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Q1: **Name of your organization.**	Lifespan of Greater Rochester
Q2: **Grant #**	20140736
Q3: **Grant Period**	November 1, 2014 - October 31, 2015
Q4: **Location of your organization**	
City	Rochester
State	New York
Q5: **Name and Title of person completing evaluation.**	Annie Wells, Director of Care Transitions
Q6: **Phone Number:**	585-244-8400 x 172
Q7: **Email address.**	awells@lifespan-roch.org

PAGE 2: Key Outcomes and Results

Q8: **Total number of clients served through this grant funding:**	52

Q9: Describe the project's key outcomes and results based on the goals and objectives:

Objective I: Decrease the ED/hospital use of participants on average by 30% by the end of one year. We will look at pre-program ED/hospital usage compared to one year after being in the program.
Activities: Recruit older adults for the project, collect background information about healthcare use from the previous year, implement project with participants, and compare data after one year.
Results:

	2012	2013	2014	2015**
# of Consumers*	23	26	32	31
Total # of Visits	363	391	370	282
Consumers to ED	7 (30%)	8 (26%)	5 (16%)	5 (19%)
ED Visits Total	8 (2%)	11 (3%)	9 (2%)	16 (6%)
Consumers to Hospital	5 (22%)	3 (10%)	4 (13%)	2 (8%)
Hosp. Visits Total	6 (1%)	3 (<1%)	4 (1%)	4 (1%)

* Represents total number of consumers with visits during the year.
** Represents data through October 2015, 10 months

• Across the four year period after implementation had stabilized and for which there were consistent data, the number and percent of consumers who visited the ED in a year decreased (e.g, 30% or 7 consumers went to the ED during 2012, 19% or 5 consumers went during the 10 months of 2015). Though it is unknown how many of these consumers visited the ED in the year prior to joining the HCC caseload, given the health challenges faced, it would not have been unreasonable to expect half or more of the consumers to have visited the ED in each year. Substantial cost avoidance likely resulted.

• The number of visits to the ED fluctuated across the years, as some consumers required multiple visits. Except in 2015, where one consumer had 10 necessary visits (6% of all visits), 3 of which resulted in hospitalization, the proportion of visits to the ED compared to visits for other purposes and to other providers was never greater than 5%. Most of the work of the HCC was getting consumers to routine screening, PCP visits and follow-up care.

• From 2012 to 2015, the number and percent of consumers who had to be hospitalized also decreased (5 of the 23 consumers --22% were hospitalized during 2012, 2 of the 31 consumers – 8% were hospitalized during the 10 months of 2015 for which we have data). As shown in related evaluations, the coverage for hospitalization is most costly. Reducing the number of people hospitalized, and keeping the number low overall, also was likely to contribute to substantial cost avoidance.

• The number of hospitalizations remained proportionately low (<2% of all visits) across the years. As described above, most visits, though numerous, were for far less involved tests and treatments than those undertaken during hospital stays.

Objective II: Increase older adults' adherence to medical treatment plans by 75%.
Activities: Review medical plans with older adults, practice "teach-back" techniques to ensure individuals understand their diagnoses/treatment plan, arrange for a nurse to set up prescription drug sets, periodically review medical plans with clients.
Results:
A total of 52 consumers have been receiving assistance through the HCC project funded by the grant. This includes 10 who received services for one-year only; 17 who received services for two years: 13 who received services for three years; and 12 who received services for 4 or more years. In 2011 78% of visits were described by the health care coordinator as having accomplished the visit purpose and 83% of visits were assessed as having contributed to the consumer's stability; in 2015 93% the visits were described as having accomplished the visit purpose and 91% were assessed as having contributed to the consumer's stability. Consumers had to actively follow treatment plans in order to accomplish the purpose of their visits.

Additionally, though only a few consumers were able to set up their own medical appointments, the proportion who did so went from 5% in the first year of the project where full data were available (2012) to 12% in the most recent program year (through October 2015), and was as high as 19% in 2014. In each year multiple visits were conducted to help each consumer regularly access medical services for prevention, treatment and follow-up.

Q10: Please describe any challenges/obstacles the organization encountered (if any) in attaining goals & objectives.

