

# Blueprint

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## Medicaid Anchors Health Reform— and the Fund's Work

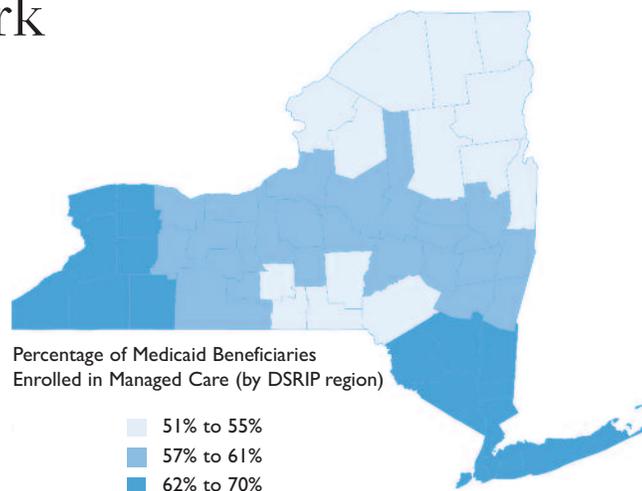
New York's health care system is in the midst of enormous change, and Medicaid—a significant focus of United Hospital Fund work for more than a decade—is at the center of the action.

The sheer size and scope of the state's Medicaid program explain in part its prominent role in health reform efforts: by far the largest insurer in the state, the \$50 billion program provides coverage for more than 6 million low-income New Yorkers annually. But beyond its size, New York's Medicaid program has been an innovator, in recent years, on efforts to improve the health of complex patient populations.

"In some states, Medicaid is viewed as simply a processor of medical claims, but in New York it is something very different," says Fund President Jim Tallon, who also chairs the national Kaiser Commission on the Future of Medicaid and the Uninsured. "Here it is a key driver in the organization of the health care delivery system. And the Fund, with our deep understanding of Medicaid, is playing a constructive role in these transformative times—analyzing key issues and developments and bringing together diverse stakeholders to address how reforms are working or should be refined."

### IMPROVING HEALTH, REDUCING COST

For leaders in both Albany and Washington, the "triple aim" of better care, better health, and lower costs is driving Medicaid reforms. Governor Andrew Cuomo's Medicaid Redesign Team, formed in 2011, focused on both short-term activities that contain costs, such as the cap on Medicaid spending growth, and broader changes aimed at long-term payment and service delivery reforms.



Moving virtually all Medicaid beneficiaries—including those with complex and special needs—into managed care is a prime example of such a broad reform. While the structure of managed care plans may differ based on the needs of the populations they serve, the underlying concept remains the same: Medicaid payment to a single entity responsible for managing the full range of patients' health-related needs—from acute to long-term to behavioral health care—should result in better and more cost-effective care than uncoordinated fee-for-service payments to disparate providers.

The move into managed care for all "mainstream" Medicaid recipients—that is, non-elderly and non-disabled adults and children—began, with federal approval, in the late 1990s. Over the past 12 years, beneficiaries with more complex, high-need conditions—certain groups of disabled adults and children, elderly enrollees using home- and community-based services, enrollees with HIV/AIDS, and homeless adults and children—followed. In the coming months and years, other vulnerable populations—including adults with substantial behavioral health needs, individuals with developmental disabilities, and the

*continued on page 2*

## Medicaid and Reform *(continued from page 1)*

frail elderly—will move into comprehensive managed care as well.

“Bringing virtually all Medicaid beneficiaries into managed care is an ambitious undertaking that State leaders have been planning for years,” says Andrea Cohen, the Fund’s senior vice president for program and a member of MACPAC, the Medicaid and CHIP Payment and Access Commission, which advises Congress and makes recommendations on Medicaid and Children’s Health Insurance Program policies and programs. “This transformation holds substantial promise for more accountable, better-coordinated and lower-cost care, but it is essential to ensure that new plan arrangements work on the ground—and are aligned with other reform efforts underway—so that they can meet the most vulnerable patients’ needs.”

### INCENTIVES SPUR INTEGRATED CARE

Coordination among providers—doctors, hospitals, rehab centers, nursing homes, and home care—is another essential reform being advanced through various initiatives, in part to reduce unnecessary and expensive hospitalizations. That concept is at the heart of New York’s long-sought federal Medicaid waiver and the advent of DSRIP, the Delivery System Reform Incentive Payment program.

