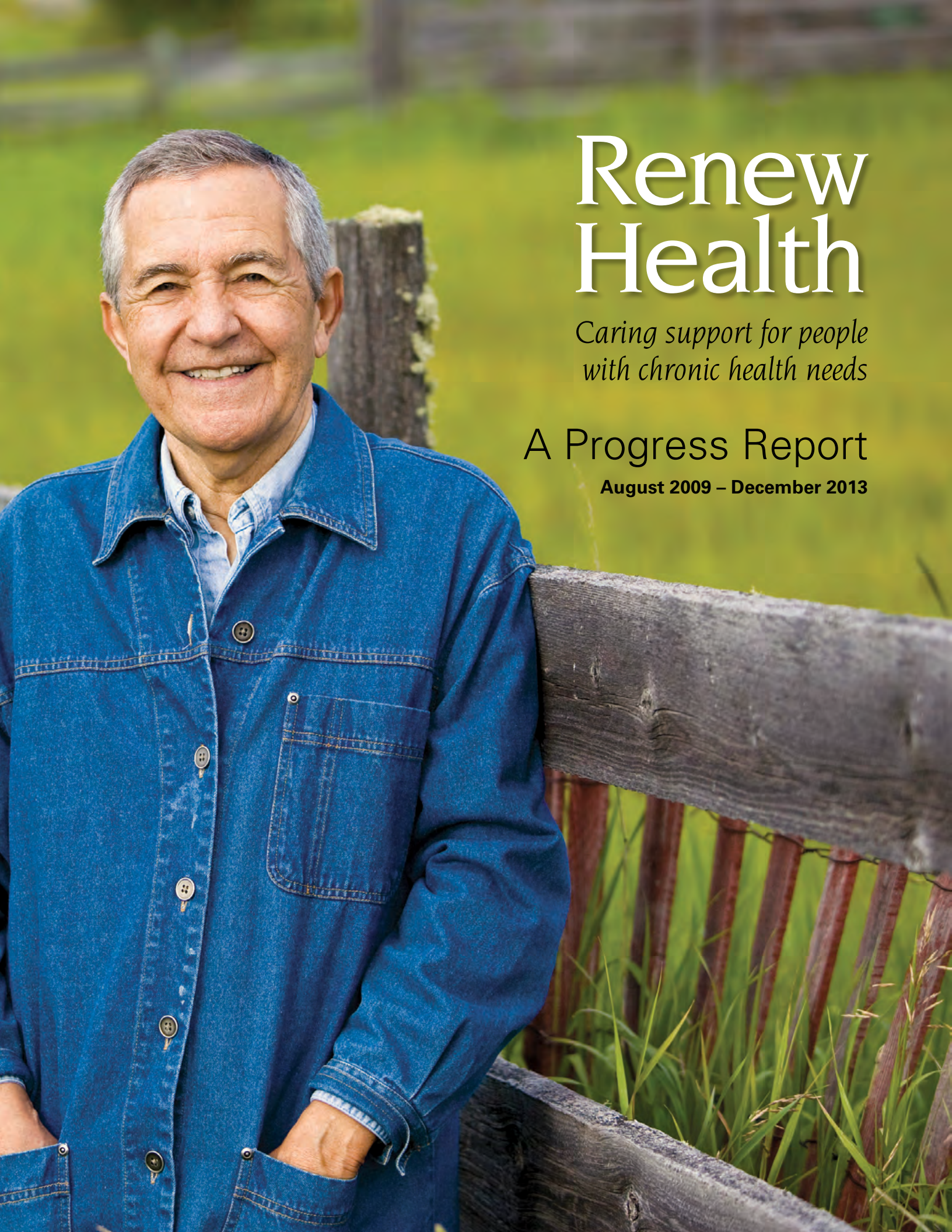


Renew Health

Caring support for people with chronic health needs

A Progress Report

August 2009 – December 2013

Providing Hope While Delivering Cost Effective Care

The Renew Health program arose in response to two stark realities about chronic disease in rural communities. One was lack of health insurance coverage. Many rural residents with chronic conditions had no way to pay for medical services. The other reality was that health care systems in our region were devoting millions in charity care each year to chronic conditions in their later stages, when they are harder and costlier to treat.

