for data sharing;
- hospitalizations decreased by 26%;
- ER visits decreased by 30%; and
- observation stays decreased by 22%.

Satisfaction:

- 95% of medical professionals surveyed feel their patients benefit from the support provided by CCC.
- 75% of older adults served rated the program as “good or “very good.”

Patient Population Data:

- The racial/ethnic composition of older adults served by CCC in 2021 was Asian, < 1%; Black, 27%; Latino, 7%; Native American, < 1%; and White, 66%.
- The greatest number of people served by CCC in 2021 lived in Monroe County (86%). In 2021 the program served a total of 730 clients: 21% under age 65; 30% between 65 and 74; 28% between 75 and 84; 21% over age 85. Seventy-two percent of individuals served in 2021 were considered frail/disabled.
- The data collected in the CCC program analysis shows 41% of those served reported an income below \$1,000 per month; 52% had an income below the federal poverty line. Since 2016, the number of Medicaid beneficiaries enrolled in CCC has increased from 19% to 31% of the total population served.
- Those with annual incomes under \$20,000 are 105% more likely to lose their teeth, 154% more likely to have diabetes, and 224% more likely to be diagnosed with depression.¹

**HOSPITALIZATIONS
DECREASED BY**

26%

ER VISITS DECREASED BY

30%

IMPORTANCE OF COLLABORATION

Community based organizations that address SDOH are crucial to improving the health and well-being of older adults. The pending New York State Medicaid Section 1115 waiver recognizes the importance of integrating CBOS with healthcare systems. An independent analysis of CCC by the New York Academy of Medicine demonstrates the effectiveness of this integrated and collaborative approach.

“Lifespan’s [CCC] intervention and advocacy for our most complex patients allows those social determinants to be identified and addressed so action can be taken to remove some of those barriers. Lifespan is an invaluable resource for our providers and patients to help our patients achieve their highest level of good health,” commented Cathy Calcagno, RN, Clinical Care Manager, UR Medicine Primary Care Artemis Health.

¹Common Ground Health. (2019) *Overloaded, the Heavy Toll of Poverty on Our Region’s Health*.
<https://www.commongroundhealth.org/news/articles/study-finds-regions-no-1-health-concern-is-poverty>

COMMUNITY CARE CONNECTIONS

CHALLENGES

At the start of the pandemic, medical offices reduced in-person appointments. CCC staff became adept at facilitating telehealth and virtual appointments using Lifespan tablets for participants who lacked the technology. Lifespan adapted a home safety checklist to ensure safe home visits. The pandemic delayed CCC participant enrollments for some funders' projects, resulting in the need to obtain no-cost extensions.

Barriers to further integration of community-based aging services with health care are rooted in the “wrong pocket problem.” Many disagree about what sector of the healthcare system should be responsible for paying CBOs to address SDOH. Therefore, shifting funding mechanisms and the regulatory framework pose serious challenges.

The Medicare beneficiary population does not have access to the same level of care management services as those with Medicaid and therefore experience a gap in their ability to navigate the healthcare system and financial benefits.

STRENGTHS

According to Lifespan, CCC works because it;

- offers medical providers and patients a central, trusted point of contact for addressing nonclinical health issues;
- closes communication gaps: patients, providers, and Lifespan staff describe multiple ways the CCC program contributes to improved communication with patients and across care settings; and
- offers Lifespan staff the time and flexibility to provide holistic and comprehensive care.

“NON-COMPLIANCE IS NOT SYNONYMOUS WITH ATTITUDE. IT'S OFTEN IMPACTED BY THE SOCIAL DETERMINANTS THAT CREATE BARRIERS A PATIENT CANNOT NAVIGATE ALONE.”

NEXT STEPS

With support from the Finger Lakes Performing Provider System, Lifespan is expanding CCC to a nine-county region of the Finger Lakes: Chemung, Genesee, Livingston, Ontario, Monroe, Seneca, Steuben, Wayne, and Yates. The model is also supported by contracts with an Accountable Care Organization, and an insurer and has been approved for funds from the American Rescue Plan Act. Lifespan anticipates approval of the 1115 waiver will provide an opportunity for sustainable funds. Lifespan became state certified to provide Health Home Care Management this year to support older adults and use Medicaid as a sustainable funding source.



STEBEN COUNTY OFFICE FOR THE AGING, STEUBEN SENIOR SERVICES FUND, AND FULL CIRCLE AMERICA PARTNERSHIP

Summary and Goals: The purpose of this collaborative model is to support older people as they age in place, through the use of technology, dedicated volunteers, and caring professionals. These individuals form a support circle around the participant, allowing for peace of mind and continuous remote monitoring.

