Community-Based Care Management: VNSNY's Journey to Value Based Care

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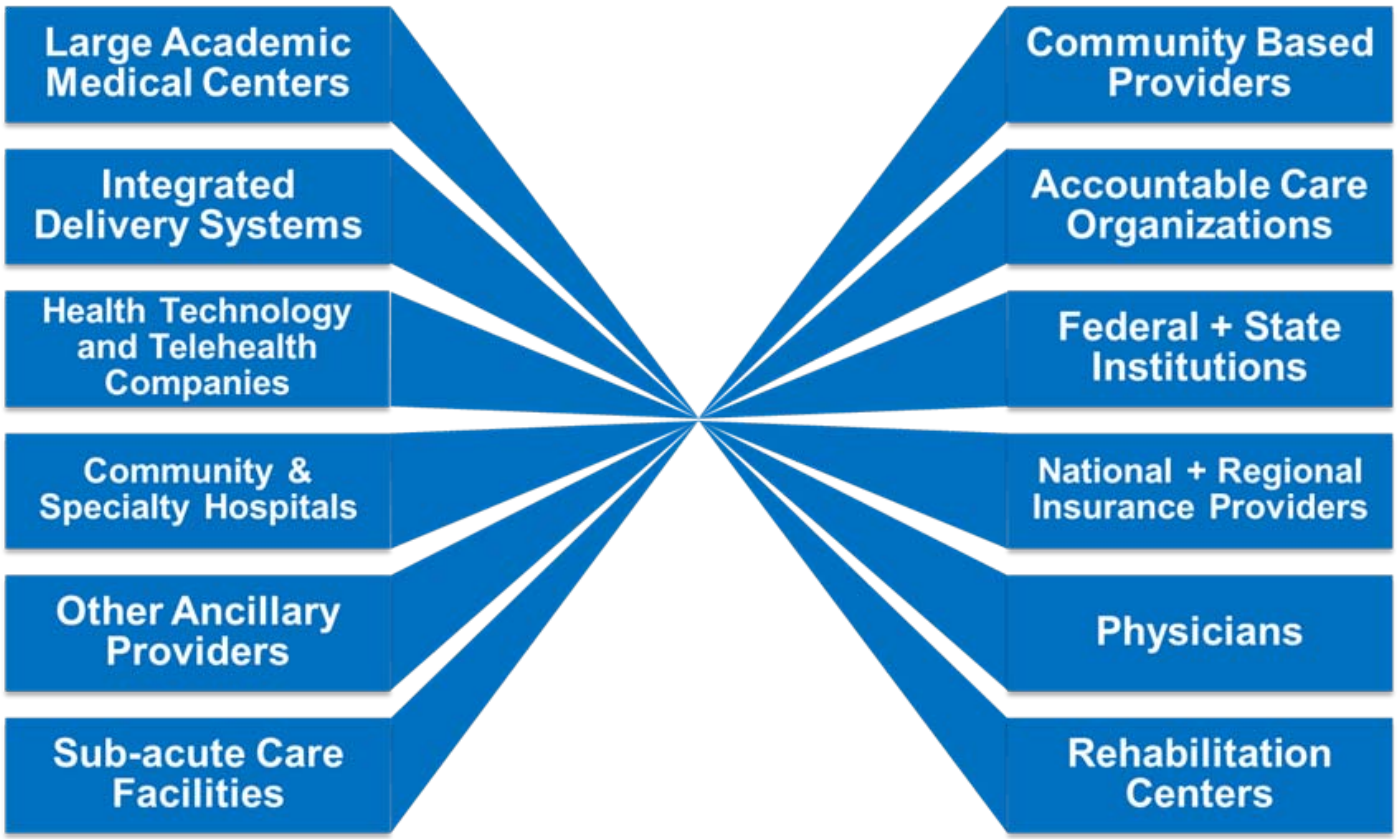
VNSNY's Approach to Value-Based Care and Payment

- Medicare and Medicaid Fee for Service is decreasing secondary to the growing penetration of Medicare Advantage and Medicaid Managed Care.
- Managed Care and providers who are taking risk are seeking a cheaper alternative to traditional facility-based care
- Can utilize our data and experience to enter into fixed payment arrangements to manage episodes or populations on total cost of care
- Can develop performance-based incentives around quality, cost and experience measures