We wanted to help rural residents lead healthier lives and help control the ever-rising cost of uncompensated care.

The Rural Health Network of South Central New York launched Renew Health in late 2009. The initial goal of this pilot program was to assist 30 adults in rural Broome and Tioga Counties who had chronic health conditions, including diabetes, asthma and cardio-vascular disease, and who lacked health insurance.

Dr. James M. Skiff, UHS Primary Care – Newark Valley (left in photo) and Jack Salo, Executive Director, Rural Health Network of S.C.N.Y. discuss National Diabetes Prevention Program classes being offered through Renew Health.

Participants came to Renew Health most often through the Health Care Access program, primarily when seeking financial assistance for prescription medication. Other referral sources included health care providers, human service agencies and food pantries. When staff learned of an individual's chronic health condition through the assessment process, Renew Health was offered as an opportunity for the individual in need to learn more about that condition and to access a medical home and health care services.

OUR COMMUNITY PARTNERS

Appalachian Regional Commission · Binghamton University School of Social Work · Excellus BlueCross BlueShield · New York State Health Foundation · New York State Charles D. Cook Office of Rural Health · Southern Tier Health Link (STHL) · Rural Health Service Corps (RHSC) · Our Lady of Lourdes Hospital · United Health Services

Renew Health took a three-pronged approach:

1. MEDICAL HOMES

Each participant was matched with a primary health care provider. Uninsured participants received up to four free primary care visits a year to address their chronic condition.

2. CASE MANAGEMENT

The participant worked one-on-one with an MSW intern or a member of the Community Health Services staff to meet specific health-related goals.

3. CHRONIC DISEASE EDUCATION

Some participants enrolled in *Living Healthy*, an evidence based, six-week chronic disease self-management program for individuals and caregivers. Other participants received one-on-one education from nursing student interns and Renew Health case managers. In 2014 another option, the New York State Diabetes Prevention Program, became available for pre-diabetic participants.

Since 2010, Renew Health has served 82 participants, with an active case load of 30 to 40 at any given time. Individuals were served by the program for up to two years.

In 2013, three significant changes impacted Renew Health:

1. In August 2013, for the first time, Renew Health started also enrolling participants who had health insurance.
2. In October 2013, the New York State of Health Marketplace opened, and NYS residents could shop for, compare and enroll in public or private health plans, with on-site, in person assistance.
3. In December 2013, New York State expanded Medicaid eligibility from 100 percent of federal poverty level to 138 percent.

These opportunities significantly increased access to health insurance for the Renew Health target population.

As of May 2014, 89 percent (25 of 28 active cases) of Renew Health participants were enrolled in health insurance plans.

Throughout the history of Renew Health, it has been a priority to help participants enroll in health insurance plans. That goal is far easier to reach today, thanks to the Affordable Care Act and the New York State of Health Marketplace. As we refer more participants to enroll in health insurance plans, Renew Health relies less on donated medical care. With more Renew Health participants becoming insured each month, we anticipate better health outcomes. Health insurance coverage is essential to the effective prevention and treatment of chronic health conditions.

OUR COMMUNITY PARTNER

The **Appalachian Regional Commission** is a partnership of federal, state and local governments that funds initiatives to improve life in the 13 Appalachian states. ARC provided funding support for Renew Health from August 2009 through September 2011.

A Solid Return on Investment

Renew Health has made a big difference for many of the 82 rural individuals who have participated in the program since 2010. For instance, enrollees were assisted with a total of 317 prescription applications to obtain initial three-month supplies of medication at no cost. The retail value of those prescriptions totaled $288,473. While participants continued to access pharmaceutical assistance for up to 24 months after receiving the initial 90 day supply, only the initial 90 day supply was factored into return on investment calculations.

PHOTO BY TOM FORBES, EAGLE POINT IMAGES

Renew Health also succeeded in providing access to primary care for the uninsured participants. People who enrolled in Renew Health were connected with medical homes (primary care providers), and when they scheduled appointments, they generally kept them.

