PROPOSAL SUBMITTAL FORM

Agency Information

Agency Name: Hospice of the Bluegrass, Inc. dba Bluegrass Care Navigators

Mailing Address: 2312 Alexandria Drive, Lexington KY 40504

Street Address: 2312 Alexandria Drive, Lexington KY 40504

Phone: (859) 276 - 5344

Is your Agency registered with the IRS as a 501(c)3 organization? ☑ Yes ☐ No
*Note: Agencies **must** be registered with the IRS as a 501(c)3 organization to be eligible for ESR Program funding.*

Does your agency have a Silver Seal of Transparency or higher profile on GuideStar.org? ☑ Yes ☐ No
Note: Agencies must have a Silver Seal of Transparency or higher profile with GuideStar.org to be eligible for ESR funding.

Website Address: www.bgcarenav.org

Agency Representative *(typically the Executive Director - Name, Title, Phone, Email)*:
Liz Fowler, President/CEO, 859-276-5344, lfowler@bgcarenav.org

Person Completing Application *(Name, Title, Phone, Email):*
Davey King, Grants Manager, 859-296-6867

Program Information

Name of program for which funds are being requested: **Bluegrass Transitional Care for Medical Respite**

Total Funding Amount Requested: $ **80000**

RFP #6-2020 PROPOSAL SUBMITTAL FORM

- **Save this PDF formatted Proposal Submittal Form to your hard drive before beginning to enter responses in it to ensure your responses are saved to the form.**
- **LIMIT RESPONSES IN TEXT BOXES TO 250 WORDS**
- **REMINDER: All proposals must be written in a clear and concise manner, as there will be no follow-up or clarifications to proposer's submittal form once the evaluation process begins.**

5.1 Program Design & Performance

5.1.1 General Shelter Information **15 Points**

The following information is required in order to evaluate capacity and scope of programming and ensure a balance of shelter options for various sub-populations of people experiencing homelessness. While the overall narrative score is a major factor in funding recommendations, LFUCG will also consider factors such as ensuring availability of critical services and an adequate number of emergency shelter beds for vulnerable populations.

- Provide a description of the shelter including;
  - shelter operating hours,
  - population served included special populations served,
  - shelter rules and procedures (submit documentation)
  - how basic needs are met such as meals and personal care,
  - operating hours outside of nighttime shelter, i.e. are staff operating during the day
  - general staffing description for the emergency shelter
- Does your emergency shelter consistently implement practices to meet people where they are, and provide person-centered care that focuses on personal strengths? **(submit documentation as an attachment)**
- What policies or value statements convey clear expectations that guests will be treated with dignity and respect, and how does the shelter monitor adherence to these expectations? **(submit documentation as an attachment)**
- Are expectations of guests clearly communicated and easily accessible for review by guests? (submit documentation of communication process
- What specific practices help ensure that the shelter exhibits cultural competency and provides appropriate protections for shelter seekers across demographic differences?
- Does the shelter involve guests in governance and operations? **(submit documentation as an attachment)**

Bluegrass Transitional Care (BTC) is a case management program developed in 2011 that contracts with payers and entities to transition at•risk frail patients to prevent avoidable hospital readmissions and emergency department utilization after discharging home or to a nursing facility. Our program is built around compassionate care, ensuring that every patient is treated with dignity and respect.

Some patients in our community do not have a home to return to when they are discharged from a hospital. BTC provides medical respite for patients who are homeless by utilizing motel/hotel rooms in the community, a model that we have used for several years in Lexington and has also been successfully implemented in many cities in the nation. This model is relatively low cost, easy to implement, requires no licensure or other regulatory conditions, allows families to stay together and is effective in protecting the patient from infections from other patients. It also helps divert patients under treatment for serious medical conditions from shelters that may not have the necessary training, expertise, and resources to provide the full complement of services needed.

Based on the number of patients we are currently serving through Bluegrass Transitional Care Medical Respite, we project that this program will provide care for a total of 96 patients experiencing homelessness in each of the next two fiscal years. These patients will be served in partnership with University of Kentucky HealthCare, Baptist Health Lexington, and Saint Joseph Hospital.

Please see attached program description for complete details.

5.1.2 Rapid Resolution, Housing Oriented **25 points**

Up to 10 points will be awarded to applicants demonstrating a shelter project that is rapid resolution and housing oriented. This means a plan is presented for how the organization works with guests to develop and implement a housing plan including diversion techniques and how quickly people move to permanent housing.

Narrative for this section should address all of the following prompts:

- Does your emergency shelter's process for accessing shelter assess options for diverting from shelter?
- Does your emergency shelter's diversion approach include, when needed, financial assistance, mediation, housing location, legal assistance, or other supports?
- What role do mainstream programs play in supporting shelter seekers and diversion efforts?
- How does your emergency shelter provide immediate assistance and link guests with housing options within the first 14 days of a shelter stay?
- How does your emergency shelter use data routinely to detect trends, identify frequent users, and monitor housing success and other performance measures?
- How your emergency shelter coordinate with the broader homelessness service and housing systems in system-level planning?
- Does your emergency shelter assess and address the safety risks for people fleeing domestic violence?
- Describe how shelter guests are assigned case management and detail how case management is provided in your emergency shelter. How often do case managers discuss housing options with guests? How and when do the conversations about obtaining housing begin? Do case managers utilize best practices when working with clients such as trauma informed care?
- How will shelter staff members or volunteers help shelter guests access documents needed for housing (birth certificates, Social Security cards, etc.) when needed?

Bluegrass Care Navigators is a community healthcare provider that focuses on helping patients achieve the highest quality of health possible. We understand that housing is an extremely important social determinant of health. As noted above, Bluegrass Transitional Care (BTC) is a case management program. As such, we seek to address all barriers impacting a patient's self-sufficiency and to connect the patient with appropriate resources in the community to help them obtain and sustain long-term housing that is affordable and appropriate for their circumstance.

This program diverts homeless patients from traditional shelter facilities. During the entire medical respite and transitional care intervention, the nurse/coach and social worker collaborate with the patient on a plan for discharge. Working in collaboration with community agencies to prepare the patient to return to the community is vital to the success of the intervention. Bluegrass Transitional Care participates in the Lexington Continuum of Care. Agencies that we coordinate care and services with include, but are not limited to, Lexington Housing Authority, Community Action Council, AIDS Volunteers of Lexington, local landlords and apartment associations, LFUCG Adult and Tenant Services, Wheels, LFUCG Office of Homelessness Prevention and Intervention, Moveable Feast, Lexington Rescue Mission, Catholic Action Center, KY Prescription Assistance Program, Kentucky Department for Community Based Services, and home health agencies.

Please see attached program description for complete details.

5.1.3 Low-Barrier **15 points**

Up to 5 points will be awarded to applicants based on an evaluation of the shelter's commitment to a housing first, low-barrier model. Low-barrier shelter is a critical piece in the homeless assistance approach that prioritizes providing people experiencing homelessness with shelter as quickly as possible – and then providing voluntary supportive services as needed. A low-barrier shelter is one which has only the least restrictive entry criteria necessary to ensure health and safety in the facility.

Narrative for this section should address all of the following prompts:

- Does the shelter set only minimal and reasonable requirements for guests, and does the shelter enforce these requirements in a fair and transparent way? **(submit documentation as an attachment)**
- Does your emergency shelter have minimal expectations or requirements of people seeking shelter? **(submit documentation as an attachment)**
- Does your shelter welcome self-defined family and kinship groups to seek shelter together?
- Can your emergency shelter identify financial resources that can support the adoption of low-barrier policies and practices and support extended or flexible hours and adapted service-delivery models?
- Does your shelter accommodate pets and belongings?
- Does the shelter make accommodations to store belongings and if so, how?
- Do your shelter intake process and housing navigation services coordinate closely with community-based outreach services and coordinated entry?
- Does your shelter create flexible and predictable access for people seeking shelter?
- Are guests required or requested to contribute funds or labor to remain in the shelter? **(submit documentation of any program fees or volunteer time required as an attachment)**
- Are guests required to participate in classes or programs as a condition of remaining in the shelter? If yes, describe the process followed to determine whether someone is admitted or removed from the shelter and appeals available to those denied access. Applicants should include with their proposal a copy of written operation procedures for denial of services. This includes drug testing.
- How many participants were turned away or banned in the past 12 months for reasons described above?