A Shared Culture of Value

- Leadership must promote a culture of value and innovation
- A network of providers –
  - Multi-disciplinary, Multi-cultural, Multi-site
    - “Today’s competitors could be tomorrow’s partners”
    - “Today’s partners could be tomorrow’s competitors”
    - Understand access and choice
  - How do you manage your outliers – Incentives, Penalties and Service Level Agreements
- Aligned participation
- Regulatory and compliance
  - Be cognizant of potential regulatory minefields

Various Partners

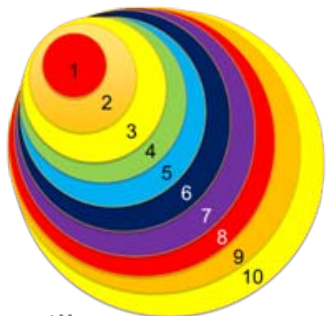


Customer and Partner Communication and Strategy

- Prioritization of strategic communications
- Consistent messaging and emphasis on value, customer experience and landscape "change"
- Articulate knowledge of pain points and meaningful metrics to customers e.g. HEDIS, claims-based measures
- Have a keen understanding of potential risk and vulnerabilities of certain clinical conditions during communication and negotiation

Service Optimization - Clinical

- Injecting Identification & Stratification into the Care Management workflow
- Clinical pathways and deciding your evidence based care rules
- Right care at the right time by the right person
- Telemedicine/telehealth opportunities
- Manage the concentric circles of Care Management
  - The importance of seamless care transitions



- Identifying and engaging outcome-based performance outliers
  - Patients
  - Providers
  - Payors

Above all else, protect the patient

VNSNY Care Redesign and VBP Arrangements

- “Time-based” case rate arrangements with performance bonuses and penalties for metrics and utilization costs
- A “Case” is 60 days including home health and post home health episode period.
- No new payment for case referral/readmission if related to prior case admission.
- Health plan “site” visits for clinical discussion, “true ups” for hospitalization costs, “member experience” and utilization
- BPCI Model 3 upside and downside risk with CMS
- DSRIP contracted care management provider
- Care management infrastructure with interdisciplinary team and “activation” based on risk cohort. Includes: type, dosing and who delivers

Population Health and Care Management
Comprehensive and Person-Centered Care

Professional Development and Creation of a High-Performing Interdisciplinary Team

- Creation of new roles and competencies
- Activation of right team member at right time
  - Operating at the highest of their license
  - Tied to appropriateness of care and risk score
- Ability to "lead" beyond the traditional nurse team including other disciplines in an interdisciplinary team and roles such as community navigators, health coaches etc. Specialized skills in person centered engagement, person centered care planning and care transitions
- Breakdown departmental silos “whole team approach”
- Create a new infrastructure for care management including more longitudinal time periods

VNSNY Model 3 Post-Acute Model: “Beyond Traditional Home Care”

Care Redesign Elements

Triggering Hospitalization

- VNSNY RN onsite hospital liaisons (~40 facilities): shift from intake processing to transitional care

Traditional home care episode (~45 days)