In addition to forming partnerships with Lourdes Hospital and United Health Services, which contributed project funding and donated primary care services, Renew Health took other steps to make sure participants could see their providers. For instance, we sometimes replaced wages lost for participants who did not have paid sick leave and had to miss work to keep medical appointments. We also provided fuel cards to people who couldn't otherwise afford transportation costs to travel to medical appointments or education classes.

The opportunity to receive primary health care also spurred participants to take further positive steps. A participant gained a medical home only if he or she agreed to fully participate in the Renew Health program, including case management and chronic disease education.

Case managers not only helped participants form strategies for managing chronic conditions, but also connected them with other health services and resources. For example, if a participant needed dental care or a cancer screening, the case manager and Renew Health staff made appropriate referrals, quickly and efficiently.

RHN also enhanced Renew Health's success by enrolling participants in Southern Tier Health Link's electronic health record system in 2012. As we helped

OUR COMMUNITY PARTNER

The **Binghamton University School of Social Work** offers a master's degree in social work (MSW). To gain practical experience, students in the program serve as interns, each working with a local agency for 15 hours per week over two semesters. Seven MSW interns have served as case managers for Renew Health.

Pictured from left to right are Marlene Whitbeck, FNP and Kelly L. Storrs, DNP of Lourdes Whitney Point Family Practice, and Pamela Guth, Director of Community Health Services at the Rural Health Network of S.C.N.Y. Having the Lourdes Whitney Point Family Practice located directly across the street from the Rural Health Network office has helped to facilitate Renew Health referrals since the new office opened in 2011.

participants establish online patient portals, they gained one-stop, real time access to information about their medical tests, treatments and medications. Armed with this knowledge, participants played a direct, active role in managing their own care and chronic conditions. Utilizing the patient portal helped to keep open lines of communication with various providers for decision making and referrals. Participants approved or denied access to their own electronic health records.

It cost $322,748 to operate Renew Health from August of 2009 through the end of 2013 (42 months at an average of $7,684 per month). The calculated benefits that the program delivered to hospitals, health care providers and Renew Health participants during that time totaled an estimated $970,925. The return on investment was calculated using formulas originated by Ascension Health for: assignment to a medical home ($6,567); receipt of prescription medication to manage chronic health conditions ($925,979); and participation in a chronic disease education program ($38,379). That's a return on community investment (ROCI) of $3 worth of benefits returned to the community and participant for each dollar invested in Renew Health.

OUR COMMUNITY PARTNER

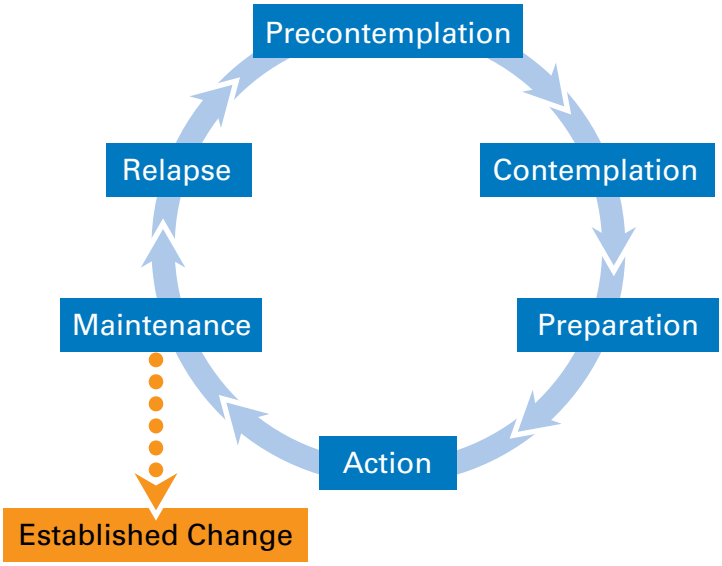
Excellus BlueCross BlueShield is a nonprofit organization that provides health insurance in 31 New York State counties across four regions—Central New York, Central New York Southern Tier and the Rochester and Utica regions. From October 2011 through 2014, Excellus has provided essential funding for Renew Health case management and education services.

