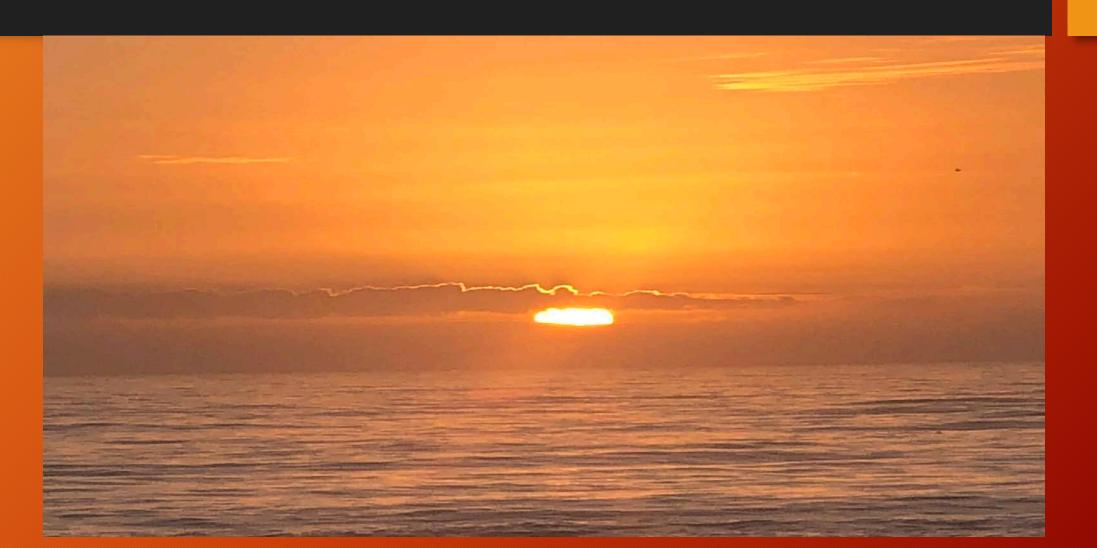
Sunrise Program

Douglas Adkins, Dayspring Village 2019 Innovation Summit Orlando, Florida

Transition back to the community - a new day



Change Creates Stressors

- 1. Relationships
- 2. Routines
- 3. Living Arrangements
- 4. Healthcare providers are different
- 5. Concerns about money
- 6. Managing conflict
- 7. Symptom Management



Let's talk about the innovation

- 1. Care Coordination is intensive
- 2. Access to Onsite Care
- 3. Resident Engagement Day #1
- 4. Benefit Restoration
- 5. On site groups
- 6. Weekly Staffing
- 7. Discharge Planning



Let's Get into Specifics

- 1. There are two designated Care Coordinators who meet with the residents daily
- 2. The Psychiatrist comes onsite twice a week for clinic.
- 3. There is a CLIA waived CBC Sysmex Hematology analyzer that will allows us to test onsite.
- 4. DSV has two med techs with phlebotomy certification.



Resident Engagement Mobility = Community

- Resident Engagement
- Money Management Program
- Cigarette Management
- Excursions in community
- Events on the campus
- Substance Abuse Education Classes
- Building Healthy Routines



SUNRISE @ Dayspring Village - 10 beds





SUNRISE - BEGAN - January 2018





There are 55,000 adults with Schizophrenia

Florida's 2017-2018
Psychotherapeutic
Medication Guidelines
for Adults published by
the University of South
Florida and the Agency
for Health Care
Administration.

The report found that Clozapine was more effective in treatment of Schizophrenia than all other antipsychotics.

It is estimated only 9% of the adult population with Schizophrenia in Florida are being prescribed Clozapine. http://www.medicaid mentalhealth.org

How are SUNRISE residents supported?

- Family Engagement
- Legislative Advocacy
- Rapid Response Protocols
- Point Click Care
- Use of Secure Messaging
- Weekly Collaborative Meetings
- www.sunrisecare.org



POINT CLICK CARE - electronic health record

- 1. We implemented Point Click Care in 2017
- 2. This new technology has revolutionized our operational platform
- 3. The ability to track data points is powerful and accurate with point of care technology.
- 4. This platform is 100% HIPPA secured



The major FLORIDA innovation

- 1. Dayspring Village is the first setting where the integration between behavioral health, pharmacy, physician, case managers and the ALF staff flows seamlessly.
- 2. What used to take days to solve a problem now takes hours or minutes.
- 3. All partners on the system have access and see the notes, access the records and send and receive HIPPA secured messages instantly from the mobile devices.



