Bundled Payment Clinical Re-engineering: A 'Model 3' Post-acute Provider Perspective *Background Slides*

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The Visiting Nurse Service of New York and the BPCI Program

- The Visiting Nurse Service of New York (VNSNY): largest not-for-profit home and community based healthcare organization in the US, serving over 160,000 patients and members per year in the New York City area

- VNSNY is actively participating in the BPCI program as a post-acute provider:

Model 2: Post-acute home care partner with an AMC Model 2 program

Model 3: Episode initiating provider in a Model 3 (post-acute only) program

  - 90-day episode length; 'clock' starts with admission to VNSNY Home Care following a qualifying hospitalization
  - Awardee Convener: Remedy Partners
  - Initial bundle set: Congestive Heart Failure
  - Go-live (Phase 2): January 1, 2014
  - Geography: VNSNY service area (metro New York City area)
  - Discharging Hospitals: VNSNY receives home care referrals from ~50 hospitals (onsite RN liaisons at ~40 facilities)

Care redesign and the VNSNY Model 3 post-acute program: beyond traditional Home Care

Initial Care Redesign Elements

Triggering Hospitalization	Traditional home care episode (~45 days)	Remainder of 90-day episode
• VNSNY RN onsite hospital liaisons (~40 facilities): shift from intake processing to transitional care	• Additional focus on transitional care & CHF home care protocols •Calculation of acuity score using enhanced risk stratification algorithm (low, rising, high risk) • Ongoing internal tracking of key outcome metrics, with frequent feed-back loop to core clinical operation teams	• Introduction of VNSNY CO•CARE 90 model, anchored by a Nurse Population Care Coordinator who delivers/manages care with other providers beyond traditional Home Care period of service • Stratification-driven mix of face-to-face, telehealth, telephonic communication; emphasis on goal-setting via motivational interviewing and behavior activation • Partnership with community resources to tailor care plans and interventions to cultural/demographic needs

Goal: Reduced 90-day rehospitalization rates and improved coordination of post-acute care

Core care redesign element: introduction of the CO•CARE 90 team, anchored by the RN Population Care Coordinator

Triggering Hospitalization

Traditional home care episode (~45 days)

Remainder of 90-day episode

Patient & family

VNSNY CO•CARE 90 Team

Hospital-based RN liaison

Home Care Nurse

Home Care Therapist

RN Population Care Coordinator

Social Worker

Health Coach

NP

Psych NP

Other Providers

Referring MD

D/C Planner

Other Care Managers

Primary Care Physician

Specialist Physicians

Post-acute facilities

Community -based orgs