Health Planning Council Long Term Care Committee
Long Term Care Council for NY Connects
Friday, August 6, 2021 12:00 - 1:15 pm (Virtual)
(Approved) **Minutes**

Attending: Sarah Askew (Statewide Senior Action Council), Carolyn Beyers (community member and HSC alumni), Diane Bradac (Cornell), Jan Bridgeford-Smith (Women's Opportunity Center), Katie Chichester (Ithaca Housing Authority), Beverly Chin (HSC Staff), Patricia Derowitsch (presenter – Noyes Hospital/ URMC) Ashley Earll, LMSW (FCS GMH), Dora Fisher (presenter - HANYS), Elizabeth Gray (presenter – Noyes Hospital/ URMC), Beth Harrington (SPCS Board), Amy Jackson (COFA), Cheryl Jewell (Love Living at Home), Danielle Jones (Cayuga Health Partners),Wil Lawrence (community member), Heidi Love (Cayuga Health Partners), John Mazzello (HSC), Anisa Mendizabal (Ithaca Urban Renewal), Lisa Monroe (COFA), Ann Nadler (FLIC), Anna Rosenblatt (Cayuga Health Partners), Lenore Schwager (community), Dawn Sprague (COFA), Serena Stern (E-Cornell), Nicole Zulu (HSC)).

Topic/ Discussion	Follow Up/ Action
Welcome, Introductions, and Announcements (includes "chat highlights") Bev started the meeting at 12:02 pm and asked the speakers for introductions. • Dora Fisher – is the Director of Post Acute and Continuing Care at the Healthcare Association of New York State (HANYS). • Patty Derowitsch – is the Director of the Med/ Surg Unit at Noyes Memorial Hospital. • Elizabeth Gray – is the Regional Care Management Coordinator and Director of Utilization Review and Care Transitions with Noyes Memorial Hospital • Sarah Askew – NEW Virtual Resident Family Action Council is reaching out to nursing home residents, family members or friends of residents who want to share their visiting experiences and learn about their rights. First meeting is August 10. Call 800-333-4374 for questions. This council is operated by the Statewide Senior Action Council. • Anisa Mendizabal – is a Community Development Planner with Ithaca Urban Renewal which administers HUD CDBG funds. She looks to understand community needs and services.	Send flyers to meeting participants.
Review of May 7,2021 Minutes Approved as written. (Beth Harrington/ Diane Bradac)	Post on website
Presentation "Age-Friendly Health Systems Upstate Action Community Initiative" Dora Fisher began with a broad overview of Age Friendly Health Systems and why/ how the statewide project launched. Age Friendly (AF) Health Systems is a concept introduced by the John A. Hartford Foundation and the Institute for Healthcare Improvement around 2017 to bring an evidence-based framework to hospitals for providing care to the older adult population. The framework, the 4 M's, addresses: What Matters to Adults (knowing an adult's preferences for health outcomes and care), Mentation (addressing mental health), Medication (ensure that meds align with other M's), Mobility (ensure that adult can move safely and maintain function as desired). The NYS Department of Health approached HANYS about developing a statewide learning collaborative that would bring AF Health Systems to hospitals with the goal of	Recording will be posted on the website.

reaching 50% by 2024. Three funders, including the Health Foundation of Western and Central New York, provided for the project to launch in April 2020 although this was delayed due to the pandemic. Experts from HANYS taught the principles over seven months and individual health providers implemented these using an iterative improvement process (plan-do-study-act). Dora observed that the AF concepts have taken off due to the Baby Boomer Generation which seeks to be active in the health care they receive. This resulted in a cultural shift for hospitals as they provide care to this population.

Patty Derowitsch spoke about Noyes Hospital's experience with the AF initiative. She provided background on Noyes Hospital (small 70-bed hospital in the rural community of Dansville, 32 MS beds, 8 ICU, and ER, a part of the University of Rochester Medical). Noyes has been designated as an Age Friendly Health Systems Participant. They became involved because the project supported Noyes and UR's mission, uses existing resources, aligns with quality and safety priorities, increases utilization of cost-efficient services and was the right action for their older adult population. Patty stated that the journey to becoming AF was well worth the time and effort.

