Roundtable on Innovations to Improve Community Health

Mary Ann Christopher, MSN, RN, FAAN

Name of project or collaborative

VNSNY Population Health Management Collaborative

Geography

Five Boroughs of New York City and Nassau, Suffolk, and Westchester counties

Brief description

Visiting Nurse Service of New York (VNSNY) is the largest free- standing home and community-based non-profit health system in the country, serving 71,000 people on a daily basis. VNSNY provides services in the five boroughs of New York City and Nassau, Suffolk and Westchester counties. We serve among the most culturally diverse communities in the nation, providing comprehensive home- and community-based programs to meet the diverse needs of our patients across the care continuum, improve their quality of life, and reduce the number and length of hospitalizations.

Target population/community:
At-risk sub-populations identified in the community with our partners; typically defined by the virtue of the specific cohort being addressed at a given time (e.g. inpatient unit, hospital, health system, individual, neighborhood, and/or membership in a health plan).

Health issue or condition that is the focus of the project/collaborative:
Frequently diagnosed chronic conditions and social determinants of health that lead to frailty, disease progression, hospital readmissions, and institutional care. Population health models have a long term impact of not just treating persons when they are sick, but also improving their overall well-being through disease prevention and rigorous care management.

Main strategies used by the project/collaborative:
VNSNY has established a population health division aimed at providing care coordination for at-risk populations throughout its geography. It employs a variety of methodologies, including transitions of care, health coaching, caregiver support, community-based peer workers, hot-spotting, motivational interviewing, behavior activation, readiness and confidence rulers, and a risk- adjusted dosing of interventions that includes face-to-face, telephonic outreach, and telehealth monitoring.

Applications of the collaborative include the Institute for Healthcare Improvement (IHI) / Rockaways Wellness Partnership (RWP) Initiative, an innovative, community based intervention for improving health of an ‘at risk’ community through proactive client engagement and self-empowerment by utilizing the Institute for Healthcare Improvement’s (IHI’s) Triple Aim framework, which targets better health, better experience of care, and lower cost.

A second example is our Post-Cardiothoracic Surgical Infection Prevention Program Partnership with major New York City hospital systems to reduce post-surgical cardiothoracic wound infections and other postoperative complications, increase patient satisfaction, and reduce avoidable admissions.

VNSNY has also secured sub-capitated arrangements with major commercial insurers to coordinate the care of their most vulnerable at-risk Medicare beneficiaries, effectively reducing first 30-day all cause readmission in order to achieve top decile performance levels and position our transitions of care approach as an effective modality for achieving the Triple Aim.

Simultaneously, we are executing and implementing a care coordination role for VNSNY in the downstate Performing Provider Systems (PPS) that have been developed to deliver services to New York State’s Medicaid population through the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP projects will focus on behavioral health, care management and transitions, chronic diseases, maternal

and child health, palliative care, primary care and emergency department services, and integration of behavioral and medical health.

We have also established Center for Medicare & Medicaid Innovation (CMMI) partnerships with hospital systems and community primary care physicians to develop a Behavioral Health Home for individuals with mental health and substance abuse disorders. A health home — as defined in Section 2703 of the Affordable Care Act — offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach linking patients and families to community resources for ongoing support. Our model employs psychiatric nurses, psychiatric nurse practitioners, and in-home visiting psychiatrists and aims to improve quality, lower costs, and centralize care management through teaching, self-management, cognitive behavioral therapy, and psychotropic medication management.

Partners/Sectors that are part of the project/collaborative:
VNSNY has partnered with Duke University and NYU College of Nursing to develop the core competencies with national recognition around the VNSNY Population Health Management program. VNSNY has also formed a partnership with Remedy Partners, a 'bundled payment company' established to help provider organizations develop and operate best-in-class bundled payment services.

Crucial Competencies:
Population health management, monitoring and tracking patient care goals and issues, integrating community resources, continuous quality improvement, evidence-based alerts and reminders, and clinical registries.

Duration/when it was initiated:
VNSNY's Population Health Management Collaborative was launched in 2013.

Relevance of project to this breakout session

VNSNY's Population Health Management Collaborative is a model for innovative, community based interventions which achieve the Triple Aim.

Results/outcomes

- Improvements in follow-up and compliance with treatment in cases of chronic disease
- Shift from acute care hospital setting to community wellness through health promotion and prevention
- Link enrollees to primary care, help them adopt healthy behaviors, and address mental health and substance abuse issues
- Reduce depression by 33% (GDS) and functional ability improved by 50% (ADLs) on average
- Reduced sub-acute facilities / hospitals
- Preliminary reduction in rehospitalizations trending at 25%
- Potential shared savings
- Meeting patient-centered goals and promoting care coordination amongst external community providers

Funding

The Visiting Nurse Service of New York has an annual budget of $2.3B and provides $30.3M in charitable care and community benefit, including direct home care services to more than 6,100 underinsured and uninsured New Yorkers. This is made possible by our at-risk population-based contracts with major payers and health systems, the NYS State Department of Health, and other generous philanthropic funding sources, including bequests that we receive from our many donors. Last year we made nearly 2.3 million professional clinical visits to more than 163,000 patients.

Contact

Mary Ann Christopher, President & Chief Executive Officer
MaryAnn.Christopher@vnsny.org.

Website: http://www.vnsny.org/community/in-the-community/community-programs