Leveraging Care Management Services to Build Strategic Referral Partnerships
Building the Value-Based Care Management Network

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The Advisory Board is Uniquely Positioned to Help
Research and Relationships at the Intersection of a Dynamic Industry

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We are …
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✓ Devoted to exceeding member expectations at every turn
And we offer …
✓ Unique visibility into provider CXOs’ world – challenges, priorities, vendor perceptions
✓ Direct access to over 500 in-house health care experts

3,400+ Hospitals and Health Systems
200+ Independent Physician Practices
2,000+ Post-Acute Care Facilities and Agencies
200+ Health Care Product and Service Companies
5,000+CXO Relationships Across the Care Continuum
The Expanding Roles of Home Health and Hospice
Receiving
How The Advisory Board Supports Home Health Members

Home Health as the Longitudinal Care Management Solution
- Benefiting from Home Health Expertise Across Post-Discharge Transitions
- Elevating the Prevention and Wellness Proposition of Home Health

Cross-Provider Chronic Care Integration
- Extending Primary Care to the Home for Chronic Patients
- Securing ACO Relationships by Caring for their Most Challenging Patient Populations

Building Hospice and Palliative Care Partnerships
- Strengthening Hospice and Palliative Care Programs in the IP, Post-Acute Setting
- Key Lessons for Developing Collaborative Cancer Center-Hospice Relationships

Optimizing the Efficacy of Hospice and Palliative Care Services
- Best-in-Class Approaches to Advanced Care Planning
- Hospice Concurrent Care Program Models and Operations

Road Map
1 The Accountability Expansion
2 Building the Value-Based Care Management Network
3 Lessons from the Field: Profiling VNSNY
### A Widening Window of Accountability

#### Post-Hospital Risk Expansion

<table>
<thead>
<tr>
<th>0 Days</th>
<th>30 Days</th>
<th>90 Days</th>
<th>365+ Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional</strong></td>
<td><strong>Redefined</strong></td>
<td><strong>Episodic Accountability</strong></td>
<td><strong>Population Management</strong></td>
</tr>
<tr>
<td>Incentive Mechanisms</td>
<td>Fee-for-service</td>
<td>Value-based purchasing</td>
<td>Pay-for-performance</td>
</tr>
<tr>
<td>Success Metrics</td>
<td>Number of procedures</td>
<td>Cost of stay at single care setting</td>
<td>Cost of post-acute episode</td>
</tr>
<tr>
<td></td>
<td>Number of visits</td>
<td>Care site-specific quality metrics, including 30 days post-hospitalization measures</td>
<td>Cost of care management for targeted patient groups</td>
</tr>
<tr>
<td>Performance Levers</td>
<td>Specialist referral network</td>
<td>Evidence-based care pathways</td>
<td>Quality metrics specific to condition outcomes as well as management trend data</td>
</tr>
<tr>
<td></td>
<td>Workshop efficiency</td>
<td>Care coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Previous levers, plus:</td>
<td>Evidence-based care pathways</td>
<td>Care coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care coordination</td>
<td></td>
</tr>
</tbody>
</table>

Source: Post-Acute Care Collaborative interviews and analysis.

### Payers, Referrers Demanding Efficiency

#### Two Economic Forces Driving Demand for Post-Acute Efficiency

**Force #1: Post-Acute Payment Reform**
- Short-Window Episodic Risk: Payer network narrowing, Medicare pay-for-performance programs, site-neutral payments
- Long-Window Episodic Risk: Bundled payments, PACE program participation, care management contracts

**Force #2: Referral Source Demands**
- Short-Window Episodic Risk: 30-day hospital readmission, mortality, and efficiency penalties
- Long-Window Episodic Risk: Bundled payments, accountable care organizations, brand impact of patient satisfaction at partner sites

Source: Post-Acute Care Collaborative interviews and analysis.
Not Just the Hospital’s Problem

