Leveraging the Power of Information for Effective Home and Community-based Care

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April 23, 2014
VNSNY has been at the forefront of innovative home and community-based models of care for over 120 years…

- Founded in 1893, VNSNY is the largest non-profit home and community-based healthcare agency in the U.S., providing a wide range of services from birth to end-of-life
- $2.0B in annual revenue
- On any given day, approximately 70,000 patients/members are under our direct or coordinated care
- VNSNY is comprised of approximately 18,000 employees working in inter-professional teams to serve the most vulnerable and needy individuals
- The enterprise includes both a provider, VNSNY Home Care, and a health plan, VNSNY CHOICE
- Partners with over 50,000 providers in the provision of services and care of patients on a daily basis
The Healthcare World is in Transition

- Health Reform (ACA)
- Consolidation
- Shared Risk (“Bundling”)
- Cross-Continuum Partnerships
- Integrated Care for Duals (“FIDA”)
- Value-Based Purchasing
- Greater Application of Technology
- More Patients at Risk
- Increased Competition
- Declining Reimbursement
- Evolving Models of Care
- More Patients at Risk
Corporations, consumers, and citizens must begin acting in concert to create a powerful third pillar of social transformation if we hope to meet the social challenges we currently face with equal force.

– Simon Mainwaring

Award-winning branding consultant & social media specialist and blogger
The Triple Aim Calls Us to Embrace Change in Care Delivery

1. COST
   Spend Less

2. ACCESS
   Improve Health

3. QUALITY
   Improve Care Experience
Transformation Toward a Patient-Centered and Community-Centric Delivery System

- Engagement
- Interprofessional
- Patient-Centered Goals
- Social Determinants of Health
- Incentives
- Self-management
- Peer Coaching
Technology will Enable the Transformation to a Patient-Centered Care Delivery Model

1. Engagement with Patients
   Communicate non-urgent issues, encourage self-management

2. Virtual Integrator
   Facilitate collaboration and information sharing across disciplines, providers, & settings

3. Decision-Making Support
   Promote standardization of best practice care
Technology as the Dynamic Stabilizer of a System in Motion

“I’m a great believer that any tool that enhances communication has profound effects in terms of how people can learn from each other, and how they can achieve the kind of freedoms that they’re interested in.”

– Bill Gates
Leveraging the Power of Information to Facilitate Care

I. Facilitate Care for the Individual Patient

II. Improve Health at the Population Level

III. Improve Community Health

IV. Drive Equity and Access in Public Policy
1. Use of predictive analytics to optimize health outcomes by driving programmatic referrals and targeting specific interventions

   a) OASIS assessment variables as predictors of falls

   b) Medication changes as predictors of re-hospitalization

   c) UAS assessment as a predictor of acuity and plan of care
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2. Technology to Optimize Patient and Member Engagement
   a) Telehealth to Promote Self-Management

Data is collected, sorted, verified and presented as critical, actionable information on a secure web portal.

Facilitate Care for the Individual Patient
2. Technology to Optimize Patient and Member Engagement

b) Text Messaging to Promote Treatment Adherence

- Grant-funded study for VNSNY CHOICE SelectHealth HIV/AIDS Special Needs Plan (SNP) and Rip Road, a mobile technology company

  ✓ **Goal:** To assess member adoption of text alerts to support medication refills and keep specialty appointments
    - 95% adherence required for HIV medication to be effective
    - Appointments with specialty providers to reduce risk of co-morbidities

  ✓ **Methodology:** Active SelectHealth members over 21 years old with an HIV+ status will be followed using Rip Road, and their adherence will be tracked and reported
Leveraging the Power of Information to Facilitate Care

3. Integrate Delivery Systems as the Key to Interprofessional and Cross-Continuum Continuity

Results In
- Continuity of care
- Superior coordination of care management
- Growth/Regional Expansion
- Empowered and accountable to lead
- Superior Service Delivery
- Integrated Data

a) VNSNY Model of Care

Facilitate Care for the Individual Patient
3. Integrate Delivery Systems as the Key to Interprofessional and Cross-Continuum Continuity

b) Single care management platform across all health plan programs to improve care management for plan members

Altruista Health GuidingCare™

- Bring assessment, outreach and claims information together
- Information visible to entire interdisciplinary team
- Analyze member health based on industry standards of care, flag health risks
- Set health goals with member to view online
- Targeted interventions
3. Integrate Delivery Systems as the Key to Interprofessional and Cross-Continuum Continuity

c) Utility of patient portals for safety net populations to boost efficiency and care quality

- Improve access to care, patient-provider communication, chronic disease management, and family involvement
- Enable patients to schedule appointments, pay bills, refill Rx’s and access lab results
- VNSNY has designed and piloted patient portals that are cognizant of low health literacy levels among the majority of safety net populations
  - Present information in an easy-to-understand manner
  - Allow patient to set goals and reminders

Facilitate Care for the Individual Patient
Leveraging the Power of Information to Facilitate Care

