Long Term Care Planning Project
Meeting 1

Notes – *Improving Coordination, Communication, and the Consumer Experience*
February 4, 2019

The first meeting of the LTCPP focused on seven discussion questions that were designed to promote conversation and recommendations about how New York can improve coordination, communication, and the consumer experience within the aging and long term care system. Meeting participants were placed into fifteen groups and assigned a discussion question. Following group discussion, each group presented the key points from their discussion.

The topics that were generated from each small group discussion are below, along with any additional input received in writing after the meeting.

Question 1 (Groups 6, 13)

A. *What can be done to provide a more cohesive and quality experience for care recipients?*
    i.   *What does the care recipient need?*
    ii. *What type of coordination/communication will provide the care recipient with the most person-centered experience?*
    iii. *What are measures of consumer experience and satisfaction, and how can they be included in program design?*

B. *What can be done to provide a more cohesive and quality experience for caregivers?*
    i.   *What does the caregiver need?*
    ii. *What type of coordination/communication will provide the caregiver with the most person-centered experience?*
    iii. *What are measures of caregiver experience and satisfaction, and how can they be included in program design?*

Notes from group discussion:

- Develop a roadmap for what aging in New York entails and provide to public, with information on different settings, services, payors, and processes
- Encourage universal usage of Health Information Technology (HIT) and the sharing of Personal Health Information (PHI)
- Establish a universal release of information – allowing communication to flow more freely between providers
- Expand Regional Health Information Organizations (RHIOs) to include Community-Based Organizations (CBOs)
- Improve cultural competency
- Improve the use of technology
- Improve transparency
- Improve volunteer coordination
- Mandate what a discharge from a hospital or other healthcare facility is supposed to entail
- Promote a common electronic platform among long term care providers
- Promote interoperability and exchange of information through RHIOs and Statewide Health Information Network for New York (SHIN-NY) – the Statewide Health

Information Network for New York enables the sharing of data statewide, ensuring that providers have access to patient's electronic medical record, with the patient's consent, wherever and whenever they need it
- Promote programs and regulations that encourage universal design and address the older housing stock in the State
- Provide training and education, especially in the discharge setting
- Provide training to caregivers
- Require incorporation of universal design in all new construction
- Provide setting education – differing facilities provide drastically different services and have differing capabilities – public is often unaware of differences

Question 2 (Groups 7, 14)

What are the barriers to coordination/communication across agencies, and how can it be improved?

> *A. What can we do at the agency level to ensure coordination of services and information?*

Notes from group discussion:

- Address the inequity of program quality and availability by income and geography
- Address conflicting information from different service providers
- Coding for long term services should be more nuanced and reflect the needs of the patient, especially for services to disruptive, behavioral health, or dementia patients
- Develop a single, integrated service delivery system
- Align metrics and funding priorities to reduce duplication of services that may limit access due to competition between organizations providing similar services
- Establish a single gatekeeper for service delivery when there are multiple providers/services – from both a case management, payment, and medical perspective
- Establish a single, trustworthy place for all to go for information on Long Term Supports and Services (LTSS)
- Establish an outreach plan to ensure New Yorkers are informed
- Issue information clarifying State agency roles and jurisdictions
- Re-certification process for Medicaid eligibility needs to be reviewed
- Staff turnover at facilities hampers quality improvement (QI) efforts as new training is always underway
- There are limits to funding and human resources
- Unclear jurisdiction for programs and services with NYS Department of Health (DOH) as to which office or division is in control
- Use of paper records

Question 3 (Groups 1, 8, 15)

What are the barriers to communication across provider types and settings, including clinical, aging, and other human services?

Notes from group discussion:

- Ability to speak to the care recipient and primary caregiver at the same time
- Education – improve and standardize provider education on services and CBOs in their areas
- Cultural competency
- Follow through on the plans of care
- Language – communication with non-English speakers
- PHI – particularly in terms of behavioral health providers; also noted general issues with the use of viewing PHI
- Primary Care Provider (PCP) involvement
- Lack of clarity to the public on types of facilities and the services available
- Inconsistent standardized information for county workers to provide with regard to services and supports in their regions
- Gather different provider perspectives on a patient at discharge
- Record releases – specific releases are needed for different types of records
- Lack of resources to make "warm handoffs" more frequent
- Role Confusion - who takes the lead role on issues and services when a client has multiple providers

Question 4 (Groups 2, 9)

Are there current systems to assist caregivers in specific service sectors that are working and why?