Impending Medicare Incentives Forcing Greater PAC Efficiency

Emerging Post-Acute Incentives

30 Days
Referrer Payment
Tied to PAC Efficiency

- 30-day mortality (PN, AMI, HF)
- 2015 30-day readmissions (TKA, THA, COPD)
- 2015 30-day efficiency

90 Days
PAC Payment Tied to Episodic Efficiency

- SNF 30-day readmission penalties
- Proposed site-neutral payment

365+ Days
Innovation Funding

- MedPAC proposed 90-day mandatory bundled payment
- 30-day readmission quality reporting post-PAC discharge

Current Post-Acute Incentives

- 30-day readmissions (PN, AMI, HF)
- Post-acute prospective payment
- Bundled Payments for Care Improvement

- Accountable Care Organizations
- PACE

Referrer Payment Tied to PAC Efficiency
PAC Payment Tied to Episodic Efficiency

A Race to Manage Post-Acute Utilization

Managed Care Eyes Dual-Eligibles, Medicare for Revenue Growth

Deals Increasing Financial Exposure to Duals, Medicare PAC Episodes

UnitedHealth Group
Purchases XL Health, Insiris, Preferred Care Partners, Medica HealthCare Plans

Remedy Partners
Contracts with 100+ providers to manage Model 2 and 3 BCPI programs

Wellpoint
Acquires Amerigroup Corporation, CareMore

Cigna-HealthSpring
Wins 3-year contract to manage Chicago dual-eligibles, acquires Arcadia and Humana MA plans in OK, AR, TX

Humana
Acquires American ElderCare, SeniorBridge, Metcare

NaviHealth
Post-acute episode manager announces investments from Ascension, Blue Cross Blue Shield

Source: Post-Acute Care Collaborative interviews and analyses.
Narrower Post-Acute Network a Commonplace Tool

Common Hospital Strategy Emerging with Widened Accountability

Limit Episode Cost

1. Narrowed provider networks
2. Added clinical resources

Manage Long-Term Resource Use

1. Evidence-based protocol creation
2. Input cost management (e.g. supplies)

Primary Care Development

1. PCP acquisition, alignment
2. Top-of-license practice (e.g. medical home)

Disease Management

1. Disease registry technology
2. Chronic disease management teams

Target Additional Care Management Investments by Patient Risk

<table>
<thead>
<tr>
<th>Tier 1 (Low-Risk)</th>
<th>Tier 2 (Rising-Risk)</th>
<th>Tier 3 (High-Risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-80% of patients; any minor conditions are easily managed</td>
<td>15-35% of patients; may have poorly managed conditions</td>
<td>5% of patients; have complex diseases, comorbidities</td>
</tr>
</tbody>
</table>

Limiting Referral Streams to the Cost-Effective

Technology, Efficiency Requirements Define Network Participation

Michigan Pioneer ACO Narrows Home Health Partners from 47 to 8

<table>
<thead>
<tr>
<th>Number of home health partners</th>
<th>Technology: Organizations with an EMR</th>
<th>Cost: Organizations below cost per case threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interest in Partnership: Organizations responding to invitation to interview

Quality: Organizations above state average on five quality measures

Capacity: Organizations with average daily census >100

Source: Post-Acute Care Collaborative interviews and analysis.
Care Management the Catch-All for Emerging Risk

Risk Assumption with Health Care Evolution
Support Required Beyond Care Setting Walls

Emerging Risk
- Medication profile consistency
- Cost-appropriate system navigation
- Self-management capability

Traditional Risk
- Site-specific clinical capability
- Delivery alignment with prospective payment system

Care Management
- Addressing the comprehensive patient and caregiver needs that influence functional outcomes, satisfaction, and long-term cost

Common Goals:
- Reduce unnecessary resource utilization (hospital, ED visits)
- Improve patient and caregiver satisfaction
- Raise clinical quality indicator performance
- Foster information exchange
- Facilitate care access

Commonalities in Hospital Roles Inform New Post-Acute Opportunities

Multidisciplinary Working Group Audits, Revises Care Management Functions

Care Management Redesign Team
Care managers, social workers, nurses convened weekly over period of nine months

