The Role of Nurses in Community-Based Health Care

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Overview

I. VNSNY and Its Nursing Workforce

II. How Technology Supports Nurses at VNSNY

III. The Evolving Role of Nurses

I. VNSNY

- 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 cases, from newborns to seniors
- 14,000 employees (2,600 RNs)
- Complex patient population

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

Visiting nurses in a row (date unknown)

Programs & Services

Prevention Programs

Congregate Care

Home Care Provider

Post-acute care
Long-term care
Hospice, palliative care

Health Plans (Payer)

Medicaid MLTC
Medicare Advantage

Support for Aging in Place in Congregate Care

- VNSNY Congregate Care works in a variety of community-based housing sites, including 32 of 43 NORCs in NYC
- Role of on-site NORC nurse:
  - Conduct health promotion, education activities for residents, families, building staff
  - Provide case management for residents who need ongoing support for chronic conditions, linkages to community resources
  - Screen, assess and link residents to home health care as needed

Coordination of Interdisciplinary Care for Home Care Patients

Goals for Patient	***Role of Nurse***
Recover and regain functioning after acute episode Learn to manage own conditions Avoid exacerbations in chronic conditions Build up physical reserves, strength, endurance	§ Assess needs, home environment, financial eligibility, coverage § Develop and implement plan of care § Facilitate communication between and among providers, patient, caregivers § Document progress, manage medications, monitor for declines, intervene before crisis § Establish appropriate follow-up care or transfer to different program

For example, at VNSNY …

- **Transitional Care** nurse ensures that critical steps have occurred within the first 30 days of home care
  - Evaluation of risk for rehospitalization
  - Emergency response plan
  - Medication reconciliation and simplification
  - Follow-up appointments with community PCP
  - Plans for discharge from home care
- **NFP** nurse works with first-time mothers for 2+ years
  - Ensure prenatal care
  - Educate about newborn care
  - Foster physical, emotional and cognitive development of child
  - Link to other community supports and programs

Care Management in VNS CHOICE Health Plans

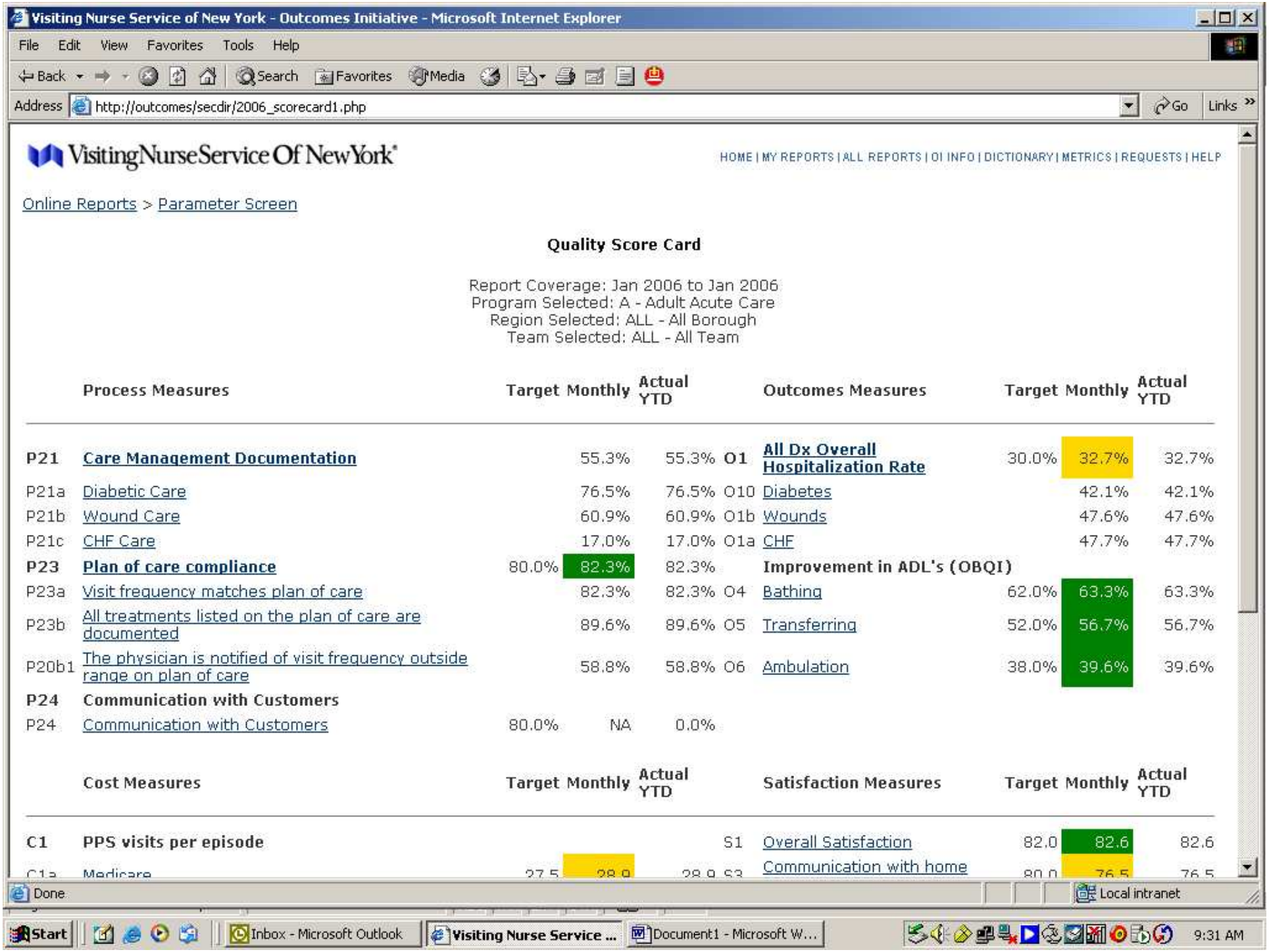
VNS CHOICE *MLTC*	VNS CHOICE *Medicare*
RN supports member in community, helps to avoid nursing home stays, manages member across settings	RN helps member avoid preventable hospital and ER visits by ensuring primary care home, addressing service gaps