Lessons Learned: More Preparation, Greater Continuity

One of the biggest lessons to emerge from Renew Health is that the people who need this program most often aren't ready or in a position to focus on improving their health.

For example, only 15 percent of individuals who joined Renew Health through the end of 2011 actually completed one of the evidence-based chronic disease education programs offered. Most of the chronic disease education was conducted informally by case managers, staff and students from the Binghamton University Decker School of Nursing.

STAGES OF CHANGE MODEL



Based on Prochaska and DiClemente's model PHEPA Project (Prochaska, J.O. et al. 1986).
Source: Prochaska, J.O., & DiClemente, C.C. (1986). Toward a comprehensive model of change. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 3–27). New York: Plenum Press.

Looking back, those results are not surprising. Many rural residents with chronic health conditions face a complex array of challenges and life stressors, including irregular and demanding work schedules, jobs that don't offer paid time off, need to care for family members and lack of transportation. Despite good intentions, these very real and immediate challenges take priority over the elective education and the behavior and lifestyle changes that would contribute to better health.

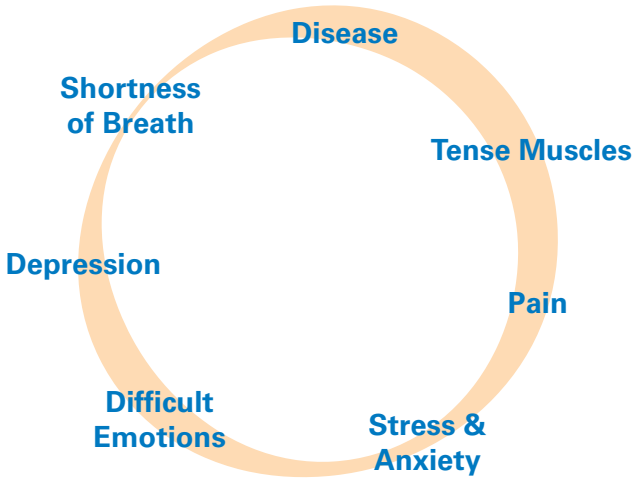
The **Prochaska Stages of Change Model** was helpful in re-directing our work with individual participants to each person's level of readiness for healthier lifestyle changes, and for aligning appropriate strategies. Prochaska identifies three preliminary levels of change (Pre-Contemplation, Contemplation and Preparation) that come before the Action stage. A person in the Action stage is ready to take definitive steps towards healthier lifestyles, such as increasing physical activity, making nutritious food choices and accessing and communicating with health care providers. Each of these measures moves the person toward the goal of self-managing his or her own chronic health condition.

As participants enrolled in the program, the Renew Health team started by establishing trust, assessing participants and their stages of change and developing individual care plans. Through motivational interviewing, we quickly learned that most individuals participating in Renew Health were in the earlier stages, which are characterized by observable denial, ambivalence and experimentation with smaller changes. The early phases of Renew Health engagement and case

OUR COMMUNITY PARTNER

New York State Health Foundation is a nonprofit organization that provides health funding, technical assistance and capacity building opportunities. One of those opportunities is a series of Scaling Up National Diabetes Prevention Programs in New York State, in conjunction with 29 grantees in 2014, including Rural Health Network of South Central New York.

SYMPTOM CYCLE



Source: Lorig K, Holman HR, Sobel D, González V, Minor M. *Living a Healthy Life with Chronic Conditions (4th Edition)*, p. 4. Boulder CO: Bull Publishing, 2012.

management were more closely aligned with a social work rather than a medical model.

Case management and chronic disease education experience show us that before people in the target population can start working on their own health, we first have to listen to their life experiences. This helps us learn about their challenges, identify their support systems, address their barriers and develop strategies that best meet their unique circumstances. We also need to better tailor chronic disease education to the individual—perhaps by sending educators to the home, rather than expecting participants to travel to a series of scheduled classes.