Functions Audited
- Job roles and responsibilities
- Use of technology, resources
- IT-based peer-to-peer communication
- Multidisciplinary rounding process across system

Staffing Resources Produced

Job Descriptions
Outlined roles for inpatient positions, transitions coaches

Day-in-the-Life Summary
Overview of daily routine, primary duties and activities

Hospital Care Management Gap Audit Tool
- Catalogs job functions, common names, and duties for hospital care management staff
- Allows Post-Acute Care Collaborative Members to recognize service gaps, identify common blind spots for hospital and physician group partners
- For complete opportunity audit tool, please contact Jared in follow-up.

Source: Post-Acute Care Collaborative interviews and analysis.
Two Distinct Types of Care Management

1. Episodic Care Management
   - Examples: 90-day longitudinal care pathing, transitional care services, length of stay management, PCP follow-up coordination

2. Long-Term Care Management
   - Examples: Primary care integration, senior wellness coaching, diabetes management, behavioral health case management

<table>
<thead>
<tr>
<th>Value to Referrers</th>
<th>Referrer Episodic Exposure Growing</th>
<th>Limited value for non-integrated hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All hospitals soon incented on PAC efficiency; readmissions a national area of focus</td>
<td>However, highly relevant for integrated systems, physician ACOs, payers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Necessity as a PAC Responsibility</th>
<th>External PAC Management Risky</th>
<th>Emerging as Primary Care Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Poor hospital or third-party management of PAC utilization can cause readmissions from early discharge or cost overruns from inappropriate setting placement</td>
<td>Uncoordinated or overly ambitious approaches may confuse patients, alienate PCPs; however, post-acute expertise a highly valuable input for primary care development</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payer Support Availability</th>
<th>Medicare Incentives Most Aligned</th>
<th>Slower Payment Alignment Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare FFS incentives, bundling, and shared savings gains realized from short-stay patients, quickest return on investment potential for Medicare innovators</td>
<td>Commercial payers lacking contracting sophistication for innovative long-term care payment; however, private payment and physician ACOs funding select innovations</td>
</tr>
</tbody>
</table>

Source: Post-Acute Care Collaborative interviews and analysis.

Road Map

1. The Accountability Expansion
2. Building the Value-Based Care Management Network
3. Lessons from the Field: Profiling VNSNY
Enhancing the Entire Patient Episode

10 Tactics to Advance Care Management

Delivering Efficient Post-Acute Care

- Tactic #1: Optimize Patient Placement
- Tactic #2: Transform Liaison Roles
- Tactic #3: Expand Comfort Care Access
- Tactic #4: Maximize Activation During Care
- Tactic #5: Streamline Downstream Transitions
- Tactic #6: Develop Full Episode Support

Addressing Gaps in Routine Care

- Tactic #7: Facilitate Interim Primary Care
- Tactic #8: Engage Community-Based Service Networks
- Tactic #9: Leverage Data to Manage Complex Disease
- Tactic #10: Expand End-of-Life Care Access

Efficient Placement a Persistent Challenge

Facility-Specific Capabilities Underrepresented in Discharge Decision

Proportion of Medicare Patients Placed in an Avoidably High-Cost Setting

Study Findings By Post-Acute Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>20%</td>
<td>15%</td>
<td>18%</td>
<td>9%</td>
</tr>
<tr>
<td>31%</td>
<td>30%</td>
<td>16%</td>
<td>18%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Specialty Service Availability Often Unconsidered

“The case manager is going to place patients based on the last time they heard a presentation, or they’ll ask their colleague ‘Hey, who takes trachs?’ or they will remember from the last liaison who bought them a cup of coffee. There’s no good rhyme or reason.”

