



## Acton Board of Health

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Doug Halley, Health Director



**Public Health**  
Prevent. Promote. Protect.

August 25, 2014

To: Steve L. Ledoux, Town Manager

From: Doug Halley, Health Director

Subject: HMS Report Options – Proposed Budgets

This memo is written as a follow-up to the Homecare Management Solutions report options and the Board of Selectmen's meeting held on August 11<sup>th</sup>. As was discussed budget details for the report options needed to be developed for the Board of Selectmen's review at their September 8<sup>th</sup> meeting. The Options as listed in the report were as follows:

	Keep ANS (no change)	Partner Parmenter for skilled services	Other agencies for skilled services	Public Health By Acton Town	Public Health outsourced (Parmenter or other entity)	Public Health Provided to Other Towns (Stow)	Navigator Program Under Action Town control
Option 1	X			X		X	
Option 2			X		X		
Option 3		X			X		
Option 4		X		X		X	
Option 5		X		X		X	
Option 6			X	X		X	X

In terms of budget impact Options 5 & 6 would be the same with the only difference being transition of skilled Nursing to Parmenter or to some other Home Care agency. The same is true for Options 2 & 3, however, we are still working on developing the cost of outsourcing public health services. It should also be noted that Option 1 has been looked at from two perspectives; as a Medicare certified agency operating within the Enterprise Fund and as a non-certified agency operating within the General Budget (Option 1A).

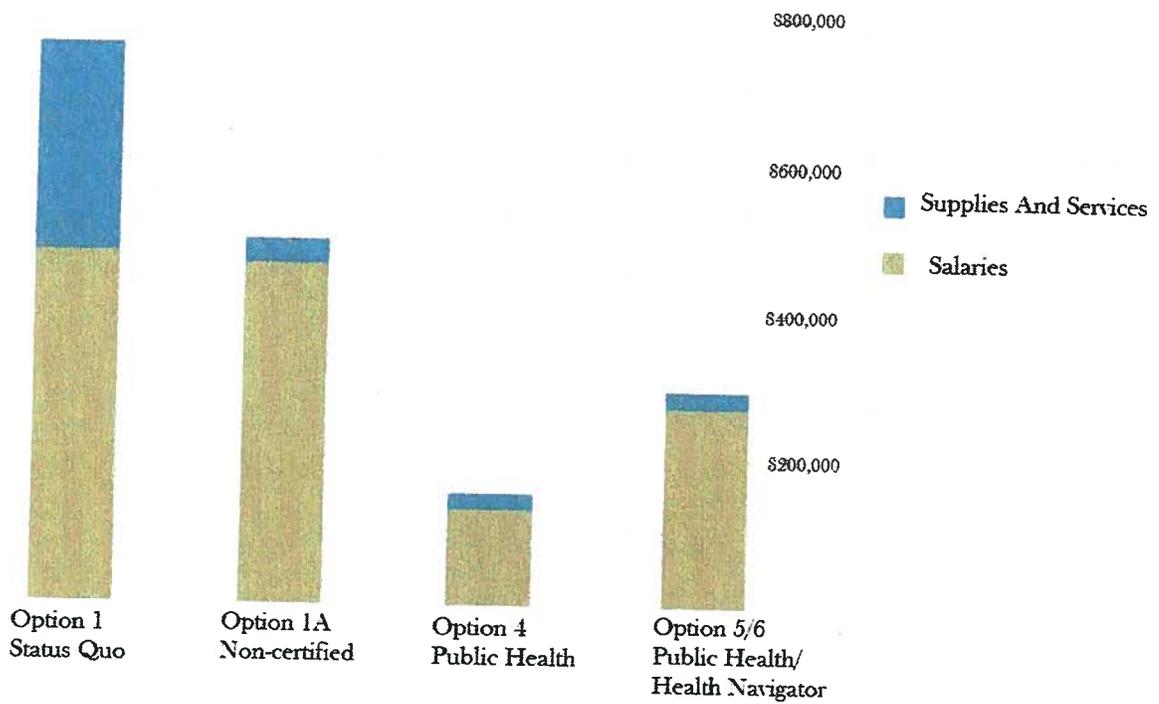
The FY 16 Budget for Option 1 (see attachment A) is based on providing level service Medicare certified skilled nursing. The major difference between the FY 15 budget and the FY 16 budget is the elimination of a 27.5 hour clinical manager position, which is currently vacant (FY 15 Budget = \$657k, FY 16 Budget \$620k). For this Option the Medicare certified skilled nursing has 4.1275 FTE's while the public health budget has 1.18 FTE's. It should be noted that under this scenario the nursing office is always staffed, which ensures that public health services can be provided M-F, 8 AM to 5 PM. The Public Health budget for this option would be \$131k for FY 16.