Key Takeaways: Collaboration is essential. The program works best when there is strong collaboration with the medical provider network and other community agencies.

PROGRAM OVERVIEW

The Steuben County Office for the Aging partnered with Steuben Senior Services Fund and FCA to enhance its offerings to support older people as they age in place. As highlighted in the book, *Alone and Invisible No More* by founder Allan Teel, MD, the partnership began studying the program in the fall 2015 and the hosting of an aging-in-place conference in Corning, New York. Enthusiasm for this new model of care was remarkable and the next steps for implementation were taken immediately. The first client was served in 2017.

Traditional OFA home care services bring welcome support to older persons and their caregivers, but there are gaps because the service is not available 24/7. The Full Circle America program uses technology and dedicated volunteers and professionals to form a circle of support around the member, allowing for peace of mind and continuous remote monitoring. Medical providers, administrative staff, board oversight, caseworkers, OFA staff, and volunteers make this program possible. Befitting OFA's mission, this program serves the 60+ population desirous of aging in place. The average age of members is 89.

The relationship with other parts of the aging network, healthcare providers, and CBOs is critical to case finding and providing responsive help to evolving situations for FCA members. FCA is an option to assist older adults with problem-solving and avoiding higher-cost care. FCA works best when there is strong collaboration with the medical provider network and other community agencies and includes virtual offerings for socialization, health, and exercise at a time when a personal connection is often in short supply. Local donations support this community program, along with grant funding from the Care Compass Network and the United Way.

KEY OUTCOMES:

The program aligns with patient wishes, with many members choosing to pass away in their homes. This program was very beneficial throughout the COVID-19 pandemic. Dining with friends and family has been the most popular offering among members.

- **\$2.2 MILLION IN COST SAVINGS SINCE INCEPTION;**
- **77 MEMBERS HAVE BEEN SERVED; AND**
- **411-DAY AVERAGE LENGTH OF STAY.**

STEBEN COUNTY OFA, STEUBEN SENIOR SERVICES FUND, AND FCA PARTNERSHIP

PATIENT SUCCESS STORY

A neighbor acting as an informal caregiver was happy to provide support to her friend but wanted to continue to enjoy her annual cross-country motorcycle trip. The FCA program enabled her to take the trip while maintaining ongoing contact with the care receiver through her smartphone.

Early on, there was a member who was considering a trip to the ED as she was feeling ill, but instead had a Zoom consultation with Dr. Teel located in Maine. She relayed her symptoms and Dr. Teel asked her about the Gatorade on her end table that was in view on the video camera. She informed him that she had been very thirsty and drinking a lot. The Gatorade turned out to be interacting with her new medication. A follow-up with her local doctor revealed that this was, in fact, the source of her medical issue, and treatment was started.

FUTURE AREAS OF COLLABORATION

This initiative can serve as an employee support model for the business community to promote employee retention and satisfaction and to reduce absenteeism due to eldercare demands. Hospital and other facility discharge planners need education so that referrals to FCA models are commonplace and a normal part of the discussion with patients and families. The use of existing and next-generation innovative technology devices can expand the reach of service providers and adults moving through the life cycle.

STRENGTHS

Following a pilot test, the success of the program resulted in permanent approval to use NYSOFA Expanded In-home Services for the Elderly Program (EISEP) ancillary dollars for EISEP-eligible member coverage. Caregivers report improved confidence and reduced stress when supporting an older adult, which promoted sustainability. Emerging programs in aging only work to the degree that they can respond to each client's unique situation.

The case manager's ability to truly get to know the participant is key to the success of FCA. The FCA case manager's deep understanding of a participant enables them to identify potential problems that might otherwise lead to a nursing home placement. The case manager, well-versed in OFA and healthcare services, can screen for care needs on an ongoing basis and make referrals where appropriate for healthcare or non-medical services and supports. This cannot be accomplished by a hands-off algorithm without human touch and insights.

Co-location in the Steuben County OFA allows for a real-time discussion about options for the members' changing needs. FCA has been a game-changer for the community as it fills the gaps that traditional services don't always reach.

NEXT STEPS

Given the positive outcomes of this initiative, Steuben County OFA and FCA will seek reliable and sustainable financing. An economy of scale will be achieved as more members are added. Community education related to long-term care planning should include a demonstration of how FCA improves the patient experience. The benefits of the program should be highlighted to show how it addresses loneliness, social isolation, and limited engagement of long-distance caregivers, families, and friends. Technology provides a vehicle for lifelong learning for members who would otherwise be disconnected from activities for personal fulfillment. High-level analysis with associated metrics can demonstrate to payers the cost-savings outcomes.