Under the Bluegrass Transitional Care innovative medical respite model, our transitional care model (TCM) and care transitions intervention (CTI) follow a client- and person-centered approach that has now been regionally and nationally recognized as extremely successful. All referrals are screened by Bluegrass Care Navigator nurses and are enrolled only for medical respite needs. Patients must be ambulatory and able to care for themselves (with assistance), including taking their medications appropriately with guidance. For patients struggling with alcohol or illegal substance use, a social worker is available for counseling and referral to community resources. Families are eligible to stay in the hotel with the patient during the medical respite for recuperation. Our medical respite initiative incorporates family caregivers into the program, as appropriate.

The primary focus of the Bluegrass Transitional Care medical respite program is on helping the patient receive adequate healthcare services to achieve treatment success, rather than imposing extraneous expectations and requirements on convalescing patients. We follow the patient-focused policies of Bluegrass Care Navigators and are a part of this organization's Compliance Plan.

Please see attached program description for complete details.

5.1.4 Actual Results **10 Points**

Applicants will be evaluated based on actual results from the previous year. LFUCG will utilize access to KYHMIS for organizations with prior year participation. ONLY non-participating first-time applicants should provide a narrative describing outcome targets and actual results for relevant existing shelter. If the organization has not operated an overnight emergency shelter in the past year, the organization may submit performance reports for any transitional housing, rapid rehousing, or permanent supportive housing program. .

The OHPI reserves the right to negotiate final targets. Results will be evaluated based on reports from the KYHMIS database, not agency records, so KYHMIS data quality and timeliness is critical.

- **Submit reports from January 1, 2019 to December 31, 2019 as attachments**
    - **CoC APR**
    - **CoC CAPER**

N/A – The Bluegrass Transitional Care medical respite program is not a first-time applicant.

5.1.5 Capacity, Cost Effectiveness, & Budget **10 points**

Every community, including Lexington, faces the challenge of ensuring that shelter capacity is scaled to meet local need and that it is financed accordingly. This does assume that we should expand emergency shelter for those in the community that are currently experiencing unsheltered homelessness.

In making decisions regarding necessary capacity, LFUCG will consider how a broad range of changes and improvements within their crisis response systems will impact need and demand for emergency shelter, including: increased emphasis on diversion strategies and services; reductions in the length of time it takes for guests to move from shelter to permanent housing, including through expanded rapid resolution interventions; removal of barriers to entry; and increased emphasis on long-term or frequent users of emergency shelter.

Complete this table by indicating the total in the column to the right, then respond to the narrative prompts below:	**Total**
***Number of individual beds available:	N/A
***Number of units available for families, if applicable:	N/A
Funds requested from LFUCG:	80,000
Average nightly census for individuals based on KYHMIS data:	N/A
Average nightly census for families based on KYHMIS data:	N/A
Total annual budget for shelter (all funding sources):	140,871
% LFUCG investment (LFUCG Request/Total Budget * 100):	57 **%**

- ***Total beds above not reflect any overflow capacity such as mats on the floor, sleeping in lobbies, dining room chairs or overflow into other buildings owned by partners such as churches or other non-profits. Also exclude beds reserved for/supported by Department of Corrections, Veterans Administration, Department of Community Based Services, or other funding sources.
- Please describe all funding sources other than LFUCG that are included in your total emergency shelter budget.

Program Budget Summary Form Instructions

Proposal Submittal shall be considered incomplete and shall be rejected without completed Budget Summary Form. *(Including total amount of ESR grant request.)* **The Program Budget will be the same for both FY21 and FY22; there will be no increases in award for Year 2 of the grant.**

For organizations requesting funding for more than one program in this RFP, combine into a single Program Budget narrative for the proposal.

Please note that the Program Budget will be part of the grantee agreement with LFUCG and regular tracking and expenditure reporting will be required.

To ensure readability and uniformity, please use the Program Budget form included. Provide brief line-item detail as specified in each section below and verify all calculations.

This section provides a summary of the total proposed Program Budget for FY 2021. It requests the allocation of all projected funding amounts (City and non-City sources) for anticipated FY 2021 program expenditures.

Total Program Budget

Column A should reflect projected expenditures for the entire program (not just the proposed LFUCG ESR grant funding request portion). When the chart is completed this column should equal ESR Grant Funding Request plus other/non-ESR program funding. (A=B+C)

ESR Grant Funding Request

Column B is the grant amount being requested from this RFP to support this program's services to eligible Fayette County Participants.

Non-LFUCG Program Funding

Column C is the non-LFUCG ESR funding that is allocated to the Total Program Budget (A-B = C).

This form is for the budget for the PROGRAM applying for ESR funds, not the total agency budget.

For each category identify the amount requested and the amount to be leveraged through other programs or organizations (if applicable).

Staff Salaries – Identify the number of Full-time position salaries allocated to the program, and part-time positions allocated to the program, and the amounts of each allocated to Columns A, B, & C.

Consultant Services – In the "List Details" box, **briefly** describe any expenses associated with providing expanded supportive services or other services for which the organization intends to contract with another entity. Any of these expenses to be provided by the proposing organization should be included in other line items.

Space/Facilities – In the "List Details" box, **briefly** list the basis of the allocation of rental costs, utilities, janitorial costs, and any other facility costs for the Program. Identify any office or program space in an LFUCG owned building, and any other costs (rent, monthly utilities, etc.) reimbursed to LFUCG.

Scholarships/Stipends – In the "List Details" box, **briefly** list the type of scholarships or stipends, and include the number of people or organizations to receive funds.

Operating Expenses – In the "List Details" box, **briefly** list the costs associated with expenses, supplies, utilities, and any other expense associated directly with the operation of the project.

Other – In the "List Details" box, **briefly** list any other costs for the Program not covered above.

PROGRAM BUDGET SUMMARY

Agency Name **Hospice of the Bluegrass, Inc. dba Bluegrass Care Navig**

Program Name **Bluegrass Transitional Care for Medical Respite**

FY 2021 (July 1, 2020--June 30, 2021) Total Program Budget

	# of Employees:	Column A Total Program Budget [= B+C]	Column B ESR Grant Funding Request	Column C Non-ESR Program Funding [A-B]
1. Staff Salaries for Program				
Full-Time (FTE)	2	96,231	35,360	60,871
Part-Time		0		
Total Salaries		96,231	35,360	60,871
3. Consultant Services	$	0	0	0
list details	N/A			
4. Space/Facilities	$	36,000	36,000	0
list details	8 clients/month at an average of 5 nights/cost of $75/night =$3,000*12months = $36,000			
5. Operating Expenses	$	8,640	8,640	0
list details	Transportation costs = $50/client * 8 clients/month = $400*12 months = $4,800 Food costs = $40/client * 8 clients/month = $320* 12 months = $3,840			
6. Scholarships / Stipends	$	0	0	0
list details - numbers & amounts	N/A			
7. Other	$	0	0	0
list details	N/A			
8. TOTAL FY21 PROGRAM BUDGET *(Program budget will be the same for FY22; no increase in award for Year 2 of the grant)*	$	140,871	80,000	60,871

Cost per Program Participant: $ 1,467

I understand that this document in its entirety is incorporated into my grant Agreement with the Lexington-Fayette Urban County Government.

Authorized Representative *(typed name)*: Laura Klumb

Title: Vice President of Philanthropy **Date**: 04-02-2020

5.2 Capacity & Sustainability

5.2.1 Staff Qualifications & Experience **5 Points**

Provide information on the key/primary individuals that will be involved in the provision of services and demonstrate that they have the capacity to address the stated need. List each position by title and name of employee, if available. Describe the anticipated roles and responsibilities for each person as it relates to this project. Describe the experience, expertise, and capacity of each individual to address the proposed activities.