The FY 16 Budget for Option 1A (see Attachment B) is based on providing non-certified skilled nursing. As a non-certified service the budget would avoid considerable costs that are required to be Medicare certified. These savings are close to \$240k per year but would also severely limit revenue as Medicare and Third party providers would no longer reimburse our services. Only private care could be billed to the patient receiving the service. The budget of \$494k would be for skilled nursing services and public health services. This option would have 4.1275 FTE's for skilled nursing and 1.18 FTE's for public health.

The FY 16 Budget for Option 4 (see Attachment C) is based on transitioning skilled nursing to Parmenter or another agency while retaining public health services in house. While the budget does not have to cover skilled nursing services it does have to take into account the absence of those nurses and their previous utilization for providing public health services through the course of the day. The major difference between the FY 15 budget and the FY 16 budget is an increase in FTE's from 1.18 to 1.75 (FY 15 Budget = \$130k, FY 16 \$151k). This increase is to ensure that the day to day level service of public health is retained.

The FY 16 Budget for Option 5/6 (see Attachment D) is based on transitioning skilled nursing to Parmenter or another agency, retaining public health services in house and implementing the Health Navigator program (see Attachment E). The major difference between Option 4 and this option is the cost (\$140k) of the Health Navigator program (see Attachment F). 3.05 FTE's ~~would be dedicated to the Public Health/Health Navigator program~~ with a total budget of \$294k.

Below is a chart of the 4 options discussed:



\*option 2/3 still in the process of acquiring quotes

It should be noted that either choosing or not choosing Option 1 will require Town Meeting action as soon as possible. If Option 1 is chosen it is unlikely the existing fund balance will be adequate for the remainder of the fiscal year. If Option 1 is not chosen the Enterprise Fund will need to be closed and the costs of closing would need to be addressed as soon as possible. No immediate decision must be made on which option is appropriate but an immediate decision is required regarding setting a Town Meeting date.

Attachment A - HMS Option 1

**Medicare Certified &  
Public Health**

**NURSING SERVICE BUDGET**

**Personal Services**

**Total**

**\$477,723.00**

**Services And Supplies**

**Total**

**\$273,440.00**

**TOTAL NURSING**

**\$751,163.00**

Attachment B - HMS Option 1A

**Non-Certified &  
Public Health**

**NURSING SERVICE BUDGET**

**Personal Services**

**Total**

**\$463,571.00**

**Services And Supplies**

**Total**

**\$31,340.00**

**TOTAL NURSING**

**\$494,911.00**

Attachment C - HMS Option 4

**Public Health Stand  
Alone**

**NURSING SERVICE BUDGET**

**Personal Services**

**Total**

**\$129,708.00**

**Services And Supplies**

**Total**

**\$21,506.00**

**TOTAL NURSING**

**\$151,214.00**

Attachment D - HMS Option 5/6

**Health Navigator &  
Public Health**

**NURSING SERVICE BUDGET**

**Personal Services**

**Total**

**\$269,871.00**

**Services And Supplies**

**Total**

**\$24,340.00**

**TOTAL NURSING**

**\$294,211.00**

## Attachment E – Health Navigator Program



### Community Care Navigation Program

**Mission:** To promote a comprehensive program of care coordination and advocacy for greater Acton residents and their caregivers to promote optimal client health, wellness, functionality, independence and quality of life as well as to be prepared, through informed decision-making, to receive the right care, in the right setting, at the right time.