Under DSRIP, the State will award \$6.42 billion in federal funds over five years to Performing Provider Systems—virtually integrated provider collaborations that will undertake a number of projects to better coordinate care, reduce avoidable hospital use by 25 percent, and achieve specified clinical improvements in patients’ health. While some funds will be granted for planning and organization, the majority will be paid based on meeting performance goals.

“DSRIP presents a unique opportunity—and very strong incentives—for providers to change the delivery system for Medicaid patients,” says Chad Shearer, director of the Fund’s Medicaid Institute, and former deputy director of the Robert Wood Johnson Foundation’s State Health Reform Assistance Network, coordinating technical

assistance to 11 states on implementation of the Affordable Care Act. “It will require enormous effort by all players, and careful monitoring and some fine tuning along the way. But the results of this innovative model—and how the system continues to perform *after* the waiver’s incentive payments have ended—may well determine the shape of New York’s health care system for decades to come.”

### AN AGENDA FOR THE FUTURE

With this kind of major change underway, the Fund’s role as an independent source of Medicaid information and analysis has never been more important. Since 2005, the Medicaid Institute ([www.medicaidinstitute.org](http://www.medicaidinstitute.org)) has produced a significant body of work exploring options for improving the program. Its most recent offering, the *Medicaid Regional Data Compendium 2014*, examines demographics, service use, and a number of quality-of-care indicators for beneficiaries throughout the state. Documenting dramatic variations by region, the *Compendium* is helping providers, insurers, advocates, and other stakeholders to identify and target particular areas for concern and improvement.

The year ahead promises a full agenda, with new work assessing the changing delivery system environment under DSRIP; the integration of physical and behavioral health services in managed care; and the ongoing move of high-need individuals into managed care. The Fund also plans to focus on specific subpopulations, such as children, who are being hospitalized at higher-than-expected rates for conditions such as asthma. And through both its own analyses and its grantmaking, the Fund will explore health care and coverage options for the 400,000 undocumented immigrants living in New York City.

“This is an unprecedented time of change, challenge, and opportunity,” notes Mr. Tallon. “Many eyes will be upon New York as we begin to understand the impact of these important new models on costs and on the health status of our most vulnerable populations.”

## Blueprint

Published three times a year by the United Hospital Fund’s Communications Division. We welcome your comments and suggestions.

The United Hospital Fund is a health services research and philanthropic organization whose primary mission is to shape positive change in health care for the people of New York.

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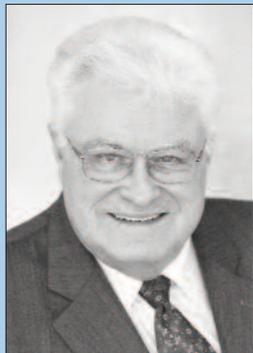
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## The Real Value of Change



With more than two decades of leading the Fund behind me, and yet another round of debate about the future of the Affordable Care Act emerging, I've been reflecting on

the enormous changes in New York's health care over the past few decades.

The introduction of New York State of Health, the insurance marketplace or exchange, has brought us well on the way to even lower single-digit rates of people without insurance—a long way from levels in the mid-teens, the standard when I began my work at the Fund. Structured marketplaces like that in New York are allowing lower-wage workers, unlikely to get health insurance through their jobs, to choose their insurance and take advantage of federal subsidies. There is a new understanding that the insurance industry may no longer find its prosperity in avoiding the risk of high-cost or high-complexity patients; instead, a structure of open enrollment and community rating allows risk to be shared broadly.

### TRANSFORMING HOW WE GET CARE

We've also seen dramatic changes in New York's \$50 billion Medicaid program. Cost-sharing, related to the program's original structuring, is no longer a threat to local governments' financial stability, with their share now effectively capped and cost growth absorbed by federal and state government. Coordinating the care of more complex patients, initially those with chronic illness or behavioral health care challenges, has been led by the program in

recent years. And now, with the assistance of a federal waiver, New York's Medicaid services will be further revamped by new entities called Performing Provider Systems. Rather than an "insoluble" problem, Medicaid is increasingly being seen as a powerful force for restructuring health care throughout the state.