Through the Chronic Disease Self-Management curriculum, the Peer Leaders, who facilitated class sessions with individuals and their caregivers, explained the vicious **Symptom Cycle** and addressed both physical and behavioral health and the mind/body connection. During home visits, Renew Health participants received chronic disease self-management information and techniques from the MSW interns. They also brainstormed solutions to break their own symptom cycles. Through this instruction, participants became more self-aware, reduced their stress and, often, improved their health.

Another lesson learned was the importance of program staff continuity. Each of the MSW interns who served as a case manager in Renew Health was available for just one academic year. A pool of AmeriCorps members that supported the program turned over annually as well, with each member on a different schedule. These young people built a strong rapport with program participants, and when they left it was often difficult to rebuild that trusting connection.

To improve continuity, Renew Health now uses only MSW interns as case managers. Also, as an intern's academic year comes to an end, that person is hired as a part-time case manager for the summer. This ensures that each participant can work with the same partner for a full 12 months, and it creates a smoother transition to the next case manager.

It is important to note that Renew Health was designed as a low cost intervention: hence the use of interns and AmeriCorps members to provide services. Providing health care for the uninsured population has been a perennial challenge. Of course, implementation of the Affordable Care Act has made health insurance available to many more individuals, including Renew Health participants, allowing them to receive critical health care services.

OUR COMMUNITY PARTNER

New York State Charles D. Cook Office of Rural Health is a major source of support for Rural Health Network of South Central New York. It provides funding to help cover Renew Health administrative costs and some direct services for health care access intakes and referrals.

CASE STUDY

Campaign Against Pain

Barbara, a resident of Deposit, N.Y., has always kept busy. In her earlier life, she sometimes worked two or three jobs at a time. She joined walk-a-thons, planned elaborate fundraisers and thought about going to law school.

Unfortunately, fibromyalgia and thoracic outlet syndrome (TOS) put an end to all that years ago. Since the 1990s, chronic pain has severely curtailed Barbara's activities. She's tried physical therapy, pain management programs, acupuncture and iron injections, all in an attempt to get back to the kind of life she enjoys.

In 2011, life dealt her a new challenge, when Tropical Storm Lee swept through the region, bringing floods that damaged her home and caused an infestation of black mold.

Barbara started working with the Rural Health Network in late 2006, through its health care access services. Over the years, RHN has given her referrals for medical and dental services (valued at $3,000), vision care ($750), and prescription assistance ($31,476).

In 2014, Barbara enrolled in Renew Health. Two of her main goals were to better manage her pain and to finally get rid of the mold, which triggers allergic reactions and a great deal of stress.

"I understand that I still have fibromyalgia," Barbara says. "I understand the TOS is still there. But the one thing I've been looking for is quality of life." She'd love to start driving again, she says. She'd love to make a trip downstate to see her daughter and grandchildren, or fix up her house so they can visit her.

Working with Georgia Tsamasiros, an MSW intern from Binghamton University, Barbara has found new sources to help pay for medications, including a pain relief ointment that works well for her.

Georgia has also helped Barbara obtain much-needed dental care.

While Barbara directs her own efforts to enroll in a New York State program for mold mitigation, Georgia assists with the massive volumes of paperwork involved. She organizes files, fills out forms and types letters—all work that Barbara's conditions make it hard to do on her own.

"Georgia's been really great," says Barbara. The two women function as a team, bouncing ideas off one another and collaborating to get results. "I love to see her each week," she says. "I love to talk about what we're doing, what we're going to do next."

"I understand that I still have fibromyalgia. I understand the TOS is still there. But the one thing I've been looking for is quality of life."

Barbara

RENEW HEALTH PARTICIPANT

OUR COMMUNITY PARTNER

Southern Tier Health Link (STHL), a regional health information organization, operates a secure patient portal that stores electronic health records, including medical history, primary care visits, hospitalizations, diagnoses, procedures, medications, allergies, radiology images and more. Participants grant or deny access to these records to service providers and medical professionals.

A Broader Vision for the Future

The success of Renew Health so far hints at how much more the program might accomplish in the years to come. By applying lessons learned in the pilot, we could help many more rural individuals take control of their chronic conditions.

Here's part of our vision:

Contract with clinical professionals. Rather than rely solely on interns, Renew Health would contract with professional social workers and nurses to provide clinical oversight and supervision of MSW and/or nursing interns.