Continuity of Care Director, Large Health System

**Optimizing Downstream Transitional Care**

**Coleman Model Reengineered to Post-Acute Patient Base**

**Genesis HealthCare’s Transitional Care Program**

**Concept Design**

- Modified Coleman Model Tailored Coleman model to SNF need with pillar added for advance care planning
- RN serves as patient’s engagement coach, not prescriptive medical manager

**Staffing Resources**

- Social worker dedicated to care transitions via telephone
- Transitional Care RN dedicated to care transitions in SNF; one per facility

**Key Delivery Features**

- Home Support: 1 RN home visit, weekly phone calls for 30 days for coaching
- Medication Management: Piloting medication provision post-discharge
- Physician Connection: Patient coached to establish PCP visit, visiting physician visit within 7 days

**Improving Through Downstream Partnership**

**Prioritizing Collaborative Home Health Agencies Drives Success**

**Cross-Continuum Care Conference**

- Occurs Weekly
- Discuss patient goals, medical progress; PCP joins ad hoc for readmission root cause

**Genesis’ Refined HHA Network Criteria**

**Collaborative Nature:**

- Willingness to collaborate on transitions program

**Service Timeliness:**

- Care continuity performance (RN in 24hrs, therapy 72hrs)

**Readmissions Performance:**

- HHA 30-day hospital readmission rates

**Two Post-Acute Providers Fulfilling Complementary Functions**

“[Home health agencies] have so many things to do to manage the patient’s condition that they often don’t have time to do the kinds of coaching that we do.”

*Chief Nursing Officer, Genesis HealthCare*
Pilot Results Promising

Heart Failure Specialist Drives Further Excellence

Medicare All-Cause Readmissions 30-Days from SNF Discharge

<table>
<thead>
<tr>
<th>Before Transitions Program</th>
<th>After Transitions Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Partnered with Medicare QIO\(^1\) to track performance

Medicare Heart Failure Readmissions 30-Days from SNF Discharge

Heart Failure Transitional Care Nurse

<table>
<thead>
<tr>
<th>Before Transitions Program</th>
<th>After Transitions Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-12%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Nurse specializing in heart failure patients drives extended performance

Before Transitions Program

After Transitions Program

Tactic #6: Develop Full Episode Support

Readmissions Reducing Through Transitional Care

Greater Baltimore Medical Center’s Transition Guide Program

GBMC

Johns Hopkins Home Care Group

RN, Critical Care Background

serves as transition guide, facilitating care transitions, patient coaching

Targets CHF\(^1\), COPD\(^2\) Patients

adding surgical site infection, other categories with expansion

Staffed by Home Health Agency

Staffing contract funds position as member of GBMC team, adding integrated, valuable patient service while fortifying preferred partnership

Strong Readmissions Results

(33%) Approximate impact on CHF and COPD readmissions

Source: Greater Baltimore Medical Center; Post-Acute Care Collaborative interviews and analysis.

1) Chronic heart failure.
2) Chronic obstructive pulmonary disease.
Enhancing the Entire Patient Episode

10 Tactics to Advance Care Management

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Chronic Disease an Ever-Present Risk

Six or More Comorbidities the Norm for Post-Acute Encounters

Medicare FFS Beneficiaries with at Least One Post-Acute Care Visit

By Number of Chronic Conditions, 2010

Medicare FFS All-Cause 30-Day Readmission Rates

By Number of Chronic Conditions, 2010

Tactic #9: Leverage Data to Manage Complex Disease

Predictive Analytics Enhance Disease Management

CareCycle Solutions’ VitalStation Telehealth Care Management Team

Care management team support patient via central call center in addition to HHA services

Multi-Source Data Visibility

- Telehealth units collect clinical indicators, update data daily to the VitalStation center
- Home health agency assessments feed up-to-date, comprehensive patient profile such as social risk factors, patient history

Critical Care Experience

- Nurses hired from critical care backgrounds
- Experience equips team to handle wider range of patient conditions and risk factors
- Background allows nurses to intervene before exacerbations lead to hospitalizations or ED visits

Patient Prioritization Analytics

- Predictive analytics platform allows critical care nurses to prioritize patients by risk factors and dynamic health metrics, improving efficiency and effectiveness
- Algorithm identifies patients trending toward adverse conditions based on predictive factors, rather than simply providing exacerbation alerts

