Future Directions for Home & Community-Based Care Services

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Alliance for Health Reform
Long-term Services and Supports: A Rebalancing Act
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The Visiting Nurse Service of New York

Who We Are:

- Founded in 1893 by Lillian D. Wald, VNSNY is the largest non-profit home health care agency in the U.S.
- Serves all five boroughs of NYC, plus Westchester and Nassau Counties
- Structure is twofold: 1) Provider System and 2) Health Plan
- Provides a range of services to an average daily census of 31,000 patients, from newborns to seniors
- 15,000 employees – most are field staff providing direct care
- Serves a socio-economically diverse population (36% speak a foreign language)
VNSNY Provides Care Across the Continuum of Needs

VNSNY’s Continuum of Care

- Post-acute
- Long-term
- End of Life

+ Mental Health

** Goal is to enable people to move across continuum as needed and to avoid institutional care and remain as independent and high-functioning as possible **
Profile of a Typical VNSNY Patient…

<table>
<thead>
<tr>
<th></th>
<th>Post-Acute Care</th>
<th>VNS CHOICE</th>
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</thead>
<tbody>
<tr>
<td>Cases</td>
<td>101,142</td>
<td>10,284</td>
</tr>
<tr>
<td>Median Age</td>
<td>74 years</td>
<td>82 years</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>75% English, 18% Spanish, 7% Other</td>
<td>38% English, 38% Spanish, 11% Chinese, 12% Other</td>
</tr>
<tr>
<td>Avg # diagnoses</td>
<td>3-4</td>
<td>3-4</td>
</tr>
<tr>
<td>Top diagnoses</td>
<td>Diabetes, nervous/musculoskeletal, hypertension, heart failure</td>
<td>Diabetes, Heart Disease, Chronic Obstructive Pulmonary Disease, Hypertension</td>
</tr>
<tr>
<td>Median LOS</td>
<td>28 days</td>
<td>53 months</td>
</tr>
</tbody>
</table>
VNSNY CHOICE Health Plans
Managed Care Plans for High-Cost Chronically Ill Dual-Eligibles

<table>
<thead>
<tr>
<th></th>
<th>Medicaid Managed Long Term Care (MLTC)</th>
<th>Medicare Advantage (Special Needs Plan and Part D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year End ‘10 Census</td>
<td>9,337 members</td>
<td>6,692 members</td>
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| Benefits and Services Provided | Alternative to long-term institutional care.  
14 home and community-based services, including care management, nursing home, adult day care, home-delivered meals  | All services in Medicare Parts A, B and D; Hospitals, Doctors, Labs, Rxs Supplemental: Dental, Vision, Hearing, and Transportation benefits |
| Payment Source       | NYS Medicaid, partially capitated, rates risk-adjusted by population (2-year payment lag) | Medicare Advantage (CMS), fully capitated, risk adjusted by individual |
| Providers            | 1,900 Network Providers 29 Nursing Homes | 2,200+ Primary care phys, 5,800+ Specialists, 37 Hospitals, 32 Nursing Homes, Labs, Pharmacies |

1,600 MLTC members are virtually enrolled in both Medicaid MLTC & MA SNP

High-Touch Care Management Model Aims
- Reduce Hospitalizations & Readmissions
- Integrate sites and settings
- Delay institutionalization
Integrating Care in a Fragmented System

Challenges:

1) Developing models to integrate care
2) Ensuring adequate capacity and a competent workforce
3) Defining and improving quality
4) Increasing efficiency and affordability
5) Better incorporate caregivers
# VNSNY is Exploring a Number of Demonstrations to Better Integrate Care for Patients with Long Term Service and Support Needs

| Federal | i. **Community-Based Care Transitions Program (CCTP)**  
|         | • Reduce all-cause readmissions for hospitals with worst readmission performance through community collaboration to deliver evidence-based transitional care |
|         | ii. **Health Homes**  
|         | • Coordinate primary, acute, behavioral health, and long term supports and services for individuals with 2+ chronic conditions, behavioral health needs, and/or HIV. Offers states 90% Federal reimbursement for 2 years |
| State   | iii. **VNSNY Transitional Care Program (EMPIRE Blue Cross)**  
|         | • Reduce readmissions within 30-days of discharge in Westchester County by successfully transitioning patients from the hospital back to their homes |
| Health Plans | iv. **VNSNY SPARK Program (VNSNY CHOICE)**  
|         | • Manage advanced illness, reduce hospitalizations and offer palliative care and hospice at earlier stage |
Ensuring Sufficient Capacity and Competent & Committed Workforce


  ✓ Currently, seniors represent 12% of the population but use:
    - 26% of physician office visits
    - 35% of hospital stays
    - 34% of prescriptions
    - 38% of EMS responses

  ✓ Inadequate workforce to meet rising demand:
    - **Lack of Specialists**: 7,100 geriatricians and declining, 1,600 geriatric psychiatrists
      - Less than 1% of nurses and pharmacists specialize in geriatrics
      - IOM report recommended enhancing geriatric competence of general workforce
    - **Direct-Care Worker Shortage**: Current # of direct-care workers is insufficient to meet demand: *additional 1 million new positions by 2016*
      - **Turnover**: 40-60% of home health aides leave in one year; 80-90% in first 2 years due to *low pay, poor working conditions, high rates of on-the-job injury, and few opportunities for advancement*
      - IOM report recommended that state Medicaid programs increase pay for direct care workers, provide access to fringe benefits, and enhance opportunities for career growth
Quality Challenge at VNSNY