GERIATRIC HOME PROGRAM: BROOME COUNTY AREA AGENCY ON AGING AND LOURDES HOSPITAL

Summary and Goals: This program was created to prevent unnecessary emergency visits by serving older adults who are homebound, have limited mobility, and those not attending primary visits. Medical providers, social workers, occupational and physical therapists, the Office for the Aging, and home care aides are all involved.

Key Takeaways: This model has been delayed due to pandemic-related staffing shortages. The intention is to reduce the social isolation of older adults and provide care that otherwise might not happen due to SDOH and gaps in the system.

PROGRAM OVERVIEW

The Broome County Area Agency on Aging met with Lourdes Hospital staff to discuss creating a Geriatric Home Program. Lourdes has seen a decline in patients attending appointments since the COVID-19 pandemic and this program aims to address their needs and prevent emergency visits.

Dr. M who sits on the Broome County OFA Advisory Board was already meeting with geriatric homebound clients in their homes. Dr. M and his team proposed creating a support program where Dr. M does the initial visits and then places nurses, occupational therapists, physical therapists, etc., in the home. In addition, OFA offers a caseworker to visit the home to provide options for counseling and acts as a team member in creating a safe home plan for the geriatric patient. In return, OFA would be a direct contractor of Lourdes Hospital and would purchase caseworker services and provide a dedicated caseworker to the Lourdes Geriatric team to contact as needed.

This initiative, while still under development, has opened the door to the collaboration of hospitals, home care, aging, and other partners to support the continuity and effectiveness of services.

NEXT STEPS

Options are being discussed for using OFA expertise, including caseworkers visiting the homes of Lourdes homebound clients to help them assimilate to telehealth technology so appointments can occur at the home. OFA is providing tablets and iPads to older adults upon request and sends interns to patients' homes to help these older adults learn the technology, which includes access to a virtual senior center and the setup of telehealth communication as needed.

Also under discussion is the operation of telehealth mobile sites at senior centers, which would provide blocks of time in which people can sign up for a telehealth appointment with their doctor at a facility that may be closer to their homes. The mobile sites would have the technology and support built in to complete telehealth visits.

Similar to the work with Lourdes, outreach is now occurring with the United Health Services health system in Broome County. Both providers have reported that older adults are not attending Medicare wellness check visits. The collaborative team hopes partnering with OFA can help address this issue and be meaningful to medical systems.

FUTURE AREAS FOR COLLABORATION

This initiative is not active yet, but this project's development has opened the door to working in collaboration with Lourdes in other capacities.

Ideas such as the one addressed here, if initiated, would reduce the social isolation of older adults and provide care that otherwise might not happen if providers' "they come to us" mentality continues. It is important to build a care model for the older adult population that can move services to the older adult when appropriate.

COUNTY MODELS OF COLLABORATION CONCLUSION

These models show current examples of what is being done in New York State between local aging network service providers, hospitals, home care, physicians, and other partners. These models are presented as a resource for potential replication or adaptation in whole or in part, to strengthen delivery system capabilities, care, and outcomes. Collaboration is possible and is happening in New York State to better serve the older and aging population.

COLLABORATION

Collaboration and innovation are necessary to meet New Yorkers' healthcare needs. While in the hospital, the typical patient experience features a cadre of health professionals working together to deliver quality care to meet complex needs. The transition to a new setting such as a long-term care facility can lead to unnecessary readmission and excess utilization of resources. Communication and teamwork skills are essential for all healthcare disciplines to deliver safe, effective, timely, and quality care. Communication can reduce the likelihood of negative outcomes and excess utilization of resources.



COLLABORATION CHALLENGES^{2,3}

LACK OF TRUST

Mistrust can result in miscommunication or conflict, potentially affecting the success of the project. Discuss any conflicts or concerns to create a trusting environment.

COMMUNICATION GAPS

If team members don't feel like they can communicate openly, they are less likely to be involved, affecting the success of the project. Create opportunities for open discussion where all members feel comfortable expressing their thoughts and opinions.

LIMITATIONS & LACK OF COMMITMENT

Partners might be engaged at first, and then begin to pull back involvement, or commitment might be uncertain from the start. Set out clear expectations early on and be open about organizational or individual limits. Schedule check-ins to revisit expectations and limitations.

ORGANIZATIONAL SILOS

Organizational silos make information sharing difficult and can obstruct communication. Create a standard operating procedure defining what protocols to follow.

FINANCIAL & REGULATORY CONSTRAINTS

Financial resources and regulatory constraints can limit collaboration. Ensure the group understands the parameters of the constraints. If necessary, members can try to introduce policy or regulatory changes to assist in achieving the group's goals. Seek financial support if possible.