Fewer Readmissions with Fewer Home Visits

Care Management Drives Efficiency for High-Complexity Population

30-Day Hospital Readmission Rate

<table>
<thead>
<tr>
<th></th>
<th>Pre-CareCycle Management</th>
<th>Post-CareCycle Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Espace Managed Care Plan</td>
<td>36%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Average Home Health Visits

<table>
<thead>
<tr>
<th></th>
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<th>Post-CareCycle Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Espace Managed Care Plan</td>
<td>16</td>
<td>4</td>
</tr>
</tbody>
</table>

2012, 30-day all-cause hospitalization rate, telehealth patients (high-complexity)

© 2013 The Advisory Board Company • 27604D Source: CareCycle Solutions; Post-Acute Care Collaborative interviews and analysis.

1) Home health agency.
Status Quo Reimbursement Limits End-of-Life Care

Medicare Comfort Care Access, Last Year of Life

1 year prognosis

6 month prognosis

End of Life

Aggressive treatment, hospitalizations without comprehensive care

Missed education opportunity thwarted timely hospice election

Unfulfilled Complex Care Needs

Hospice Services

No comfort care access

Hospice eligible

25%

Medicare costs incurred in the last year of life

Source: Post-Acute Care Collaborative interviews and analysis.

Tactic #10: Expand End-of-Life Care Access

Going Beyond Traditional Hospice Services

@HOMe Key Components

Advanced Illness Management Team Individualizes Care Model

• Always-available RNs, social workers, patient-family assistants and advocates, volunteers, others trained in Advanced Illness Management (AIM)
• Incorporates education and counseling, palliative care to tailor program around patient preferences
• Coordinates care with patient’s primary care physician

$3,416

Average total cost reduction per month

$3.5M

Savings delivered to Michigan Pioneer ACO

Franchising AIM: Model Scales Beyond Hospice of Michigan Service Area

• 50+ hospices in talks to franchise the model
• HOM Cares mobile app, which alerts client’s family members with updated information each time a staff member or clinician visits the patient, set to launch for licensing in late 2013

Source: Post-Acute Care Collaborative interviews and analysis.
Road Map

1. The Accountability Expansion

2. Building the Value-Based Care Management Network

3. Lessons from the Field: Profiling VNSNY

Today’s Speaker

Donna Lichti
VP Enterprise Market Development

- Leads business growth by promoting VNSNY as optimum solution to address customer needs
- Leads Enterprise Market Development, presenting “one face” representing all VNSNY services to hospital, physician, skilled nursing, and community customers

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

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

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
Referrers’ Care Management Expectations Rising

A Dual Imperative for Home Health Providers

Traditional Care Management Under Medicare Fee-for-Service

Care management capabilities leveraged for beneficiaries covered under Medicare Fee-for-Service

Care Coordination and Management Outside Core Patient Population

New expectation from hospitals to provide non-reimbursed population health management services, for broader range of patients

Creative Programs, Partnerships Key for Success

Thriving Under New Expectations

Creative Programs to Meet Demand

Develop innovative strategies to care for all patients for 30, 60, or 90 days—or even beyond—post-discharge

Payer Partnerships to Fill Payment Gap

Cultivate partnerships with payers, including managed care and ACOs, to generate payment to make programs sustainable
Three Components of Care Management

“Traditional” Care Management
- Core care management services during home health episode
- For Medicare Fee-for-Service CHHA patients

Population Care Coordination
- Ongoing telephonic, referral-based care management
- For patients under VNSNY’s health plan, outside traditional episode of care
- Commercial plans, ACO’s, Medicaid waiver programs

Transitional Care
- Bridge for patients from acute to post-acute care, or across post-acute settings
- For Medicare Fee-for-Service CHHA patients or patients under health plan

VNSNY’s Model of Care

Elements of VNSNY Model
- Risk stratification
- Comprehensiveness assessment
- Continuous care management, with emphasis on in-person home visits
- Collaborative relationships with hospitals and PCPs
- Teaching and coaching for caregivers
- Interdisciplinary team
- Transitional care
- Palliative care
- Information technology
- Frequent staff training on protocols and skills
Technology Links Caregivers, Information Across Continuum

