SUMMER 2017 | VOLUME 3, ISSUE 3

VNSNY TODAY

NEWS FROM THE VISITING NURSE SERVICE OF NEW YORK

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VNSNY care management provides specialized monitoring and support to patients admitted under value-based home care models. Above: A VNSNY nurse tends to a wound patient. Above left: Members of a VNSNY interdisciplinary care team convene to discuss their cases.

VNSNY Partners with Mount Sinai to Provide Community Paramedicine for Home Care Patients

When VNSNY call center nurse Wanda Lopez recently got an alert that a heart failure patient, newly discharged from Mount Sinai Health System (MSHS) to home care, was complaining of weakness and a severe headache, Lopez contacted Mount Sinai to arrange for a community paramedic to visit the patient's home. Finding the patient badly dehydrated, the paramedic used a special app to immediately set up a three-way video conference with the VNSNY call center nurse and a physician from Mount Sinai who is specially trained and certified in online medical control.

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New York State has mandated value-based purchasing for all Medicaid Managed Long Term Care (MLTC) plans by next year. Can you explain how this will work?

The state is requiring that all New York Medicaid MLTC plans convert their provider contracts—that is, their contracts with the licensed home care agencies who care for their members—into Level 1 value-based purchasing arrangements by December 31, 2017. That means the providers will have to meet the state's MLTC Category 1 quality measures, which cover things like frequency of patient falls and visits to the emergency room, patient satisfaction rates, and avoidable hospitalizations. The details are still being finalized, but they'll include some sort of bonus for meeting these measures and penalties for failing to meet them.

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The blizzard outreach is just one example of the attention given to patients admitted to VNSNY's care under value-based models. These patients fall into two categories—those in Medicare bundled payment models, which cover all medical expenses incurred during the 90 days following hospitalization, and those in private insurance case rate arrangements, where the coverage period is typically 60 days.

These models benefit VNSNY's referring providers as well. "Hospitals, sub-acute facilities, and physicians taking on population risk may take a financial hit if their patients get readmitted," Flannery explains. "As the agency caring for these patients following discharge, we're committed to seeing that doesn't happen." Since its expansion to other managed care plan populations early this year, adds Flannery, VNSNY's care management approach has already reduced hospital readmission rates by 5 to 10% for its case rate patient population.

To keep recovery of discharged patients on track and prevent readmissions, VNSNY's care management team employs an array of evidence-based protocols, starting with a comprehensive evaluation that includes screens for depression and anxiety, analysis of nutritional status and medication adherence, and an assessment of rehospitalization risk. Once a patient's formal home care episode is completed—usually after three to four weeks—the team continues to check in with each patient for the rest of the value-based period, monitoring key health parameters, confirming that medical equipment is in place and medications are being taken appropriately, making sure doctor's appointments are made and kept, as well as addressing dietary, behavioral, and social need issues, and intervening directly if a problem arises.

"Each value-based patient is assigned a care manager who coordinates the activities of the care team members," notes Rose Madden-Baer, Senior Vice President, Population Health and Clinical Support Services, who directs the program for VNSNY. "We may arrange for the patient to get an in-home visit from a nurse, social worker or nutritionist as needed, and we will also contact the patient's physician if certain warning signs occur." If a patient in a value-based arrangement shows up at an area emergency room or hospital admitting facility, the care management team gets an automatic alert, enabling VNSNY team members to reach out with alternative health services options that may prevent a hospital admission.

VNSNY care management provides specialized monitoring and support to patients admitted under value-based home care models. ***Right:*** *A VNSNY nurse tends to a wound patient.*

Besides taking all possible steps to prevent hospital admissions during the value-based care period, VNSNY's care management team also educates patients and connects them with resources to help keep them healthy once VNSNY is no longer supervising their care. "For example, we teach our patients and their family caregivers how to identify potential crises early on, so they can manage the problem with their doctor rather than go to the emergency room," says Joan Cassano, Vice President, Clinical Operations Improvement and Care Coordination. "We take our job very seriously—and that includes giving our clients the tools to stay out of the hospital once we are no longer caring for them directly in their home."