MAINTENANCE

Maintenance of data tracking, information collecting, training, and invoicing can be difficult. Identify point people to be responsible and set regular deadlines.

ESSENTIAL COMPONENTS OF COLLABORATION^{2,3}

Accept that members will show different levels of engagement and progress, and some will need more support. Reorganize, re-strategize, and plan accordingly. Be open and flexible and find a balance in structure with reporting requirements and timelines. Avoid “that’s not how we do it here” attitudes because when demands become too restrictive and dictatorial, it can remove individual freedom and diminish the quality of the collaboration.

STAFF AND TEAM ENGAGEMENT

To avoid miscommunications and future conflict, lay out roles, responsibilities, engagement, and communication expectations at the start. Use open communication to resolve conflict. Priorities among partners might change, and communication during this time is a must to avoid delays and duplication. Use shared workspaces to make communication easier.

COMMUNICATION

Keeping it simple can improve chances of success. Ensure topics and goals of the collaboration are focused and be realistic about what can be achieved. If the goal is unreachable and progress cannot be seen, the team can lose motivation.

SIMPLICITY

Collaborating takes time and effort to build working relationships. Some might be unable to dedicate time to improving these relationships. Getting organized into a shared workspace to seamlessly share data, resources, and support will help with this transition and time constraints.

TIME & ORGANIZATION, SHARED WORKSPACES

HOW TO COLLABORATE^{2,3}

Step 1: Identify the goal and vision

- Identify the goal.
- Map the vision.
- Identify individual strengths.
- Identify personnel and knowledge gaps.
- Review past collaborative efforts and models; reflect on lessons learned.
- Identify immediate barriers.
- Set realistic priorities.

Step 2: Stakeholder mapping and plan development

- Select engagement strategies and mechanisms.
- Identify needed stakeholders.
- Establish clear, realistic expectations.
- Clarify goals.
- Review team roles.
- Develop a plan.
- Consider available or needed resources.
- Consider a timeline.

Step 3: Preparation and Logistics

- Focus on long-term goals.
- Determine logistics.
- Use collaboration tools to strengthen engagement strategies and assist in information sharing.
- Become familiar with team member roles and capacities.
- Describe how to overcome barriers.
- Layout a timeline and responsibilities.

Step 4: Engagement and Review

- Ensure equitable stakeholder contribution.
- Mitigate any tension.
- Encourage open-mindedness and innovation.
- Build consensus.
- Review the engagement process and pinpoint the most effective approach.
- Review task delegation.

Step 5: Action Plan

- Identify opportunities for feedback.
- Revisit goals.
- Plan for follow-up activities.
- Determine if the group is on the right track to meeting goals.
- Reflect on group participation and chosen engagement strategies.
- Adjust as needed.

²Adapted from: Alison Taylor, et al., "Five-Step Approach to Stakeholder Engagement," BSR, April 2019, <https://www.bsr.org/en/our-insights/report-view/stakeholder-engagement-five-step-approach-toolkit>.

³Adapted from: Sandeep Kashyap, "8 Steps to Collaboration to Work in a Collaborative Environment," Proofhub, <https://www.proofhub.com/articles/collaborative-working-environment>.

BACKGROUND: AGING IN NEW YORK STATE

NEW YORK STATE'S AGING POPULATION

The number of New Yorkers ages 65 and older increased by 647,000 (26%) over the past decade. During the same period, New York State's overall population grew by 3%. There are now more New Yorkers aged 65 and older statewide than there are children under the age of 13.⁴ A total of 4.6 million individuals are 60 years of age or older, and 4.2 million are between the ages of 45 and 59.⁵ The number of age 85+ New Yorkers has increased from 353,299 to 444,005 (26%) since 2007.

**BY 2030, MORE THAN
5.3 MILLION NEW
YORKERS WILL BE
OVER THE AGE OF 60.⁶**

OLDER ADULTS:⁴

- are the fastest-growing segment of the population statewide;
- contribute significantly to the local, state, and care economy;
- are more diverse than ever: the number of older immigrants has increased by 41% compared to 21% in 2007;
- more older adults live in poverty: increased from 401,488 older adults in 2007 to 443,941 today, an 11% increase;
- make up 65%, \$481 billion, of all household income generated by New York State; and
- support local businesses, schools, and Medicaid through home ownership.

CHRONIC CONDITIONS AND LONG-TERM CARE NEEDS⁵

Approximately 6.2 million (41.1%) of adult New Yorkers suffer from a chronic disease. Those living with chronic diseases are more likely to report their poor health status and activity limitations than those living without chronic diseases. Examples of chronic diseases include arthritis, asthma, stroke, heart disease, diabetes, and cancer.

