PROMISING OUTCOMES AT VNSNY

A VNSNY Population Health initiative among health plan members with chronic conditions is demonstrating greater engagement and lower costs.

- *Exceeded target engagement rate*
- *Reduced utilization*

The Need

- A leading employer-based health plan identified a large population of "well working" members with chronic conditions
  - Vulnerable, frequently unstable population, likely to have diabetes
  - Often medically complex with multiple social determinants of disease
  - Putting significant strain on health plan costs

Program Overview

- In 2013, VNSNY and the health plan co-created a Population Health Management program to identify and manage plan members who have or are at risk of developing common and costly chronic conditions, such as:
  - Diabetes, hypertension, osteoarthritis, asthma, hypercholesterolemia, cancer and depression
- Program design addresses needs of participants with a suite of proactive health and wellness services

Program Objectives

- Improve quality of care, including better compliance and reduction of risk behaviors that impede health
- Improve member satisfaction through empowerment to engage and take control of self-care
- Reduce cost of care

BRINGING MEDICINE HOME

Key Program Elements

- Risk assessment and stratification
  - Member health data analyzed, focusing on 'at-risk' patients
  - Participants stratified according to health plan's predetermined metrics and then via VNSNY predictors of risk
- Personalized action plan
  - Health Buddy (certified VNSNY Population Care Coordinator or Registered Nurse) invites participant to enroll
  - Builds care profile of member's health and well-being
  - Helps member set goals and develop plan to meet them
- Care management
  - Activities led by Health Buddy, part of the Population Health Team
  - Population Health Manager (PHM) schedules regular follow-up sessions with Health Buddy to help member achieve goals
  - Follows member until graduation or when goals have been met (approximately three months)
- Coaching and support
  - Telephonic and on-site outreach by plan nurses
  - Educational tools provided to members

Outcomes

- Engagement rate (primary metric)[1]
  - Exceeded target goal, with 25% of plan members enrolled vs. target of 20%
- Quality of life[2]
  - QOL score 4-5 at completion of program (Likert 5-point scale)
- Positive financial impact[3]
  - Reduced utilization

[1] Based on Adjusted Engagement Rates from Health Plan Dashboard. July 2015. Rates adjusted to reflect those unable to contact, wrong phone number, ineligible, and closed.
[2] Average Quality of Life Scores, based on VNSNY Quality Audit. January 2014-July 2015.
[3] Based on health plan's analysis. February 2015.