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During the encounter, the paramedic performed clinical and diagnostic assessments, including an EKG and blood glucose monitoring, and administered aspirin and intravenous saline solution under standing orders, resulting in symptom relief. The physician proceeded to complete a physical exam using the virtual technology and recommended the patient not be transferred to an emergency department (ED). Because the patient's pacemaker responded inappropriately to normal heart rhythm, the physician also recommended an appointment with her cardiologist. The next morning, a VNSNY field nurse followed up with a home visit to assess the patient and arrange for a cardiologist's appointment that day. Meanwhile, a potential crisis had been averted.

This coordinated in-home consultation is the centerpiece of a new Community Paramedicine collaboration between VNSNY and MSHS, in which specially trained community paramedics call on patients requiring immediate care—often avoiding the need for a trip to the ED that may otherwise have occurred. "Any patient discharged from Mount Sinai's Manhattan facilities to VNSNY Home Care in Manhattan is eligible for the program," explains Lorna Canlas, Project Manager with VNSNY's Solution Development group, who is overseeing the initiative along with Yaffa Vinikoor, Quality Manager for Strategy.

If a patient in the program contacts one of VNSNY's call center nurses with certain symptoms, an automatic pop-up in the system will prompt the nurse to activate the Community Paramedicine protocol. After arriving at the patient's home, the paramedic loops in the VNSNY nurse and a Mount Sinai physician associated with the program. "It's then up to the physician to decide whether home treatment will resolve the problem. If the physician decides that the patient does need ED level of care, the patient will be transported there by ambulance," says Canlas.

Of the 11 patients who have received Community Paramedicine visits since the program's launch this past April, all but three were successfully managed through the collaborative efforts of the VNSNY call center nurse, community paramedic and Mount Sinai physician.

The Community Paramedicine partnership is administered by Mount Sinai Health System's DSRIP (Delivery System Reform Incentive Payment) initiative through the Mount Sinai Performing Provider System (MSPPS), part of the statewide DSRIP initiative designed to reduce New York State's hospital readmission rates. As the first home care agency to participate in this program, VNSNY has worked closely with Mount Sinai to design guidelines and procedures. Rigorous quality reviews are done on each case, allowing the program to fine-tune its processes and optimize outcomes.

"We're thrilled to be partnering with VNSNY on this innovative program that combines home care and emergency medical service capabilities," says Dr. Kevin Munjal, Associate Medical Director of Prehospital Care and Clinical Champion for Care Transitions for MSPPS. "This collaboration demonstrates how health care professionals across the service provision spectrum can work together to optimize clinical care and patient experience."

In the coming months, VNSNY will be extending the program to its Bronx home care patients who have been discharged from Mount Sinai. "This is an emerging model, both in New York State and nationwide," notes Canlas. "It really represents a new paradigm in home health care."

A new collaboration with Mount Sinai connects VNSNY nurses, paramedics like the one pictured at left, and emergency physicians to provide in-home emergency care for patients in distress.

An Interview with the President of VNSNY CHOICE Health Plans

Dr. Hany Abdelaal Discusses Where Managed Long Term Care Is Heading

New York State has mandated value-based purchasing for all Medicaid Managed Long Term Care (MLTC) plans by next year. Can you explain how this will work?

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How is VNSNY CHOICE preparing for this shift?

We've developed a quarterly scorecard for the hundred or so licensed home care agencies we contract with, charting their performance on these quality measures, which we rolled out this year. We haven't set any target benchmarks for our providers yet—we're still testing the dashboard to get the metrics right—but we think this tool will be a great help in making sure our value-based purchasing agreements go smoothly once they're all in place.

How will you ensure these quality measures are being met?

On the member side, VNSNY's IT team has developed an amazing care management dashboard that monitors all quality metrics for everyone enrolled in any of our plans. This is a real-time dashboard that's updated daily. At any time, our assessment nurses and care management nurses can view quality measures across our different plans, including the metrics for different vendors, care teams, and individual clinicians and patients. It allows us to immediately spot any areas or individual members where quality metrics appear to be falling off, and move swiftly to address the issue.

Are there any other developments at CHOICE you'd like to share?

This past summer, we also launched an electronic assessment tool that can be used by all of our different vendors. It's a customized software platform, developed in collaboration with VNSNY's IT department, that incorporates our 20 years of experience in managed long term care. CHOICE is now using it with all of our Medicaid MLTC members as well as our dual-eligibility FIDA and Medicaid Advantage Plus members, to manage assessments and monitor utilization management more efficiently.

Do you think MLTC plans across the U.S. will continue to grow?