- The number of people over age 60 with functional impairments will grow by more than 20% by 2025.
 - Of these people, 81% will live in the community and 19% will live in nursing homes or group care facilities.
- The number of people with self-care limitations is projected to rise to 15% for those age 75 and older and 25% for those 85 and older.
- 10% of the population that has a health condition that lasts for six or more months has difficulty with bathing, dressing, or getting outside the house.
- 20% of the population that has a health condition that lasts for six or more months has mobility limitations and has difficulty going outside the house alone. This number is projected to rise to one-third for those 75 and older and 50% for those aged 85 and older.

⁴González-Rivera, C., Bowles, J., and Dvorkin, E. (February 2019) New York's Older Adult Population Is Booming Statewide. Center for an Urban Future. <https://nycfuture.org/research/new-yorks-older-adult-population-is-booming-statewide>.

⁵New York State Office for the Aging. (July 2022) Over 1.3 million New Yorkers received services through NYSOFA and aging network programs in 2021. <https://aging.ny.gov/news/nysofa-annual-report-details-services-older-new-yorkers-aging-population-trends-statistics>.

⁶Long Term Care Planning Project. https://www.health.ny.gov/facilities/long_term_care/planning_project.

BACKGROUND: AGING IN NEW YORK STATE

HOSPITAL AND HOME CARE SERVICES FOR THE AGING POPULATION

As the older population continues to grow and shift, increasingly, older adults prefer to “age in place” in their homes and communities.⁷ For many, staying in a familiar environment is ideal. Moving into a new and unfamiliar location such as an assisted living facility or nursing home can be an uncomfortable and potentially distressing adjustment.⁸ As time goes on, aging in place comes with health and mobility challenges that threaten independence and the ability to successfully stay in the home.⁹

Because of the growing preference to age in place, multiple sectors must collaborate to fortify care transitions. The transition from the hospital to the home is particularly crucial. Poor care transitions can negatively impact a patient’s health and could be prevented by ensuring better collaboration across the system.

Without collaborative care transitions, family caregivers are often left with the responsibility of caring for aging relatives with limited knowledge concerning the needs, disease process, or available treatments and supports. Collaborative care from professionals across sectors can help reduce the caregiving burden and lead to a better quality of life for the aging and their families.

AGING SERVICES IN NEW YORK STATE

The New York State Office for the Aging

The New York State Office for the Aging works to help the state’s 4.6 million older adults be as independent as possible for as long as possible. This is achieved through advocacy, development, and delivery of person-centered, consumer-oriented, and cost-effective policies, programs, and services. NYSOFA aims to improve access to, and the availability of appropriate and cost-effective non-medical supportive services for older individuals to maximize their ability to age in the community and avoid higher levels of care and publicly financed care. NYSOFA achieves these goals through its network of 59 AAAs.

Association on Aging in New York

The Association on Aging in New York represents New York State’s 59 AAA’s, also known as the offices for the aging, or OFAs. The association provides advocacy, education, and other capacity-building opportunities to the AAAs.

Area Agencies on Aging

AAAs are responsible for designing, funding, and coordinating programs that maintain older New York State residents in their homes, postpone the need for more medically intensive and costly health care services, and avoid what’s often referred to as “spending down” to Medicaid. AAA services supplement the assistance provided by family support and help keep New Yorkers from spending down their resources, going on Medicaid, or being admitted to skilled nursing facilities. A local office can be found in every county in the state. New York City has one office that covers all five boroughs.

⁷AARP. (November 2021) AARP Survey Shows 8 in 10 Older Adults Want to Age in Their Homes, While the Number and Needs of Households Headed by Older Adults Grow Dramatically. <https://press.aarp.org/2021-11-18-AARP-Survey-Shows-8-in-10-Older-Adults-Want-to-Age-in-Their-Homes-While-Number-and-Needs-of-Households-Headed-Older-Adults-Grow-Dramatically>.

⁸Oakley, D. (August 2011) The Psychological Impact of Moving to Assisted Living and Residential Care. *Women’s Health and Wellness*. <https://www.empowher.com/caregiving/content/psychological-impact-moving-assisted-living-and-residential-care>.

⁹National Institute on Aging. (November 2020) Maintaining mobility and preventing disability are key to living independently as we age. <https://www.nia.nih.gov/news/maintaining-mobility-and-preventing-disability-are-key-living-independently-we-age>.

