Filling in potential gaps in care for patients across the cardiac disease continuum.
THE CARDIAC DISEASE CONTINUUM

HEART FAILURE

STROKE

CORONARY ARTERY DISEASE (CAD)
HEART FAILURE PATIENT PROFILES

- The Pre-Heart Failure Patient
- The Early Stage Heart Failure Patient
- The Acute Heart Failure Patient
- The Non-Adherent Heart Failure Patient
- The Complex Heart Failure Patient
- The Advanced Heart Failure Patient
The Pre-Heart Failure Patient

- Those who may be symptom-free but are at high risk of developing heart failure, including patients with:
  - High blood pressure
  - Diabetes
  - Coronary artery disease
  - Family history of cardiomyopathy
  - History of rheumatic fever or alcohol abuse

- Treatment often begins with lifestyle changes such as regular exercise and cessation of smoking or substance abuse

COMMON GAPS IN CARE

- Behavioral health specialty care
- Population health management
The Early Stage Heart Failure Patient

- Stage A, newly diagnosed or at high risk of developing heart failure
- Hypertension and/or atherosclerotic heart disease
- Frequently presenting risk factors for metabolic syndrome
- Some limitation of physical activity. May have difficulty leaving home
- Possibly challenged by other comorbidity requiring PT or skilled nursing
- May need to make necessary lifestyle changes

COMMON GAPS IN CARE

- Population health management
- Skilled nursing
- Rehabilitation therapies
The Acute Heart Failure Patient

- Typically Stage B heart failure with structural heart disease, uncontrolled hypertension and cardiac remodeling or Stage C
- May be recuperating from surgery or acute illness
- Stable with ongoing clinical maintenance needs
- 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

- Complex wound care
- Rehabilitation therapies
- Fluid management
- Skilled nursing
- Geriatric care management
- Telehealth
- Palliative care
- Transitional care
- Private care nursing
The Complex Heart Failure Patient

- Typically Stage C heart failure with current or ongoing symptoms resulting from myocardial infarction, valvular heart disease or onset of atrial fibrillation or arrhythmias
- Often condition is further complicated by multiple comorbidities and/or psychosocial issues
- May be homebound recuperating from surgery or acute illness, or stable with ongoing clinical maintenance needs
- May live alone, 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

- Complex care management
- Private care nursing
- Complex wound care
- Rehabilitation therapies
- Fluid management
- Skilled nursing
- Geriatric care management
- Telehealth
- Palliative care
- Transitional care
The Advanced Heart Failure Patient

- Stage D heart failure with extensive disease, ongoing shortness of breath and fatigue at rest
- Palliative Performance Scale (PPS) score < 70
- Often bedbound, unable to work or perform most activities without assistance
- Increased cognitive decline
- Weight loss, inability to maintain hydration or caloric intake
- May need Mechanical Assist Devices (LVAD)
- High risk for rehospitalization

COMMON GAPS IN CARE

- Fluid management
- Personal care/companionship
- Geriatric care management
- Rehabilitation therapies
- Hospice care
- Short-term inpatient hospice care
- Palliative care
- Skilled nursing
The Non-Adherent Heart Failure Patient

- Often frail and elderly, homebound, with exacerbated condition or increased symptoms
- Has functional limitations, history of falls, socioeconomic barriers, cognitive issues and gaps in self-management skills
- Often lacks caregiver support
- May have complex medication regimen, and complications from comorbidities
- High risk for rehospitalization

COMMON GAPS IN CARE
- Ambulatory escort
- Medication management
- Behavioral health specialty care
- Personal care/companionship
- Complex care management
- Private care nursing
- Geriatric care management
- Skilled nursing
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:
  - 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 other 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
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 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 specialty care
- Private care nursing
- Complex care management
- Rehabilitation therapies
- Geriatric care management
- Skilled nursing
- PRI assessment
- Telehealth
- Palliative care
- Transitional care
The Advanced Stroke Patient

- Recurrent stroke with expanding cerebral insufficiency
- Palliative Performance Scale (PPS) score < 40
- 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

- Complex care management
- Rehabilitation therapies
- Hospice care
- Short-term inpatient hospice care
- Personal care/companionship
- Social work
- Private care nursing
The Non-Adherent Stroke Patient

- Often frail and elderly, homebound, with exacerbated condition or increased symptoms
- Has functional limitations, history of falls, socioeconomic barriers, cognitive issues and gaps in self-management skills
- Often lacks caregiver support
- May have complex medication regimen and complications from comorbidities
- High risk for rehospitalization