Team members working in Bluegrass Transitional Care Medical Respite include:

Susan Swinford, MSW, VP of Administration: Project Lead, CV attached

Jamie Cody, RN, Transitions Program Supervisor, Resume attached

Hospital-based Nurse/Coach: works closely with UK HealthCare to identify eligible homeless medical respite patients, enrolls the patients into transitions, in collaboration with UK case management, medical staff and social workers plans for patient discharge to the hotel. There are 3 hospital-based coaches at UK that will also enroll patients at Baptist Health Lexington and Saint Joseph Hospital.

Home Nurse/Coach: sees the patient at the hotel within 24-hours of hospital discharge and begins the medical respite intervention in the hotel. The nurse/coach sees the patient once a week for 4 weeks, telephonic when needed and in the fifth week, in-person visit in week 6 to discharge the patient. There are 3 Lexington home nurse/coaches that will provide the intervention.

Home Social Worker: Position Description: provides hotel visits as needed for community resource and program referrals, counseling and assessments.

5.2.2 Partnership & Resource Leverage **5 Points**

How do your programs and services support our community's comprehensive response to the identified priority area of Community Wellness & Safety? Does your organization have any formal agreements or informal working relationship with other local service programs?

What role does your governing board members, volunteers, and / or donors play in facilitating viable service delivery and program administration? Does your program have any major civic benefactors or corporate sponsors? Describe other secured funding sources and committed operational resources your organization has allocated for the proposed program.

The Bluegrass Transitional Care Medical Respite program has existing partnerships with University of Kentucky HealthCare, Baptist Health Lexington, Saint Joseph Hospital, physician practices, housing providers, and social services agencies that are leveraged regularly to ensure the medical respite program is successful and part of a continuum of care in the community. Working in collaboration with a wide range of community agencies to prepare the patient to return to the community is vital to the success of this intervention. Bluegrass Transitional Care participates in the Lexington Continuum of Care. Some of the agencies with which we coordinate care and services include, but are not limited to, Lexington Housing Authority, Community Action Council, AIDS Volunteers of Lexington, local landlords and apartment associations, LFUCG Adult and Tenant Services, Wheels, LFUCG Office of Homelessness Prevention and Intervention, Moveable Feast, Lexington Rescue Mission, Catholic Action Center, KY Prescription Assistance Program, Kentucky Department for Community Based Services, and home health agencies.

The Bluegrass Care Navigators Board of Directors oversees quality improvement, fiscal management, and fund-raising efforts. Our organization engages hundreds of volunteers whom we train to support our patient care programs in various capacities. We rely upon philanthropic support from the community to cover the gap not funded through traditional medical payers so that we can provide compassionate care to every eligible patient, regardless of ability to pay or level of insurance coverage.

Please see attached program description for complete details.

5.2.3 Outreach & Inclusion Strategy **15 Points**

Demonstrate how the program will ensure services are available and accessible by all potential participants, especially related to language barriers for persons with limited English proficiency; persons with physical or other disabilities; and persons impacted by poverty and economic distress.

Has your organization enacted any policies (or employs any standard operating procedures) to ensure equitable service opportunity and / or benefit program to a diverse cross-section of the greater community?

Participants in the Bluegrass Transitional Care Medical Respite program come from a situation of homelessness. As such, this program targets some of the most marginalized members of our society. These individuals are impacted by poverty and economic distress. In order to qualify for medical respite services, they must have been immediately discharged from the hospital for a physical or other disability. Program participants may also present with limited English proficiency.

One overarching goal is to help every qualifying patient in need by providing the highest quality physical and psychosocial support, without regard to race, color, religion, sex, sexual orientation, handicap or national origin. To this end, Bluegrass Care Navigators has instituted a "Non-Discrimination in Patient Care" policy to ensure that every service and benefit we provide remains inclusive to all patients. Further, our policies provide that the organization will not exclude or deny a qualified individual with a disability from participating in or benefitting from our services, programs, or activities. BCN works creatively with limited English proficient patients and their families to address any language barriers they may experience. BCN contracts with Language Line Solutions to respond to the need for translation services. BCN honors patient translation preferences and, within certain safeguards, will collaborate with a patient's preferred family member with better English proficiency or preferred community-based (volunteer or paid) translators.

Please see Non-Discrimination in Patient Care and other policy statements attached.

Required attachments with Proposal Submittal Form (8 total):

5.1.1 General Shelter Information

- Does your emergency shelter consistently implement practices to meet people where they are, and provide person-centered care that focuses on personal strengths? **(submit documentation as an attachment)**
- What policies or value statements convey clear expectations that guests will be treated with dignity and respect, and how does the shelter monitor adherence to these expectations? **(submit documentation as an attachment)**
- Does the shelter involve guests in governance and operations? **(submit documentation as an attachment)**
- **Submit reports from January 1, 2019 to December 31, 2019 as attachments:**
  - **CoC APR**
  - **CoC CAPER**

5.1.3 Low Barrier

- Does the shelter set only minimal and reasonable requirements for guests, and does the shelter enforce these requirements in a fair and transparent way? **(submit documentation as an attachment)**
- Does your emergency shelter have minimal expectations or requirements of people seeking shelter? **(submit documentation as an attachment)**
- Are guests required or requested to contribute funds or labor to remain in the shelter? **(submit documentation of any program fees or volunteer time required as an attachment)**

Applicant: Bluegrass Care Navigators, d/b/a Bluegrass Transitional Care

Lead Applicant: Elizabeth D. Fowler, President and CEO

Susan Swinford, VP of Administration, Project Lead

Contact: 2312 Alexandria Drive, Lexington, KY 40504

(859) 276-5344 susans@bgcarenav.org

Project: Bluegrass Transitional Care for Medical Respite

Bluegrass Transitional Care (BTC) proposes to provide medical respite care for the Lexington homeless population transitioning them from the hospital when they are too ill, injured, or frail to recover in a shelter or on the street. BTC is a case management entity, developed in 2012 to offer evidenced-based models of nurse transitions for patients at hospital discharge who are at risk of readmitting to the hospital within 30 days of discharge. BTC proposes to continue utilizing the nationally recognized hotel/motel respite care model, which has successfully been utilized with University of Kentucky HealthCare homeless patients since 2017. Patients that are enrolled in the medical respite transition intervention are identified by hospital case managers and medical staff. The BTC intervention begins during the hospitalization with the hospital-based coach working closely with the medical staff and case managers to prepare for discharge and transition to the hotel/motel for medical respite. The BTC home nurse coach transitions the patient into the hotel on the day of discharge and follows throughout the intervention and medical respite stay.

5.1 Program Proposal and Design: Scope of Work

The Problem of Homelessness at Hospital Discharge

When most patients transition from the hospital to home they are often in poor health, recovering from an illness or injury, and generally have a new diagnosis that will require self-management or assistance from a caregiver or family member. After leaving the hospital it is the patient's responsibility to adhere to their discharge instructions, obtain their medications, make follow-up and attend physician and therapy appointments, and accurately tell new physician consultants about their medical conditions and treatments.