Point Click Care - innovation at work

- Medication Records are now more accurate, and the system helps the med techs build "practice" skills and help reduce mistakes.
- It will prompt you to specify that "pain meds" were effective or not.
- It has its own algorithm that will detect a drug to drug interaction and flag the severity so you can stop a problem.



FUNDING - blended methodology

- 1. The base is the LSF funding monthly amount
- 2. The social security benefits when restored help meet the program needs.
- 3. Optional State Supplementation will provide the resident \$54 personal needs allowance.
- 4. Medicaid Assistive Care Services
- 5. VA Aid and Attendance

Sliding fee scale is important - \$18,375 is the cap - you must monitor.



FUNDING - THE CHALLENGES

- Income Erosion recoupment action taken by SSA
- Medicare Part D Often plans will demand a \$100 payment for premium amounts that were not paid the month client was admitted to hospital
- Notice of Case Action Be prepared to request an extension of time when you get a denial due to not all documents being received.
- <u>Income Verification Letter</u> This is critical to almost all other benefits. You must request it.



SUNRISE = BRIDGE to community transition

- 1. SUNRISE team upon notification of person awaiting discharge will within ten days conduct an evaluation at the state hospital.
- 2. SUNRISE team within 30 days of the evaluation will provide the hospital with a decision to accept or deny the person for admission.
- 3. The SUNRISE PROGRAM will help with transition over a six to nine-month period.



Helping people find success starts with ensuring they have stable housing paired with stable services and SUNRISE has been effective because of access to on-site care coordinators, linkage to appropriate clinical services and timely restoration of benefits prior to program discharge

LET'S TAKE A CLOSER LOOK AT THE DATA

SUNRISE OUTCOMES (since January 2018)

25 residents in SUNRISE PROGRAM

12 residents successfully transitioned to community



ZERO SUNRISE residents discharged back to State Hospital.

Cost of Care - State Hospital - NEFSH

- All Inclusive per diem \$407.44/day*
- Daily Sunrise Rate \$55.56
- \$3,717,890 25 residents for 1 yr
- \$55/ day x 9 months \$14,850
- Sunrise Program also collects SSA amounts, Medicaid to assist with cost of care.
- Sunrise Program helps improve access to state hospital beds and improves use of state resources.



SUNRISE residents exercise CHOICE in their community placement:

Supportive Housing - 1

Nursing Home - 1

Family Members - 3

Assisted Living - 7

www.SUNRISECARE.org



The average length of stay in State Hospital prior to SUNRISE placement =

26 months

Let's look at the other DATA

Benefit Restoration

- The average time to restore the Social Security was 3-5 months
- 2. The average time to restore Medicaid was 3-5 months

Health Issues

- 1. Diabetes 5 cases
- 2. COPD 2 cases
- 3. Tachycardia 3
- 4. Gerd 7
- 5. Hypertension 7

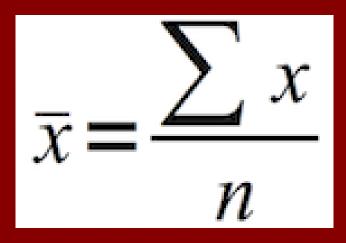
Hospitalizations

- 1. Went to ER for eval NOT admitted 2
- 2. Hospitalized for psychiatric reasons 5
 - Professional Certificate 2
 - Baker Acted by LEO 3

For the 12 residents discharged from the program ...

The average length of stay in SUNRISE program =

265 days or 8.55 months



www.SUNRISECARE.ORG

- www.SUNRISECARE.org allows us to credential a network of providers who will rise up to the task of meeting the needs of these state hospital residents.
- Once we have credentialed these facilities, we conduct checks and verify information, safety and ensure they are appropriate.
- SUNRISE will arrange to ensure transport to these facilities.
- We can monitor bed openings, securely transfer information to our partners and help move the process faster.



DISCHARGE PLANNING - team effort

- There is a weekly team meeting to discuss discharge planning.
- The team will include the mental health provider (Starting Point Behavioral Health) and the DSV Care Coordinators.
- Careful attention is paid to the safety of the area and looking for "good actors".
- We will examine the "pattern of conduct" and look for supportive environments that align with consumer choices.





"I really feel like my life is moving forward."



"I am 40 years in and out of the hospital."

Current SUNRISE participant talking about SUNRISE Care Coordinators



SUNRISE Care
Coordination
includes help
with
Pharmacy
Assistance





Finding the right fit...



QUESTIONS?

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