Notes from group discussion:

- Caregivers are an integral part of the care team
- Collaborate to provide more rural transportation services and options
- Develop a standard electronic database
- Develop ad campaigns targeted at caregivers
- Encourage appropriate use of technology
- Establish Centers for Excellence for Caregivers
- Include Home Health Aides (HHAs) and others in care coordination
- Invest in quality training for the workforce
- Look at Health Link NY, a member of the Strategic Health Information Exchange Collaborative, to learn best practices in ensuring patients and providers are appropriately connected to receive and provide the best care
- Promote all providers to be in RHIOs/SHIN-NY with interoperability
- Promote and incentivize the use of HIT and interoperability with access for all – CBOs, caregivers, patients, physicians, facilities
- Provide educational materials to caregivers via web

Question 5 (Group 10)

How do we ensure all providers, care recipients, and caregivers have the most up-to-date information without creating additional burdens? What are your ideas on how to improve this process?

Notes from group discussion:

- Develop one source of information for all payors – should include cost of services
- Incentivize the use of user-friendly HIT and information sharing
- Issues with the CARE Act – caregiver is appointed in the acute care setting, but downstream providers do not always get the necessary information
- People do not know what they need to know about long term care until a crisis occurs
- Provide a navigator for the NYS Long Term Care system
- Review pop up social day programs that are paid for by Medicaid; review the Centers for Medicare and Medicaid Services (CMS) discharge planner guide
- Standardize information provided at discharge for care planning
- Standardize RHIO with one consent form

Question 6 (Groups 4, 11)

What does an ideal communication and coordination system look like?

Notes from group discussion:

- Develop a person-centered one-stop shop for PHI sharing with caregivers having access
- Develop an open-access, web-system for sharing information
- Emphasize, incentivize greater connectivity between LTSS providers, CBOs and physicians (some providers do not use Electronic Health Records (EHR) at all)
- Home health aides need access to the EHR as a key to care coordination
- Improve RHIO connectivity, include CBOs
- Need stronger clinical components across providers including physician to physician and physician to CBO
- Promote EHR usage and interoperability in all facilities
- Provide access to wireless and cellular services to every resident to facilitate better use of HIT
- Provide more training, or standardize training and resources for discharge planners – to ensure that all patients receive the same information and options
- Review United Hospital Fund (UHF) work on hospital to home – Provide discharge planners with more training to provide best information on community services and resources available within a given region
- Service delivery expectation should be open and honest
- There should be stronger linkages to all program operators through EHR/HIT

Question 7 (Groups 3, 5, 12)

How can we better coordinate a person's care? With multiple care managers, who really takes the lead? Should a hierarchy of care management be established? What are your ideas and/or examples of how care coordinators and case managers working in different systems might collaborate to better coordinate a person's care and social supports?

Notes from group discussion:

- Care for the patient should be fundamental
- Clarify acronyms – lack of understanding from consumers
- Consider development of a single assessment tool
- Do physicians know enough about community care/providers?
- Educate providers on tools and services that are available
- Establish a standard for expertise on services and programs within the Area Agencies on Aging (AAA) region
- Establish accountability for a patient's overall care plan within a single agency
- Improve communication on which provider should take the lead for a patient with multiple providers
- Link the medical record with the social service record and house them in one location
- Need better communication among multiple regulatory types
- Need more investment and direction on common technology systems for facilities and providers to facilitate communication and data exchange across RHIO and SHIN-NY – allow CBOs to access and view/update
- Payor source creates barriers – all individuals should receive the care they need regardless of payor
- Provide better guidance and information to providers and facilities on what information and data is available and make it more "shareable" so facilities and providers are not duplicating assessments
- Provide clear instruction on how to coordinate and who should take the lead – considering each payor's rules and liabilities
- Provide patients and caregivers greater access to their EHR and access on the RHIO
- Undertake Medicare Care Management streamlining

Additional Comments Received After Group Discussion (including submission by email)

- Universal Consent – look at what other states are doing
- Housing – what is being developed and where? We need smaller homes closer to downtown/services
- Cultural competency allows for trust
- Playing field is stacked against CBOs
- Can Naturally Occurring Retirement Communities (NORC) play a bigger role downstate?
- Health plans would like to work with CBOs, but there is no one place to find out about what is offered
- Need measurement for consumer satisfaction
- Look at ease of access for services and providing stability for caregivers
- Encourage mutual education meetings between agencies and care managers

During this meeting there were certain themes that emerged across all discussion questions and groups. Those themes are:

- Information sharing across Aging and Long Term Care
- Support increased use of available technology
- Education for consumers