3. Integrate Delivery Systems as the Key to Interprofessional and Cross-Continuum Continuity

360° view of patient from referral to discharge including clinical, back office, and billing

- Reduce Minimum Data Set at Intake
- Utilization Management – Number of Visits Based on Risk Stratification Score, Derived From Assessment
- Centralize Assignment and Scheduling to Increase Compliance to Plan of Care, Based on Industry Benchmarks
- Establish Episodic Care Guidelines Based on Risk Stratification

Estimated $20-40M in annual savings due to workflow redesign

d) Transforming workflow for Electronic Medical Records to improve patient outcomes and reduce spend

Facilitate Care for the Individual Patient
3. Integrate Delivery Systems as the Key to Interprofessional and Cross-Continuum Continuity

- VNSNY is an active participant in multiple HIE programs
- RHIO event notifications alert each provider when a patient is admitted to a partner facility and alert care managers when patients visit the ED
- ProHealth eReferrals program integrates medical records systems across physician practices
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1. Duke Population Care Coordination Program (PCCP)

- **Application**: Using Duke’s PCCP model as the underpinning framework, VNSNY will design, implement, and evaluate a ‘Transitional Care Coordinator’ role for the intake and HCC staff in the hospital setting.

- **Curriculum**: 12 weeks, 12-15 hours/week for coursework; students are placed in designated physician practices for guided learning and mentorship.

- **Crucial Competencies**: Population health management, monitoring and tracking patient care goals and issues, integrating community resources, continuous quality improvement, and clinical registries, evidence-based alerts, and reminders.

- **Partner**: NYU College of Nursing partnering to provide the clinical residency component.
### VNSNY BEHAVIORAL HEALTH PROGRAM

#### Patients
- Homebound Medicare patients admitted to VNSNY care and treated for behavioral health problems
- Major depression is twice as common in elderly patients receiving home care than in those receiving primary care
- Depression strongly associated with falls, medical and functional disabilities, risk of rehospitalization
- Goal to help patients transition from acute care to home and community
- Risk assessment (predictive risk algorithm)
- Clinical assessment (medical, functional, psych)

#### Protocol / Intervention
- Employs psychiatric nurses, psychiatric nurse practitioners, and in-home visiting psychiatrists
- Receives referrals from community primary care physicians, hospitals and family members
- Teaching, self-management
- Cognitive behavioral therapy
- Psychotropic medication management
- Linking patients and families to community resources for ongoing support

#### Outcome
- Depression reduced by 33% (GDS) and functional ability improved by 50% (ADLs) on average
2. Data to Enhance Care for Payor Beneficiaries
   b) Data within the Payor Claims Data

Transitional Care Program (TCP): Empire-White Plains Hospital

**Intervention:** Nurse Practitioner (NP) led interdisciplinary team provides short-term medical and mental health case management to patients in the community during a 30-day transition period from hospital to home to avoid hospital readmissions.

**Risk Stratification:** Risk for readmission is determined based on the severity and number of individual risk factors (i.e., chronic comorbidity, number of medications, depression screen, cognitive status, inpatient admissions, level of social support, functional status and continence).

**Outcomes:** Achieved nationally benchmarked outcomes in first 30-day all-cause readmissions.
Leveraging the Power of Information to Facilitate Care

2. Data to Enhance Care for Payor Beneficiaries
   c) Data as Catalyst to Innovation

The new VNSNY **Co-Care-90®** Model is designed to address specific care needs while improving quality and reducing costs.

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<tr>
<th>Patients</th>
<th>Protocol / Intervention</th>
<th>Outcomes</th>
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| • Current target population includes Medicare beneficiaries immediately post-discharge for hospitalization due to Congestive Heart Failure exacerbation  
• Current 90-day rehospitalization rates for this population are between 40-50%  
• Acuity assessed by the Co-Care algorithm | • “Dosing” interventions of face-to-face, telehealth, telephonic, and electronic communications  
• Augmented by web-based group education  
• Triggered by the integration of the Morisky Medication Adherence and the Patient Activation Measure (PAM) assessment tools  
• Driven by readiness and confidence rulers | • Preliminary results show early indicators of reducing 90-day rehospitalization rates  
• Other anticipated outcomes: meeting patient-centered goals & promoting care coordination amongst external community providers |
Leveraging the Power of Information to Facilitate Care

3. **Data at a Unit Level – Cardiothoracic Post-op Program Partnership with Mount Sinai**

**PARTNERSHIP GOALS:**

1. Reduction of post-surgical cardiothoracic wound infections & other post-op complications

2. Reduction in avoidable admissions for post-surgical cardiothoracic wound patients

3. Increased patient satisfaction for post-surgical cardiothoracic wound patients

**Improves Health at the Population Level**
Leveraging the Power of Information to Facilitate Care

Cardiothoracic Wound Program Partnership with Mount Sinai

- Results: March 2013 through December 2013

Improvement in Variable Compared to National Benchmark

![Bar chart showing improvement in various variables compared to national benchmark.]