Reach of VNSNY Technology

- VNSNY Services
- Care Management Components
- External Providers

Technology
- HIE
- Risk stratification tool
- Care management platform
- Community-based mobile alerts
- Mobile community resources

Sample Benefits of Cross-Continuum Technology

- Integrates data
- Reduces costs
- Enhances reporting
- Facilitates communication
- Ensures compliance

HIE Supports Timely Communication

Key HIE Functions

Secure Mailboxes
- Allow faster exchange of information, supports handoffs via secure texting

Patient Status Alerts
- Inform VNSNY in real time when patient is admitted to ED or hospital in real time

EMR to EMR Capabilities
- Use Delta and Altruista platforms to integrate with hospital EMRs and HIE

Technology in Brief
- Connected to several New York State regional HIEs
- Requires membership, not ownership, at a relatively low cost
- Able to integrate with EMRs via connecting platform
Risk Stratification Tool Identifies High-Risk Patients

Enables Determination of Appropriate Intervention

Risk Stratification and Alert Process in Brief

Admission:
Patient admitted to hospital or home health agency

Email Alerts:
Clinicians notified of high-risk patients, individual risk factors

Data Entry:
Patient information run through statistical model associating patient characteristics with hospitalization risk

Targeted Interventions:
Patient-specific risk factors addressed as appropriate

1) Statistical model developed using clinician input and historical data.

Real-Time, Automated, Mobile

Customize Notification Attributes Based on Use-Case, Patient Population

Push Notification Trigger Event Examples

- ED registration
- ED admission
- Inpatient admission
- Intra/inter-hospital transfer
- ED discharge
- Inpatient discharge
- Discharge to PCP followup, i.e. “Time for foot check”
- Discharge/admit to SNF/HHA

Customized Frequency

- In real time
- Once a day
- Once a week
- Once a month
Minimizing Acute Episodes with Risk Management

Sample New Patient Email Alert

To: dr.jones@vnsny.org
Date: Tuesday, September 14, 2012 3:02 PM
Subject: Hospitalization Risk Email Alert

The following patients were recently admitted to home health. Please review the risk scores. Click on the risk levels to see scores on individual risk factors.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Admit Date</th>
<th>Hospitalization Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>TC</td>
<td>9/13/2012</td>
<td>High</td>
</tr>
<tr>
<td>JM</td>
<td>9/13/2012</td>
<td>Low</td>
</tr>
<tr>
<td>AD</td>
<td>9/13/2012</td>
<td>Very High</td>
</tr>
<tr>
<td>SM</td>
<td>9/13/2012</td>
<td>Rising-High</td>
</tr>
<tr>
<td>CR</td>
<td>9/13/2012</td>
<td>Low-Rising</td>
</tr>
<tr>
<td>NM</td>
<td>9/13/2012</td>
<td>Rising-High</td>
</tr>
</tbody>
</table>

Hospitalization Rate of VNSNY Patients

32% Before Risk Model
24% After Risk Model

Representative Patient Risk Factors

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer: Private Insurance</td>
<td>NO</td>
</tr>
<tr>
<td>Payer: Other</td>
<td>NO</td>
</tr>
<tr>
<td>Caregiver</td>
<td>NO</td>
</tr>
<tr>
<td>Hospitalization Last 6 Months</td>
<td>YES</td>
</tr>
<tr>
<td>Pressure Ulcer: Not Healing</td>
<td>YES</td>
</tr>
<tr>
<td>Stasis Ulcer: Not Healing</td>
<td>YES</td>
</tr>
</tbody>
</table>

Care Management Platform Collects Patient Data

Enables Quick, Informed Decision-Making

<table>
<thead>
<tr>
<th>Information Collected from Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNSNY</td>
</tr>
<tr>
<td>Other post-acute providers</td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>Behavioral health organizations</td>
</tr>
</tbody>
</table>