In **Medical Home partnership** between VNS CHOICE and large IPA (60 MDs), nurse case managers coordinate care for *all* IPA patients who are plan members, but focus intensive efforts on the 15% of patients who are high-risk

- Telephone follow-up and initiation of other services to address unmet needs in the home
- Communication between RN case manager and PCP to share critical patient/member information

II. How Technology Supports Nurses at VNSNY

- All VNSNY clinicians use portable laptops equipped with proprietary Patient Care Record Suite (PCRS), a structured EHR
- Clinician synchronizes laptop with VNSNY network from field, is able to retrieve current data for caseload, at the point of care
- These data are also used by managers to provide actionable feedback and foster continuous quality improvement
  - VNSNY Outcomes Website provides real-time reports on utilization, key clinical indicators, quality scorecard measures, patient satisfaction – based on data entered in PCRS


Visiting Nurse Service of New York - Outcomes Initiative - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Address http://outcomes/secdir/2006_scorecard1.php
Go Links
VisitingNurseService Of NewYork
HOME | MY REPORTS | ALL REPORTS | OI INFO | DICTIONARY | METRICS | REQUESTS | HELP
Online Reports > Parameter Screen
Quality Score Card
Report Coverage: Jan 2006 to Jan 2006
Program Selected: A - Adult Acute Care
Region Selected: ALL - All Borough
Team Selected: ALL - All Team
Process Measures Target Monthly Actual YTD
P21 Care Management Documentation 55.3% 55.3%
P21a Diabetic Care 76.5% 76.5%
P21b Wound Care 60.9% 60.9%
P21c CHF Care 17.0% 17.0%
P23 Plan of care compliance 80.0% 82.3% 82.3%
P23a Visit frequency matches plan of care 82.3% 82.3%
P23b All treatments listed on the plan of care are documented 89.6% 89.6%
P20b1 The physician is notified of visit frequency outside range on plan of care 58.8% 58.8%
P24 Communication with Customers
P24 Communication with Customers 80.0% NA 0.0%
Outcomes Measures Target Monthly Actual YTD
O1 All Dx Overall Hospitalization Rate 30.0% 32.7% 32.7%
O10 Diabetes 42.1% 42.1%
O1b Wounds 47.6% 47.6%
O1a CHF 47.7% 47.7%
Improvement in ADL's (OBQI)
O4 Bathing 62.0% 63.3% 63.3%
O5 Transferring 52.0% 56.7% 56.7%
O6 Ambulation 38.0% 39.6% 39.6%
Cost Measures Target Monthly Actual YTD
C1 PPS visits per episode
C1a Medicare 27.5 28.9 28.9
Satisfaction Measures Target Monthly Actual YTD
S1 Overall Satisfaction 82.0 82.6 82.6
S3 Communication with home 80.0 76.5 76.5
Done
Local intranet
Start
Inbox - Microsoft Outlook
Visiting Nurse Service ...
Document1 - Microsoft W...
9:31 AM

Health Information Exchanges

- VNSNY is actively involved in establishing exchange of health data with hospitals, physicians, outpatient clinics in NYC region
  - RHIOs, NYCCHIP
- Physician Web Portal enables exchange of key data, non-urgent clinical messaging for shared patients between VNSNY nurses and physicians
  - Data includes demographics, diagnoses, medications, allergies, procedures, labs, plan of care, visits and encounters

III. The Evolving Role of Nurses

Task-oriented

Transactional

Single professional

Short-term relationship

FFS payment

Outcomes-oriented

Episode of care

Coordinator of interdisciplinary team

Partner with physicians, hospitals

Longer-term relationships

Care management, ongoing support

Risk-based, prospective payment

In the future, more nurses must have the competencies and skills to …

1. Assess risk level, functional impairments, medical and support needs of individuals
2. Partner with the patient/family to develop a reasonable, achievable plan of care
3. Manage a cross-disciplinary team, including informal caregivers
4. Coordinate care with other providers across settings
5. Aggregate, synthesize, interpret and act on clinical data
6. Effectively communicate with patients and entire caregiving team

This requires resources for training and education.

VNSNY has been a leader in supporting education and training (through nursing internships, clinical rotations) to widen the pipeline of nurses and physicians with

- Practical experience in home and community settings
- Competencies and skills to manage complex patients
- Ability to apply technologies to provide more effective, efficient care