VNSNY
FULL-SPECTRUM
NEUROLOGY
SOLUTIONS

Filling in gaps in care for
patients across the continuum
of neurological disorders.
THE NEUROLOGY CONTINUUM

STROKE

PARKINSON’S DISEASE

MULTIPLE SCLEROSIS
STROKE PATIENT PROFILES

- The Pre-Stroke Patient
- The Acute Stroke Patient
- The Non-Adherent Stroke Patient
- The Complex Stroke Patient
- The Advanced Stroke Patient
The Pre-Stroke Patient

- Patients at higher risk of stroke, including those with:
  - Hypertension (uncontrolled or poorly controlled high blood pressure)
  - High cholesterol
  - Atrial fibrillation
  - Diabetes
  - Circulatory problems
  - Carotid artery disease
  - Family history of cerebrovascular incident
- Common lifestyle factors include poor nutrition, obesity, smoking, lack of exercise and alcoholism or substance abuse
- Treatment often begins with lifestyle changes such as regular exercise and cessation of smoking or substance abuse.
The Acute Stroke Patient

- Recovering from stroke or TIA, surgery or chronic condition
- May have residual weakness or paralysis, dysarthria, with or without aphasia and/or dysphagia
- Inability to communicate needs and wants with family, caregivers and medical team
- Frequently non-compliant and battling feelings of anxiety, frustration, anger and sadness
- May live alone, often homebound with limited community support
- Difficulty with ADLs and IADLs, with no skilled nursing requirements
- Cognitive impairment, depression and/or behavioral maladaptation are common

COMMON GAPS IN CARE

- Behavioral health management
- Physical therapy
- Complex wound care
- Private care nursing
- Geriatric care management
- Skilled nursing
- Occupational therapy
- Speech-language pathology
- Personal care/companionship
- Telehealth
The Non-Adherent Stroke Patient

- Difficulty following prescribed medical plan of care and keeping physician follow-up appointments
- May have complex medication regimen and complications from comorbidities or side effects
- Limited understanding of diagnosis; gaps in self-management skills
- Functional limitations and socioeconomic barriers
- Often lacks caregiver support
- High risk for rehospitalization

COMMON GAPS IN CARE

- Ambulatory escort
- Personal care/companionship
- Behavioral health management
- Physical therapy
- Complex care management
- Skilled nursing
- Geriatric care management
- Social work
- Medication management
- Transitional care
The Complex Stroke Patient

- Stroke complicated by multiple comorbidities and/or psychosocial issues
- May be recovering from surgery or acute illness
- Medically stable with ongoing clinical rehabilitative and possible clinical maintenance needs
- May live alone, often homebound, with limited community support
- Difficulty with ADLs and IADLs, with no skilled nursing requirements
- Cognitive impairment, often with depression and/or behavioral maladaptation

COMMON GAPS IN CARE

- Behavioral health management
- Private care nursing
- Complex care management
- Physical therapy
- Geriatric care management
- Skilled nursing
- PRI assessment
- Speech-language pathology
- Palliative care
- Telehealth
The Advanced Stroke Patient

- Recurrent stroke with expanding cerebral insufficiency
- Palliative Performance Scale (PPS) score < 50%
- Often bedbound, unable to work or perform most activities without caregiver assistance
- Progressive or global aphasia, possible dementia or related cognitive deficits
- Inability to swallow safely, with weight loss, inability to maintain hydration or caloric intake

COMMON GAPS IN CARE

- Behavioral health management
- Physical therapy
- Complex care management
- Private care nursing
- Hospice care
- Short-term inpatient hospice care
- PRI assessment
- Social work
- Personal care/companionship
- Speech-language pathology
PARKINSON’S DISEASE PATIENT PROFILES

- The Parkinson’s Patient
- The Non-Adherent Parkinson’s Patient
- The Complex Parkinson’s Patient
- The Advanced Parkinson’s Patient
The Parkinson’s Patient

- Tremors and/or rigidity and stiffness of limbs and trunk
- Impaired balance, postural instability, pre-syncope (dizziness before fainting)
- Autonomic dysfunctions may include:
  - Decreased gastrointestinal motility (loss of appetite due to fullness, constipation)
  - Dysphagia (swallowing deficit)
  - Bradykinesia (slowed movement)
- Suffers from physical pain
- Speech/voice deficit
- Emotional withdrawn, frequently depressed and/or anxious
- Slowed cognition; confusion and memory loss

