The Evolving HCBS Landscape: *Challenges, Solutions and Recommendations*

Carol Raphael
President & CEO,
Visiting Nurse Service of New York

The Hilltop Institute Symposium
Home and Community-Based Services:
Examining the Evidence Base for State Policymakers
June 11, 2009

Overview

I. VNSNY

II. Issues Confronting HCBS Providers

- A. Workforce
- B. Quality
- C. Financing
- D. Models of Care for Complex Populations
- E. Charitable Care and Community Benefit Commitment

III. Solutions at VNSNY

IV. Policy Recommendations

I. VNSNY

Who Are We?

- 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
- Provides a range of services to an average daily census of 30,000 patients, from newborns to seniors
- 12,660 employees

The "Henry Street Family" (*c.* 1900)

Visiting nurses in a row (date unknown)

II. Issues Confronting HCBS Providers

A. Workforce

- HCBS workforce is diverse – includes MDs, RNs, social work, rehabilitation, direct care workers, family caregivers
- Anticipated shortages in all disciplines
- Inadequate preparation to care for complex older adults
  - Monitoring for symptoms of decline
  - Geriatric knowledge base
  - Working as part of interdisciplinary team
  - Communication skills
- Roles of workers are changing
  - Tasks/procedures → Managing care, patient outcomes

Too few workers, inadequate preparation to meet future demand and need

Direct-Care Workers (DCWs)

- Current numbers already insufficient to meet demand; personal care aides and home health aides will be 2nd and 3rd fastest growing occupations between 2006 and 2016 (BLS)
- Training (initial and continuing) is minimal or nonexistent
- The job, as currently defined, leads to instability and turnover in workforce
  - Low wages, lack of benefits
  - Few advancement opportunities
  - Not integrated into clinical team

Family Caregivers

- Number is substantial and likely to increase
- Inadequate preparation
  - No training around managing patient transition back home, ongoing care
  - Confusion about community resources, options, financing and insurance
- Role must be recognized, supported and integrated with formal care system to minimize:
  - Burn out from day-to-day responsibilities
  - Potential loss of work time and income
  - Deterioration of caregiver health

B. Quality

Post-Acute Care

- Medicare CHHAs required to collect quality measures via OASIS assessment
  - Includes indicators of functional improvement, hospital admissions and ER visits
  - Incentivized through public disclosure (Home Health Compare)
  - P4P pilots emphasize reducing hospital and ER use
  - Population measured includes long-term care cases

End of Life Care

- Quality assessed against Perforum benchmarks
  - Incorporates indicators of patient and family experience
  - Qualitative scores (Excellent, Very Good, etc.)

Long-Term Care

- Population not expected to recover from chronic conditions or disability; little consensus among providers and payers on appropriate measures
  - Quality of life, prevention of decline, highest level of functioning, hospital and ED use
  - Process, patient experience
- Emphasis has been on regulatory compliance, nursing homes
- Opportunity to lay a foundation for future payment incentives and incorporate more consumer perspective in shaping LTC system

C. Financing

- Providers facing significant reductions in payments
  - **Medicare**
    * Home Health – deep cuts slated to help finance reform ($37 B over 10 yrs, 3.4% in 2010)
    * Hospice – 1.1% cut in 2010; rate increase lower than anticipated
    * Bundling proposal
  - **Medicaid** – cuts in NYS include no trend factor, gross receipts tax; no longer cost-based
  - **Managed Care** – rates do not cover costs; administratively burdensome; high rate of denials
- Difficult to restructure costs
  - Labor-dependent; little flexibility in employee compensation
  - Need for investments for future (e.g., technology)
- Financing for LTC is inadequate, with burden falling on individuals to pay out-of-pocket – impacts economic security

Little Integration of Financing for Short-term and Long-term Care Across Settings

- Frail elders have both acute and long-term needs
  - Medicare pays for hospital, short-term medical care
  - Medicaid pays for long term care
- Little or no coordination between two payers results in…
  - Expensive duplication of services
  - Considerable cost-shifting
- This drives poorer health outcomes (e.g., re-hospitalization)
  - Especially true for “dual eligibles”

D. Models of Care for Complex Populations

HCBS providers see a range of patients:

1. Independent with short-term, post-acute need
2. Chronically ill with mix of short- and long-term needs
   - Varying in severity of, number of co-occurring conditions
   - Varying in degree of functional impairment
3. End-of-life
   - End of chronic illness
   - Acute and terminal illness