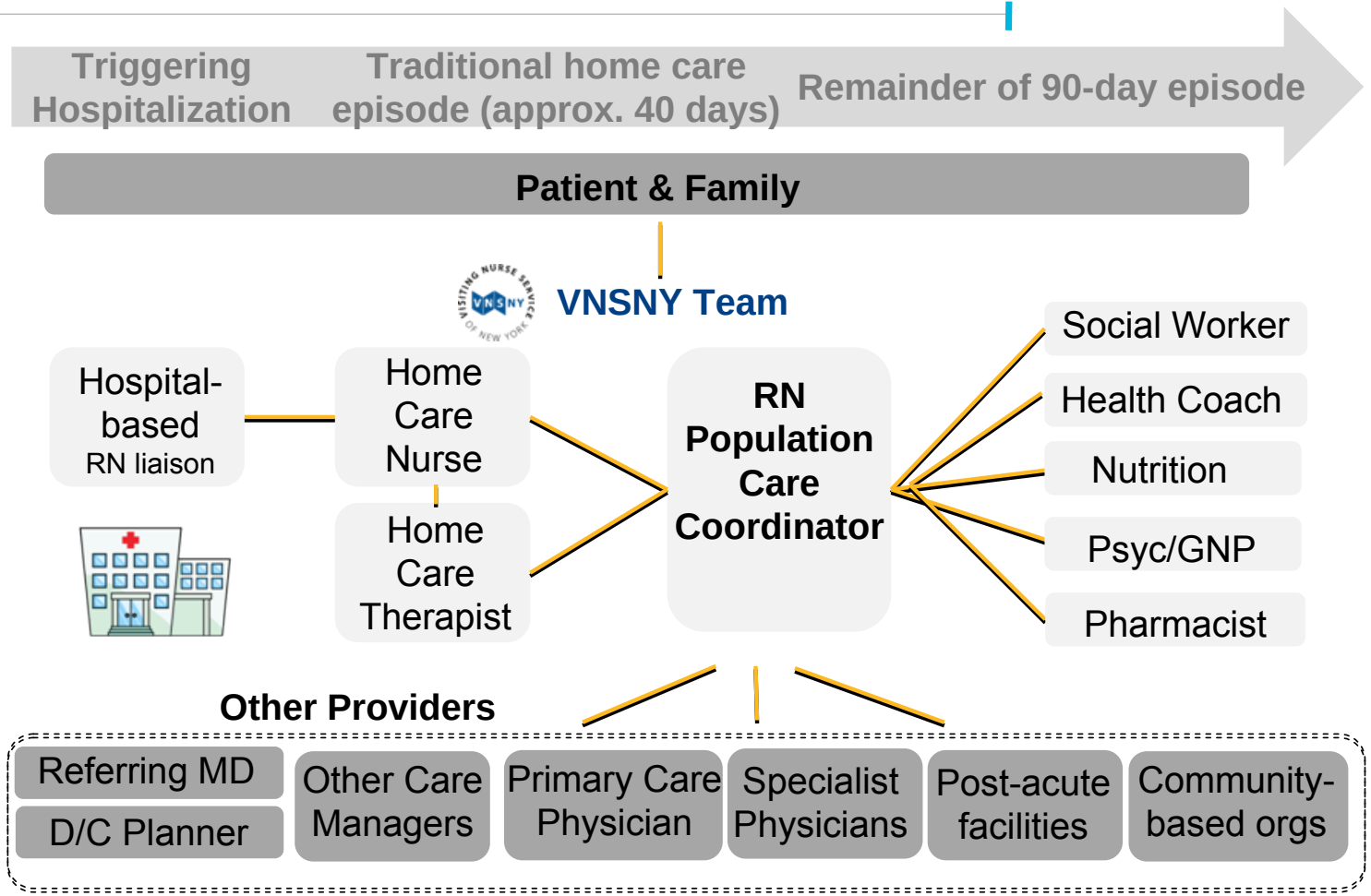
- Additional focus on transitional care & CHF and MI home care protocols
- Calculation of acuity score using enhanced risk stratification algorithm (low, rising, high risk)
- Ongoing internal tracking of key outcome metrics, with frequent feed-back loop to core clinical operation teams

Remainder of 90-day episode

- Introduction of VNSNY care management model, anchored by a Nurse Population Care Coordinator who delivers/manages care with other providers beyond traditional Home Care period of service (90 days)
- 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 re-hospitalization rates and improved coordination of post-acute care

BP3 Core care redesign element: anchored by the RN Population Care Coordinator



Technology and Integration

- EMR/EHR (electronic health record) standardization to the extent possible
- EMR/EHR interoperability to extent possible
    - Clinical Integration is Ideal
- EMR/EHR usability for alerts e.g. regional health information organization (RHIO) alerts
    - Care standardization to extent possible
- Understand existing and emerging technologies and tools
    - Risk stratification and probability tools
    - Data capture and reporting tools
    - Care management platforms and use of Evidence Based Practice (EBP) tools
    - Telehealth/Telemedicine technologies

Data and Communication

- Claims data and analysis: understanding your risk
- Predictive and prescriptive analytics
- Key Performance Indicators (KPIs) and dashboards
- Data sharing among and across providers
- Assessment of both the clinical, administrative and financial metrics will provide you with the overall organizational evaluation picture
- Collaboration of Clinical Operations, Finance, IT and Analytics teams are paramount to success