Focus on health outcomes. Once we had established support from health professionals, the program would work with participants who were ready to address their chronic health conditions. Together, we would establish more rigorous health management plans and track health indicator data such as blood pressure, BMI/weight and pre-diabetic and diabetic participants' A1c test results. The next version of a patient portal via Southern Tier Health Link (STHL) will include diagnostic results that can be monitored by clinical staff.

Most likely, we could establish health indicator measurements only with participants who are ready to take an active role in managing their chronic health conditions. With those participants who aren't yet ready, Renew Health would continue to work to establish trust, support and small positive changes.

Develop more effective education. Working with a partner such as Binghamton University's Decker School of Nursing, we would participate in a research project to develop chronic disease education that better fits the needs of the target population. The project would design an alternative to the multi-week classroom sessions we offer now, probably involving one-on-one or family-oriented education. We would then implement that model and measure its success.

OUR COMMUNITY PARTNER

The **Rural Health Service Corps (RHSC)** is an AmeriCorps National Service Program administered by Rural Health Network of South Central New York. RHSC provides health-related service and learning opportunities throughout South Central New York. Five RHSC members have served as case managers in Renew Health.

Broaden the scope of Renew Health. Although it started as the name of a tightly-defined pilot, "Renew Health" has become a brand that encompasses a wide range of community-based chronic disease education and case management services for rural individuals. We want to expand Renew Health, offering services that start before birth and continue throughout life. Focusing on prevention, early detection and ongoing care, Renew Health would assist families and make opportunities for prevention, education and chronic disease management available through schools, community centers, support groups and other venues.

Lay a foundation for sustainability. To fulfill the vision outlined above, Renew Health must develop ongoing financial support. This will require some creative thinking. For example, some of our services might qualify for reimbursement from public or private health care plans or through formalized partnerships with health care providers and accountable performing systems.

OUR COMMUNITY PARTNER

Our Lady of Lourdes Hospital operates a hospital in Binghamton and a network of primary care offices in Broome, Tioga and Delaware Counties. Lourdes has supported Renew Health with matching funds, the donation of primary care services for uninsured Renew Health participants, and referrals to the program.

Renew Health Quick Facts

AUGUST 2009 – DECEMBER 2013

Participant Chronic Disease Profiles

Chronic Health Condition	Number of Participants with Health Condition	Percentage of Total
Arthritis	30	20%
Asthma	18	12%
Cardiovascular Disease	12	8%
Chronic Obstructive Pulmonary Disease (COPD)	19	13%
Diabetes	27	18%
Hypertension	27	18%
Other Various Chronic Health Conditions (Includes: anxiety, Carpel Tunnel, Chronic Pain, Depression, Glaucoma, Sleep Apnea, Thoracic Outlet Syndrome)	16	11%
Participants with two or more chronic health conditions	46	53%

Summary Information

Description	Metric
Participants establishing Patient Portal through Southern Tier Health Link to access and share their medical records (2013 only)	34
Binghamton University Masters of Social Work interns that have provided case management services for Renew Health	7
Rural Health Service Corps – AmeriCorps members that have provided case management and/or program support for Renew Health	5

Return On Community Investment (ROCI)

The Return on Community Investment calculations below utilize formulas and templates developed by Ascension Health.

Benefit	$ Value	ROCI
Assignment of participants to a Medical Home	$6,567	2%
Three month supply* or prescription assistance provided to participants	$925,979	287%
Participant attendance in chronic disease/diabetes education classes	$38,379	11%
Total $ Value of Benefits Provided **Cost of Project**	**$970,925** **$322,748**	**300%** **3:1**

**Only the initial 3 month supply of prescription medication provided for each participant was used for ROCI calculations. In many cases participants received no cost or low cost prescription assistance for a year or longer.*

OUR COMMUNITY PARTNER

United Health Services operates four hospitals in Broome, Chenango and Delaware Counties, 25 primary care locations and a variety of other services. UHS has supported Renew Health with matching funds, the donation of primary care services for uninsured Renew Health participants, and referrals to the program.

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