Key Uses and Capabilities of Platform

Aggregates Data Feeds from Across Continuum

Inputs information from disparate providers into a single view; caregivers able to separate into individual components

Shows Patient Risk Score

Risk assessment tool and corresponding alerts to be built into, automated in technology

Identifies Gaps in Care, Needed Tasks

Enables caregivers to easily identify key patient needs not currently addressed, facilitate corresponding intervention
Traditional Care Management Component
Interdisciplinary Team Improves Collaboration, Coordination

Interdisciplinary Care Team Manager (ICTM)

Nurse  |  Therapist  |  Social Worker  |  Care Manager

ICTM Responsibilities
- Open CHHA episode
- Align staff to appropriate cases by analyzing patient metrics, identifying strengths and weaknesses on team
- Serve as central reporting mechanism for all team members
- Oversee care to ensure adequate quality

Benefits of ICTM Model
- Reduces siloes between team members
- Brings staff closer to patient experience
- Enables top-of-license practice

Transitional Care Component
Transitional Care Staff Provide Bridge Between Care Settings

Patient Prepares for Discharge  |  Providers Hand Off Patient Across Settings  |  Patient Adjusts to New Setting

• Assist in pre-discharge assessment of appropriate discharge setting
• Assist care managers in preparing patient for discharge
• Ensure smooth handoff, a high-risk point in transition episode
• Transfer patient information
• Set up first MD appointment following discharge
• Provide medication management and reconciliation
• Ensure self-management capabilities via patient and family engagement, education
• Red flags

Leverage new care management platform to consolidate data

Care coordination staff provide range of services to prepare and implement safe and timely passage from one setting to another
NP or RN-Led Transitional Primary Care Program

Health Plan Partnership to Offer Short-Term Care for High-Risk Patients

Key Elements of Transitional Care Program

Identify Patients at High Risk for Readmission
- Risk assessment tool categorizes patients as low, rising, or high risk for readmission
- Nurse-led interim care prioritized for moderate- and high-risk patients

Deploy NPs to Provide Interim Primary Care at Patient’s Home
- NP/RN visits patient in hospital before discharge and at least twice at home
- NP/RN develops transitional care plan that addresses psychosocial and other issues that often prevent patients from self-managing care
- Ongoing telephonic support

Coordinate Patient Access to PCP After Intervention
- Goal is to ensure patient has follow-up PCP visit within seven to 10 days of discharge
- NP/RN works jointly with health plan to find new provider for patients without timely access to PCP

49% Reduction in 30-day hospital readmissions

Population Health Coordination Component

Managing Three Distinct Populations

- High-Risk Patients: 5% of patients; usually with complex disease(s), comorbidities
- Rising-Risk Patients: 15-35% of patients may have conditions not under control
- Low-Risk Patients: 60%-80% of patients; any minor conditions are easily managed

Trade high-cost services for low-cost management
Avoid unnecessary higher-acuity, higher-cost spending
Keep patient healthy, loyal to the system
Low-Cost Management of High-Risk Patients

Care Managers Step Back to Remotely Manage, Rather Than Deliver, Care

Previous Model: Delivery

- Focused on direct provision of services to VNSNY health plan members
- Prohibitive costs required adoption of alternative model

New Cost-Saving Model: Management

- Telephonic care coordination used following initial in-person assessment
- Nurses coordinate self-management support and disease management activities
- Appropriate services offered through referrals to VNSNY CHHA or outside organization

Escalating Benefits to Expanded, Innovative Care Management

1. Improved Quality of Care
   - Lower readmissions via enhanced care management capabilities

2. Tightened Referral Relationships/Collaborations
   - Referral partners view VNSNY as integral referral partner, resulting in increase in referral volumes
   - Ability to expand current, develop new care management programs with partner support

3. New Partnerships and Revenue Streams
   - Innovative population health programs developed with ACOs, bundled payment participants, managed care payers
   - Open access to new revenue streams beyond Medicare and Medicaid
Leveraging Care Management Services to Build Strategic Referral Partnerships

Building the Value-Based Care Management Network

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