COMMON GAPS IN CARE
The Non-Adherent Parkinson’s Patient

- Difficulty following prescribed medical plan of care and keeping physician follow-up appointments
- May have complex medication regimen and complications from comorbidities or side effects
- Limited understanding of diagnosis; gaps in self-management skills
- Functional limitations and socioeconomic barriers
- Often lacks caregiver support
- High risk for rehospitalization

COMMON GAPS IN CARE

- Ambulatory escort
- Personal care/companionship
- Behavioral health management
- Physical therapy
- Complex care management
- Skilled nursing
- Geriatric care management
- Social work
- Medication management
- Transitional care
The Complex Parkinson’s Patient

- Multiple comorbidities
- Physical debilitation
  - Shuffling gait with small steps
  - Rigidity and trembling of head
  - Forward tilt of trunk
- Non-motor manifestations
  - Mood disorders
  - Psychosis
  - Dementia
  - Sleep disorders
  - Impulse-control disorders
  - Autonomic dysfunctions
- Fluctuating blood levels of medication may lead to hyperkinesia and freezing
- Descending neural pathways are interrupted, producing constipation, urinary frequency, orthostatic hypotension, drooling
- Neuropathic pain syndrome

COMMON GAPS IN CARE

- Ambulatory escort
- Personal care/companionship
- Behavioral health management
- Physical therapy
- Complex care management
- Private care nursing
- PRI assessment
- Skilled nursing
- Palliative care
- Speech-language pathology
The Advanced Parkinson’s Patient

- Declining verbalization
- Hallucinations
- Complex medication regimens
- Multiple hospitalizations
- Physical decline, weight loss, Serum albumin < 2.5 gm/dl
- Infections, often due to immobility, possibly stage 3-4 pressure ulcers
- Multiple comorbidities
- Often bedbound and dependent on assistance for most ADLs
- Increasing pain, dyspnea, difficulty talking, eating or swallowing
- Karnofsky or Palliative Performance Scale (PPS) Score ≤ 70 %
MULTIPLE SCLEROSIS PATIENT PROFILES

- The Multiple Sclerosis Patient
- The Non-Adherent Multiple Sclerosis Patient
- The Complex Multiple Sclerosis Patient
- The Advanced Multiple Sclerosis Patient
De-myelination of central nervous system due to white matter lesions, resulting in:
- Paresthesia (tingling or pain in parts of the body) or intermittent tremors
- Painful spasms in the back, lower extremities
- Lhermitte's sign (strong pain sensations with certain neck movements)
- Ataxia, lack of coordination, unsteady gait and history of falls
- Nystagmus (involuntary eye movement) and blurred vision
- Dizziness, fatigue or vertigo
- UTI, bladder dysfunction or problems with sexual function
- May have significant side effects from experimental drugs
- Depression is common

COMMON GAPS IN CARE

- Ambulatory escort
- Personal care/companionship
- Behavioral health management
- Physical therapy
- Geriatric care management
- Private care nursing
- Medication management
- Skilled nursing
- Occupational therapy
- Speech-language pathology
### The Non-Adherent Multiple Sclerosis Patient

- Difficulty following prescribed medical plan of care and keeping physician follow-up appointments
- May have complex medication regimen and complications from comorbidities or side effects
- Limited understanding of diagnosis; gaps in self-management skills
- Functional limitations and socioeconomic barriers
- Often lacks caregiver support
- High risk for rehospitalization

### COMMON GAPS IN CARE

<table>
<thead>
<tr>
<th>Ambulatory escort</th>
<th>Personal care/companionship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health management</td>
<td>Physical therapy</td>
</tr>
<tr>
<td>Complex care management</td>
<td>Skilled nursing</td>
</tr>
<tr>
<td>Geriatric care management</td>
<td>Social work</td>
</tr>
<tr>
<td>Medication management</td>
<td>Transitional care</td>
</tr>
</tbody>
</table>
The Complex Multiple Sclerosis Patient