BACKGROUND: AGING IN NEW YORK STATE

HOME CARE AND HOSPITAL PARTNERSHIP STRENGTHS WITH AGING PROVIDERS

Hospital, home care, and aging services bring unique strengths to the table. Sharing these strengths through collaboration can benefit community members. Different providers know of various community resources and have partnerships that can be shared.

Hospital providers know of supports in the community to help with the care transition, including transportation services, assistance with durable medical equipment, home modifications, access to food, and receiving necessary medications upon discharge.

Familiar with the home and community setting, and the growing sector of consumer-preferred care, home care providers are able to support aging in place. Home care providers have an existing and engaged partnership with managed care, hospitals, physicians, and other community service support providers.

Aging service providers understand concerns specific to the aging population's needs and how to best address these needs. Home care and hospital providers may have less knowledge of patients who are aging and can therefore learn from those who work in the aging service network.

TOGETHER, HOME CARE, AGING SERVICES, AND HOSPITAL PROVIDERS CAN CREATE A HOLISTIC CARE PLAN FOR OLDER INDIVIDUALS IN THE COMMUNITY.

WORKFORCE BARRIERS TO HOSPITAL - HOME CARE - AGING COLLABORATION

The COVID-19 pandemic drastically impacted the healthcare system and will leave a lasting imprint on healthcare delivery. Workforce shortages, present before the COVID-19 pandemic, were exacerbated by the emergency and will continue to impact the healthcare system. Facilities that do not have enough staff may face difficulties collaborating.

The number of workers continues to remain below the pre-pandemic numbers at skilled nursing and assisted living facilities. In February 2020, care facilities had 976,100 employees nationwide. In July 2022, these facilities had only 892,200 employees (an 8.6% decrease). Between 2017 and early 2020, employment was growing in every health service industry except for nursing care facilities.¹⁰

In addition to workforce shortages, the lasting impact of the COVID-19 pandemic and associated regulations are among the barriers that can interfere with collaboration among hospitals, aging services and home care providers.

¹⁰ Wager, E., et al. (August 2022) What impact has the coronavirus pandemic had on health employment? Peterson-KFF. *Health System Tracker*. <https://www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment>.

RELATED INITIATIVES

NEW YORK STATE MASTER PLAN FOR AGING

Executive Order No. 23: Establishing the New York State Master Plan for Aging

The Master Plan for Aging framework provides an opportunity for a coordinated and comprehensive approach that spans traditional service, infrastructure, and program boundaries to achieve results for older New Yorkers and all residents in New York. These initiatives address many healthcare challenges including workforce recruitment and retention and service delivery for older adults. The plan aims to enable older adults and those with disabilities to choose to remain in their communities. Meaningful choice requires access to a broad range of public and private programs, resources, and supports. These include health care, home care, food and nutrition, human services, housing, and transportation. The goals of this plan align with the information and goals of the shared models in this primer.

Learn More: [New York State Prevention Agenda 2019-2024 \(ny.gov\)](https://www.ny.gov/newsroom/new-york-state-prevention-agenda-2019-2024)

NEW YORK STATE PREVENTION AGENDA, HEALTH ACROSS ALL POLICIES INITIATIVE

The 2019-2024 New York State Prevention Agenda is a health improvement plan for state and local action. This blueprint aims to improve the health and well-being of all New Yorkers and promote health equity across populations who experience disparities.

Learn more: [roadmap_report.pdf \(ny.gov\)](https://www.ny.gov/newsroom/new-york-state-prevention-agenda-2019-2024)

MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT PROGRAM (MOLST)

The MOLST program is designed to improve the quality of care for people who are seriously ill at the end of their life. Honoring patient preferences is a critical element in providing quality end-of-life care. To help physicians and other health care providers discuss and convey a patient's wishes regarding cardiopulmonary resuscitation and other life-sustaining treatment, DOH approved MOLST form (DOH-5003), which can be used statewide by health care practitioners and facilities.

Learn more: [eMOLST Physician-Hospital-Home Care Collaborative | Dr. Patricia Bomba, NYU Hospital, Visiting Nurse Service of New York](https://www.ny.gov/newsroom/new-york-state-prevention-agenda-2019-2024)

[WATCH Webinar: https://hanys.adobeconnect.com/pahshkucx4al/?proto=true](https://hanys.adobeconnect.com/pahshkucx4al/?proto=true)

STATEWIDE VIRTUAL SENIOR CENTER (VSC)

The Statewide Virtual Senior Center is a partnership between HCA and Selfhelp Community Services to support isolated homebound New Yorkers. HCA Education and Research and Selfhelp Community Services are working together under a grant from the Mother Cabrini Health Foundation to build up capacity and expand access to Selfhelp's Virtual Senior Center so that all patients or clients served by home and community-based care providers can access this powerful platform in every region of the state.