For people experiencing homelessness, transitioning from the hospital to the community has numerous obstacles that often lead emergency department utilization and hospital readmissions, both high-cost options for health care. Homeless patients that are transitioning to a shelter or the street, find adhering to discharge instructions and obtaining adequate rest for recuperation is nearly impossible if shelters are closed during the day and there are restrictions in lying down in public spaces, in addition to limited access to restrooms. It is not unusual for medications to be lost or stolen following discharge, leading to non-compliance is a risk for hospital readmission. According to the National Health Care for the Homeless Council, in a study on transitions for homeless patients, 59% reported no post-discharge transportation plans, and a number of the participants were concerned for their safety when discharged after dark and had to find a safe place to rest or go to a shelter. (Greyson, R., Allen, R, Lucas, G. I., Wang, E, Rosenthal, M. S. (2012). Understanding transitions in care from hospital to homeless shelter: a mixed-methods, community-based participatory approach. *Journal of General Internal Medicine.*)

Low health literacy and poor cognitive functioning are leading factors in putting people at risk for 30-day hospital readmission and high emergency department utilization. This is prevalent among low socioeconomic groups, which often includes the homeless. Patients with low health literacy have difficulty reading and understanding their discharge instructions, including medication and diet regimens that leads to poor health outcomes. The ability to communicate their hospital course to follow-up physicians and other providers is especially challenging for patients with low health literacy. Finally, living with homelessness causes and worsens poor health. The homeless are at high risk for chronic, uncontrolled medical conditions such as asthma (4-6 times higher), cardiovascular diseases (2-4 times higher), and diabetes (up to 2 times higher) than are people with consistent housing. (Bonin E, Brehove T, Kline S, Misgen M, Post P, Strehlow AJ, Yungman J. *Adapting Your Practice: General Recommendations for the Care of Homeless Patients.* Nashville: Health Care for the Homeless Clinicians Network, National Health Care for the Homeless Council, 2004) Multiple health conditions, such as tuberculosis, substance abuse, HIV and mental illness, are difficult to manage with patients who don't have housing, especially following a hospitalization. Poor diet, exposure to weather, lack of insurance, no physician follow-up, along with the stressors of being homeless all contribute to poor discharge outcomes. It is not surprising that homeless patients discharging from an acute hospitalization frequently end up in the emergency department and readmitting to the hospital frequently. Providing medical respite accommodations after hospital discharge for patients too fragile to return to the street or shelter will provide the environment to safely recuperate from the hospitalization. Medical respite will prevent readmissions, emergency department utilization and

improve health care outcomes through evidenced-based nurse transition interventions and dependable respite housing. Additionally, reducing health care costs.

Bluegrass Transitional Care

Bluegrass Transitional Care (BTC), originally KY Appalachian Transition Services, is a case management program developed in 2011 that contracts with payers and entities to transition at-risk frail patients to prevent avoidable hospital readmissions and emergency department utilization after discharging home or to a nursing facility. In February 2013, BTC was one of 100 community-based organizations that was awarded the Centers for Medicare and Medicaid, Center for Innovations' Community Based Care Transitions Demonstration Project. The goal of the demonstration was to test evidenced-based model of care transitions for persons at-risk of 30-day readmission. Each awardee had to partner with the highest readmission hospitals in the state, BTC worked with four Appalachian Regional Health Care acute hospitals in Eastern KY. The 5-year demonstration ended in March 2017 and BTC was one of sixteen high performers to finish the demonstration.

Transitions of care are a range of time limited services that are designed to ensure that patients and caregivers can understand and utilize health care information, ensure health care continuity and avoid preventable poor outcomes as they move from one level of care to another, among multiple providers across settings. Medication reconciliation, medication education, ensuring physician follow-up, assessment, resource referral, coaching regarding their medical conditions are all components of the transition intervention. BTC uses two transition models, the Dr. Mary Naylor Transitional Care Model (TCM), through the University of Pennsylvania's Ralston

PENN Center that has been tested and refined for over 20 years. The model has proven to prevent avoidable hospital readmissions and emergency department visits. The intervention begins in the hospital, with the hospital-based nurse coach enrolling, orienting, assessing and preparing the patient for discharge. The TCM is a six-week intervention with five home visits, one a week for four weeks, telephonic in week five and a discharge home visit in week six. BTC also uses Dr. Eric Coleman's Care Transition Intervention (CTI), which is similar to TCM, but shorter in duration, three home visits over thirty days. For the medical respite program, BTC will solely utilize the Naylor TCM intervention.

The hospital-based coach hands off the patient to a home coach at discharge, a visit is made within 24-hours of discharge and the home intervention is initiated. The hospital nurse/coach utilize the following clinical instruments to assess areas that could lead to readmission:

Short Portable Mental Status Questionnaire: measures intellectual function by assessing response to ten items

Geriatric Depression Scale: validity was established by correlation with both diagnostic clinical ratings and other self-report measures of depression

Instrumental Activities of Daily Living: Lawton's IADL is used to measure ability to perform money, medication management, shopping and household chores

KATZ Activities of Daily Living: measures ability to conduct self-care

Overall Quality of Life: high correlation has been demonstrated between perceived and actual quality of life and outcomes

Subjective Health Rating: high significant correlations have been reported between self-reports and physician ratings of health status

Symptom Bother Scale: positively associated with difficulty with activities of daily living and depression, and negatively associated with subjective health

Rapid Estimate of Adult Literacy in Medicine SF: tests the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

Generalized Anxiety Scale-7: screening tool to measure the severity of generalized anxiety disorder

Proposed Medical Respite Program

BTC utilizes motel/hotel rooms for homeless respite care, a model that has also been successfully implemented in many cities in the nation. This model is relatively low cost, easy to implement, requires no licensure or other regulatory conditions, would allow families to stay together and is effective in protecting the patient from infections from other patients.

Based on the number of patients we are currently serving through Bluegrass Transitional Care Medical Respite, we project that this program will provide care for a total of 96 patients experiencing homelessness in each of fiscal years 2021 and 2022. These patients will be served in partnership with University of Kentucky HealthCare, Baptist Health Lexington, and Saint Joseph Hospital. BTC has utilized the Bluegrass Extended Stay Hotel, Richmond Rd, for homeless medical respite. Each room has a kitchenette with a full-size refrigerator, microwave and coffeemakers. There is an attendant at the front desk 24-hours a day, laundry facilities, handicapped accessible rooms, free coffee/tea and a light breakfast. UK HealthCare homeless patients that BTC has placed in the hotel for medical respite have been pleased with the accommodations. The hotel is secure through the 24-hour front desk, individual room locks and

routine hotel security. BTC has an on-call program 24 hours a day, 7 days a week for the patient to contact with questions and emergencies.

Process

Referral Process: BTC will target homeless patients at University of Kentucky Health Care, Baptist Health Lexington and Saint Joseph Hospitals. Hospital-based coach/nurses, 3 total, at UK will work closely with UK case managers and social workers to identify eligible patients for the medical respite intervention. The hospital coaches are on-site Monday-Friday identifying and enrolling patients into the transition intervention and begin the program. As part of the admission process, the patient signs a BTC Consent Form and for the medical respite intervention and addition Consent/Agreement Form will be developed that outlines expectations. The coach will visit the patient daily and begin planning for discharge and transition to the motel, working closely with UK case managers, medical staff and social workers. The hospital coach contacts the BTC office staff designated to arrange for the hotel medical respite, who begins the outpatient plans for discharge, working with the hotel and other community programs. The designated office staff is medical respite motel manager. BTC is fully integrated into the UK HealthCare electronic health record system and internally utilizes an electronic health record that is web based, ContinuLink, that all hospital and home coaches access via laptops and chart in real time. The UK HealthCare medical record is also loaded into the BTC system to ensure the home coach is knowledgeable on the hospital stay, specifically the physician's discharge summary instructions.

For patients that will be discharged from Baptist Health Lexington and Saint Joseph Hospital, the BTC staff will work closely with case management, medical staff and social workers to identify eligible patients. The UK hospital coaches will go to the hospitals and enroll the patients in the program and begin the discharge planning process with the designated office staff coordinating the hotel stay and discharge.

Eligibility: Patients must be ambulatory and able to care for themselves (with assistance), including taking their medications appropriately with guidance. Patients should not be actively using alcohol or illegal substances, although a social worker is available for counseling and referral to community resources. Families are eligible to stay in the hotel with the patient during the medical respite for recuperation. Friends may be eligible to stay with the patient on a case-by-case basis. With the motel medical respite model there is not a limit on the number of patients that can access the service at the same time.

