Care Integration and Network Models: How to Become a Player

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November 1, 2013

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I. The Changing Healthcare Landscape
The Healthcare World is in Flux & Change is Imminent

- Value-Based Purchasing
- Consolidation
- Declining Reimbursement
- More Patients at Risk
- Shared Risk
- Increased Competition
- Greater Application of Technology
- Evolving Models of Care
- Health Reform (ACA)
- Integrate Care for Duals
- Cross-Continuum Partnerships

Prevalence of Chronic Illness in U.S. Population will Continue to Increase

Population with multiple chronic diseases have greater risk of disability and greater need for care coordination.
The Need for Superior Care Management and Care Coordination is Growing

U.S. population is aging and chronic illness increases with age

High prevalence of comorbidities among the elderly make care management particularly important for this group

Controlling Spending is Vital

National Healthcare Expenditures 2012: 18% GDP = $3 Trillion
The Affordable Care Act & The Triple Aim

- Designed to be a collaborative process that focuses on receiving feedback from various stakeholders including payers, providers, and patients

II. VNSNY: An Integrated Care Delivery System
VNSNY is focused on vulnerable populations, those with Medicare and/or Medicaid, and special needs populations. VNSNY seeks to serve our patients because we have an opportunity to:

- Develop an innovative care coordination model
- Repair the fragmented care system
- Remove unnecessary utilization of services
- Better serve the poorest and sickest patients
- Improve consumer and family experiences
- Move furthest upstream

Opportunity to fill consumer niche as a low cost, high quality managed care plan, focusing on the medically frail and people with limited income.
Guiding Principles

- Offer benefits that improve access to appropriate care, including assistance with navigating an increasingly complex health care system
- Shift the focus of care from the institution to the home and community
- Target and customize interventions
- Believe care coordination is the cornerstone of all options and all members are provided with a care manager that facilitates integration across all care settings

The VNSNY Model of Care
The VNSNY Model of Care (Continued)

<table>
<thead>
<tr>
<th>Person Centered</th>
<th>Evidence Based</th>
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| • Holistic, integrative  
  – Physical, emotional, social, spiritual  
• Personal goal-setting  
• Address psycho-social complications  
• Self-management a key objective  
• Personalized plan of care  
• Culturally congruent  
| • Data collection and data mining  
• Timely and ongoing assessment  
• Protocols and best practices  
• Center for Home Care Policy & Research  
  – Proprietary Risk Stratification algorithm  
  – New Nurse Research Professor |

<table>
<thead>
<tr>
<th>Nurse Led</th>
<th>Mission Driven</th>
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</table>
| • Clinical expertise  
• Compassion + savvy  
• Embedded in community  
• Advocate  
• Navigator  
• Integrator  
| • History and legacy  
• Immersion in community (the new healthcare hub)  
• Dedication to most vulnerable  
• Expertise in high risk populations  
• Safety net  
• Public policy leadership |

III: Care Coordination in Practice
Care Coordination

Population-based management

- RN
- HHA
- MD
- OT
- PT
- Pharmacist
- Patient Population

Care Coordination in Practice

VNSNY BEHAVIORAL HEALTH PROGRAM

<table>
<thead>
<tr>
<th>The Patients</th>
<th>The Protocol</th>
<th>The Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Homebound Medicare patients admitted to VNSNY care and treated for behavioral health problems</td>
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<tr>
<td>- Depression strongly associated with falls, medical and functional disabilities, risk of rehospitalization</td>
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<tr>
<td>- Goal to help patients transition from acute care to home and community</td>
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<tr>
<td>- Risk assessment (predictive risk algorithm)</td>
<td></td>
<td></td>
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<tr>
<td>- Clinical assessment (medical, functional, psych)</td>
<td></td>
<td></td>
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<tr>
<td>- Teaching, self-management</td>
<td></td>
<td></td>
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<tr>
<td>- Cognitive behavioral therapy</td>
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<tr>
<td>- Psychotropic medication management</td>
<td></td>
<td></td>
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<tr>
<td>- Linking patients and families to community resources for ongoing support</td>
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<td></td>
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<tr>
<td>Depression reduced by 33% (GDS) and functional ability improved by 56% (ADLs) on average</td>
<td></td>
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</tr>
</tbody>
</table>
### VNSNY STERNAL WOUND INFECTION REDUCTION PROGRAM