There have been other major departures from the past as well. There is wide acceptance, finally, after much work by the Fund and others, that family caregivers are an essential part of interactions between the health care system and chronically ill people who are being cared for at home—that these caregivers are not just beleaguered family members who need

*The real test of the profound changes we call health reform will be the well-being of those who suffer the challenges of illness and aspire to better health.*

support, but a critical source of both information and patient care. We are learning more of the vital role that enhanced information technology will be playing. And we get that the ultimate goal of "population health" will be achieved by understanding socioeconomic characteristics, and linking important medical services with community supports.

All in all, it's been a time of simply extraordinary change.

Such profound transformation naturally brings a host of new questions. Will people gaining coverage through New York State of Health fully understand the complex choices they'll face—in picking their insurance plans, and in linking to those

plans' provider networks—and the cost-sharing implications of the ACA's multiple levels of coverage? Will care coordination move from concept to effective reality—whether individual professionals working as a team or dozens of entities working under a common operational umbrella? Will the quality and safety of our interactions with a highly complex, scientifically sophisticated health system move toward the risk-reduction standards that we take for granted at every airport? Will information technology, new forms of service delivery, changes in the way we pay for care, and—embracing all of those—changes in the way patients, or consumers, engage with the health care system actually achieve the healthier outcomes that are the goal of all we do?

### A TEST FOR THESE TIMES

I was reminded recently, by work by my colleague Carol Levine, of perhaps the most important measurement of the value of these changes. Carol has, for two decades, spoken of the need to better understand the reality that patients and family members experience in interacting with the system. Her message makes it clear that the real test of all of these profound changes that we label "health reform" will ultimately be the well-being of individuals who aspire to better health, who suffer the challenges of illness and injury, and who feel the pain associated with so many conditions. Will they, will we, ultimately benefit from the change?

In many respects, the measurement of personal experience may be far more telling than the sociology, the organizational dynamics, and the economics of health systems change.

GRANTMAKING

# Pilot-Testing Diabetic-Friendly Meals for Seniors

More than a quarter of all seniors in Washington Heights/Inwood have diabetes, and many more are at high risk for the disease. But encouraging them to embrace healthier meals that help prevent and control diabetes isn't simple.

A recent pilot program—conducted with support from a United Hospital Fund grant to the Aging in New York Fund—took on that challenge. While the project confirmed just how difficult it can be to change seniors' attitudes about food, it also uncovered a wealth of valuable data and insights to guide future efforts.

In tandem with several community partners in Washington Heights, the initiative tested the acceptance of new diabetic-friendly menus by low-income seniors receiving meals from one of two programs supported by the Department for the Aging (DFTA)—home-delivered lunches provided by the Walburg Center Meals on Wheels and congregate lunches at the ARC XVI Ft. Washington Senior Center.

The pilot was a natural extension of the United Hospital Fund's Together on Diabetes—NYC model initiative, which has been working with a wide variety of community partners over the past three years to help Washington Heights seniors with diabetes manage their disease.

## CHANGE IS ON THE MENU

"All of the participating organizations learned a great deal about what worked and what didn't," says Fredda Vladeck, director of the Fund's Aging in Place Initiative. "Now DFTA—and other organizations serving seniors—can use that vital information to refine menus and

models and consider expanding healthier meals to more at-risk seniors throughout the city."

Developing the new menus was a complex process. Nutritionists from DFTA and the two meal programs needed to consider key factors including federal, state, and city nutrition requirements, DFTA's "diabetes friendly" parameters, seniors' food preferences, and costs. The results, revealed by surveys before and after the new meals were introduced, showed markedly different reactions between the two groups.

Seniors receiving diabetic-friendly meals via home delivery reacted very favorably to them. Eighty-four percent rated the new meals "excellent," "very good," or "good"—up from 77 percent before the six-week trial. They were also more satisfied with the portion size of the new meals than with that of the traditional meals. Significantly, these seniors were all diabetic or pre-diabetic and had chosen to receive the healthier meals. They were also older and more racially diverse than seniors in the congregate meal program.

The vast majority of seniors in the congregate program—a group including non-diabetics as well as diabetics—found the taste, variety, portion size, and cultural appropriateness of the new meals, served over a four-month period, to be unsatisfying. Only 26 percent judged them to be "excellent," "very good," or "good," compared to 63 percent approval of the traditional menus. Largely Hispanic/Latino, these seniors were particularly unhappy with the scarcity of white rice and beans. And although project staff had



*More than 41,000 elderly New Yorkers throughout the city participate in congregate lunch programs or receive "meals on wheels" each day.*

announced and discussed the new menus prior to their introduction, 76 percent of the seniors said they were "not informed" of the change. A number of them voted with their feet: lunch attendance dropped after the pilot began, with seniors likely moving to another local center.