No one care model or program will fit all

- The most complex patients account for the lion's share of a provider's resources
  - High cost, high utilization, high risk
  - Rarely have only one diagnosis; co-occurring medical, mental and cognitive disorders
  - Often have chronic, progressive diseases with acute exacerbation
  - Care at many sites, by many physicians
  - May need medical and supportive services over long-term
  - Often are dual eligibles

E. Community Benefit and Charitable Care Commitment

- As a not-for-profit, VNSNY is committed to:
  - Serving the uninsured and under-insured
  - Community benefit initiatives
  - Being a safety net provider
- In 2008, VNSNY contributed $28.6 M in community benefit activities

III. Solutions at VNSNY

Workforce Development

- Improving retention, long-term commitment of workforce
  - Focus on high quality hires with good fit
  - Upgrading paraprofessional workforce
- Preparation and training
  - CHAMP/“Geriatric Framework” Project
  - Hospice rotations for MDs
  - Clinical rotations for RN students
  - BSN Internship Program
  - Adjunct faculty, distinguished lecturers
  - PHI Program
- Fostering teamwork

VNSNY has reputation as an “employer of choice.”

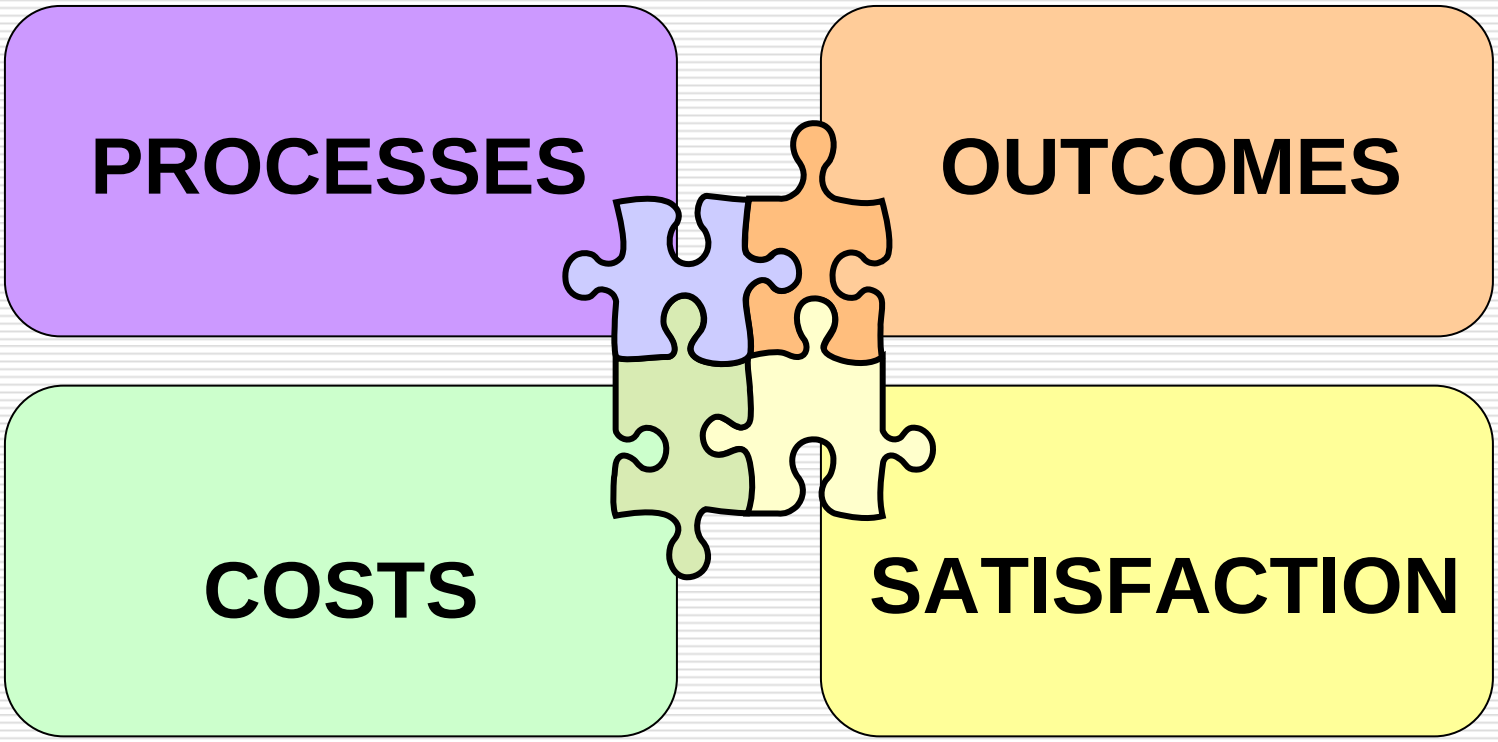
- RN COC turnover rate was 7.7% in 2008 (compared to 9.1% in hospital RNs [GNYHA])
- 2008 Employee Survey found overall satisfaction and employee commitment to be significantly higher compared to previous years and national health care average
- Employer recognition awards