Transportation reliability has been a challenge. Year to date, 25% of all missed appointments have been due to transportation problems.

Q11: How did you overcome and/or address the challenges and obstacles?

We talked with the CEO of Medical Motors, Bill McDonald about our transportation concerns. He gave a few tips:
• When contacting MAS there are several different levels of service Medicaid will cover:
- Bus Pass
- Taxi
- Ambulatory assistance
- Wheelchair
- A physician can also order door through door transportation
- We can request a vendor-(or the client can express their personal choice)

• Once we have confirmation for the vendor, we should contact the vendor and make sure they know the referral is coming and confirm the ride. MMS has a person dedicated for MAS referrals, I am not sure about the other providers we use. It may be worthwhile to establish those contacts for greater success.

• BIll also said MAS has a complaint line; we should report any issues we have with rides so they are aware.

Q12: Describe any unintended positive outcomes as a result of the efforts supported by this grant.

There has been a significant increase in the number of participants who have successfully completed preventative health screenings.
We have helped to decrease caregiver stress.

Q13: Briefly describe the impact this grant has had on the organization and community served.

We have developed strong relationships with community health care providers; physician practices, hospital systems and home care agencies.

PAGE 3: Budget

Q14: Please provide a brief narrative on how the funds were used to fulfill grant objectives.

The funds were primarily used to support staffing to provide the healthcare coordination service.
A detailed summary of applied expenses will be e-mailed per instructions.

PAGE 4: Success Stories

Q15: Please relate a success story:

After several submissions one woman was finally approved for and has received a power wheelchair. The power chair will allow her to join her family for lunch at the diner down the street from her apartment. She will be able to shop at the store next to her home and even get to her doctor's office or lab on her own if needed.

The Health Care Coordination program has been able to help another family get connected with counseling services to help cope with the stresses going on at home. Less stress at home or work can mean better health.

L. was living in a group home for individuals with intellectual/developmental disabilities. She decided she would like to move out to a home she will share with a few friends. Since she was able to receive Healthcare Coordination services through Lifespan, L. was able to make the move a reality. L. and her parents are both very happy with her new living arrangements.

Q16: Please relate a success story here:

The Health Care Coordinator is acting as a liaison between a consumer with stage 4/5 kidney failure and her family and with her nephrologist. The consumer and her family are in the process of deciding if dialysis is a viable option. This is an incredibly difficult and personal decision. The HCC helps to ensure the family's wishes are respected and helps to facilitate communication between the family and the healthcare provider. Providing the family with unbiased information and helping them to make connections with providers in the community (in this case a dialysis educator) goes a long way in helping them make the best decision for their personal health and quality of life.

Q17: Please relate a success story here:

When first meeting M. he was very confused about upcoming appointments, missing many of them. He did not always remember to take his prescribed medications. We were convinced he had dementia. He had prostate cancer a few years ago and had radiation therapy, and was receiving Lupron injections to keep his PSA low. He would tell us that after receiving these injections he would be very forgetful. It was very concerning, in speaking with him he struggled to get the words out. We advocated for him with the physician. M.'s last Lupron injection has been over 6 months ago, and in the last few time that we have spoken his thoughts are clear and his speech is no longer garbled. He has taken an out of town trip to visit his mother (who is 96). He seems so much more relaxed and there is so much happiness in his voice. He has had several follow up's with his oncologist, checking his PSA levels and as of right now his PSA level is WNL and as long as it stays that way he will not need to receive the Lupron injections and his memory will keep improving !!

PAGE 5: Organizational Information

Q18: Which category best describes the organization. Please choose only one.	Service Organization
Q19: What is the organization's primary program area of interest?	Elder Care

Q20: Percentage of clients served through grant in each ethnic group category. Total must equal 100%

African American	33
Caucasian	67

Q21: Approximate percentage of clients served from grant funds in each age category.

Adults	73
Senior Citizens	27

Q22: Approximate percentage of clients served with disabilities from grant funds.

Other Disability	100

Q23: Approximate percentage of clients served in each economic group.	*Respondent skipped this question*

Q24: Approximate percentage of clients served from grant funds in each population category.

Single Adults	40
Families	60
Elderly	26