## LESSONS FOR THE FUTURE

The pilot's results provide rich lessons. The greater embrace of the healthier meals among the home-delivered-meal group suggests that seniors prefer an opt-in approach. In congregate settings, which serve a generally healthier group, gaining buy-in requires even more extensive advance work, and perhaps a more gradual roll-out. More input from seniors on menu development and testing is also critical. And, for meal providers, working toward cost neutrality is important; the healthier meals were more expensive for both programs.

"Providing a nutritionally balanced, diabetic-friendly meal is an important option to present to our seniors," says DFTA Commissioner Donna M. Corrado. "This project has shown us that there is no one-size-fits-all approach to nutrition. The role that human behavior plays in the acceptance of healthy meals is guiding the development of alternate approaches that could serve as flexible models for a wide range of programs."

## Fund Grant to Help Fight New “Superbugs”

While the dangers of incorrectly prescribing or using antibiotics—the growth of antibiotic-resistant “superbugs”—are becoming better understood, how to address the problem is less clear. Changing patterns of resistance, especially in the hospital setting, make it difficult to define and implement prudent antibiotic-prescribing practices. It’s a challenge familiar to the Fund, which partnered with the Greater New York Hospital Association in 2010 to help acute care and long-term care facilities establish

antimicrobial stewardship programs for effectively managing antibiotic use. Results of that earlier project included a resource for professionals cataloging various antibiotic management strategies.

Much has changed in the ensuing years, including patterns of antibiotic resistance. To address today’s challenges, the Fund and GNYHA are joining forces again, with the support of a Fund grant. Together, they will partner with metropolitan-area hospitals to assess current practices, barriers to optimal antibiotic use, and the need for additional stewardship programs. Their findings will inform further guidance for hospitals that can benefit most from it.

The Fund and GNYHA will also develop a learning network to support stewardship programs in area hospitals.

Participating hospitals will benefit from the expertise of pharmacy and infectious disease specialists, key revisions to the resource created in 2009, and additional technical support.

“We are excited about this project and our grant to support it,” says Hillary Jalon, director of the Fund’s quality improvement initiative. “There is consistent attention to this topic at the state and national levels, with the Centers for Disease Control recently rolling out a new way for hospitals to track and control drug-resistant bacteria through its data collection and reporting module. This new Fund-supported effort will bring regional experts together, aggregate our knowledge, and share best practices to help hospitals prevent the creation of superbugs and ensure appropriate antibiotic usage.”

## Research Symposium Examines Incentives for Healthy Behavior

Promoting healthy behavior through incentives was the theme of the 25th Annual Symposium on Health Care Services in New York, co-hosted by the Fund and the GNYHA Foundation. Some 300 health services researchers, health care providers, insurers, and others attended the November 19 event.

“Individual behavior is a key driver of health and health costs,” keynote speaker Kevin G.M. Volpp, MD, PhD, reminded participants, underscoring the importance of helping people make healthier choices. Dr. Volpp is director of the Center for Health Incentives and Behavioral Economics and professor in the School of Medicine and the Wharton School at the University of Pennsylvania.

Studies show that the best motivators are not so obvious, especially since the rules of traditional economics can differ

from those of “behavioral economics.” Offering free medications, for instance, isn’t enough to ensure adherence, and financial “rewards” programs that offer a smaller amount of cash in hand can play a stronger role in motivating behavior than a larger amount paid later and credited to income tax, Dr. Volpp noted. People typically prefer a payoff in the present to one in the future, and are influenced by peers; the timing and order of choices, and whether people have to opt out of them, are significant too. Simplification—reducing a health plan description to two pages, for example, from a typical 20—can also increase desired behaviors by ensuring that any incentives are easy to see and understand.

The symposium also explored practical



*Dr. Kevin Volpp*

and ethical perspectives on incentives. Michael G. Dermer, senior vice president and chief incentive officer at Welltok, and James A. Riccio, PhD, director of the Low-Wage Workers and Community Policy Area at MDRC, provided real-world examples of what has and hasn’t worked to influence different populations’ behavior. Rosamond Rhodes, PhD, professor of medical education and director of bioethics education at Mount Sinai’s Icahn School of Medicine, examined the ethics of linking healthy behaviors and financial incentives.