**Philosophy:** The Care Navigation program will strive to nurture, educate, support, coordinate services and advocate for clients and caregivers, with respect and consideration of each client's choices, dignity, independence and individuality.

**Care Navigators** will assist at risk clients in attaining and maintaining their maximum potential to live safely at the most appropriate level of care and to prepare and assist the client/resident/patient in short-term and long-term transitions of care as dictated by health status, caregiver support, mandated guidelines and financial resources. Care navigators do not perform any skilled clinical services but can coordinate with licensed skilled home health agencies, private caregivers, and primary care and specialty physicians, etc. to maintain advocacy services during periods of acute need and also serve as a "step-down" safety net to clients discharged from skilled services. Timely and appropriate referrals to community resources and supportive services, and the coordination of these services, are an essential responsibility of the care navigator.

This health care professional, through a unique relationship with clients and caregivers, and knowledge of network providers and resources, coordinates care across the continuum, acts as a client advocate, and facilitates the achievement of clinical, and quality outcomes.

**Focus Population:** Clients with one or more of the following characteristics could be referred for Care Navigation services:

- Social issues including lives alone, lack of caregiver support, primary caregiver burnout.
- Un-insured or under-insured
- Chronic illness, multiple diagnoses
- Reported decline in health, safety, self-care and /or cognitive abilities
- Multiple or frequent readmissions to acute hospital, or Emergency Room services.
- Polypharmacy
- Seeing multiple specialists
- Inability to cope with illness
- Needs education and assistance in end of life planning
- Inability to facilitate wellness as evidenced by missed appointments, over-utilization, need for education and support in primary and secondary prevention.
- Needs financial and legal advocacy

## Attachment E – Health Navigator Program

**Program Services** will focus on client screening and assessment (falls, home safety, medications, depression, SF 12, cognitive); identification of high risk behaviors, barriers to wellness, and limited Health IQ of client/caregivers; collaboration with primary care physician (PCMH); recommendations for/and referral to community resources and supportive services; and ongoing facilitation of the care navigation plan as accepted by client/caregivers and providers. Special emphasis will be made on short-term high touch interventions and long-term education, planning and coordination.

- Home visits
- Phone Contacts
- Mobile health tools for client and caregiver
- Encourage and monitor compliance w primary care/specialty physician and OP services
- Coordinate/refer to support services such as senior center activities, wellness/flu/foot clinics, Meals on Wheels, church or support group services etc
- Facilitate Advance Directive/End of Life Planning
- Develop and educate on diagnosis-specific chronic disease management and emergency plans to reduce exacerbations of illness and emergency department visits
- Act as advocate and facilitator for transitions of care, either acute or long-term

**Critical Success** Factors include the engagement and support of:

- Local health system leaders
- Physician practices
- Clients and Caregivers
- Community Resources  
and
- Identification of meaningful performance measurement outcomes

### **Staff Resources**

#### **Phase 1:**

The addition of a Nurse Care Navigation program will add the value of a medical care management model to the Town of Acton Department of Public Health service line. The program can be phased in over a year, in increments by quarter, as the model is developed, community education initiated and first clients are enrolled. The creation of a Community Resource Steering Committee is recommended to ensure engagement of community based organizations (CBO's) and provide direction and opportunities for grant funding collaborations.

#### **Phase 2:**

As the program matures, it will be important to enhance the model to that of a multidisciplinary care navigation team, including a nurse, social worker and resource coordinators to optimize care coordination, reduce administrative burden on the professional staff and maximize community outreach, client assessment and provider engagement. The current resources of the DPH may be restructured and/or grant monies should be solicited to support the program design and implementation. Leadership may consider the creation of a sliding scale private pay assessment and care navigation program to subsidize expenses and enhance scope of care.