Independent evaluation has found that joining the VSC has multiple emotional and physical health benefits including reducing isolation and loneliness and increasing connectedness and self-reported health status. Social isolation has long afflicted older adults and is linked to higher physical and mental health risks. With COVID-19, this kind of social isolation has intensified exponentially. The VSC can help bridge this gap for patients who may be struggling.

The VSC allows homebound older adults to connect with peers, volunteers, professional caregivers, and community members through virtual social sessions, educational and exercise classes, personal and cultural enrichment, health self-management, and wellness activities. Participants can log into the VSC whenever they choose (24/7), review the weekly calendar, and join classes that interest them.

THE VSC IS FOR INDIVIDUALS WHO:

- Are homebound or socially isolated;
- want to have social interaction/meet people;
 - want to contribute to class discussions;
- are willing to learn or know how to use a computer;
 - have access to the internet; and
- have access to a computer, tablet, or other devices.

AGE FRIENDLY INITIATIVE

Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association and the Catholic Health Association of the United States.

The U.S. Census Bureau reports that the U.S. population aged 65+ years is expected to nearly double over the next 30 years, from 43.1 million in 2012 to more than 83.7 million by 2050. Older New Yorkers participate meaningfully in community and family life now more than ever. However, they continue to face challenges in accessing patient-centered care. These challenges — from overmedication to falls and treatable cognitive concerns — are largely preventable.

HANYS launched the New York State Age-Friendly Action Community in 2020 with support from the Department of Health, The John A. Hartford Foundation, and the IHI.

- The Action Community helps participating health systems accelerate the adoption of the 4Ms framework (What Matters, Medication, Mentation, and Mobility) using an “all teach, all learn” model.
- Participants receive group education through monthly webinars and topical coaching calls and attend a half-day virtual summit.
- Teams then perform tests of change to identify which approaches work best in their unique care settings. Under the expert guidance of the HANYS team and our four faculty, teams then scale and spread 4Ms care across their facility, transforming the care delivered to older adults. Sites earn official recognition from IHI as Age-Friendly Health System participants.

ACTION COMMUNITY PARTICIPANTS WILL:

- attend monthly “deep dive” webinars with case studies and discussions to address common challenges, led by HANYS staff and the four expert faculty;
- receive one-on-one technical assistance while testing and implementing 4Ms care;
- attend a half-day virtual summit to develop an action plan to scale up efforts of local 4Ms adoption and sustain Age-Friendly care for every older adult in your clinical setting;
- connect with other participants to share strategies, identify lessons learned, overcome barriers, and expedite the implementation of the action community goals; and
- build quality improvement knowledge that can be applied beyond the scope of this initiative.

Learn more about the Age-Friendly Initiative: <https://www.hanys.org/age-friendly/>

EVERHOME COLUMBIA

EverHome Columbia, Inc. and Apollo Care LLC developed a proposed Pilot Program funded by the Home for the Aged. The pilot's primary goal is to demonstrate the efficacy and cost savings of an integrated platform of products and services delivered to individuals who want to age in place and receive care in their homes. The population served is a diverse group of chronically ill individuals in Columbia County. Professional care coordinators, an Advisory Board of stakeholders, and essential representatives from Columbia County and New York State guide EverHome, which provides virtual care in 400 homes throughout the county.

The Pilot will create "Virtual Homes for the Aged" in partnership with the OFA, social services, and emergency services. This project will bring 21st Century care to the homes of older adults in Columbia County, and beyond. An innovative app by VivaLynx will transform patient residences into "virtual care homes." This new technology will help to avert further deterioration of health; improve healthcare, communication, and outcomes; and identify potential care crises. Professional care coordinators enable the health team to assess every individual's needs, resources, and home environment to craft a unique care plan.

COMMUNITY PARTNERSHIP

Community partners support EverHome initiatives by providing guidance through the maze of care options to promote health, independence, and quality of life. EverHome works collaboratively with community organizations including Columbia Memorial Hospital, Columbia County Healthcare Consortium, NYS OFA, Columbia County Chamber of Commerce, emergency medical services, and medical providers.

HOW IT WORKS:

STEP ONE: COMPREHENSIVE IN-HOME ASSESSMENT

- Full review of goals, challenges, and worries that exist now or may exist in the future.
- Home evaluation and modifications to accommodate care.
- Medical history, nutritional status, and medication assessments.
- Physical and cognitive issues investigation for care needs.
- Determine options for affordable care and Medicaid eligibility.
- Create a personalized care options report.

