

ALLIANCE CARE NETWORK (ACN)

STRATEGIES TO IMPROVE THE HEALTH AND WELL-BEING OF
PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

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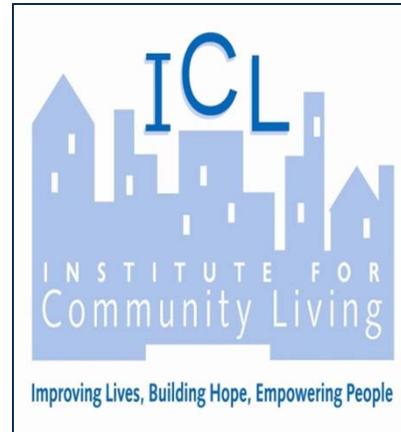
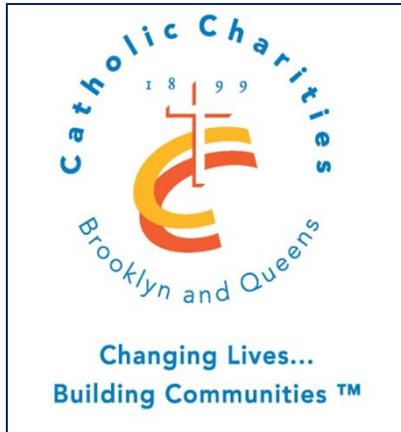
OUR PRESENTATION WILL ADDRESS

- Who is **Alliance Care Network (ACN)**
- What our Vision is for a more **person-centered service system**
- What our innovation is -- **“Health Home” care coordination and a consumer/family friendly health care network**
- How our innovation will **improve quality of life** for people with intellectual and developmental disabilities (I/DD)

WHO WE ARE

- A collaboration of 7 not-for-profit agencies who offer the **full array of community-based services** to approx. 6,000 consumers
- A **provider partnership** offering high-quality developmental disability, medical, behavioral health, employment & community services
- **Decades of experience** running quality programs for consumers with intellectual and developmental disabilities (I/DD) ranging from 18 to 60 years
- Leaders in NYC/LI **Health Homes** for people with chronic medical/behavioral disorders
- A diverse group who **continues to develop its network**

