



**New York State Department of Health
Medicaid Incentive Payment System (MIPS)
External Stakeholder Feedback**

Visiting Nurse Service of New York

February 19, 2010 | 11:30 a.m.-12:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Visiting Nurse Service of New York. Comments were received on February 19, 2010, at the NYS Department of Health in Albany, NY. The Visiting Nurse Service of New York offers a wide range of home health-care services, including medical nursing, management of chronic conditions, and care to meet the needs of every generation, from at-risk infants to those at the end of life. The Visiting Nurse Service of New York provides services to residents in Manhattan, Brooklyn, Queens, Bronx, Staten Island, Nassau County, and Westchester County. In attendance were:

New York State Department of Health – Office of Health Insurance Programs

James J. Figge, M.D., M.B.A., Chair Medical Director
Phyllis E. Johnson, HIT Policy Coordinator

Visiting Nurse Service of New York

Elizabeth L. Buff, Sr. Vice President for Quality
Thomas Check, Sr. Vice President and CIO
Judy A. Farrell, MPA Associate Director of Government Affairs

New York State Technology Enterprise Corporation (Program Consultants)

Jack Menzies, Information Security Consultant
Donna O'Leary, PMP, Program Consultant
Peter Poletto, Account Executive



Visiting Nurse Service of New York (VNSNY) - Background

The Visiting Nurse Service of New York is the largest not-for-profit home care provider in the country. With more than 3,500 nurses and therapists, all throughout New York City, Westchester, and Nassau Counties, they serve more than 30,000 patients, more than all the hospitals in New York City, on any given day. A mobile workforce with computer

The VNSNY cares for more than 30,000 patients at any given time.

technology makes it possible. With 138,000 patients a year, as many as 22,000 different physicians are signing orders. This requires a great deal of coordination with physicians and other providers. Subsequently, the VNSNY collects *a lot* of patient information.

“Because we have so much patient information, we're able to analyze it currently and retrospectively,” says Thomas Check, Sr. Vice President and CIO for the VNSNY. “To find the most effective clinical interventions, we make sure the care we're delivering to the patient meets quality standards, which makes us a good partner for demonstrations.”

The Case for Home Care and Information Coordination

A large number of VNSNY patients are Medicaid beneficiaries with complex medical needs and multiple chronic conditions. Patients require treatment for more than one condition, hence the need for home care. To understand these conditions and apply evidence-based practice, interventions, and assessment, all VNSNY nurses have laptop computers, as do rehab therapists and social workers.

With so many patients, in so many locations, with innumerable conditions and care plans, maintaining patient health status is critical. Core to that maintenance is a patient-centered medical home. The VNSNY can often fulfill many of the functions of the patient-centered medical home, where a physician is formally providing that structure.

“We see the patient-centered home as an opportunity to improve outcomes and reduce utilization by coordinating the care using evidence-based practice and engaging the patient.”

Thomas Check

RHIOs and the Case for Sharing EHR

Regional Health Information Organizations, a product of previous New York State EHR funding, serve as regional providers of EHR transactions and database management. This just-in-time service is a lifeline between the VNSNY and its patients.

“We are members of four RHIOs in New York City, as well as LIPIX on Long Island,” says Thomas Check. “We’re finding that connecting through those RHIOs is more effective for the provider, and we believe it will also be a more effective way to disseminate material through the state enterprise service bus. And it’s actually one of the things I think the RHIOs can excel at.”

“We know that our patients see value in health information exchange.”

Thomas Check

The local focus of RHIOs makes them a perfect match for the VNSNY’s care plans and patient demographics. The RHIOs are able to work collaboratively with the VNSNY and others, making the implementation of EHR a solid map point on the horizon. One example would be patient consent to merge their information into the greater universe of EHR, RHIOs, and the like. The VNSNY was able to negotiate a common consent form among four RHIOs. In turn, this makes patient participation easier.

Ninety percent of VNSNY patients see value in health information exchange. Among patients in long-term Medicaid-funded programs, ninety-five percent agree to share their information. To-date the VNSNY has submitted data on more than 70,000 consented patients.

Patient Centered Medical Homes –Home Care Implications

VNSNY patients have complex needs; they are more susceptible to condition deterioration, inpatient admissions, and Emergency Department (ED) visits, all of which can be expensive and can actually complicate their condition. If a patient enters the ED and the physician does not know the patient's history, it's hard to get the right intervention.

“During a homecare episode, we’re in the home seeing the patient much more frequently than the patient is going to be in the doctor's office, so we’re getting more real-time information. We’re giving more current intervention and coaching to the patient.”