STEP TWO: IMPLEMENT THE CARE OPTION PLAN

- Guidance for the selection of appropriate care and resources.
- VivaLynx home care technology installation.
- Full assessment for successful implementation.

STEP THREE: MONITORING FOR PEACE OF MIND

- Monitoring daily activities and responding to alerts through touchless technology.
- Technology provides information to family members, caregivers, and providers.
- Assist with in-home telemedicine visits and any transition needs to other levels of care.

NEXT STEPS

The collaboration models outlined in this primer provide a foundation for collaborative work to unite multiple healthcare and service sectors on behalf of older New Yorkers. Solutions must address the wide array of factors impacting an older person's ability to access aging services in the home and community setting. All stakeholders must work together toward this goal.

HCA, HANYS, IHA, and the Association on Aging produced this primer of collaborative models and key takeaways to share widely across the health continuum; educational system; business community; with local, state, and national leaders; and the public. This primer acts as a catalyst for all stakeholders to begin or continue collaborative efforts.

These collaborative efforts are an important component, but broader change is necessary to address society's aging needs. We need a renewed commitment to education and training, investment and mobilization of the consumer as a key partner in healthcare, and innovations in technology, and regulatory changes.

CONTACT INFORMATION

**KAYLEE WHITE,
BSPH, CNA**

Associate for Public Health and Policy
Home Care Association of New York State (HCA)
kwhite@hcanys.org

**DORA FISHER,
MPH**

Director, Post-Acute and Continuing Care
Healthcare Association of New York State (HANYS)
dfisher@hanys.org

**EILEEN B.
MURPHY, MA**

Senior Director, Special Projects
Iroquois Healthcare Association (IHA)
emurphy@iroquois.org

BECKY PREVE

Executive Director
Association on Aging in New York
becky@agingny.org

LEARN MORE

Hospital-Home Care Collaboration Site

Direct link: <https://hca-nys.org/statewide-hospital-home-care-collaborative/>

Association on Aging in New York

Direct link: www.agingny.org

ACKNOWLEDGMENTS

The contributions of the models, participants, and the support and generosity of the Mother Cabrini Health Foundation under the *Statewide Hospital-Home Care Collaborative*, are appreciated.

We thank the following for participating and sharing their perspectives and models of collaboration:

AGING SERVICES COLLABORATIVE WITH ESSEX COUNTY OFFICE FOR THE AGING AND UNIVERSITY OF VERMONT ELIZABETHTOWN COMMUNITY HOSPITAL

Krissy Leerkes

Director
Essex County Office for the Aging
Aging Services Provider

Vicki Smith

Accredited Case Manager
University of Vermont at Elizabethtown
Community Hospital
Social Work/Case Management

Julie Tromblee

Vice President/Chief Nursing Officer
University of Vermont at Elizabethtown
Community Hospital
Administration

COMMUNITY CARE CONNECTIONS: IMPROVING OLDER ADULTS' HEALTH THROUGH COMMUNITY-BASED AGING SERVICES AND HEALTHCARE INTEGRATION

Annie Wells

Division Leader, Healthcare
Initiatives
Lifespan of Greater
Rochester

Christine Peck, LMSW

VP of Care Coordination
Lifespan of Greater
Rochester

Sandy Schencke, BSW

Program Coordinator
Lifespan of Greater
Rochester

Richard Gangemi, MD

Rochester Regional Health

Ann Marie Cook

President and CEO
Lifespan of Greater
Rochester

Judy Rowe

Chief Operating Officer
Lifespan of Greater
Rochester

William Hall, MD

University of Rochester
Medical Center

STEBEN COUNTY OFFICE FOR THE AGING, STEUBEN SENIOR SERVICES FUND, AND FULL CIRCLE AMERICA (FCA) PARTNERSHIP

Allan Teel, MD

Founder and Consultant of
the Program

Linda Tetor

Executive Director
Steuben Senior Services
Fund

Patty Baroody

OFA Director
Steuben County

Gabe Smalt

Caseworker/Coordinator

GERIATRIC HOME PROGRAM: BROOME COUNTY AAA AND LOURDES HOSPITAL

Mary Whitcombe

OFA Director
Broome County

Lucia Esposito

OFA Manager/MIS
Coordinator/Transportation
Specialist
Broome County

Jerome Miklouchich, MD

Geriatric Services
Lourdes Hospital

Matthew Johnson, RN

Clinical Service Line Director
Lourdes Hospital

PREPARED IN COLLABORATION WITH THE FOLLOWING PARTNERS



This collaboration was made possible through the generous support from the Mother Cabrini Health Foundation.