- Swallowing problems or slurred speech
- Tremors, muscle stiffness or even paralysis, typically in the legs
- Lack of coordination or unsteady gait/history of falls
- Autonomic dysfunctions
  - Decreased gastrointestinal motility (loss of appetite, constipation)
  - Incontinence (problems with bladder, bowel)
  - Dysphagia (swallowing deficit)
  - Bradykinesia (slowed movement)
- Prolonged double vision or partial or complete loss of vision, often with pain during eye movement
- May have significant side effects from experimental drugs
- Motor sensory cognitive deficits, such as forgetfulness or mood swings
- Often anxious or depressed
The Advanced Multiple Sclerosis Patient

- Multiple hospitalizations
- Physical decline, weight loss, Serum albumin < 2.5 gm/dl
- Infections, often due to immobility, possibly stage 3-4 pressure ulcers
- Multiple comorbidities
- Often bedbound and dependent on assistance for most ADLs
- Increasing pain, dyspnea, difficulty talking, eating or swallowing
- Karnofsky or Palliative Performance Scale (PPS) Score ≤ 70%

COMMON GAPS IN CARE

- Behavioral health management
- Physical therapy
- Complex care management
- Private care nursing
- Hospice care
- Short-term inpatient hospice care
- PRI assessment
- Social work
- Personal care/companionship
- Speech-language pathology
<table>
<thead>
<tr>
<th>VNSNY NEUROLOGY SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• VNSNY Ambulatory Escort</td>
</tr>
<tr>
<td>• VNSNY Behavioral Health and Dementia Management</td>
</tr>
<tr>
<td>• VNSNY Complex Care Management</td>
</tr>
<tr>
<td>• VNSNY Complex Wound Care</td>
</tr>
<tr>
<td>• VNSNY Geriatric Care Management</td>
</tr>
<tr>
<td>• VNSNY Haven Hospice Specialty Care Unit</td>
</tr>
<tr>
<td>• VNSNY Hospice and Palliative Care</td>
</tr>
<tr>
<td>• VNSNY Medical Social Work</td>
</tr>
<tr>
<td>• VNSNY Medication Management</td>
</tr>
<tr>
<td>• VNSNY Occupational Therapy for Neurology Patients</td>
</tr>
<tr>
<td>• VNSNY PRI Assessment</td>
</tr>
<tr>
<td>• VNSNY Palliative Care</td>
</tr>
<tr>
<td>• VNSNY Personal Care and Companionship</td>
</tr>
<tr>
<td>• VNSNY Physical Therapy for Neurology Patients</td>
</tr>
<tr>
<td>• VNSNY Population Health Management</td>
</tr>
<tr>
<td>• VNSNY Private Care Nursing</td>
</tr>
<tr>
<td>• VNSNY Skilled Nursing</td>
</tr>
<tr>
<td>• VNSNY Speech-Language Pathology for Neurology Patients</td>
</tr>
<tr>
<td>• VNSNY Telehealth</td>
</tr>
<tr>
<td>• VNSNY Transitional Care Program</td>
</tr>
</tbody>
</table>
**VNSNY Ambulatory Escort**

(Partners in Care private pay services)

Helps ensure safe transfer of patient to and from the hospital, same-day surgery, medical and dental appointments, and social events or other functions.

- Assures physicians and family members that patient will arrive at appointments safely and on time
- Facilitates continuity of personal care and companionship support at home for short term or long term needs
- Available with as little as 24 hours notice

Customized services are available for patients who want home care not covered by insurance, paid for out of pocket or with long term care insurance.
Specialty care to improve clinical outcomes and patient satisfaction for psychiatrically and/or functionally homebound elderly patients with mood or cognitive disorders, including Alzheimer’s Disease. Using an interdisciplinary team, this innovative, person-centered approach allows Alzheimer’s patients to remain at home with the least restrictive level of care. The program includes:

- Comprehensive assessment of mood and cognition, using evidenced-based screening tools
- Individualized treatment plan, utilizing diagnosis-specific clinical pathways based on patient acuity
- Medication management, with strategies to improve adherence
- Diagnosis-specific psycho-education, using self-management tools with teach-back
- Supportive counseling and goal-setting
- Instruction in stress-reduction through coping skills, relaxation exercises, negative talk strategies, self-esteem building techniques and wellness
- Care coordination and clinical monitoring of condition
- Caregiver education for patients with dementia:
  - Disease process and symptoms
  - Caregiver techniques for ADLs and IADLs
  - Home safety, strength development and falls prevention
  - Promoting independence and positive behaviors
  - Managing difficult behaviors such as wandering, sun-downing, agitation and aggression
- Identifying community linkages including support groups

