Discussion of NY Medicaid HIE/MITA Enterprise Architecture under ARRA

February 19, 2010

Visiting Nurse Service of New York

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Overall Comments

VNSNY is very supportive of the goals and priorities in New York Medicaid's Enterprise Architecture – Using ARRA Funding to Improve Care for Medicaid Beneficiaries. Specifically, VNSNY:

- **Is committed to improving outcomes and reducing costs for these beneficiaries. The facilities outlined by NYS DOH will promote these goals.**
- **Encourages engaging RHIOs to enable the information exchanges outlined in the Enterprise Architecture, drawing on the policies of the Statewide Collaboration Process, and using the capacity funded by CMS in the State HIE and RHITEC awards.**
- **Recommends engaging homecare providers in clinical information exchange in support of the Patient Centered Medical Home.**

We also have specific questions about the HIT incentive payments for Nurse Practitioners at VNSNY.

Background on VNSNY

VNSNY provides post-acute and long-term homecare and care management services for Medicaid beneficiaries with complex medical needs and multiple chronic conditions.

• Care management and care coordination, evidence-based practice, and patient education can improve health outcomes, reduce utilization of services, and reduce costs for these individuals and populations.

• These patients benefit greatly from a Patient Centered Medical Home.

VNSNY is the largest not-for-profit homecare provider in the United States:

• On any given day our more than 3,500 nurses, rehab therapists and social workers serve over 30,000 patients in their homes in New York City and Nassau and Westchester counties, and more than 138,000 patients each year. In 2008, 22,000 physicians signed medical orders for these patients.

• We have extensive clinical collaborations with other providers across the continuum of care throughout our service area.

• We have robust capacity to capture and analyze clinical and operational data and quality measures.

• VNSNY offers and ideal laboratory to develop, apply, and evaluate new approaches before extending them more broadly.

Background on VNSNY (cont.)

VNSNY serves Medicaid beneficiaries in programs funded by Medicaid and in programs funded by Medicare:

- **The Managed Long Term Care (MLTC) and Long Term Home Health Care (LTHHC, or Lombardi) programs serve only Medicaid eligible patients – with a census of over 7,000 and over 3,600 patients respectively.**

- **The Acute Care and Congregate Care programs serve Medicaid beneficiaries in episodes reimbursed by Medicaid, and in post-acute episodes reimbursed by Medicare. On a typical day we provide Medicare post-acute services to over 700 patients who are also members of our Medicaid MLTC program.**

- **The Hospice program serves Medicaid beneficiaries with a Medicare benefit.**

- **VNSNY also runs a Medicare Advantage Special Needs Plan for Medicare beneficiaries who are dually eligible for Medicare and Medicaid. Their medications are covered by Medicare Part D rather than by Medicaid.**

Homecare and care management services in these programs improve health outcomes for Medicaid beneficiaries, drawing on both Medicaid and Medicare reimbursement. Clinical data from both Medicare- and Medicaid-covered services is needed to develop a complete medical understanding of the patient.

VNSNY's engagement in HIE was discussed in a presentation on January 11.

Benefits of Using RHIOs in the Exchange

The HIE/MITA Enterprise Architecture document presents several exchanges that can be facilitated by RHIOs.

- **In the areas of New York State served by the 13 existing RHIOs, providers can exchange data with the RHIO, and the RHIO can communicate with the MITA Enterprise Service Bus. This can simplify connectivity for the providers and facilitate the rollout of new functionality throughout the State.**
- **The Statewide Collaboration Process (SCP) has already addressed many challenging pre-requisites such as Consent, Authentication, and Security.**

VNSNY is a founding member of four RHIOs in our service area: NYCLIX, BHIX, the Bronx RHIO and the Interboro RHIO. VNSNY submits now or by end of Q1:

- **Patient demographic data, including insurance**
- **Current medications – will be in NCP format in Interboro RHIO by end of Q1**
- **Lab results – test name, date, results, normal ranges, LOINC coding**
- **Diagnoses – in ICD 9 format**
- **Dates of service**
- **Patient consent for provider's access to data through the RHIO**

Benefits of Using RHIOs in the Exchange (cont.)