I do. Over a dozen states now have MLTC programs similar to New York's, and other states are following suit as they realize that helping seniors age in place in their own homes is often a better option than placing them in nursing homes. Not only does MLTC cost less than nursing home care, but people prefer it. Whatever happens with health care legislation, the future is all about managing the care of high-risk Medicare and Medicaid members. The best way to do this is through the kinds of high-quality, lower-cost home-based interventions that MLTC plans provide. And that's where VNSNY CHOICE is leading the way.

Partners in Care Home Health Aides Receive LGBT Cultural Sensitivity Training

As part of VNSNY's ongoing LGBT educational initiative, the nearly 10,000 home health aides in its Partners in Care division are each attending a specialized training session designed to raise their awareness of cultural issues and sensitivities around sexual orientation and gender identification. The training program, based on a curriculum developed by the SAGE (Services and Advocacy for GLBT Elders) organization, covers topics such as confidentiality, the need to avoid making assumptions about a client's partnership or marital status, an overview of LGBT history, and the use of gender-appropriate terminology with transgender patients and clients.

"The sensitivity training is being given as part of the aides' annual in-service training, and they report they're finding it engaging and informative," says Barbara Maccaro, Director of Quality Assurance and Education at Partners in Care. "We're currently conducting two training sessions a day. Our aim is to have 90 percent of our aides trained by the end of the year."

VNSNY's Home Care division and its Hospice and Palliative Care operations have already been awarded Platinum certification from SAGE, indicating that 80 percent of their employees have received SAGE training. Now Partners in Care, representing the paraprofessional part of the VNSNY workforce, is on track to earn that designation as well.

"Our goal is always to provide the very highest quality of care to our customers," notes Jennifer Rajewski, Senior Vice President of Partners in Care. "With this training, our diverse patient and client population can be confident they'll be treated with understanding, sensitivity and respect by all of our Partners in Care home health aides, regardless of their sexual orientation or gender identity."

VNSNY Shifts to HomeCare HomeBase EHR System

After an extensive review process, the Visiting Nurse Service of New York has announced that its home care and hospice operations will transition to a new electronic health records (EHR) platform, HomeCare HomeBase, starting later this year. Considered the industry leader, the cloud-based platform is currently used by 7 of the 10 largest U.S. home health and hospice providers. Its features include a flexible, intuitive interface that lets field clinicians, office staff, and physicians securely view and transmit real-time medical and scheduling information on their laptops, tablets or mobile devices.

"The HomeCare HomeBase platform will replace a number of applications that we currently support in-house, and serve as the host for a much easier-to-manage system," says Robert Plaszcz, VNSNY's Chief Information Officer.

VNSNY anticipates piloting the software for its Hospice and Palliative Care staff in November of this year. VNSNY's Home Care division will follow shortly thereafter, launching the EHR platform across its clinical and administrative operations in 2018. All employees will undergo comprehensive training in the new system prior to its rollout.

"Besides making our operations more efficient, the new platform will make it easier for our clinicians to document care in the home," says Susan Northover, Senior Vice President for Patient Care Services. "It will also enhance care coordination by allowing our interdisciplinary team to share patient information quickly and seamlessly."

Among other benefits, HomeCare HomeBase's integrated workflow processes will support in-depth note-taking and management reporting and result in streamlined approval, compliance and billing.

New Clinical Protocols Are Helping to Guard Against Opioid Overuse

With opioid addiction surging across the nation, VNSNY is implementing a series of cutting-edge programs across its business units to encourage alternative approaches to pain management, and to flag and address any cases among its patients or health plan members involving potential overuse of opioid medications.

"For home care patients who are referred to us following surgical procedures like hip or knee replacements, we're now urging their prescribing physicians to use non-opioid medications like ibuprofen and acetaminophen whenever possible, along with other modalities such as heat and ice, exercise therapy, meditation and massage," says Angela Barody, VNSNY's Vice President for Quality and Customer Experience. "And when patients are prescribed an opioid, we're advising their doctor to switch to a milder medication once the initial prescription is finished, so that no one is on opioids for longer than two weeks."

VNSNY has established an opioid reduction workgroup that is working with its Home Care division to finalize specific protocols in this area, notes Barody. In one change, clinicians are no longer automatically advising patients to take their pain medication prior to physical therapy sessions. "Instead, we're instructing them to assess patients' pain levels prior to each session, to see if medication is required," says Barody.