VNSNY Staffer

Fully half of all VNSNY patients have had data uploaded to the regional RHIO from more than one source (hospital, medical center, community health center), so it's clear that people are getting care from more than one location.

A Patient-Centered Medical Home (PCMH) is one solution worth investigating, and experience suggests that the VNSNY has the background to fill this need. Fully half of all VNSNY patients have had data uploaded to the regional RHIO from more than one source (hospital, medical center, community health center), so it's clear that people are getting care from more than one location. The PCMH acts as the catch-all for these patients, or as Thomas Check puts it, "Mostly we see the patient-centered home as an opportunity to improve outcomes and reduce utilization by coordinating the care using evidence-based practice and engaging the patient."

Keeping a PCMH up-to-date requires constant monitoring; intermittent notes from a primary care physician or a specialist are too few and far between. Here, home-care providers are especially important. During a home-care visit, providers are in the home seeing the patient much more frequently, getting more real-time information, giving more current intervention and coaching. For example, among the first things a VNSNY provider does is complete a medical reconciliation. A home-care patient may have numerous prescriptions from numerous providers. The VNSNY nurse enters those into the tablet computer, where software runs a review for potential conflicts. Further consultation with the physician resolves any issues with the regimen.

The Transitional Care Model – VNSNY's Approach for Planned Care

The VNSNY's Transitional Care Model is a plan for providing care to a patient as he or she moves from one setting to another. Typically, this move is from the hospital or ED to home, a nursing home, or a long-term care setting. Or, the patient may simply be moving from independent living into a new home with a loved one. Regardless, a great deal of information must move with the patient. What level of care was provided in the clinical setting? What were the discharge orders? Medications? As Elizabeth L. Buff, Sr. Vice President for Quality for the VNSNY puts it, "From the patient's perspective, why did they go to the hospital? Often what we see is a diagnosis that isn't related to what the patient believes they went for. And that often helps us understand what we need to do for interventions."

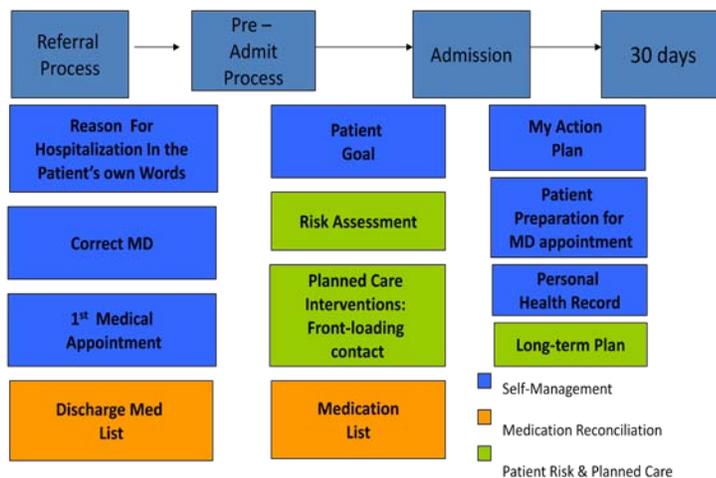
The Transitional Care Model has three components: 1) self management, actions the patient is ultimately responsible for; 2) medication reconciliation, includes medication lists and discharge medication lists; and 3) planned care, like risk assessments and long-term planning. The last two components likely involve several providers, such as hospitalists and specialists; all the clinicians involved with caring for the patient. The flow of information, *timely* information, is critical for care and avoiding rehospitalization. For

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Elizabeth Buff

example, the admitting physician may not have written the discharge plan, and the physician doing follow-up will almost certainly be a third player in the process. Literature has shown that if a patient receives a follow-up appointment within the first two weeks of discharge, rehospitalization is avoided. “So, we want that appointment,” remarks Elizabeth Buff. “And particularly for our Medicaid recipients who are taken care of,

VNSNYS' Transitional Care Model



in large part, by hospital practices. We need to know who the doctor is.”

Among the more critical pieces of information that care givers need is the patient's medication list. Ideally, the patient has this list, but that's not always the case. Having this information available via EHR is one solution. Further, care plans and symptom management strategies, all the information a patient needs, could be readily available to the home care professional via EHR.

Ms. Buff explains, “Within the first thirty days of the transition, we work with the patients and give them the tools to avoid going back to the hospital. We help them prepare for their physician visits, with items like their medication list and care plan. And we have found the communication between the patient, our clinicians in the field, and others is the right mix for patient care and planning. It just would be wonderful if it was all electronic communication from provider to provider and to patient. I can't think of a better way.”