BTC utilizes the Naylor TCM Risk Assessment Tool to determine the patient's risk factors for readmitting to the hospital within 30-days of discharge. Risk factors include: Age 80 or older, moderate to severe functional deficits, history of mental/emotional illness, 4 or more co-existing health conditions, 6 or more prescribed medications, 2 or more hospitalizations within past 6 months, hospitalization in past 30 days, inadequate support system, "poor" self-rating of health, and documented history of non-adherence to therapeutic regimen. The hospital-based coach conducts the risk assessment prior to discharge and documents the score in the medical record and BTC electronic medical record. The risk factors are part of the comprehensive assessment and assist in the development of a plan for service.

UK HealthCare utilizes the LACE Risk Assessment Too as well to identify patients at high risk of readmitting to the hospital following discharge. LACE is the acronym for **L**ength of Stay, **A**cute Admission, **C**o-morbidity, and **E**mergency Room visits during the previous 6 months. The LACE Tool has a score from 1-19 and patients scoring ≥11 are at high risk for readmission. BTC hospital-based coaches receive a list of the LACE highest risk patients daily for enrollment and there are generally at least one (1) homeless patient identified. The daily LACE report will also be utilized to identify patients for the medical respite intervention.

Hospital Discharge: The hospital case managers are responsible to arrange transportation to the hotel; however, this proposal includes funds to pay for cab vouchers for transportation to the hotel and follow-up appointments. The patient will receive their filled medications prior to discharge from the hospital through the hospital's "meds to bed" program. The designated BTC office staff representative will meet the patient at the hotel on the day of discharge to stock the hotel refrigerator with food staples (BTC utilizes Bluegrass Moveable Feast for daily meals). The office representative also gives the patient a document that details expectations during the respite and orients them to the hotel and how meals will be handled.

The nurse/home coach visits the patient within 24-hours of hospital discharge at the hotel. The nurse assesses the effects of the transition from the hospital on the overall status of the patient. The nurse/home coach ensures that the patient understands and has access to all prescribed post-discharge medications and therapies and reviews their hospital discharge instructions with the patient. A comprehensive medication reconciliation is conducted and all discrepancies are

reported immediately to the hospital discharging physician. The nurse/coach ensures that the physician follow-up appointment is scheduled within seven (7) days of discharge, arranges transportation through Wheels or a volunteer, obtains any needed medical equipment or supplies and arranges for any other needed community or medical service. When and if a patient doesn't have a primary care provider, the nurse/coach is responsible for referring them to a practice and following through to ensure an appointment is scheduled. If the patient has a skilled nursing intermittent need, the nurse/coach refers the patient to home health, if that was not done prior to discharge and obtains a physician order. It is anticipated that seventy-five percent (75%) of the patients utilizing medical respite will require a visit by the BTC social worker to arrange for additional community services and begin the permanent housing process when applicable. BTC has processes in place to report to the referring hospital case management and medical staff what they observed and all concerns found during the first home visit within 24 hours. This can include medication errors, no discharge instructions, patient doesn't understand treatment plan, no follow-up appointment scheduled, etc. This not only ensures continuity of care, but provides the hospital with a "look into first day in hotel" and an evaluation of their discharge process.

The nurse/coach visits the patient as needed in the hotel, although at least weekly for the first four (4) weeks, telephonically in the fifth week, and in-person visit for the six and final week. It is expected that the average length of stay in the hotel will be seven (7) days, based on historical experience. When the patient discharges to a shelter or permanent housing the nurse/coach completes the intervention in those locations. For each visit, the goal is to encourage the patient's coping and well-being by focusing on: managing risk factors to prevent decline; managing problem behaviors; assessing and managing physical symptoms; preventing functional decline;

managing depression; promoting adherence to therapies; assuring proper medical management; validating knowledge of the medical condition.

Hospital 30-day Readmissions

BTC uses an evidenced-based Root Cause Analysis Tool (RCA) for all 30-day hospital readmissions. The hospital nurse/coach completes the RCA with the patient during the readmission and works with the patient to prepare for discharge and communicates regularly with the home nurse/coach. The RCA assists in determining if the readmission could have been avoided and includes medical admission information and the following questions: 1. When you left the hospital the first time, did you feel ready to leave or that you left too early? 2. When did you start to feel poorly again? What did you do when you felt poorly? 3. When you left the hospital, were you able to get the medications you were prescribed? 4. We know that many people don't take their meds every day. What problems have you had taking your medications? 5. Did you see your doctor/NP/PCP for follow-up since your hospital discharge? If no, why not? 6. When you need help, who do you ask? 7. Why do you think you ended up in the hospital again so soon? 8. Is there anything we could have done better, either when you were in the hospital the last time or after you left, that might have prevented you from coming back to the hospital? The BTC medical director reviews the medical information and RCA to determine if the readmission was avoidable. The RCA is sent immediately to case managers in the hospital. Approximately 95% of all readmissions in the BTC program are unavoidable.

Medical Respite & BTC Intervention Discharge

During the entire medical respite and transitional care intervention, the nurse/coach and social worker will be working with the patient on a plan for discharge. Working in collaboration with community agencies to prepare the patient to return to the community is vital to the success of the intervention. Agencies that BTC will coordinate care and services with are, but not limited to, Wheels, homeless shelters, LFUCG Office of Homelessness Prevention and Intervention, Moveable Feast, Lexington Rescue Mission, AIDS Volunteers, Adult and Tenant Services LFUCG, Catholic Action Center, LFUCG Housing Authority, KY Prescription Assistance Program, and home health agencies. BTC is fully integrated into the UK HealthCare system and its physician practices and works closely in transitions with all physician practices and provider groups in Lexington. Through its many lines of service, BCN has close collaborations with Baptist Health Lexington and Saint Joseph Hospital.

The BTC intervention will continue after the patient leaves the medical respite hotel and transition the patient to a shelter or permanent housing, for a maximum of six (6) weeks post hospital discharge. This will provide an opportunity to ensure the patient attend follow-up appointments and treatments. At six (6) weeks, arrangements will be in place for follow-up medical care and treatments. The patient will receive a written discharge instructions that reinforces goals attained, strategies developed, and emergency plan to manage their illness. BTC nurse/coaches use teaching sheets that include specific diagnosis "Red Flags" that help the patient manage their conditions and recognize warning signs and plans to address symptoms. The primary care provider physician also receives a Discharge Summary of services provided.

Marketing Medical Respite

BTC has a well-established process to secure referrals from Lexington hospitals, physicians, case managers and social workers that currently includes medical respite in hotels for UK HealthCare patients discharging that are too fragile to return to shelters, through the July 2017 LFUCG Extended Social Resource Grant. The same processes will be used with Baptist Health Lexington and St. Joseph Hospital case managers, medical staff and social workers. Bluegrass Care Navigators has an extensive marketing department that includes two (2) Lexington dedicated Provider Liaisons that will include the medical respite program as well as all lines of service.

BTC provides monthly reports to its partner hospitals on the outcomes of the transition program, that includes homeless medical respite. A regular report will be provided to the Office of Homelessness Prevention and Intervention as well as the homeless coalition. BTC has experience in keeping the community and key stakeholders informed of program outcomes and new initiatives in various venues that includes social media. Further discussion of securing additional funding is in 5.5 Program Sustainability Section.

5.2 Experience and Qualifications, Organizational Capacity

Bluegrass Care Navigator's (BCN) mission is to provide patient-centered care to seriously ill and their families with excellence and compassion and engaging community partnerships and the Bluegrass Transitional Care innovative transition service's mission is to improve patient satisfaction, improve health outcomes and reduce health care costs. The organization's missions align with the goals of Innovation and Sustainable Solutions to Homelessness Fund to provide medical respite for persons experiencing homelessness that are discharged from local hospitals

and need a place to rest and recuperate, which will lead to better health care outcomes, lower cost to medical facilities and lead to stable housing and improved quality of life in the community. Bluegrass Care Navigators, recognized as a leader, for nearly 40 years, in the hospice and palliative care arena, has provided expert, compassionate care to thousands of individuals and families. The organization's commitment to providing a full continuum of care is exhibited through innovative lines of services, such as Bluegrass Transitional Care, Bluegrass Extra Care Private Duty, CMS CMMI Medicare Care Choices Model, Primary Care and extensive services through Bluegrass Palliative Care. BCN operates a free-standing hospice facility in Hazard, Kentucky, a unit within Saint Joseph Hospital and will open a unit within Markey Cancer Center in the first quarter of 2018. Recently, BCN was successfully awarded a Certificate of Need for Bluegrass Adult Day Care in Franklin County and will be operational in April 2018.