**GALA**

# Honoring Health Care Leadership, Excellence

This year's honorees "enrich the long, storied history of health care leadership in New York," President Jim Tallon told nearly 600 guests at the Fund's annual Gala. The October 6 event presented the Health Care Leadership Award to Michael A. Stocker, MD, the Distinguished Community Service Award to Jennie L. and Richard K. DeScherer, and a Special Tribute to Paul E. Francis.

Dr. Stocker was honored for his active role in the transformation of the health insurance industry, as president and CEO of Empire BlueCross BlueShield, and for his leadership, later, of the nation's largest public health care system, as chairman of the New York City Health and Hospitals Corporation. During seven years at Empire he stabilized its functions and finances, creating a more efficient and competitive business, and successfully led the conversion from not-for-profit to publicly traded status. At HHC, he advised and supported management as they dealt with the challenges of infrastructure, staffing, money, and corporate compliance. During his five years there, Dr. Stocker was credited for his efforts to enhance quality of care and—in the context of national health reform—prepare HHC's facilities to be seen as "providers of choice" as fewer New Yorkers go uninsured.

For the past 40 years Jennie and Richard DeScherer—honored for their pioneering leadership of the SLE Lupus Foundation and the Lupus Research Institute—have worked to ensure that those with lupus and their families have

the lifeline they need, and to spur research toward more effective treatments and ultimately a cure. Mr. DeScherer is the SLE Lupus Foundation's president, and Mrs. DeScherer is an active member of its board, helping shape each of the foundation's program initiatives, which include support groups, doctor referrals, summer vacation camp for children with lupus and their families, public awareness and advocacy, and model storefront outreach efforts in underserved neighborhoods. They are both also founding members of the board of the Lupus Research Institute, the world's leading private supporter of novel, out-of-the-box research, which has awarded \$42 million in grants to scientists in 21 states.

Paul Francis was recognized for his many contributions to New York and to health care. Following a successful private-sector career, Mr. Francis played critical budget and advisory roles for three New York governors; today he is increasingly focusing on improving health care. He serves on the board of directors of the New York State Health Foundation; on the board of trustees of Interfaith Medical Center; and on the boards of the New York e-Health Collaborative and of GNYHA Ventures. In 2014 his work on behalf of New York's spinal cord injury community helped restore \$7 million in annual funding for research.

Dr. Stocker currently serves on the Fund's board and both Mr. DeScherer and Mr. Francis are former board members.

The 2014 Gala, chaired by board chairman J. Barclay Collins II and kicking off the 136th annual campaign, raised more than \$1.6 million to help further the Fund's work of shaping positive change in health care.



*Gala honorees and presenters (from left) Paul Francis, Jim Tallon, Richard DeScherer, Michael Stocker, Jennie DeScherer, Barclay Collins, and Roger Ferguson, president and CEO of TIAA-CREF, underwriter of the Distinguished Community Service Award.*

## **GALA DONORS**

**UNDERWRITER, 2014 DISTINGUISHED COMMUNITY SERVICE AWARD**  
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EmblemHealth, Inc.; Montefiore Medical Center; Mount Sinai Health System; NewYork-Presbyterian Hospital; North Shore-LIJ Health System; Jim and Marilyn Simons; Merryl and James Tisch

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### **LEADERS**

The Commonwealth Fund; Geller & Company; Maimonides Medical Center; Manatt, Phelps & Phillips, LLP; RWJF Special Contributions Fund of the Princeton Area Community Foundation; Michael A. Stocker, MD

### **BENEFACTORS**

Stephen Berger and Cynthia C. Wainwright; Bloomberg; Bronx-Lebanon Hospital Center; John K. Castle; Healthcare Association of New York State; Healthfirst, Inc.; HealthPlus Amerigroup; Hospital for Special Surgery; Josh N. Kuriloff; Josiah Macy Jr. Foundation; Sullivan, Cotter and Associates, Inc.; TD Bank

## SUPPORTING THE FUND

## Legacy Society: “An Investment in Sound Public Policy”

Since the Fund’s creation more than 135 years ago, many thoughtful individuals have had the foresight and generosity to plan for the Fund’s future by making a bequest or another form of planned gift.