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare and Medicaid. Medicare patients must meet homebound criteria.
VNSNY Complex Care Management

The management of populations most at risk for hospitalization with multiple chronic conditions has always been a core expertise at VNSNY. Defining elements of the program include:

- Reducing preventable rehospitalizations and avoidable ED visits
- Integration of physical and behavioral health interventions
- Care coordination from a Registered Nurse, a Social Worker or both
- Patient education and training in self-management
- Rehabilitation services (PT, OT, SLP) delivered across all settings
  - Restorative or maintenance care
  - Home safety programs
  - Caregiver training for decreased burden of care
  - Adaptive care planning
- Consultative outpatient and inpatient communication to PCP
- Facilitation of transfer to palliative care as needed

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Complex Wound Care

Evidence-based, best-practice treatment of complex wounds, with educational training to engage the patient and the caregiver. Our highly skilled, certified Wound, Ostomy and Continence Nurses (WOCN) provide services and strategies designed to optimize healing and ostomy management. Working closely with the patient’s physician and home health care team, they customize a treatment plan and evaluate progress throughout the course of treatment. Services may include:

- Topical wound care, prevention and management of infection
- Therapeutic interventions for slow-healing surgical wounds or chronic wounds such as pressure ulcers
- Self and caregiver training in how to change dressings, monitor healing, manage pain and recognize potential complications
- State-of-the-art therapies, such as negative pressure wound therapy (NPWT) technology to promote tissue growth and healing
- Compression dressings and devices to assist with venous stasis and ulcers (may want WOCN to review)
- Support and education in self-care management for ostomy patients
- Digital photos of wounds may be emailed to WOCN specialists or physicians for consultation

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Geriatric Care Management
(Partners in Care private pay services)

A comprehensive, fully customizable program providing expert geriatric advocates to help patients and their caregivers navigate long term care options to remain safely at home. Particularly beneficial for patients who live alone with limited community support. A registered nurse case manager will assess, coordinate, and manage a range of services including:

- Coordination of everything from medical care to household assistance
- Accessing and leading a multidisciplinary team of clinicians, based on the patient’s specific needs
- Medication management and reconciliation
- Recommending home safety improvements and appropriate community resources (such as Meals on Wheels)

Customized services are available for patients who want home care not covered by insurance, paid for out of pocket or with long term care insurance.
The Haven provides round-the-clock care for patients with acute symptoms in a setting that promotes comfort, dignity and quality of life. The unit provides:

- Care by a dedicated, interdisciplinary team of professionals for acute symptom management until patients are stabilized and safe to return home
- Accepts patients with or without DNR/DNI
- A place where family members are welcome at all times, with chair beds that allow family members to be with patients
- Access to a comfortable and welcoming family lounge for dining and relaxation
- A family conference area for consultations with the care team

Hospice care benefits are covered by Medicare, Medicaid and most private health insurance plans.
VNSNY Hospice and Palliative Care

Care that improves quality of life for patients and families living with advanced illnesses. Provided predominantly in the home setting, in long-term care nursing facilities and in the Goodman Brown Residence. Services include:

- Care from an interdisciplinary team that may include a physician, nurse practitioner, nurse, social worker, spiritual care counselor and home health aide
- Treatment for control of pain and other symptoms, beginning with a Comfort Pack delivered to the patient’s home
- Cardiac Hospice Care program to address the special needs of advanced-stage Heart Failure patients
- Personal care at home
- Counseling and guidance on planning in the context of disease progression
- Emotional and practical support for patient and their families during an advancing illness
- Bereavement counseling after death of a loved one for as long as 13 months

Hospice care benefits are covered by Medicare, Medicaid and most private health insurance plans.
Licensed VNSNY social workers provide consultation, assessment and support for patients’ socio-economic, financial, cultural and emotional needs:

- Identify community linkages (such as Meals on Wheels or senior day care centers)
- Help navigating the complexities of health insurance
- Assistance in applying for social and/or financial services
- Arrange for transportation or home improvement services
Our field clinicians work with patients, caregivers, and community physicians to help manage any and all medications the individual takes in the home. Goal of making the patient or caregiver as independent as possible in their own medication administration. Services include:

