

Developing a Patient-Centered Geriatric Home Care Management Model

Gail Silver, APRN, GNP-C

Background: Older Adults prefer to remain in their home and community even when they experience physical or functional decline. The Visiting Nurse Service of New York's Long Term Home Health Care Program (LTHHCP) provides home based supportive services to over 3,500 people daily. The average age of patients is 71 years, and 66% are 65 years of age or older. Patients 65 and over have an average of 4.1 conditions with congestive heart failure (CHF), diabetes, hypertension, and coronary artery disease (CAD) being among the most common.

A 2007 analysis of health care utilization for this population revealed a significant use of high-cost medical care. More than 80% of the patients experience at least one hospitalization annually. This impacts patients' quality of life and puts a high-cost burden on federal and state payers. When patients are hospitalized, the agency loses revenue that could be used to enhance service delivery.

Project description: Throughout 2007, I worked with the LTHHCP management team to develop staff education initiatives aimed at reducing hospital admissions and re-admissions. The team created a Care Management Assessment Tool (CMAT), to risk stratify patients and guide clinician assessment of patient needs. This project aims to enhance the care management model to include the patient, clinician, and multidisciplinary team as part of the planning process. The clinical model will place patient engagement at the center of care management activities by integrating the four pillars of Care Transition Intervention (CTI) developed by the University of Colorado Health Services Center, and redesign the risk-stratification processes (CMAT) to incorporate patient activation assessment and coaching guidelines. We will rely on VNSNY's current technology for service delivery, data collection / analysis and outcomes reporting. Our current initiative to prepare nurses to sit and successfully complete the American Nurses Credentialing Center (ANCC), Geriatric Nurse Certification in Home Care will be utilized to enhance the skill set of our staff.

Sustainability: This model reflects the care management strategy embraced by the executive leadership of VNSNY, which is cost neutral and will generate additional revenue for the program. This project will build a business case that supports the investment necessary to make the changes in the LTC care management model. There is broad applicability for the geriatric population beyond the VNSNY organization as this model will reduce unnecessary healthcare utilization in a high cost Medicaid/Medicare population.

Please [email Gail](#) with any questions or comments regarding this project.