The process to become AF was facilitated by the extensive support of HANYS at each step. They formed their six-person team based on the composition recommended by HANYS; this included an older adult member who was 65 or older. Interactive monthly webinars were hosted by HANYS which provided more than just time to share experiences. Participants shared contact information and could easily reach out to other organizations or HANYS staff whenever they had questions during the process. They were given resources to use by HANYS.

The team began with an evaluation of their current work through a 4 M's framework. This process was invaluable as they learned that many of their work practices already incorporated one or more principles. Patty briefly described highlights under each "M":

- What **M**atters: Noyes already has an electronic health record that captures patient goals; provides a list of community resources to patients when they leave; follows patients under Noyes' longitudinal case management systems, which falls under all Ms.
- **M**edication: uses a multi-disciplinary medication reconciliation system; do not have pre-checked medication lists so providers are forces to review meds each time and actively select meds; daily huddle that includes a medication review and all patients needs; has a pharmacist consult with each patient while they're here.
- **M**entation: each patient is assessed at admission and during their stay; white boards in each room and clocks to orient patient as to day, time, and place; IPADs and other electronic communication devices are available to maintain contact with friends/ family.
- **M**obility: the electronic health record system triggers a Physical Therapist consult during the patient stay; bedside mobility assessment is conducted; patients must be out of bed for meals unless otherwise indicated.

After evaluating their current workflows, they identified soft spots and areas which needed more work, and used a 4M worksheet to plan their actions. She described a patient interaction that demonstrated how using the "what matters" concept allowed

them to identify the patient's real concerns. Once this was revealed, they were able to address the root of her anxiety to improve her hospital stay.

The team also analyzed hospital data to assess how frequently they employed AF practices. For example, they found that the pharmacist consult was enacted for 55% of the older adult population in a five-month period. They also found that 69% of all patients had their care managed through the longitudinal case management and collaborative discharge process.

Liz Gray discussed Noyes' longitudinal case management and collaborative discharge process. Care transition plans must address a multitude of factors because all patients are complex. With adults 65 and over, the plan addresses the comorbidities which are more common in this population and emphasizes factors relating to the social determinants of health such as: home safety, transportation access, affordability and accessibility of medications, and food stability. Historically, many barriers to discharge planning exist: poor integration of patient data between different areas, lack of follow-up responsibility after discharge, ineffective communication between inpatient and outpatient areas, misunderstandings due to cultural and health literacy factors, misaligned goals between health care team, family and patient, siloed acute and outpatient programs.

With discharge planning, time is critical, and follow up services must be put into place quickly. It often takes more time to connect with outside organizations. The key to success is making a difference at the transition point and the goal is to take the discharge plan from one that is not only safe, but is safe and sustainable. The recovery plan must take the patient's wishes into account relative to life sustaining measures. It must be understandable when they are in the acute setting and manageable when discharged. Noyes screens for all high-risk attributes upfront and reassesses these throughout the stay. The patient's recovery plan is built on the disease process and the social determinants of health services that are necessary to support the patient. This requires an open and transparent discussion of goals and the integration of community-based programs into the care management plan from the time of admission.

In 2019, Noyes improved their discharge planning from one that is episodic to one that is longitudinal. They used patient activation strategies to focus on and assess the patient's knowledge, skill and confidence in self-management. Caregivers and family are included in the discussion of goals. Discharge planning staff are trained in motivational interviewing to remove judgement, therefore patients never viewed as noncompliant, but having their own set of motivating factors.

Liz summarized the main principles of their longitudinal care management program which focuses on having shared goals with the patient, clear roles, collaborative discussion, mutual trust, effective communications, and family and friends included in the decision making.

Meeting attendees posed questions about the presentation and programs. Dora reported that another learning collaborative is planned for the future and open to all health systems.	
Committee Reports • Advance Care Planning – The next meeting is September 2. • Home Care Workforce Group – there have been two meetings to date. The group has proposed different actions which were summarized and will be discussed at the next meeting. • Home Aide Recognition Event – discussion about an in-person event is under consideration. At least four to five people have agreed to assist with the event.	
Next Meeting and Adjournment The fall meeting is scheduled for November 5. The meeting was adjourned at 1:00 pm.	

Submitted by Beverly Chin