- Using electronic database, review all prescriptions (plus OTC and herbal medications) to identify and notify patient’s physician of potential interactions
- Education focused on self-management and strategies that simplify regimes to improve adherence
- Instruction in correct use and safety techniques of oxygen, inhalers, nebulizers or other respiratory equipment
- Adjustments to medications based on patient’s current clinical status, with ordering physician’s approval

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
Utilizing an interdisciplinary rehabilitation approach, VNSNY Occupational Therapy can help restore your patient’s ability to meaningfully participate in vital Activities of Daily Living (ADLs) such as dressing, feeding and bathing. It also may assist with patients regaining physical, cognitive and visual perceptual abilities in their homes.

- Ergonomic assessment and activity modifications for home safety
- Assess and instruct in proper positioning, body mechanics and DME as required
- Teach therapeutic activities and exercises to increase motor, visual, cognitive and perceptual skills for improved independence:
  - Identifying adaptive methods to complete tasks
  - Retrain or modify personal care or other IADLs
  - Developing a workable routine
- Educate patients and caregivers on patient safety, assistive care methods and transfer skills
- Training in the use of energy conservation techniques, including the use of adaptive and assistive devices and modified daily routines to ensure adequate rest

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY PRI Assessment

(Partners in Care private pay services)

Required by law for individuals considering a move to a nursing facility. Our private-pay nurses are trained to assess whether a patient can function safely in the community or would be more appropriately cared for in a skilled nursing facility. Appointments available seven days a week, often within 24 hours of a request. A PRI assessment can determine:

- Medical condition/diagnosis
- Required medications and therapies
- Special diets
- Physical and mental abilities and limitations
- Ability to perform daily tasks
- Behaviors that may need management, such as aggressiveness, anxiety or depression

Customized services are available for patients who want home care not covered by insurance, paid for out of pocket or with long term care insurance.
VNSNY Palliative Care

A team approach to care focused on improving patients’ and families’ quality of life, and achieving personal goals for patients living with complex, progressive, life-threatening or life-limiting illness. VNSNY clinicians:

- Teach about illness and understanding choice of treatment options
- Treat pain and symptoms
- Design program to support maintenance of functional ADLs as appropriate
- Provide emotional support
- Connect families to community resources
- Emphasize importance of Advance Care Planning (ACP)
  - ACP discussed with all patients at start of VNSNY care
  - Enhanced clinical assessment to better identify palliative care needs
  - Increased clinical expertise to deliver palliative care interventions

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria.
Patients are carefully matched with a highly trained, certified home health aide – or a team of aides – to provide assistance with activities of daily living. A registered nurse supervises the aide, oversees the care plan and updates it as necessary. Flexible scheduling is available, from hourly service through round-the-clock care, for short- or long-term, periodic or continuous care needs. Services include:

- Reminders to take medications
- Recording vital signs
- Getting to and from medical and other appointments
- Food shopping, cooking and meal preparation
- Bathing, dressing and grooming

Customized services are available for patients who want home care not covered by insurance, paid for out of pocket or with long term care insurance.
VNSNY Physical Therapy for Neurology Patients

Our physical therapists strive to improve patient safety, strength, flexibility, balance, and coordination through services focused on:

- Falls risk management, strength training, gait training, increasing/maintaining range of motion and assessing the need for assistive devices or mobility equipment
- Evaluating home environment for safe mobility, educating patients and caregivers on patient safety and techniques to safely assist patients in ADLs
- Improving posture and balance
- Creating customized exercise programs to address individual needs
- Teaching energy conservation to limit strain on joints and muscles, and pacing for cardiopulmonary conditions
- Providing training on how to safely move from bed or chair, walk on level ground and navigate steps
- Reinforcing post-operative instructions for surgical patients
- Instructing in use of equipment such as walkers, canes, wheelchairs and other assistive devices

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
Our nurse leaders, trained as certified Population Care Coordinators, focus on proactive, patient-centered, team-based care to reduce avoidable hospitalizations and prevent the development of new conditions or exacerbation of existing conditions. VNSNY uses risk stratification and analytics to aggregate data from across the continuum, generate patient risk scores and identify needed interventions. VNSNY Population Health Management programs include:

- **Gaps In Care Management**, targeting healthy patients or those with chronic conditions needing preventive services
- **Chronic Disease Management**, targeting patients with chronic disease or other risk factors who could benefit from education to improve adherence
- **Transitional Care Coordination**, targeting patients hospitalized within past 7 days who have clinical and psycho-social barrier to obtaining needed care
- **Certified Home Health Care Episode**, targeting homebound patients requiring skilled nursing and/or rehabilitation services

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria.
Registered nurses, who are experienced in disease-specific care and the care of medically complex patients, offer private duty nursing services not covered by most insurance. Helps reduce hospital length of stay, assist with safe transition across settings and minimize setbacks or potential risk of infection. Flexible, customized care can be arranged for short-term or ongoing needs, including:

- Coordination of care and assistance in following doctors’ orders
- Pain management and medication reconciliation
- Supervision and clinical treatment for continuous care needs, such as:
  - Ongoing infusion therapy
  - Wound, colostomy and ileostomy care
  - Tracheostomy care and tube feeding
  - Catheter care
- Guidance for self-care and nutritional education

Customized services are available for patients who want home care not covered by insurance, paid for out of pocket or with long term care insurance.
VNSNY Skilled Nursing

Utilizes best practices based on established national (AHA/VNAA) guidelines to help achieve the goal of maximizing patients’ physical, cognitive and behavioral gains. Helps to ensure a high level of independence at home, in the community and returning to work, and to reduce avoidable rehospitalizations and hospital length of stay, improve recovery and assist with safe transition across settings.

- Coordination of care and guidance in adherence to doctors’ orders
- Instruct patient or caregiver in self-management of disease and need for medication adherence
- Conduct respiratory assessment including auscultation of breath sounds
- Demonstrate correct use and safety techniques of oxygen, inhalers, nebulizers or other respiratory equipment
- Evaluate home environmental or situational triggers and recommend strategies to mitigate them
- Assess and formulate action plan for changes in symptoms
- Identify strategies to assist complex medication management
- Linkages to psychological support or smoking cessation assistance
- Instruct in nutrition and hydration measures
- Optimize preventive measures such as appropriate vaccines and proper hygiene

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Speech-Language Pathology for Neurology Patients

Through hands-on care rooted in best practice protocols, our speech language pathologists focus on restoring communication skills for everyday situations and promoting effective, safe swallowing to improve outcomes and speed recovery for patients.

- Assess and diagnose speech, language, cognitive communication and swallowing disorders
- Customize treatment plan based on the patient’s diagnosis and acuity level
- Educate patients and caregiver in methods to improve communication, social interactions and overall quality of life by teaching:
  - Speech production
  - Voice inflections and intensity
  - Receptive and expressive language, including non-verbal communication
  - Augmentative and alternative communication (AAC) systems for individuals with severe expressive and/or language comprehension disorders (common in progressive neurological disorders)
- Functional swallowing strategies to address dysphagia

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Telehealth

In-home telecommunication solutions to improve outcomes and reduce hospitalizations by tracking vital health information. Particularly beneficial for patients with chronic illnesses who take several medications or who require extra monitoring between physician or nursing visits. Physicians are notified promptly of any problematic shifts in vitals to help ensure patient stability.

- Advanced nurse practitioner on call 24 hours/7 days a week
- Data is automatically transmitted to VNSNY Telehealth team and communicated to physician as needed
- Ensure patients are confident using equipment and understand the results:
  - Respiratory rate
  - Pulse oximeter
  - Blood pressure monitor
  - Weight scale
  - Glucometer
- Cellphone capability with no LAN required

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria.
In collaboration with provider partners across the continuum, VNSNY offers transitional care to help improve health outcomes, reduce avoidable rehospitalizations and improve the patient experience. Key principles include:

- Best practices enhanced by VNSNY hands-on experience
- Plan for safe discharge to the home setting
- Use of proprietary risk stratification algorithm
- Emphasis on patient goal-setting, self-management and caregiver involvement
- Ongoing review for gaps in care or red flags
- Regular communication with community-based PCP, including confirmation of post-hospitalization follow-up appointment

Our clinical pathways are disease-specific, based on patient acuity and developed with evidence-based best practices. VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.