New Models of Care: Population Health at VNSNY

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About VNSNY

Visiting Nurse Service of New York (VNSNY)

- Nation’s largest not-for-profit home health organization
- Offers home health, hospice and palliative care, private duty, and a health plan
- On any given day, approximately 70,000 patients and members under direct or coordinated care
- 2.3 million clinical visits in 2013

VNSNY Patient Profile:
Safety Net Mission to Serve the Most Vulnerable

- Medically frail, high-risk individuals all ages
- Dual-eligibles
- Patients without primary care physician
- Patients with multiple chronic conditions

Rose Madden-Baer
SVP, Population Health Management

- Description of role
A Dual Imperative for Home Health Providers

Traditional Home Care Under Medicare/Managed Care Fee-for-Service

Ensuring a financially-viable model for traditional home care services in a declining reimbursement environment

Care Coordination and Management Outside Core Patient Population

Opportunities and share in value by providing population health management services for broader range of patients
Our Vision

To become the most significant, best-in-class, nonprofit, community-based integrated delivery system providing superior care coordination and care management services to vulnerable populations across a broad regional footprint.
Population Care Management

Patient Interactions: face-to-face, telephonic, and electronic

1. Risk Stratification
2. EB Tools, Engagement & Motivational Interviewing
3. Person Centered Goals and Care Plan
4. Assessment and Care Coordination by RN
5. Health Coaching and Support
6. Collaboration with Primary Care and Other Providers
7. Financial and Clinical Outcomes & Reporting

Predictive Analytics & Risk Stratification
The VNSNY Population Care Coordination team, anchored by the RN Population Care Coordinator

VNSNY Population Care Coordination Team

**PATIENT AND FAMILY**

- Hospital-based RN liaison
- Social Worker
- Health Coach

**OTHER PROVIDERS**

- Referring MD
- Discharge Planner
- **Home Care Nurse**
- **Home Care Therapist**
- Primary Care Physician
- Post-acute facilities
- Specialist Physicians
- Other Care Managers
- Community-based orgs
- Psych NP
- Pharmacist
- Paraprofessional Svcs
Population Health at VNSNY: Applications

- 2 Medicare-sanctioned bundled payment demonstrations
- Delegated disease-specific care management for health plans
- Post-hospitalization transitional care for ACOs and health plans
- Ongoing population health management for vulnerable communities
- Remote and embedded care coordination for emerging provider systems as part of NY State Medicaid Delivery System Reform (DSRIP)
- Care coordination for largest Managed Long Term Care Plan in NY State
Success Factors and Challenges

Success Factors

• Use of evidence-based tools
• Partnership with leading-edge academic institution on training curriculum
• Standardized approach across all applications of model
• Stratification-driven, dosed mix of interventions