BCN has the organizational infrastructure to expand its transition program and medical respite intervention, including Finance, Human Resources, IT, Quality Department and Marketing departments.

In 2016, BCN admitted 5,436 hospice patients, conducted 9,111 palliative care visits and admitted 5,280 transitional care cases, touching over 40,000 lives in central, northern and eastern Kentucky. BCN has 611 employees across its lines of service and 622 trained volunteers.

BCN began transitioning patients for UK HealthCare in February 2015, initially in hospital medicine, expanding cardiovascular, Good Samaritan Hospital, neurology, NICU NAS babies

and to emergency medicine in August 2016, which led to the Lexington homeless population. The UK HealthCare program to date November 2017 enrolled 995 patients of which 77 readmitted within 30-days (without ESRD patients) for a 7.7% readmission rate. Inclusion of the ESRD patients the average readmission rate is 14.4%, a very successful outcome.

In July 2017, BTC was awarded the Extended Social Resource Grant by the LFUCG to provide medical respite in hotels and other services for the homeless patients transitioning from UK HealthCare. BTC transitions patients discharging from UK HealthCare to local shelters and provides the transition intervention within the shelter. Following are examples of the homeless transitions and medical respite.

Patient 1: 49-year-old divorced male originally from the Northwest that is Bipolar and quit taking medications that led to him crossing the country and ending up in Lexington. His initial hospitalization vis the emergency department for chest pain that required a CABG 4 valves and a length of stay at UK for 14-days. The patient was too fragile too fragile to return to the homeless shelter and was discharged to a hotel for recuperation, with the ultimate goal of assisting him to return to the Northwest when released by his cardiologist. The patient had multiple co-morbidities including Hypertension, Diabetes, Anxiety, Chronic Obstructive Pulmonary Disease, PVD both legs, Heart Disease, Manic Depression and recent suicide attempts. The patient did have a planned readmission for surgery to clean the wound site, 2-day length of stay. The patient was in the hotel for 5 weeks and then released from his cardiologists and assisted with travel back to the Northwest. During his hotel stay he received multiple services including 3 nursing visits and 2 social work visits.

Patient 2: 68-year-old divorced male that was admitted to UK for Pneumonia for a 5-day stay. The patient has multiple co-morbidities including Hypertension, history of alcohol abuse,

Chronic Obstructive Pulmonary Disease, tobacco abuse and oxygen dependent. The patient needed a new special portable oxygen concentrator that UK HealthCare agreed to purchase, which would take 4-5 days to arrive. Rather than remain in the hospital, BTC transitioned the patient to a hotel and had a temporary oxygen concentrator delivered. The patient remained in the hotel for 5 days and transitioned back to the homeless shelter. The nurse/coach transitioned the patient to the shelter and completed the intervention. The patient didn't have a hospital readmission.

Patient 3: 55-year-old male hospitalized for Bacterial Pneumonia, 18-day length of stay. The patient has multiple co-morbidities, including HIV, Cellulitis and Hep C. The patient was awaiting a placement at Solomon House and rather than stay in the hospital BTC transitioned him to a hotel. He was at the hotel for 5 days and then transitioned to Solomon House. He was seen by the nurse/coach 3 times and by the social worker 2 times over the 6-week transition. Provided the patient with clothing to wear to his mother's funeral, food and obtained Wheels. The patient didn't have a hospital readmission and had one emergency department visit for an ear ache.

BTC has existing partnerships with hospitals, physician practices, social services agencies, such as Moveable Feast that will be leveraged to ensure the medical respite program is successful and part of a continuum of care in the community.

Team Members Working in Medical Respite:

Susan Swinford, MSW, VP of Administration: Project Lead, CV attached

Kelly Adkins, Associate of Business Management, Administration Office, Hotel Medical Respite Coordinator, Position Description: is responsible for coordinating with the hospital-

based coach and hospital case manager to arrange for the hotel, stock food, Moveable Feast, applicable durable medical equipment and coordinate the hotel stay, and assigning the home nurse/coach and social worker.

Hospital-based Nurse/Coach: Position Description: works closely with UK HealthCare to identify eligible homeless medical respite patients, enrolls the patients into transitions, in collaboration with UK case management, medical staff and social workers plans for patient discharge to the hotel. Section 5.1 has detailed descriptions of the roles and responsibilities for the hospital-based nurse/coach. There are 3 hospital-based coaches at UK that will also enroll patients at Baptist Health Lexington and Saint Joseph Hospital.

Home Nurse/Coach: Position Description: sees the patient at the hotel within 24-hours of hospital discharge and begins the medical respite intervention in the hotel. The nurse/coach sees the patient once a week for 4 weeks, telephonic when needed and in the fifth week, in-person visit in week 6 to discharge the patient. There are 3 Lexington home nurse/coaches that will provide the intervention. Section 5.1 has detailed descriptions of the roles and responsibilities for the home nurse/coaches.

Home Social Worker: Position Description: provides hotel visits as needed for community resource and program referrals, counseling and assessments. Section 5.1 has further detail on the roles and responsibilities.

Trained Volunteers: BCT will use the BCN organization's trained volunteers that work in all lines of service to provide transportation as needed, deliver food and offer companionship.

5.3 Timeline

BCN and BTC currently provide medial respite in hotels in partnership with UK HealthCare and the Extended Social Resource Grant and the program protocols, policies and procedures are in-place to immediately begin the program.

July 1, 2018: Start date of one-year funding

July 2018: Work with the LFUCG and Office of Homelessness Prevention and Intervention to determine the data collection and reporting requirements. Responsible Person: Susan Swinford

July 2018: Enroll first eligible patients at UK HealthCare for medical respite transition. Responsible Parties: Hospital Nurse/Coaches, Home Nurse/Coaches, Hotel Coordinator

July/August 2018: Meet with key stakeholders at Baptist Health Lexington and Saint Joseph Hospitals to develop and finalize processes for identifying eligible patients, referral process, enrollment and discharge processes. Responsible Person: Susan Swinford and BTC team

July/August 2018: Finalize meetings with community agencies that will collaborate in the medical respite program including homeless shelters, Wheels, Moveable Feast, housing agencies, etc. to develop streamlined processes for referrals for needed services. Responsible Persons: Susan Swinford and BTC team

September 2018: Provide first monthly report to hospital partners, Homeless Coalition, Office of Homelessness Prevention and Intervention: Responsible Persons: Susan Swinford and BTC team

October - December 2018: provide in-person reports on program progress and outcomes: Responsible Persons: Susan Swinford and BTC team

January – June 2019: provide in-person reports on program progress and outcomes: Responsible Persons: Susan Swinford and BTC team

5.4 Sustainability, Cost and Overall Program Budget

BCT currently contracts for transitions for KY Medicaid Managed Care Organizations, specifically Aetna Better Health and Anthem MCO and is in the contractual stage with Humana CareSource. The MCOs pay for the transition intervention and BTC provides weekly reports on the activities and outcomes for their members as well as regular large detailed reports. During the grant period, BTC will meet with MCO leadership to present proposals on the outcomes of the medical respite program and request that they pay for the hotel at the end of the grant for their members. BTC will approach all five KY MCOs as well as Medicare Advantage programs. Hospital partners will receive regular reports on the program's outcomes that will lead to proposals for the hospitals to also share the cost of the medical respite program, which will provide them with cost avoidance and bed opportunity days.

BCN has an extensive Philanthropy Department that will work with BTC to evaluate what opportunities for additional grants and funding there are for the medical respite program.