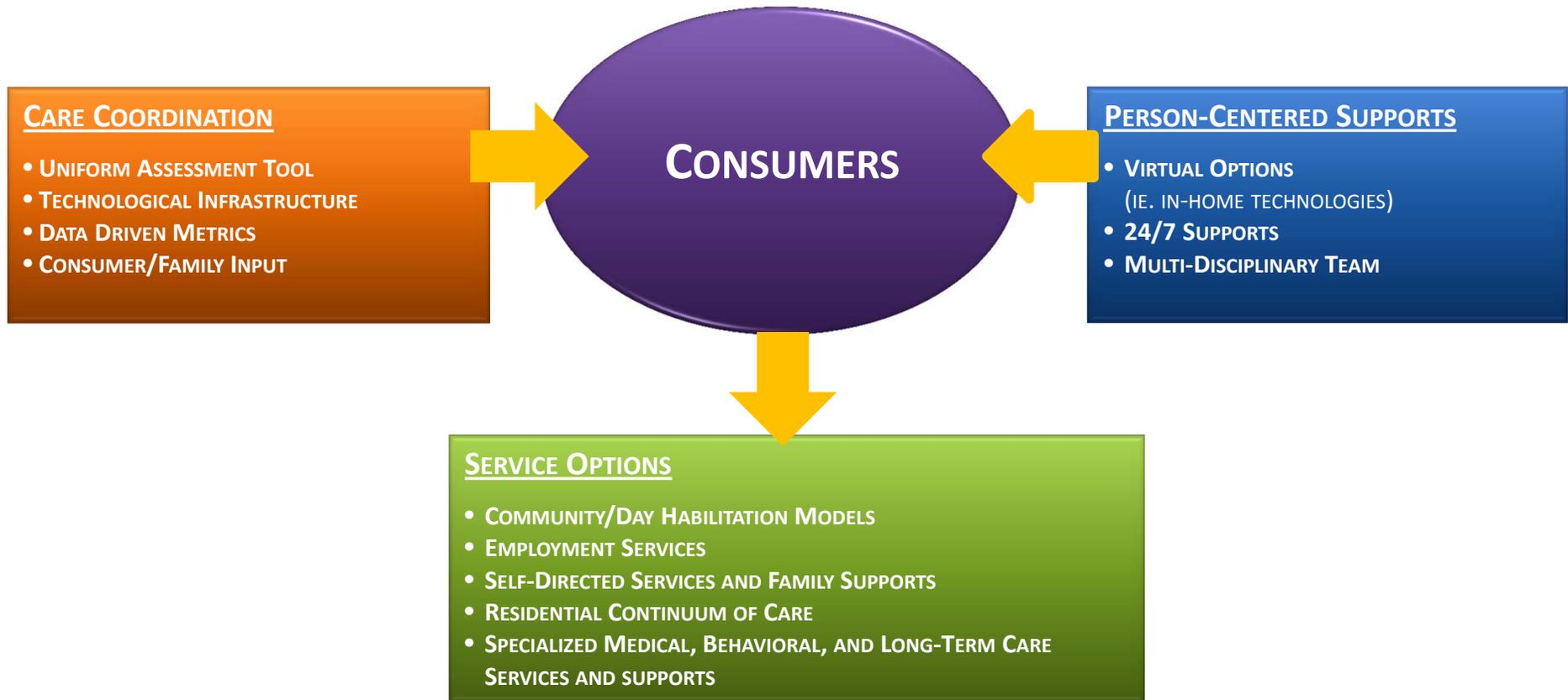
OUR FOUNDING PARTNERS



OUR MISSION

ACN is committed to coordinating a broad range of high quality, integrated, and person-focused resources and services centered around evidence-based best practices that enable people with I/DD to lead independent, healthy, fulfilling, and meaningful lives. ACN's core values and operating principles are grounded in an approach that fosters and encourages independence, family engagement, vocational success, healthy living, and habilitation to maximize individual potential.

OUR PERSON-CENTERED SYSTEM



THE HEALTH HOME MODEL

- **Consumers and Families:** Engaged from the start to create an integrated service plan and monitor satisfaction with providers
- **Care Coordinator:** A single point of accountability to plan and coordinate health care and other necessary services
- **Providers:** A comprehensive provider network that is best able and willing to deliver integrated care
- **Communication:** Technology enables all to share information and coordinate care

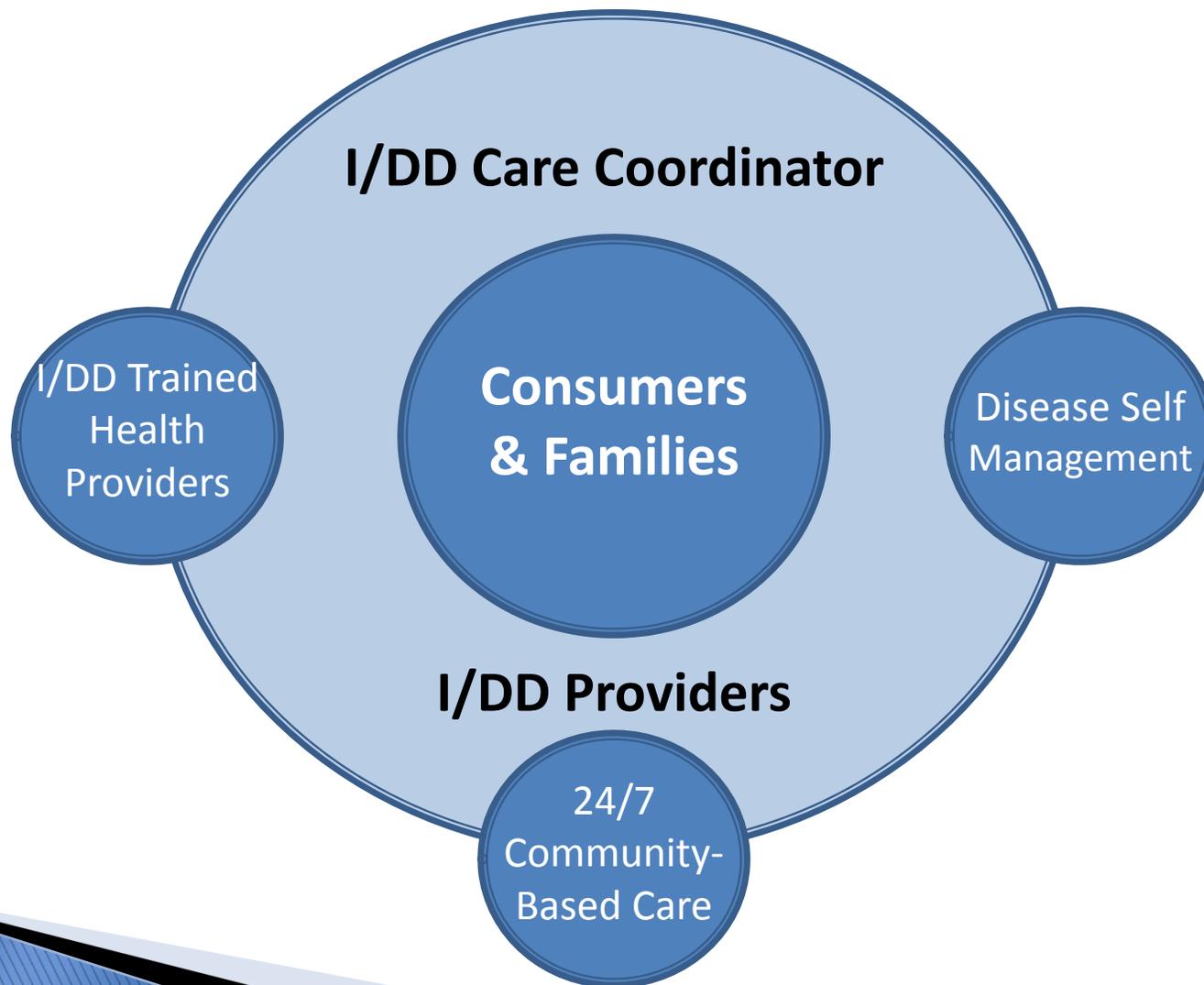
LESSONS LEARNED FROM EVIDENCE-BASED PRACTICE