The SCP has developed common standards for patient consent:

- **The patient provides written (or on-line) consent for the provider to access his/her information through the RHIO, including sensitive data such as HIV-related, mental health, alcohol and substance abuse. Consent for minors has not been fully resolved.**
- **VNSNY now uses the same consent form for all of our patients and all four RHIOs (see handout).**
- **Patients see the value in HIE, and grant written consent in large numbers:**
  - **At VNSNY, 90% of patients grant consent and 10% withhold consent.**
    - **Among our patients in long-term Medicaid-funded programs (MLTC and LTHHC), 95% grant consent and 5% withhold consent.**
    - **To date, VNSNY has submitted data of 70,000 affirmatively consented patients to the RHIOs we participate in.**
  - **Of patients who make a consent decision at NYU, Mount Sinai and St. Vincent's Hospitals, 80% grant consent and 20% withhold consent.**

Engaging Homecare to Support the PCMH

Medicaid beneficiaries who require homecare services tend to have complex medical needs and multiple chronic conditions, making them more susceptible to ED visits and inpatient hospital admissions.

• EG: NYCLIX now contains patient data from VNSNY, a community health center, and eight academic medical centers. Of the more than 72,000 patients whose data VNSNY has submitted to NYCLIX, 50% also have data in NYCLIX from one of these other providers.

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Engaging Homecare to Support the PCMH (cont.)

The PCMH can improve outcomes and reduce utilization by coordinating care among providers, applying evidence-based practice, and engaging the patient in his/her own health maintenance. A cornerstone of PCMH is communication among providers and exchange of the patient's clinical information.

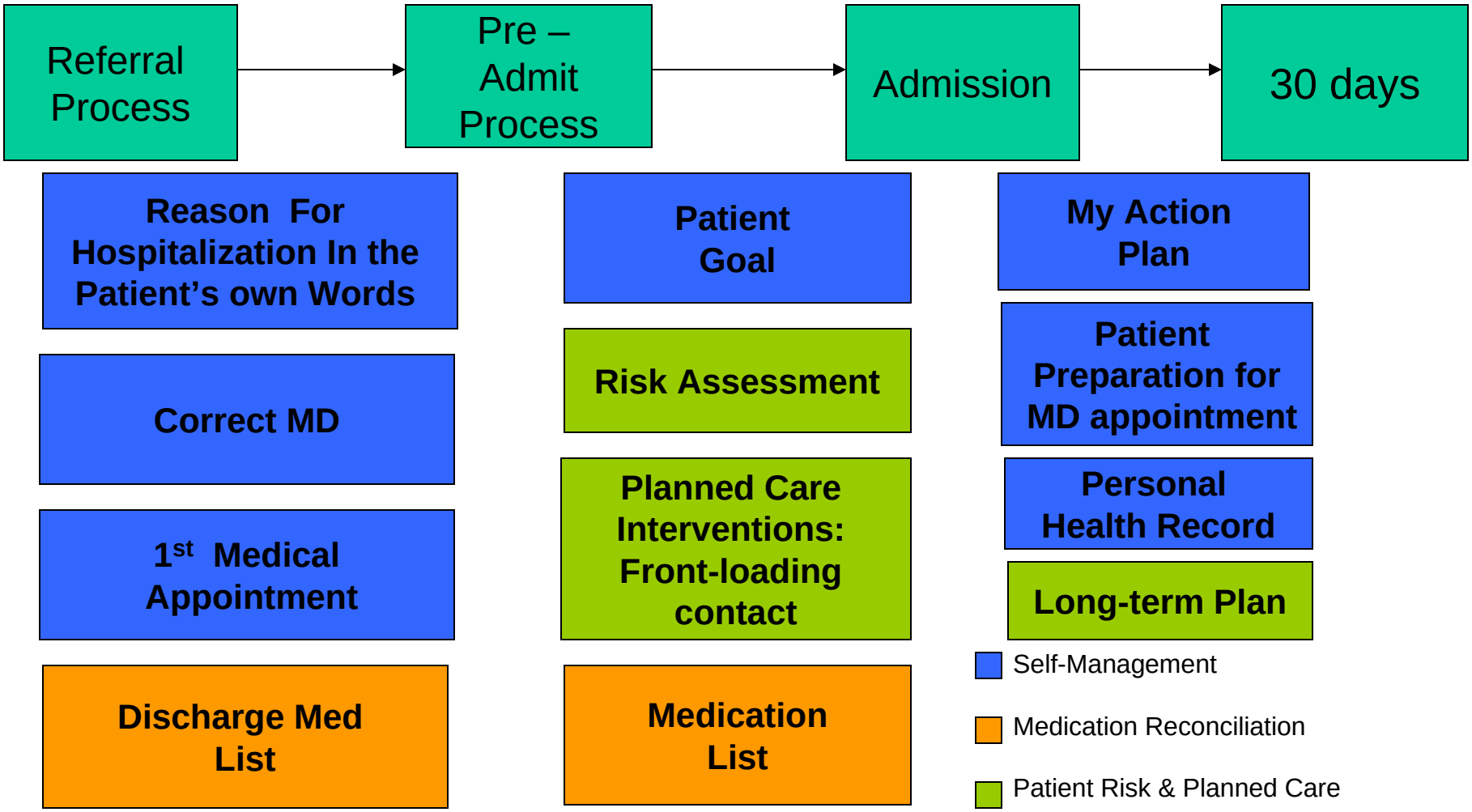
- **The homecare provider is a key participant in the PCMH. The frequency of homecare visits ensures extensive and current clinical assessment and facilitates intervention before the patient's condition deteriorates.**