Improve Health at the Population Level
## 4. Data at a Systems Level

### a) Emergency Department Diversion

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<th>Outcomes</th>
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<tbody>
<tr>
<td>• Patients accessing the Emergency Department (ED) for ambulatory services and conditions</td>
<td>• VNSNY NP and RNs embedded in the ED&lt;br&gt;• Patients receive extended observation to ensure they do not require hospitalization&lt;br&gt;• Successful treat and release: coordinate the development of safe plans of care for patients who need home care after leaving the hospital&lt;br&gt;• Text message with Health Home Case Management</td>
<td>• ED throughput improvement&lt;br&gt;• Decrease in ED wait times&lt;br&gt;• LOS reduction&lt;br&gt;• Reduced avoidable rehospitalizations&lt;br&gt;• Reduced nosocomial events&lt;br&gt;• Improve care transitions&lt;br&gt;• Position VNSNY for CMMI grant based on Hospital to Home (H2H) methodology</td>
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### 4. Data at a Systems Level

#### b) CMS Bundled Payment for Care Improvement (BPCI)

**NYU Langone Medical Center Bundling Initiative**

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<tbody>
<tr>
<td>Any Medicare FFS patients hospitalized at NYULMC for DRGs associated</td>
<td>CMS Model 2 – protocolized cross-continuum plans of care for surgical patients from</td>
<td>Reduced sub-acute facilities / hospitals</td>
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<td>with one of three surgical procedures: 1) total joint replacements,</td>
<td>preadmission testing through post-discharge rehabilitation</td>
<td>Preliminary reduction in rehospitalizations trending at 25%</td>
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<tr>
<td>2) cardiac valve procedures and 3) spinal surgeries</td>
<td>Includes enhanced clinical data sharing through:</td>
<td>Potential shared savings of up to $750K for VNSNY</td>
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<td></td>
<td>- Initial summary of the patient’s medical condition</td>
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<td>- Weekly clinical reports</td>
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<td>- Digital patient summary sent automatically to caregivers’ tablets, where it can</td>
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<td>be shared by the clinical team</td>
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<td>- Software that automatically searches each patient’s VNSNY electronic medical</td>
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<td>record to assemble clinical data</td>
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**IHI / Rockaways Wellness Partnership (RWP) Initiative ($1.4M NYS grant)**

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<td><em>Residents aged 18+ in three zip codes of the Rockaways, located in the New York City borough of Queens</em>&lt;br&gt;<em>Largest public housing project in New York City (40 buildings with over 15,000 low-income population)</em></td>
<td><em>VNSNY as Integrator and Care Coordinator to organize a community-wide collaboration of providers to improve the Triple Aim</em>&lt;br&gt;<em>Goal is to shift from disease to wellness focus, including health promotion and prevention through self-management &amp; technology</em>&lt;br&gt;<em>Geo-Mapping process to pinpoint zip codes in Rockaways with poor clinical, social, psychological, and behavioral indicators to determine “Hot Spots”</em>&lt;br&gt;<em>Partnership employs professional wellness coaches and community wellness workers to help individuals and families connect with healthcare services</em></td>
<td><em>Improvements in follow-up and compliance with treatment in cases of chronic disease</em>&lt;br&gt;<em>Shift from acute care hospital setting to community wellness through health promotion and prevention</em>&lt;br&gt;<em>Link enrollees to primary care, help them adopt healthy behaviors, and address mental health and substance abuse issues</em></td>
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1. VNAA Vulnerable Patient Study

- Initiated in 2010 to better understand inconsistencies and potential deficiencies in Medicare Home Health reimbursement

- **Sample:** VNA’s collected data on a range of patients and their associated costs:
  - OASIS for all Medicare episodes ending in 2011
  - Medicare claims for all episodes ending in 2011
  - Chart review for 100 randomly selected episodes ending in 2011

- **Key Findings:** Medicare Home Health reimbursement was found to be significantly lower relative to cost in patients with clinically complex conditions, limited or absent caregiver assistance, stasis or pressure ulcers, low median household income, lack of access to primary care, functional disabilities with poor rehabilitation potential

- **Policy Implication:** Home Health reimbursement should take into account the complex service needs of beneficiaries when formulating new payment policies

- Health and Human Services (HHS), in collaboration with the National Quality Forum (NQF), funded a project to identify whether or not outcome performance measurement should be adjusted to account for sociodemographic factors.

- NQF convened an expert panel of 26 individuals with a variety of expertise related to disparities, performance measurement, and risk adjustment methods, as well as varied stakeholders.

- The effects of current policy (no adjustment of measures for sociodemographic factors on disadvantaged populations) was examined closely by the expert panel.

- Eight recommendations were made to adjust performance measures and support making correct conclusions about quality of care to prevent unintended consequences such as the worsening of healthcare disparities.
Questions / Comments