For this issue of Blueprint, we asked Frederick W. Telling, PhD, vice chairman of the Fund’s board, to talk about his reasons for joining the Fund’s Legacy Society and including the Fund in his estate plans. Until retiring in 2007, Dr. Telling was vice president and head of Pfizer Inc’s Corporate Strategic Planning and Policy Division. He now lives in northeast Florida in the “world’s largest fly-in community,” where he can indulge his love of flying—a legacy he has already passed on to his daughter, who first soloed, in a helicopter, on her 16th birthday.

When I joined Pfizer in 1977, the pharmaceutical business fell pretty much outside mainstream health care policy—for most people, drugs were not reimbursed, so the company’s direct involvement with

public policy was mostly limited to things like intellectual property issues. With new legislation like the Hatch-Waxman Act, however, which created the generic drug



Fred Telling, with his daughter Jennifer (left) and wife Barbara (right), in front of Baby Boomer.

industry, I became increasingly involved with national and state policy issues. That was also when I became more acquainted with the Fund and its work on Medicaid. When Jim Tallon—whose work in the State legislature I knew and admired—

the need for products and systems to help family caregivers, not try to replace them, and stressed the continued importance of the human role in care.

A delegation from Israel’s health care sector visited in September for a lively give-and-take on health care reforms and issues including accountable care, quality improvement, preventable hospital readmissions, and managed long-term care. The Fund’s Senior Vice President for Program **Andy Cohen** and senior program staff briefed the director general of Israel’s Ministry of Health, the director general of

joined the Fund in 1993, I thought he was a great choice. So I became involved for both personal and professional reasons.

I’ve always appreciated the Fund’s focus on rational policy alternatives that balance stakeholder needs, trying to make health care more workable—that’s exactly the kind of thing I wanted to be involved with. I continue to be impressed by its initiatives, like efforts to ensure that qualified New Yorkers enroll in Medicaid—a critical element of the safety net—and receive high-quality services. The Fund’s work to understand high-cost patient populations and manage them better is also vital for improving quality and possibly reducing costs.

To me, leaving a bequest to the Fund is a way to continue to be part of improving the things I care about. I would say to anyone who cares about the development of sound public policy on health care that there is no better way to help make that happen than investing in the Fund.

For information about the Legacy Society, and the advantages it provides the Fund and you, please contact Director of Development Christina Maggi at [cmaggi@uhfnyc.org](mailto:cmaggi@uhfnyc.org) or 212-494-0728, or see [www.uhfnyc.org](http://www.uhfnyc.org).

## NEWS BRIEFS

How technology entrepreneurs and investors are responding to the challenges of an aging population was the focus of a plenary session at VentureBeat’s October HealthBeat conference in San Francisco, and **Carol Levine**, director of the Fund’s Families and Health Care Project, was an invited speaker. Appearing on a panel with geriatrician and technology consultant Wen Dombrowski, MD, and Rajiv Mehta, a former NASA and Apple engineer now focused on family caregiving, Carol noted



Andy Cohen with Arnon Afek, MD, MPH, director general of the Israel Ministry of Health, and Bruce Rosen, DSc, director of the Smokler Center for Health Policy Research.

the National Insurance Institute, the manager of the health care sector in the Ministry of Finance, and other health policy leaders on Fund initiatives and impact.

THERE'S STILL TIME TO MAKE YOUR YEAR-END DONATION TO THE FUND.  
SUPPORTING OUR WORK HELPS IMPROVE HEALTH CARE FOR ALL NEW YORKERS.

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**ON  
THE  
CALENDAR****MARCH 2**

Deadline for the next round of the Fund's Health Care Improvement Grant proposals.

**MARCH 13**

The annual Hospital Auxilian and Volunteer Achievement Awards tea and ceremony. The Waldorf-Astoria

**MAY 11**

The annual Tribute to Hospital Trustees luncheon and awards ceremony. The Waldorf-Astoria

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**OFF  
THE  
PRESS**

*Medicaid Regional Data Compendium, 2014* offers, through 17 short regional chartbooks, a high-level overview of Medicaid service utilization across New York State—data helpful for providers, policymakers, and other stakeholders tackling Medicaid delivery system transformation.