    - **EG: the medications reconciliation at the start of care ensures that the patient is following the correct medication regimen. The nurse enters all of the patient's actual medications into the tablet computer, runs Drug Utilization Review (DUR) software to detect potential conflicts, and resolves the conflicts with the physician. The nurse then provides a complete list of the correct medications to the patient and his/her healthcare providers.**

- **The key elements in the Transitional Care model, which VNSNY follows whenever the patient experiences a change in setting (EG: hospital to home), are shown in the following slide.**

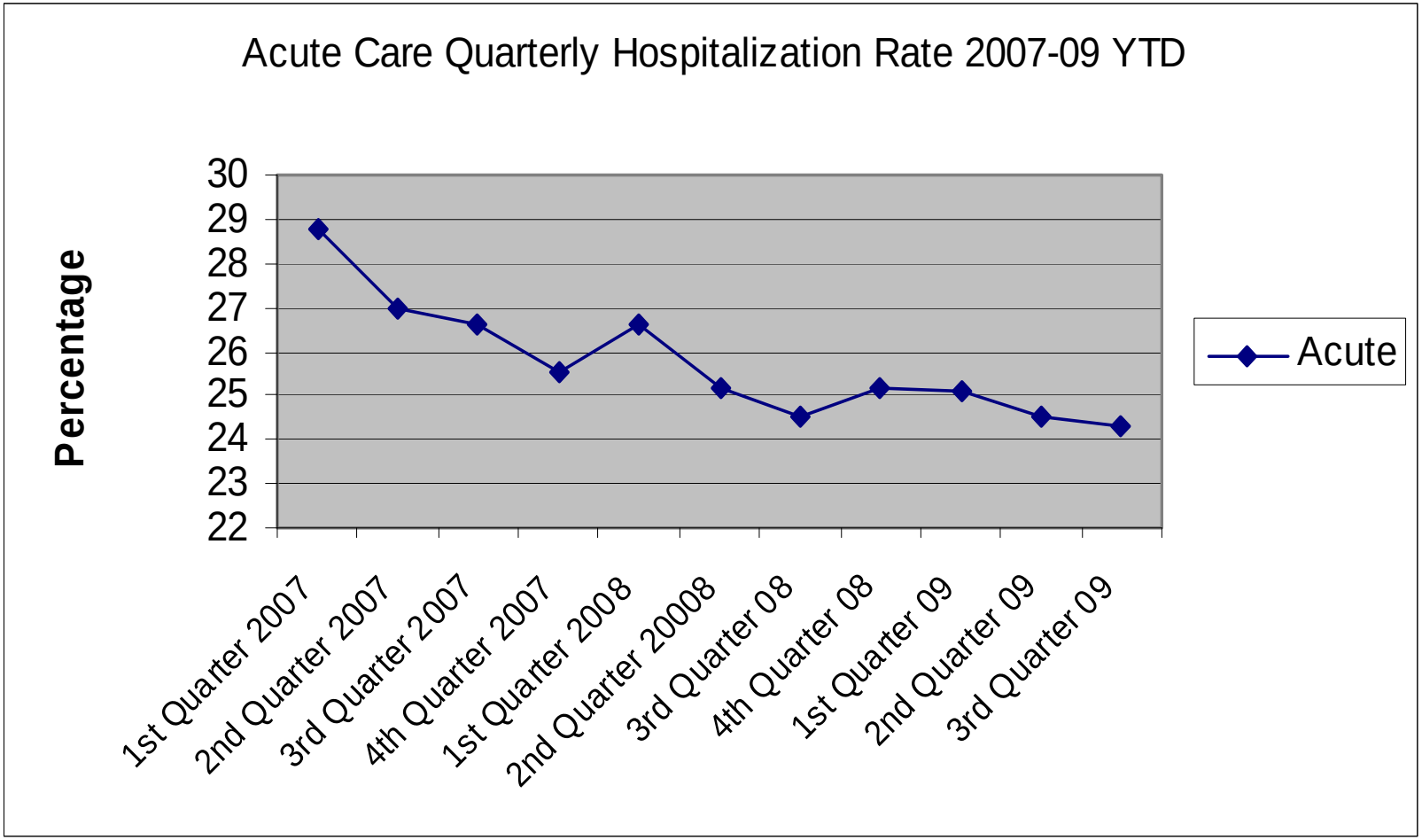
Engaging Homecare to support the PCMH (cont.)

The Transitional Care Model



Engaging Homecare to Support the PCMH (cont.)

Decline in Hospitalization Rate since Initiation of Transitional Care Model



Engaging Homecare to Support the PCMH (cont.)

Information in the HIE/MITA Enterprise Architecture is of great interest to VNSNY for better care management of both our homecare patients and for the dually-eligible members of our Medicare Advantage SNP:

- **Pharmacy claims data, including prescriber and pharmacy.**
- **Prior ED visits and hospital admissions, dates and diagnoses.**
- **Clinical Risk Group (CRG) classification.**
- **Lab tests including name, results, normal range, and date. LOINC coding would be especially helpful.**
- **All of the above should include HIV and mental health services.**

Engaging Homecare to Support the PCMH (cont.)

The Medicare Plan of Care (CMS 485) is a standard statement of the patient's condition, treatment plan, and planned outcomes (see handout). It serves and the principal document to coordinate homecare with the PCMH.

• We recommend funding the design and development of standard segments within the CCD / HITSP C32 document to contain the Plan of Care, for incorporation in the HIE/MITA Enterprise Architecture.

- **On February 23, VNSNY will go live with an electronic exchange of Plan of Care (not yet in CCD format) with a physician EMR, funded by HEAL 1.**
- **In 2010 and 2011, VNSNY will develop an electronic exchange of Plan of Care (in CCD format) with two physician EMRs through BHIX, in HEAL 10.**

HIT Incentives for Nurse Practitioners at VNSNY

The ARRA provides for enhanced funding for NP's who service Medicaid beneficiaries and make meaningful use of EHRs.

- **VNSNY employs approximately 40 NP's.**
- **What are the time periods for enhanced funding:**
  - **For implementation of EHR?**
  - **For meaningful use of EHR?**

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