**The Patients**
- From March through May 2013, 131 patients with sternal wounds
- A subset also given VNSNY Intensive Cardiac Rehab (ARB) in lieu of sub-acute care
- Average age 62
- Average over 5 comorbid conditions
- Risk of hospitalization moderate

**The Protocol**
- Confirms patient/caregiver receives printout of discharge medications
- Patient engagement and education in self care, especially hygiene
- Coordination of admission visit with PT if Intensive Rehab is ordered
- Orders pulse oximetry
- Ensures follow-up visit with cardiologist within 7 days, surgical team within 4-6 weeks
- Coaches patient/caregiver/HHA on early symptom management at every visit

**The Outcomes**
- One in three receiving ARB able to recover at home in lieu of sub-acute
- 100% of patients in intensive rehab show wound improvement
- Patients surpassed six of seven national benchmarks for essential quality of life functions (against CMS OBQI outcome measures)

### VNSNY INTENSIVE ORTHO REHAB PROGRAM

**The Patients**
- 510 surgery patients from January through June 2013
- Knee, hip and other joint replacements
- Averaged 5.3 comorbid conditions and 7.7 ADL’s needing assistance
- Over 75% had at least one risk for rehospitalization

**The Protocol**
- Intensive home-based therapy designed to mimic sub-acute care
- Includes PT up to six days per week and OT up to three days per week
- Home exercise program tailored to patient’s functional level and speed of recovery
- Nursing visits for post-surgical care and patient education
- HHA assistance according to functional need

**The Outcomes**
- Alternate, less costly site of care
- 30-day rehospitalization rate of just 2.8%
- Hospitalization rate of 2.7% compared to national benchmark of 22%
- Emergent care admission rate of 2% compared to national benchmark of 14.7%
- Significant improvement in all patient outcome measures (CMS OBQI Methodology)
## Care Coordination in Practice

### VNSNY CHF Transitional Care Program
(in collaboration with a New York City hospital)

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<th>The Patients</th>
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</thead>
<tbody>
<tr>
<td>Cohort receiving VNSNY Transitional Care were 43% less likely to be readmitted within 30 days</td>
<td>• Integration of caregivers into discharge and care plan • Education, self-management, coaching • Telehealth monitoring • Care Transitions Nurse dedicated to program • Scheduling physician appointment within 7 days • Nursing assessment of home environment • Medication reconciliation • Ongoing collaboration with community providers</td>
<td>• 223 Heart Failure patients receiving VNSNY Transitional Care protocol vs. 224 receiving standard home care • Patients average 79 years of age with 5+ comorbidities • High likelihood of rehospitalization based on proprietary predictive risk algorithm</td>
</tr>
</tbody>
</table>

### Transitions of Care

- **Patients**
- **Home Care**
- **Hospitals and Sub-Acute Facilities**
Health Risk Assessments

- Appropriately tailored care plan, lower rates of disenrollment
- High risk (plan uses this to stratify membership, utilizes RN to coordinate care)
- Post-discharge transitional care
Hospital to Home

What All These Programs Have In Common

- They break new ground
- They require collaboration and partnership
- They require new protocols
- They require new skill sets, training and education
- They invest in new ways to help our hospital partners send patients home more safely with better outcomes
IV: Market Opportunities: Moving Forward

Payment Innovation

**EPISODE OF CARE MODEL**
Healthcare services provided for a specific illness during a set time period

**Definition**
- Description
- Included Services
- Excluded Services
- Hardware, etc.

**Participating Providers Network**

**Compensation Model**

**Starting Point**
e.g. 30 days prior to the Date of Surgery

**Trigger Point**
Decision to initiate an Episode

e.g. 99 days following the Date of Surgery

**Stopping Point**

**Diagnostic**
30 days

**Event**
2-5 days

**Follow-up Care**
90 days

**BUNDLED PAYMENT**
Reimbursement to health care providers on the basis of expected costs for clinically-defined episodes.
Accountable Care Organizations (Continued)

“Menu” of Opportunities Through Which to Interface With ACOs:

- Governance
- Investor
- Care Coordination
- Nurse Practitioner Access
- Homecare
- Community Health Outreach and Education
- Primary Care
- Hospice
- Transitions of Care
- Health Promotion
Health Information Exchange