- Individuals with special needs benefit from health care coordinated at specialty care provider sites
- A single point of accountability for service coordination is key
- A service system needs to work for the people using it
- Access is often linked to a “friendly front door”
- Integrated care is best practice
- Service providers from different systems must work together—that is a “real” network

OUR HEALTH CARE INNOVATION

- Makes I/DD providers the “hub” of integrated care system
- Based on experience with I/DD services and more recent expertise coordinating health care and preventive services
- Builds on the skills of founding agencies who are designated as Health Homes for Medicaid beneficiaries with chronic illnesses and complex needs
- Expands innovative prevention services that promote wellness skills and disease management for people with I/DD
- Combines the strengths of partners with a comprehensive service network that better addresses the needs of people with I/DD
- Improves access and quality, while reducing unnecessary costs

HEALTH HOME CARE MODEL



BARRIERS TO BETTER HEALTH OUTCOMES

- Prevention, disease management and medical risks are not a uniform priority in the I/DD service system
- There is no single point of responsibility and authority that coordinates services across the continuum of care
- Not enough specialists are trained and comfortable treating people with I/DD
- Primary care providers are often not accessible on evenings, weekends and holidays

RELIANCE ON ERs AND URGENT CARE



KEY COMPONENTS OF OUR NEW MODEL

- Offers comprehensive health care coordination
- Expands disease self management, preventive care and wellness programs
- Promotes consumer/family friendly medical care
- Improves access to medical centers of excellence
- Creates an IT platform for health information sharing
- Trains staff on uniform evidence-based protocols
- Uses health outcomes data to inform future service delivery

COMPREHENSIVE CARE COORDINATION

- **Engages consumers, families and providers** in treatment, planning and care coordination
- Arranges/coordinates services through a **trained professional on I/DD provider staff** knowledgeable with all systems of care
- Utilizes a **provider network committed to integrated care**
- Arranges **access to medical centers of excellence** for specialty care
- Provides **flexible service options** that will better meet consumers and their families' needs and preferences
- Leverages the **best technology**, quality metrics and program resources

INNOVATION IMPROVES QUALITY OF LIFE

- Same/next day services will be available to consumers
- Unnecessary ER visits and hospitalizations will be reduced
- Medications will be better coordinated
- Consumers, families and providers will be partners in promoting healthy eating, living active lifestyles and managing chronic diseases
- “Healthier” consumers will be better able to learn new skills, pursue meaningful activities and live more self-sufficiently

MEASURES OF SUCCESS

- Positive feedback from consumers and family satisfaction surveys
- Continuity of care with primary care physicians
- Indicators for the appropriate use of medical services, specialty care and medications
- Reductions in unnecessary ER visits and hospital admissions
- Evidence-based disease management protocols

TIMELINE FOR HEALTH HOME INNOVATION

ACN will work closely with OPWDD to:

- Start upon approval of the People First Waiver and/or OPWDD pilot project
- Launch within 120 days of approval
- Pursue grants to begin prevention and wellness components

CONTACT INFORMATION

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