Budget and Narrative

2018 Medical Respite Care Grant Budget Narrative

1. Personnel - total amount requested: $37,043.28
    a. Id each position allocated to the grant
        i. Fayette County Home Coaches – $28,440 requested
        ii. Part time Social Worker - $2,970 requested
        iii. Administrative Assistant - $5,633.28 requested

b. What is their role in the project

i. Fayette County Home Nurse/Coaches will be the primary medical support for the patient

ii. Social Worker will provide one counseling visit in addition to nurse visits to 75% of patients

iii. Administrative Assistant will secure motel room and food provisions for patient

c. What % of FTE allocated –

i. Fayette County Home Coaches: .50 FTE

ii. Social Worker: .25 FTE

iii. Administrative Assistant:

2. Fringe Benefits – total amount requested: $3,094.20

a. Organization fringe benefit rate –

i. 24% for administrative assistant

ii. 7.65% for nurses and social worker

3. Equipment: small durable medical equipment, such as canes: in-kind donations

4. Travel: emergency cab vouchers: in-kind

5. Contractual – N/A

a. Describe expenses associated with providing expanded supportive services or other services or other services for which the organization intends to contract with another entity – THIS IS NOT APPLICABLE

6. Operating Expenses – total amount requested: $38,520

a. Breakdown supplies, office space, contracts for supportive services, HMIS expenses and other. For each category, ID category and give justification.

   i. Other: Motel room @ $70 per night for homeless patients to receive care. $35,280 requested

   ii. Supplies: $40 basic food supply for motel room. - $2,880 requested

   iii. Supplies: Medication Sets - Utilized to teach medication management, utilized with low literacy individuals - $360 requested

7. Indirect Costs – total amount requested: $3,932.87

   a. Is there an indirect cost rate? Yes

   b. If yes – provided evidence of an approved indirect coast rate from appropriate cognizant agency – SEE ATTACHMENT ??

   c. If no – provide clear indication of administrative costs as differentiated from direct operating expenses.

Line Item Budget

LFUCG Medical Respite

Budget 2018

Personnel	Amount Requested	
Fayette County Home Coaches	$28,440.00	
PT Social Worker	$2,970.00	based on 75% or 54 clients
Administrative Kelly Atkins	$5,633.28	
Fringe Benefits	$3,094.20	

Equipment

Travel

Contractual

Operating Expenses

Hotel Room	$35,280.00
Food	$2,880.00
Pillboxes	$360.00
Indirect Costs	$3,932.87
TOTAL	**$82,590.35**

Average cost per client	$1,147.09
# of clients	72

5.5 Program Outcomes and Performance Measures

BTC, through its work with CMS CMMI Community Based Care Transition Project, contractual relationships with KY MCOs, hospitals, and Medicare Advantage plans has extensive data collection, analysis and reporting processes in place. BTC utilizes an electronic medical record that includes all data collection items. Hospital nurse/coaches begin the medical record and then the home nurse/coach continues the documentation through the intervention. Monthly reporting

leads to program evaluation and modifications based on outcomes. Hospital electronic medical records that are loaded into the BTC EMR also provide data elements for review and reporting.

Data Elements Collected:

Patient demographics: date of birth, marital status, insurance, county of origin, support system, shelter usage, education, employment

Hospital: admitted via emergency department/clinic, admission conditions, all diagnoses, hospital course, length of stay, hospital physician, discharge diagnosis, medications, discharge disposition: home health, cardiac clinic, etc.

Hospital Readmissions/Emergency Department Utilization/Observation Stay: Collect all elements on the Readmission Root Cause Analysis described in Section 5.1. Reason for readmission, via emergency room, days home prior to readmission, length of stay of readmission, avoidable/unavoidable. Collect all emergency department visits and observation stay and whether they could have been avoided

Transition Intervention: Findings at the first hotel visit, medication discrepancies, patient's understanding of medical condition and treatments, etc. Risk Factors, LACE Score

Clinical Assessment Instrument Scores: Short Portable Mental Status Questionnaire, Geriatric Depression Scale, Instrumental Activities of Daily Living, KATZ Activities of Daily Living, Overall Quality of Life, Subjective Health Rating, Symptom Bother Scale, Rapid Estimate of Adult Literacy in Medicine-SF, Generalized Anxiety Scale-7

Quality Measurement:

Structure Measures: evaluating promptness of nurse intervention upon entry to the program, frequency of visits, frequency of contacts, medication reconciliation

Process Measures: Medication reconciliation, adherence to documentation requirements

Care Team Process: follow up with primary care provider within 7-days of discharge

Outcome Measures: patient experience of care and satisfaction, provider satisfaction

Health Care Resource Utilization: readmission within 30-days of discharge, emergency department utilization

Specific Medical Respite Outcome Data Elements: all tracked in EMR and Finance

Average cost per client and community savings: length of their medical respite stay, savings with avoided extended hospitalization, readmission, emergency department utilization, observation stay, number of staff visits, food costs

Housing Status at Discharge: percentage of patients placed or referred to permanent housing, percentage of patients preferring to return to shelters, percentage patients moving to other housing options

Supportive Services Offered/Accepted/Outcome: BTC will develop expected services to be offered, such Wheels, and track that utilization by acceptance and outcome. Other non-expected supportive services offered will be tracked as well.

Professional VITAE

Susan Swinford
1885 Blairmore Road
Lexington, KY 40502
Home (859) 269-6977
Work (859) 276-5344

EDUCATION

University of Kentucky- Lexington, KY 40506
1981 Completed Bachelor of Science degree in Social Work
1986 Completed Master of Science degree in Social Work

EMPLOYMENT EXPERIENCE

3-89 to Present — Hospice of the Bluegrass, Inc. d/b/a Bluegrass Care Navigators
2312 Alexandria Drive
Lexington, KY 40504
VP of Administration, VP of Innovation and Advocacy 2019

Responsible for administration operations activities including negotiating contracts, managing contract relationships, facilities, negotiating third party insurance contract, Medicare/Medicaid/Managed Care partnerships, Certificate of Need, regulatory issues, legislative issues, and licensure oversight. Responsible for developing, implementing and overseeing new projects and programs. VP over Bluegrass Transitional Care.

Developed the Palliative Care of the Bluegrass program in 1999, lead in the development of the CAPC Palliative Care Leadership Center, Extra Care Private Duty in 2002, Bluegrass Transitional Care in 2012, Project Lead in the CMS Community-Based Care Transition Project demonstration, Project Lead for CMS CMMI Medicare Care Choices Model, developed new home health program, and developed the Bluegrass Adult Day Health. Project Lead for Bluegrass Navigators for the new UK HealthCare HEAL NIH grant to reduce opioid overdose deaths by 40% in 4-years, leading community navigators.

6-89 to 3-98 — Jessamine County Hospice
P.O. Box 873
Nicholasville, KY 40356
Executive Director

Program merged into Hospice of the Bluegrass. Responsible for all aspects of managing the hospice program including, administration, finance, clinical, board development and management, and legislative and regulatory activities.

7-83 to 6-89 — Hospice of the Bluegrass, Inc.
2312 Alexandria Drive
Lexington, KY 40504
Social Worker

Direct patient services, conducted support groups, assisted with developing the program.

10-82 to 7-83 Caretender's Home Health
Lexington, KY
Social Worker

Medical social worker providing direct client services.

5-82 to 10-83 Meadowbrook Nursing Home
2020 Cambridge Drive
Lexington, KY
Director of Social Services

Direct client services, responsible admissions, group work and developing new projects.

PROFESSIONAL CONSULTANT EXPERIENCE

Consultant nationally on hospice organizational, clinical and regulatory issues. Consultant nationally on program development, especially transitional care and proposal development and value propositions.

PROFESSIONAL PRESENTATIONS

Frequent national speaker on: AIDS (1980's), hospice, program development, regulatory and legislative issues, transitions, private duty, proposal development/making the case, working with payers, Medicare Care Choices Model, etc.

Active member of the Kentucky Association of Hospice and Palliative Care, past President, Regulatory Chair and current member of Regulatory Committee. Active member of the National Hospice and Palliative Care Organization, past Regulatory Chair during the major Conditions of Participation revision with CMS in 2008, current Regulatory member, past Medicaid workgroup chair, as well as other workgroups and committees. Co-leaders of the Palmetto GBA Coalition since 1995 and CMS Region IV hospice leader. CMS CCTP frequent speaker and leader for monthly webinars and in-person meetings.