VNSNY is taking similar steps in its other business units. Its insurer arm, CHOICE Health Plans, has instituted a program that automatically flags incoming prescription requests for opioid medications that exceed a certain dosage. These prescriptions then require either a pharmacy override or prior authorization from the ordering physician before they can be filled. CHOICE has also implemented an Opioid Overutilization Intervention Program that identifies plan members who have received opioid prescriptions from three or more providers and three or more pharmacies over a 90-day period. The CHOICE in-house pharmacy staff then contacts the prescribers to verify that their prescribing patterns and dosages are clinically appropriate. If a CHOICE plan member does develop problems with opioid dependence, the CHOICE member may be referred to a multifaceted treatment approach that could include medications to counter opioid-related cravings.

"VNSNY's Partners in Care division is also working with our workgroup to adapt these reduction practices and to determine how their home health aides can assist in opioid reduction," adds Barody. "At the same time, a number of our Community Mental Health clinicians who work with clients struggling with opioid use have undergone training in how to reverse overdoses through methods such as Narcan." In addition, VNSNY Hospice and Palliative Care is working to educate families of its hospice patients about proper opioid disposal practices and is sharing this training with VNSNY's Home Care staff.

With all of these approaches, VNSNY is collaborating closely with its referring hospital partners. "Our partner hospitals have told us how important opioid reduction is to them, and we're pushing equally hard on our end," says Barody. "Because our field staff and care coordinators are in frequent touch with our patients and plan members, we're an ideal gatekeeper to help make sure opioids are prescribed responsibly, and that people only take them when they're really needed."

Cardiac Hospice Program Reduces Hospital Admissions and Improves Patients' Quality of Life

At 92, Pearl* is a prime example of how VNSNY's cardiac hospice program is giving patients a better quality of life in their final days. A resident of Manhattan's Upper East Side, Pearl recently had two valve replacement surgeries and lives at home, having learned to keep her heart failure symptoms in check. "She's the kind of woman who's made friends with the gardeners in Central Park," says her VNSNY Hospice nurse, Katarina (Katie) De Hoog. "Her doormen told me all they need to have a good day is to have her come down and talk to them."

Pearl's days aren't always lighthearted, of course. She tends to retain fluids, which causes shortness of breath, a symptom that can lead to acute anxiety and possibly other complications. VNSNY's cardiac hospice team is trained to manage such symptoms proactively and tamp them down quickly, so that patients like Pearl don't end up in the hospital—exactly where they don't want to be when trying to navigate their last months in serenity at home, surrounded by their loved ones.

"Our team monitors symptoms closely. Our hospice home health aides track changes to the cardiac patient's weight every morning to spot any fluid retention, and we check continually for normal breathing," explains De Hoog. Should a problem arise, Pearl's hospice team moves into high gear, immediately increasing diuretics and other medications that help with symptoms of shortness of breath, ordering more oxygen, and calling the patient's cardiologist if needed.

"It's about connecting the advanced heart failure patient with the right level of care," says Frances Dooley, a cardiac nurse practitioner and coordinator of VNSNY's cardiac hospice program. "Bringing a nurse trained in cardiac care into the home quickly is a key element," she explains. "Trying to talk patients through these symptoms doesn't work. You have to have a nurse there. If we intervene early, we can establish a trust that helps patients relax and become confident that they don't have to leave their homes to get treated."

When patients enter the cardiac hospice program, VNSNY works with them to develop their own hospice plan and goals using a team approach that includes spiritual counselors, social workers, nurses and physicians. The team encourages patients to put in place advance directives and maintains an ongoing conversation with patients and their families, teaching them how they can help manage symptoms at home. "For patients to continue meeting their goals of care, ongoing communication about their chronic illness with the hospice team is essential," Dooley notes.

Some 16 months after the VNSNY cardiac hospice program began, the program's admission rates are up—out of the 1,000-plus patients typically in VNSNY's hospice program at any given time, between 160 and 170 are now receiving specialized cardiac care—and hospital readmissions for this group are down significantly. "The program has definitely improved quality of care for our cardiac patients," says Dooley.

* *The patient's name has been changed for privacy.*

In VNSNY's cardiac hospice program, clinicians like hospice nurse Katarina De Hoog are trained to manage cardiac symptoms proactively, so that hospice patients don't end up in the hospital.