## Town of ACTON, MASSACHUSETTS



Position: Care Navigator  
Department:  
FLSA status:  
Reports to:  
Staff Supervised:  
Date:

### Job Summary:

Care Navigators are health care professionals who, through a special relationship with clients and knowledge of local providers and resources, coordinate care across the continuum. The Nurse Care Navigator serves as a client advocate who provides consultative services to referred clients and families who are at risk due to short-term need or chronic medical and/or mental health issues which may require assessment, care planning, and risk reduction. This individual will collaborate with the Acton Public Health Department (DPH) and identified community resources and providers, to develop a care navigation model which will improve home and community based service delivery through appropriate referral and follow-up, maintain timely communication between clients, caregivers and providers, develop strategies for both individual client and population management, and track and report outcomes.

### Duties and Responsibilities:

- Identifies at risk populations to be served by the care navigation program in collaboration with DPH.
- Identifies and evaluates trends in healthcare, local and economic conditions and develops strategies to respond to these trends on behalf of DPH and clients.
- Represents the DPH and serves as liaison and a channel of communication between hospitals, health plans, other health organizations, physicians and community providers, etc, as necessary, to facilitate the department's strategic goals.
- Performs care navigation services including client assessment, planning, implementation, coordination and evaluation of personal care navigation plan and service options.
- Develops close, trusting relationships with clients/caregivers and providers by maintaining excellent on-going communication and follow-up.
- Proactively addresses each client's needs and promptly resolves individual requests, inquiries and problems.
- Travels to client/caregiver/provider sites as necessary to complete assessments and facilitate optimal outcomes.
- Coordinates and provides health & wellness education programming to increase the community Health IQ and enhance patient engagement and active participation in self care.

- Monitors department performance according to agreed-upon standards.
- Maintains professional affiliations and enhances professional development to keep current in the latest health care trends, regulations and guidelines.
- Completes special projects and all other duties as assigned.

Qualifications:

- Clinical and case management experience, public health or home health care preferred.
- Strong customer service and diplomacy skills.
- Ability to work with diverse clients and employees.
- Excellent ability to communicate orally and in writing.
- Proven ability to work independently and handle multiple tasks.
- Experience with integrated software systems with ability to learn new systems.
- Reliable automobile with valid driver's license and current insurance.

Education and Experience:

- Registered Nurse/Licensed Practical Nurse
- Case management experience in the healthcare field preferred

Working Conditions:

Duties are performed in a variety of environments. Job requires sitting or standing for prolonged periods of time interfacing with clients and community providers and resources. Travel is required. Some physical effort is necessary.

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(Print Name)

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(Signature)

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(Date)

Attachment F - Health Navigator Budget

[8/19/14]

# Budget Year 1

## Budget for FTE: EXPENSES

Salaries and Wages	DPH	Grants	Endowments
Care Navigator (FTE)	\$72,800.00		
Case Manager (PTE)	\$44,000.00		
<b>Total</b>	<b>\$116,800.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Equipment	DPH	Grants	Endowments
Computer	In-kind		
IT/Telecon	In-kind		
Mobile Phone/IPAD	\$500.00		
Phone Contract	\$720.00		
<b>Total</b>	<b>\$1,220.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Fringe Benefits	DPH	Grants	Endowments
Employee Benefits	\$18,200.00		
<b>Total</b>	<b>\$18,200.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Materials/Supplies	DPH	Grants	Endowments
Office Equipment	In-kind		
Supplies	In-kind		
Utilities	In-kind		
Marketing Items	\$1,200.00		
<b>Total</b>	<b>\$1,200.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Travel/Mileage	DPH	Grants	Endowments
Travel			
Mileage Reimbursement	\$1,750.00		
<b>Total</b>	<b>\$1,750.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Community Seminars	DPH	Grants	Endowments
Refreshments	\$300.00		
Education Materials	\$600.00		
<b>Total</b>	<b>\$900.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Other	DPH	Grants	Endowments
	\$0.00		
	\$0.00		
<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

Total Expenses	DPH	Grants	Endowments
	\$140,070.00	\$0.00	\$0.00