Jamie Cody, RN
47 Brashear Drive Hazard, KY 41701
606-436-8229 Home
606-438-8668 Cell
jcodyrn@yahoo.com

Education

Currently licensed as a Registered Nurse in Kentucky.
Currently certified in CPR as a BLS Healthcare Provider through American Heart Association.

April 2012: Completed "Transitional Care Model: Evidence Based Transitional Care for Chronically Ill Older Adults" course through University of Pennsylvania's Ralston-Penn Center.

1996-1999 Associate Degree in Nursing, Hazard Community College
1992-1996 Advanced Placement Commonwealth Diploma, Perry County Central High

Employment

March 2018-present: RN, Transitions Program Supervisor Bluegrass Transitional Care/ Kentucky Appalachian Transition Service (KATS)
Currently fulfilling full-time supervisor position within transitional care program. Duties include orientation, training, and supervision of nursing staff, screening and admitting hospitalized patients to the transitional care program and working with chronically ill patients, their caregivers and health care providers to promote optimal level of health and prevent unnecessary hospitalizations.

March 2012-March 2018: RN, KATS Nurse Manager, Kentucky Appalachian Transition Service (KATS)
Fulfilled position as a lead transitional care nurse within the Kentucky Appalachian Transition Service, assisting chronically ill adults in managing their health care and preventing hospital readmissions. Duties included screening and admitting hospitalized patients to the KATS transitions program, completing in home follow up visits, and collaborating with patients and other health care providers.

Jamie Cody, RN
47 Brashear Drive Hazard, KY 41701
606-436-8229 Home
606-438-8668 Cell
jcodyrn@yahoo.com

2004-July1, 2013: RN, Nurse Administrator,
LKLP Compassionate Hearts Adult Day Health Center
Fulfilled position of Nurse Administrator of adult day health care center. Responsibilities included overseeing operations of adult day health center, ensuring state and federal regulations were met without omissions, and supervision of all nursing and ancillary staff. Other duties include developing and implementing staff training and patient care plans, ensuring infection control guidelines were met, preparing staff schedules, assisting with hiring and orientation of new employees, and quality improvement.

July 2011-2013: RN, Hospice of the Bluegrass, Extra Care Private Duty, PRN
Fulfilled prn position within Hospice of the Bluegrass' Extra Care Private Duty Nursing Service. Duties include providing direct patient care and family support to patients with terminal illness at the end of life. Also work as prn Hospice staff nurse in several counties in Eastern Kentucky, performing assessments and providing in-home care for terminally ill adult and pediatric patients.

2003-2004: Horizon Adult Health Care, RN Charge Nurse
Fulfilled part time position as charge nurse for Adult Day Health Care Center.

1999-2001: Registered Nurse, MDS Assessment Coordinator, Nim Henson Geriatric Center
Fulfilled full-time position of RN Assessment Coordinator for a skilled nursing facility; coordinating interdisciplinary assessments of nursing home residents, initiating individualized patient care plans, and implementing staff inservices to promote quality and continuity of patient care. Responsible for initiating schedules and completing MDS assessments of 44 skilled patients, as well as ensuring completion of other assessment forms by staff.

Jamie Cody, RN
47 Brashear Drive Hazard, KY 41701
606-436-8229 Home
606-438-8668 Cell
jcodyrn@yahoo.com

1999: Registered Nurse, Nim Henson Geriatric Center
Fulfilled position of staff nurse at a skilled nursing facility, caring for patients with a variety of physical and psychological disorders, implementing necessary interventions to improve quality of life and promote physical and psychological well being.

Professional Activities

- 2012-2013: Regional Representative on the board of the Kentucky Association of Adult Day Centers (KAAD)
- 2006-2008: Eastern Regional Representative for the Kentucky Association for Gerontology (KAG)

NOTICE OF PRIVACY PRACTICES
Policy No. 12.05 Page 1 of 2

PURPOSE

To provide guidelines for the protection of patient/client private health information.

POLICY

The privacy practices of BCN, designed to protect the privacy, use, and disclosure of protected health information, are clearly delineated in the hospice's Notice of Privacy Practices, which was developed and used in accordance with Federal requirements.

PROCEDURE

1. The privacy practices of BCN are described in the Notice of Privacy Practices (see Addendum 7-030.E for Notice of Privacy Practices).

2. The privacy practices and requirements of BCN are further detailed in BCN's Privacy Policies and Procedures.

3. The Notice of Privacy Practices is given to all patients/clients no later than the date of the first service delivery.

4. A good faith effort is made to obtain written acknowledgement of the patient/client's receipt of the BCN Notice of Privacy Practices.

5. When written acknowledgement of the patient/client's receipt of the Notice cannot be obtained, there is documentation to explain efforts made to obtain it and the reason(s) why it was not obtained.

6. The Notice of Privacy Practices is available to anyone who requests it.

7. The Notice of Privacy Practices will be revised as needed to reflect any changes in BCN 's privacy practices. Revisions to the Notice will not be implemented prior to the effective date of the revised Notice.

8. When policy-altering revisions to the Notices of Privacy Practices are necessary, all current patients/clients, employees, and business associates will receive a revised copy with notation of the changes made.

9. The Privacy Officer retains copies of the original Notice of Privacy Practices and any subsequent revisions for a period of seven (7) years from the date of its creation or when it was last in effect, whichever is later.

10. Documentation is retained for seven (7) years after the patient's/client's written acknowledgment of receipt of BCN's Notice of Privacy Practices or of efforts made to obtain this written acknowledgment and the reason(s) why it was not obtained.

11. All employees and business associates of BCN are required to adhere to the privacy practices as detailed in the Notice of Privacy Practices, privacy policies and procedures and business associate contracts.

12. Violations of BCN's privacy practices will result in disciplinary action, up to and including, termination of employment or contracts.

NON-DISCRIMINATION OF PATIENT NEEDS
Policy No. 11.27 Page 1 of 1

PURPOSE

To ensure that care, treatment, and services are consistent with Hospice's mission, vision, and goals. Hospice can provide the services that patients need within an established time frame.

POLICY

Patient with comparable needs receive the same standard of care, treatment, and services throughout the organization.

Care, treatment, and services are consistent with Hospice's mission, vision, and goals.

PROCEDURE

1. Hospice provides the services that patients need within established time frames;

2. Hospice ensures those providing the care, treatment, and services have the required competence by following procedures outlined by the HR department, and

3. Variance in payment source do not affect the outcomes of care, treatment, or services in a negative way.

Reviewed	Revised
01/05/09	08/26/09

CONFIDENTIALITY
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PURPOSE

To ensure that all persons hired by BCN understand and agree to comply with rules and regulations governing the disclosure of patient/client information.

POLICY

BCN will protect the confidentiality of its patients/clients/families/caregivers.

PROCEDURE

1. The confidentiality policy is provided to employees in their pre-employment packets and must be returned on or before the first day of employment.

2. No information about the patient/clients/family/caregiver will be released by a member of BCN which might identify the person without the informed consent of that person or his/her legal representative, unless otherwise required by court order, federal, state or local monitoring agencies, or for payment, treatment and healthcare operations.

3. Lists or forms about patients/clients/families/caregivers will be compiled for information and referral purposes only. These will be used solely for inter-BCN purposes.

4. Only personnel involved in the care/service or supervision of care/service on specific patients/clients will access patient/client information.

5. Patients/clients will not be discussed by clinical or non-clinical BCN personnel outside of the clinical setting.

6. Comments and conversations relating to patients/clients made by physicians, nurses or other BCN personnel will be made in confidential settings. It will be standard, acceptable, and necessary practice to share information with other members of the care team. The decision to share information can be aided by considering the intent of the discussion.

7. All requests for information will be reviewed on an individual basis per BCN policy and HIPAA regulations.