Menu of opportunities for HIE interface

- Care Coordination
- Back Office MSO
- Health Promotion
- Disease Prevention
- Wellness Intervention
- Screening
- Chronic Disease Management
- Alternative Therapies
- Mother and Child
- Community Relationships

V: The Future of Care Integration
The Industry Needs to Align Health Plan, Provider, and Beneficiary Incentives

HEALTH PLAN
- Accountability
- Reduced fragmentation
- Coordination of care
- Improve network access
- Expense management
- Superior quality
- Return on investment

PROVIDER
- Autonomy as a practitioner
- Revenue maximization
- Improve patient experience

BENEFICIARY
- Value
- Simplicity
- Improved health outcomes
  - Positive patient experience
  - Navigation in increasingly complex system
  - Advocacy
- Enhanced choice

Collaboration is Crucial
- Partnering / Coordinating with other healthcare entities and systems is and will continue to be essential as changes are absorbed from the ACA and the industry transitions further to Managed Care

- Medicare
- Medicaid
- MLTC
- Managed Care
- SNP
- FIDA
New Product Approaches to Coordinating Care

State Demonstrations to Integrate Care for Dual Eligible Individuals

- The Fully Integrated Duals Advantage (FIDA) program is a demonstration project in collaboration with NYS and CMS
- Integrates all Medicare and Medicaid physical health, behavioral health, LTSS, and transportation services
- A comprehensive benefit package that includes all Medicare and Medicaid medical, pharmacy, behavioral health, long term services and other supplemental benefits
- A model of care that incorporates both CMS and State requirements
- A comprehensive provider network that ensures access to Medicare and Medicaid services
- Fifteen states across the country were selected to design new approaches to better coordinate care for dual eligible individuals:
  - California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin

Partnerships Are Key

VNSNY Teams Up With Other Providers and Payers to Improve Outcomes, Costs and Readmissions

- New York-Presbyterian Hospital
  - Take Heart
- NYU Faculty Practice
  - Home Visits
- Empire BlueCross Blue Shield / White Plains Hospital
  - Transitional Care
- Mount Sinai
  - Sternal Wounds Program
- NYU Langone Medical Center
  - Bundled Payments
- Multiple Hospital & Skilled Nursing Facility Partners
  - Heart Failure Program
Recent Center for Medicare & Medicaid Innovation (CMMI) Award Application Submissions

VNSNY partnered with other organizations on 9 applications for CMMI Health Care Innovation Awards. Awards provide ~$1 billion to test new payment and delivery models aimed at driving health care system transformation, lowering costs, and delivering better outcomes.

<table>
<thead>
<tr>
<th>CMMI Project</th>
<th>Partner Organization</th>
<th>Description</th>
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<tbody>
<tr>
<td>VNSNY SPARK Program</td>
<td>Mount Sinai Medical Center</td>
<td>Referral of MSMC’s ACO patients to VNSNY’s SPARK community-based palliative care mgmt program</td>
</tr>
<tr>
<td>Mobile Acute Care Team (Hospital at Home)</td>
<td>Mount Sinai Medical Center</td>
<td>Payment and operational model for delivery of acute inpatient &amp; hospital-level care in the home</td>
</tr>
<tr>
<td>Accountable Care Community</td>
<td>Nassau University Medical Center</td>
<td>Leverage VNSNY Population Care Coordinators to support ACC partnership including social services</td>
</tr>
<tr>
<td>Cardiology/Oncology Specialty</td>
<td>NYU Langone Medical Center</td>
<td>Enhanced ambulatory care to cancer and heart failure patients</td>
</tr>
<tr>
<td>Hepatitis C Bundle</td>
<td>NYC Dept of Health</td>
<td>Bundled medical/behavioral health services for persons with HCV</td>
</tr>
<tr>
<td>WeCare Project</td>
<td>NYU School of Nursing</td>
<td>Healthcare portals for comprehensive dementia care</td>
</tr>
<tr>
<td>Reinventing EMS</td>
<td>Mount Sinai Medical Center</td>
<td>Transformation of EMS delivery model</td>
</tr>
<tr>
<td>Primary Care Information Project</td>
<td>NYC Dept of Health</td>
<td>Leverage VNSNY Strong Foundations in fall prevention screening</td>
</tr>
<tr>
<td>Pediatric Pt-centered Med Home</td>
<td>NYP Children’s Hospital</td>
<td>Expansion of PCMHs to children with special health care needs</td>
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