Quality Infrastructure

- ✓ Board and top leadership involvement
- ✓ Performance measurement system
- ✓ Practice improvement
- ✓ Information technology support
- ✓ Incentives
- ✓ Data, analysis, action

Performance Measurement System

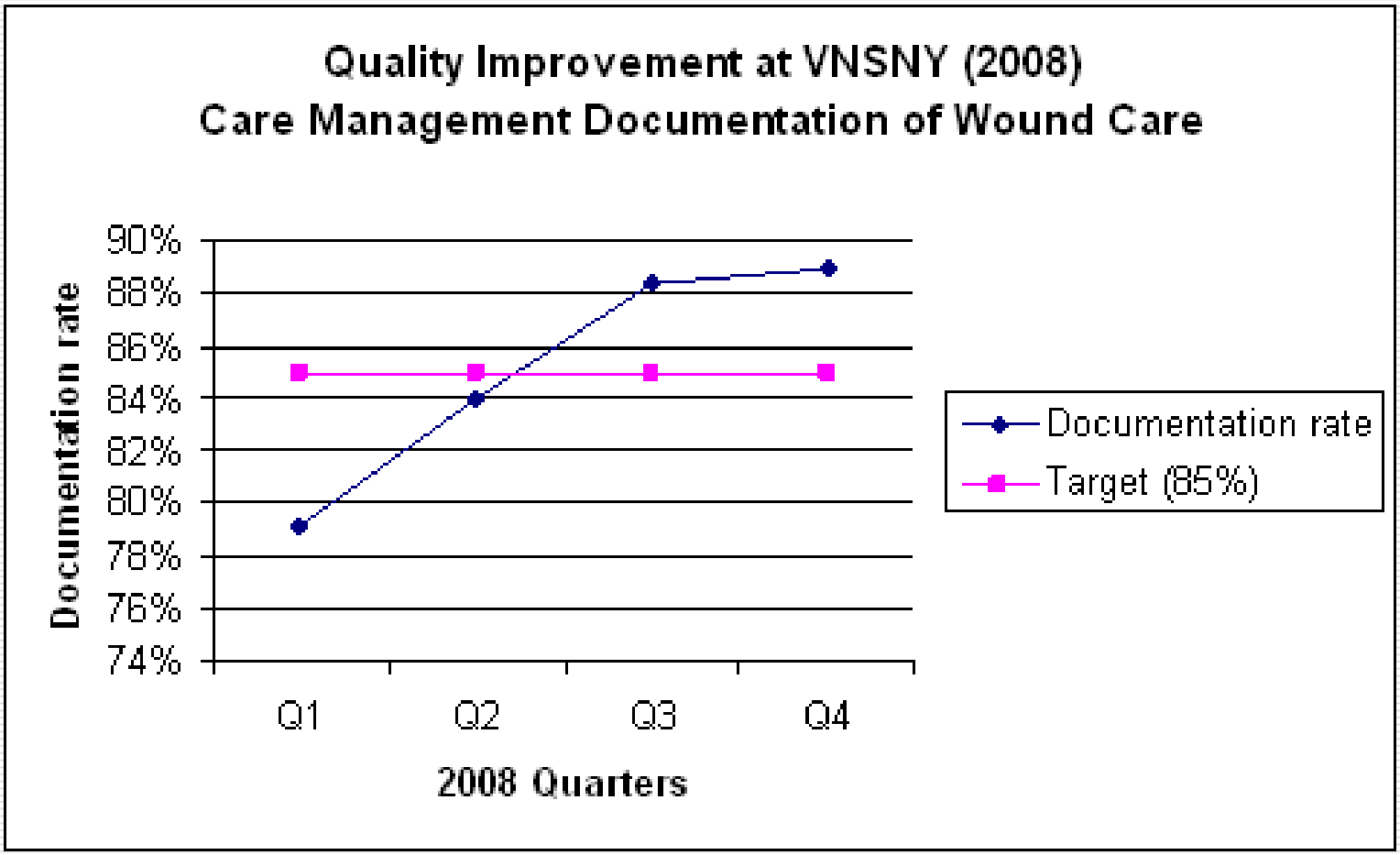
REGULATORY COMPLIANCE



Outcomes website provides actionable feedback to staff.