COMMON GAPS IN CARE

- Ambulatory escort
- Personal care/companionship
- Behavioral health specialty care
- Rehabilitation therapies
- Complex care management
- Skilled nursing
- Geriatric care management
- Social work
- Medication management
- Transitional care
CORONARY ARTERY DISEASE (CAD) PATIENT PROFILES

- The Pre-CAD Patient
- The Newly Diagnosed CAD Patient
- The Acute CAD Patient
- The Non-Adherent CAD Patient
- The Complex CAD Patient
- The Advanced CAD Patient
The Pre-CAD Patient

- Patients with risk factors, or clusters of risk factors, that put them at higher risk of coronary artery disease:
  - Smoking
  - Uncontrolled or poorly controlled high blood pressure
  - High cholesterol
  - Diabetes
  - Obesity
  - Sedentary lifestyle
  - Family history of heart disease

- Treatment often begins with lifestyle changes such as regular exercise and cessation of smoking
The Newly Diagnosed CAD Patient

- Chest pain
- Hyperlipidemia
- Inflammation markers for development of atherosclerosis
- Metabolic syndrome (including elevated blood pressure, high triglycerides, elevated insulin levels and excess body fat around the waist)
- Often requires skilled nursing care or physical therapy owing to current diagnosis or other comorbidity
- Leaving home requires exhaustive effort and ambulatory support (homebound by Medicare definition)
- May desire support for lifestyle change

COMMON GAPS IN CARE

- Ambulatory escort
- Physical therapy
- Behavioral health specialty care
- Skilled nursing
- Geriatric care management
- Social work
The Acute CAD Patient

- Recuperating from coronary event, surgery or other chronic condition
- May have symptoms of thrombosis, unstable angina, myocardial infarction, acute coronary syndrome
- 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 specialty care
- Personal care/companionship
- Complex care management
- Rehabilitation therapies
- Complex wound care
- Skilled nursing
- Geriatric care management
- Telehealth
- Palliative care
- Transitional care
**The Complex CAD Patient**

- CAD complicated by multiple comorbidities and/or psychosocial issues
- May be recuperating from surgery or acute illness
- Stable with ongoing 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 specialty care
- Private care nursing
- Complex care management
- Rehabilitation therapies
- Complex wound care
- Social work
- Geriatric care management
- Transitional care
- PRI assessment
The Advanced CAD Patient

- Extensive disease or recurrent myocardial infarction with progressive cardiac muscle loss
- Risk of advanced heart failure
- Palliative Performance Scale (PPS) score < 70
- Often bedbound, unable to work or perform most activities without assistance
- Progressive dementia or cognitive deficits, weight loss, inability to maintain hydration or caloric intake
- May have LVAD

COMMON GAPS IN CARE

- Geriatric care management
- Rehabilitation therapies
- Hospice care
- Short-term inpatient hospice care
- Personal care/companionship
- Skilled nursing
The Non-Adherent CAD Patient

- Often frail and elderly, homebound, with exacerbated condition or increased symptoms
- Has functional limitations, history of falls, socioeconomic barriers, cognitive issues and gaps in self-management skills
- Often lacks caregiver support
- May have complex medication regimen and complications from comorbidities
- High risk for rehospitalization

COMMON GAPS IN CARE

- Ambulatory escort
- Medication management
- Behavioral health specialty care
- Personal care/companionship
- Complex care management
- Skilled nursing
- Geriatric care management
VNSNY CARDIAC SOLUTIONS

- VNSNY Ambulatory Escort
- VNSNY Behavioral Health Specialty Care
- VNSNY Cardiac Rehabilitation Therapies
- VNSNY Complex Care Management
- VNSNY Complex Wound Care
- VNSNY Geriatric Care Management
- VNSNY Haven Hospice Specialty Care Unit
- VNSNY Heart Failure Fluid Management
- VNSNY Hospice and Palliative Care
- VNSNY Medical Social Work
- VNSNY Medication Management
- VNSNY PRI Assessment
- VNSNY Palliative Care
- VNSNY Personal Care and Companionship
- VNSNY Population Health Management
- VNSNY Private Care Nursing
- VNSNY Skilled Nursing
- VNSNY Telehealth
- VNSNY Transitional Care

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
**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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Behavioral Health Specialty Care

Designed to address the specific psychiatric or neurological needs of patients with mental health conditions. Particularly helpful for patients who have recently had surgery, a newly diagnosed medical condition or a fall, which can lead to mental impediments such as depression and anxiety. Services include:

- Cognitive assessment
- Self-management techniques and goal-setting
- Training in evidence-based cognitive behavioral therapy techniques from Beck Institute
- Psychopharmacology consultations
- Management of psychotropic medications
- Caregiver education and family conferencing
- Identifying community linkages

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Cardiac Rehabilitation Therapies (PT, OT, SLP)

Our physical and occupational therapists and speech-language pathologists strive to improve patients’ safety, strength and quality of life through evaluation, treatment and teaching. Based on the patient’s needs, they offer an interdisciplinary approach to hands-on care that is rooted in best practice protocols.