*New York's Medicaid in Transition: A New Primer for 2014* provides grounding in the

dramatically changing program, presents recent data on spending and enrollment, and examines reforms underway and slated for implementation in the coming months.

*Reducing Hospital Readmissions: Lessons from a Multi-Hospital Initiative* examines the findings, interventions, and lessons of the Fund's Preventable Hospital Readmission Initiative.

*Family Caregivers Providing Complex Chronic Care to People with Cognitive and Behavioral Health Conditions*, co-authored with AARP, finds additional caregiving challenges, and high levels of self-reported depression, for caregivers of people with challenging behaviors—and offers recommendations to improve services and supports.

These and other Fund reports are available at [www.uhfnyc.org](http://www.uhfnyc.org).

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WEB****[WWW.UHFNOC.ORG](http://WWW.UHFNOC.ORG)**

Access the latest Fund news and publications, sign up for e-mail alerts, or make a tax-deductible gift. Recently posted: *Work in Progress*, the 2014 annual report.

# Recent Grants

*Fall/Winter 2014*

The United Hospital Fund's philanthropy is made possible by our own fundraising campaign.

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## **ABOUT THE UNITED HOSPITAL FUND'S GRANTMAKING PROGRAM**

*The United Hospital Fund awards grants to not-for-profit and public hospitals, and to health care, academic, and public interest organizations, to support the development of model projects and analysis of systemic problems, and to foster innovative solutions to health care issues. Grants are awarded for a one-year period unless otherwise specified. The Fund makes grants three times a year; in October 2014, six grants totaling \$388,000 were awarded.*

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### *Expanding Health Insurance Coverage*

#### **COMMUNITY SERVICE SOCIETY OF NEW YORK (\$75,000)**

To explore the viability of three health insurance coverage policy options for New York State's undocumented immigrant adults: coverage for those ages 19-30; a high-deductible plan covering preventive and primary care for persons eligible for Emergency Medicaid; and coverage through a State-funded Basic Health Plan.

#### **YOUNG INVINCIBLES (\$75,000)**

To research barriers to health care coverage and access for young undocumented immigrants in New York City—both those with and without DACA, or temporary relief from deportation, status—through focus groups and interviews; and to develop recommendations for eliminating those barriers. Young Invincibles will also prepare toolkits and infographics, to be distributed through immigrant organizations, on obtaining coverage and care.

### *Improving Quality of Care*

#### **GREATER NEW YORK HOSPITAL ASSOCIATION (\$125,000)**

To continue the UHF/GNYHA quality improvement partnership, focusing on four key activities: strengthening quality improvement education and training for doctors and nurses through the Clinical Quality Fellowship Program; improving and standardizing transitions between nursing homes and home care as part of efforts to reduce avoidable hospital admissions and readmissions; reducing the spread of multi-drug-resistant organisms through antimicrobial stewardship programs in area hospitals; and sustaining and disseminating the results of these and other quality improvement activities.

*Continued on reverse*

*Promoting Health Care Voluntarism*

**JAMAICA HOSPITAL MEDICAL CENTER (\$36,000)**

To provide post-discharge support to seniors at increased risk of readmission or other poor health outcomes, through the Seniors Coaching Seniors peer coaching program. Volunteers will use twice-weekly follow-up calls to determine whether patients are following discharge plans, keeping medical appointments, and understanding medication regimens. Activities will also include role playing and “teach back” to increase patients’ health literacy and ability to communicate with their doctors.

**NEW YORK METHODIST HOSPITAL (\$37,000)**

To enroll patients in MyNYM, a web portal connecting patients to their medical history and information from their hospital stay—including lab results, discharge summaries, and educational materials—from any place with an Internet connection. Trained volunteers will explain the portal and its functions and register patients or more able family members, and then follow up with patients who have not used the portal within two weeks of discharge.

**NEWYORK-PRESBYTERIAN/MORGAN STANLEY CHILDREN’S HOSPITAL OF NEW YORK (\$40,000)**

To provide one-on-one education and follow-up support to young patients with complex medical regimens, and their parents/caregivers, in the outpatient pediatric cardiology department’s heart transplant, pulmonary hypertension, and Holter (ambulatory electrocardiography) monitoring services. Volunteers will be drawn from medical or public health school or health-related undergraduate programs.



*Shaping New York's Health Care:  
Information, Philanthropy, Policy*

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