- Accessible to VNSNY staff via web
- Provides a variety of reports for clinicians, such as reports on patient characteristics, utilization, census, key clinical indicators, quality scorecard measures, learning collaborative results/feedback, patient satisfaction
- Reports can be drilled down to programs, regions, teams – so that the outcomes can be used immediately for staff management, feedback and improvement

Improvement Over Time



Innovations in Caring for Complex Populations

- Targeted models that span continuum of individual needs, e.g.:
  - Aging in Place Programs
  - Transitional Care
  - Health Plans
  - End-of-Life Care
  - Family Caregiver Support
  - “Right Program, Right Time”
- Technology

Aging in Place Programs

- VNSNY Congregate Care provides education and care management at a variety of housing sites
  - Present in 31 of 44 NORCs in NYC, lead organization in Chinatown NNORC
- Community Connections TimeBank is a strength-based model that recognizes value of older people and creates a community support network

Goal is to move upstream to prevent disability, support healthy aging, help seniors remain in their communities

VNS CHOICE Health Plans

- Medicaid MLTC
  - Nursing home-eligible population
  - Covers LTC and supportive services across sites to help member remain in the community
  - Capitated premium not adjusted for individual risk or provider case mix
- Medicare Advantage SNP
  - Dual eligible population
  - Goal is to ensure regular source of primary care, coordinate primary and specialist care, reduce hospital and ER costs
  - Risk-adjusted premium

VNSNY health plans focus on care management, identifying a medical home for every member, sharing clinical data, establishing strong provider network

- Integrated MLTC + MA Plan
  - VNSNY working with NYS to establish
  - Would be a lab for testing integrated care delivery and financing across all settings for complex population
- Potential:
  - Clear accountability – single entity responsible for member outcomes, primary, acute, post-acute and long-term care
  - Aligned incentives, mitigation of cost- and site-shifting
  - Shift to longitudinal perspective on patient care

Transitional Care

- Identify patients at high risk of re-hospitalization
- Focuses on the first 30 days after discharge from hospital
  - Emergency response plan
  - Reconcile medications, simplify regimen
  - Ensure that first F/U physician visits is scheduled
  - Implement home care treatment plan
  - Plan in advance for discharge from home care to community or long-term care
- Crosses sites and disciplines

Goal is to manage vulnerable transitions, reduce number of handoffs, avoid preventable re-hospitalization during home care episode

End-of-Life Care

- VNSNY Hospice Care is the largest provider in metro NYC, where hospice is underutilized
  - Hospice Residence
  - Advanced Illness Management Program
  - SPARK

Goal is to expand reach of hospice approach to end-of-life care by increasing awareness, availability and utilization

Family Caregiver Support

- Efforts underway to better integrate caregivers into care team:
  - UHF Home Care "Bundle" – being piloted in Nassau region and Visiting MDs program
- Under consideration:
  - Respite care
  - Caregiver assessments
  - Caregiver training
  - Resource directory
  - Telephone reassurance

Targeting: “Right Program, Right Time”

- Internal system for assessing long-term needs of VNSNY’s short-term patients and matching to appropriate programs
  - Personal care
  - Lombardi waiver program
  - Long-term managed care
  - Hospice

Technology as a Platform for Integration and Care Management

- Electronic Health Records (EHRs)
- NYCCHIP
- Regional Health Information Organizations (RHIOs)
- Telehealth

IV. Policy Recommendations

What can HCBS providers do in the short-term to weather the challenging financial forecasts?

- Restructure costs
- Reduce overhead
- Consolidations
- Telework
- Improvements in productivity
- Greater application of technology

In the longer term, payment policy must support development of sustainable, scalable home and community-based care models.

- Risk adjusted payments
- Recognition of different organizational entities in an integrated delivery system in the chronic and long-term care space
- Support for “health care home” that is based in an organization that is a cross of traditional home care agency and community health center
- PPS – across the board
- Payments tied to quality of care
- Stabilization of workforce through targeted wage pass-throughs