- Assess ROM, strength, gait and need for assistive devices or mobility equipment
- Educate patients and caregivers on patient safety and assistive care methods
- Reinforce precaution instructions for surgical patients
- Physical therapy to increase activity and improve balance, coordination and strength
  - Teach energy conservation, pacing and heart rate monitoring for activities
- Occupational therapy to increase range of motion, strength and endurance
  - Retrain homemaking skills and other instrumental activities of daily living
- Speech-language pathology to improve communication skills (speech, voice, receptive and expressive language, cognitive-communicative) and swallowing functions, if appropriate

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
The management of populations most at risk for hospitalization with multiple chronic conditions has always been a core expertise at VNSNY. Defining elements of our program include:

- Decreasing preventable rehospitalizations and avoidable ED visits
- Integration of physical and behavioral health interventions, including cognitive behavioral therapy techniques
- Care coordination from a Complex Care Manager – 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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. 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
- Support and education in self-care management for ostomy patients
- Digital photos of wounds may be emailed to WOCN specialists or physicians for consultation

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. 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 care 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)

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Haven Hospice Specialty Care Unit

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
- 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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Heart Failure Fluid Management

Designed to promote fluid balance and to prevent complications resulting from abnormal or undesired fluid levels.

- Monitor blood pressure, pulse, weight, abdominal girth, orthostatic BP and lung sounds and alert parameters (HR>110, Systolic BP>200 or <91, Diastolic BP>110 or <40)
- Administer daily diuretic medication
- Reinforce fluid restriction of 1500ml, 2 gram sodium diet or as otherwise ordered
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
- 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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Medication Management

Our field clinicians work with patients, caregivers, and the community physicians to help manage any and all medications the individual takes in the home. Particularly beneficial for newly diagnosed patients or those with acute or complex needs. Services include:

- Review and confirmation prescription, OTC and herbal medication at every home visit, with changes confirmed by the patient’s physician
- Education regarding individual medications and drug interactions
- Adjustments to medications based on patient’s current clinical status
- Goal of making the patient or caregiver as independent as possible in their own medication administration

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. 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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
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 are certified to:

- Educate patient and family on advance care planning
- 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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Personal Care and Companionship
(Partners in Care private pay services)

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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Population Health Management

Promoting health as a means of reducing avoidable hospitalizations and preventing the development of new conditions or exacerbating existing conditions. Our nurse leaders, trained as certified Population Care Coordinators, focus on proactive, patient-centered, team-based care:

- Engaging patients in their own health through education and coaching
- Providing longitudinal rather than episodic care to manage disease-specific interventions and necessary lifestyle changes
- Using EMRs and other technologies to promote more timely reporting and sharing of data
- Coordinating care between and across providers and settings
- Identifying community linkages

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
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
- Pre- and post-surgical care, from addressing patient concerns to advocacy in post-anesthesia care unit and home escort
- Guidance for self-care and nutritional education

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
VNSNY Skilled Nursing

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

- Coordination of care and assistance in adherence to doctors' orders
- Pain management and medication reconciliation
- Instruction in self-management of disease
- Assistance with symptoms management
- Providing wound care using evidence-based guidelines
- Infusion care services
- Smoking cessation assistance and support
- Helping patients acquire and use medical equipment, including bringing innovative solutions to the home

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. 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 telecommunications 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 physicians as needed
- Ensure patients are confident using and understand the results of equipment:
  - Weight scale
  - Glucometer
  - Blood pressure monitor
  - Pulse oximeter
- Cellphone capability with no LAN required

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.
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

VNSNY accepts Medicare, Medicaid and most private insurers. Medicare patients must meet homebound criteria (taxing effort, either physical or mental, in leaving home), and some insurers may require authorizations. Private care services are available for patients who want home care not covered by insurance, or to supplement or extend existing care.