- VNSNY has created an infrastructure to measure quality including performance measurement & scorecard, and an outcomes website to track and monitor key metrics.
- Quality Indicators on the Scorecard are reported by each program in four domains:
  1) Care Management Processes – high risk/high volume populations (DM, CHF, Falls Risk), plan of care compliance
  2) Clinical Outcomes – emergent care; improvements in ADL’s (e.g. bathing, transferring, ambulation)
  3) Patient Satisfaction – overall satisfaction, voluntary disenrollment rate
  4) Utilization/Cost – PPS visits per episode, pmpm costs, HHA utilization consistent with assessed need
- Secure, internal Outcomes Website provides real-time reports on readmissions & emergent care to clinical staff and monthly reports to agency management by program, geographic region, and team.
- Public disclosure of process and quality outcome measures:
  - Home Health Compare: CMS reported metrics about the quality of care provided by “Medicare-certified” home health agencies
  - Star Ratings for MA Plans: CMS rates Medicare Advantage plans on a scale of 1-5 stars, with five stars representing the highest quality.
Efficiency Challenge at VNSNY

• Use of Technology
  ✓ Information technology has the ability to coordinate care and produce results:
    − **Virtual integrator**: facilitate collaboration, information sharing across disciplines, providers, settings
    − **Decision-making support**: promote standardization of care
    − **Engagement with patients**: communication on non-urgent issues, self-management
  ✓ **Electronic Health Records (EHRs)**:
    − All VNSNY nurses use portable laptops equipped with proprietary **Patient Care Record System (PCRS)**, a structured EHR enabling retrieval at point of care of current patient-assessment data for caseload
      ▪ Initial comprehensive patient assessment
      ▪ Plan of care
      ▪ Medication management
      ▪ Diagnostic tests & lab results, digital wound images
      ▪ Charting Progress and milestones
      ▪ Summary Reports
  ✓ Exchange initiatives with Physicians and Hospitals
The Efficiency Challenge (cont.)

- Caregivers
  - Play a large role in the delivery of increasingly complex health care services to older adults
    - Provide needed personal assistance with Activities of Daily Living (ADLs)—e.g. bathing, dressing, eating
    - Act as emotional support structure, especially for patients with depression or mental health disorders
  - Number is substantial and likely to increase
    - 29 million to 52 million family caregivers (as much as 31% of the U.S. adult population) provide on average 20 to 25 hours per week of assistance of varying intensity
  - Currently lack recognition, support, and integration with the formal care system
  - IOM report recommended that public, private, and community organizations provide training and support for informal caregivers
How to Adapt to Changing Direction of NY State Medicaid Program

NY State Medicaid Program Background:

- Total Medicaid spend of $58.3B
- New York ranks 21st out of all state for overall health system quality and ranks last among all states for avoidable hospital use and costs
- 20 percent of high-cost enrollees drive 75% of Medicaid spending
- 720K dual eligibles in NYS; 200K are Long-Term Care eligible
- Total 2009 Long-term Care Spending: $12.4 billion (21% of State Medicaid Expenditures)
- 300K behavioral health recipients, accounting for an additional $5B in Medicaid expenditures

The newly created Medicaid Redesign Team (MRT) was tasked by Governor Andrew Cuomo to find ways to reduce costs and increase quality and efficiency
Medicaid Redesign: Results

- **Phase I:**
  - MRT developed a package of reform proposals that achieved the Governor’s Medicaid budget target: $2.85B
  - Introduced significant structural reforms that will bend the Medicaid cost curve
  - Imposed a global cap to limit annual growth to 10-year rolling average of medical CPI (≈ 4%/year)
  - Achieved savings without any cuts to eligibility

- **Phase II:**
  - Creation of Work Groups to address more complex issues to develop recommendations for the MRT:
    - Behavioral Health Reform Work Group
    - Basic Benefit Review Work Group
    - Program Streamlining and State/Local Responsibilities
    - Health Disparities Work Group
    - Managed Long Term Care Implementation and Waiver Design

- Recommendations are to be finalized by November 2011
Future Directions

**Key:** Bring populations traditionally left out of managed care into the system

✓ Enrollment in *Managed Long-Term Care* or *Care Coordination Program* – for all Medicaid beneficiaries 21 & older enrolled in any post-acute or LTC option for 120 days
  - Targets dual-eligible beneficiaries
  - Becomes mandatory April 1, 2012, pending Federal approval

➢ Benefits of Approach:
  - Care management offers enhanced coordination and integration
  - Increased incentives to utilize home and community-based care
  - Standardized assessment is built in
  - Quality measurement system to differentiate and eventually reward performance
  - Appropriate risk-adjustment
  - Allows for flexibility
Future Directions (cont.)

• **Issues Raised**

  1) Building capacity and utilizing existing home and community-based options
  2) Assumption of risk by provider agencies
  3) Network development
  4) Ensuring adequate consumer education, protections, and engagement
  5) Laying the groundwork for the integrated Medicare/Medicaid system of the future