
Managing Chronic Conditions for Elderly Adults: The VNS CHOICE Model

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Chronic illness combined with functional impairment often results in an increased need for medical care and supportive long-term care (LTC) services. Navigating the health care system is challenging and complex, and even more so for patients with complex needs. Traditional fee-for-service care does not support and facilitate coordination and collaboration between providers and service settings. In New York State, managed LTC, a model of coordinated care for the chronically ill, endeavors to provide a bridge between primary, acute, home and community-based, and institutional LTC services for a medically complex and functionally frail nursing home eligible population.

MANAGING CHRONIC ILLNESS

For many frail older adults, the need for medical and LTC services are intertwined. The very factors that prompt the need for medical care often drive the need for supportive LTC services. Adequately addressing both requires care coordination that crosses health care providers and settings. Over time, chronic disabilities are linked to a decline in physical and functional ability, an increased risk and likelihood of future illness, social isolation, and loss of independence. For many clinically and functionally impaired older adults without supportive LTC services, the option to remain

in their home and community becomes less likely, and their quality of life is significantly diminished.

Managing chronic illness is a challenge for health care providers. In the U.S., approximately one-half of the population suffers from a chronic condition and one-quarter has multiple chronic illnesses. Seven out of every 10 deaths in this country are attributed to a chronic disease and, in less than 20 years, health care spending on chronic disease will reach approximately 80 percent of total spending. (New Democrats Online, 2004). Approximately 80 percent of the U.S. senior population suffers from at least one chronic illness while 50 percent of this population has been diagnosed with at least two chronic illnesses (Centers for Disease Control and Prevention, 2004). As this population continues to grow and age, the prevalence of chronic illness is likely to increase. For older adults, chronic disease is often linked to a higher rate of injuries, functional limitations, and cognitive impairments. In 1998, 31 percent of New York State adults age 65 to 69, and 38 percent of adults age 70 or over reported the prevalence of a functional limitation, such as a physical impairment or health condition, that affected their ability to perform activities (New York State Department of Health, 2000).

For an older person living alone or without a formal caregiver, seeking and receiving treatment for such conditions is much more challenging. In New York, a majority of the State's elderly population lives in the community. In 2000, approximately 94.2

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percent of adults age 65 or over lived in a community-based household. A small percentage, 5.8 percent, of New York State's seniors age 65 or over lived in a group quarter such as a congregate care facility, adult home, or other group living arrangement. Of those older adults living in the community and not living in a group quarter, 35 percent lived alone, and of those seniors age 75 or over, almost 40 percent lived alone. Approximately 4.5 percent of seniors lived in a nursing home—down 7 percent from 1990 (New York Association of Homes and Services for the Aging, 2004).

Given the increased demand for services that adequately support both the medical and LTC needs of New York's growing elderly population, this article describes the health and LTC service options available through a managed LTC model and the strategies utilized by one New York City managed LTC program in particular, VNS CHOICE¹, to provide comprehensive care coordination and integration of clinical services to effectively impact the level of care required by a chronically ill elderly population.

In the early 1990s, New York State explored several strategies to increase the number of LTC service options available to its growing and more culturally diverse elderly population while addressing the State's rising Medicaid budget. During this period, New York initiated a Medicaid managed LTC demonstration program with the aim of achieving several key goals as defined by the New York State Department of Social Services (1996) request for proposal. Goals included: (1) increasing choices for LTC clients and their families; (2) increasing client satisfaction through a more flexible delivery system; (3) improving the health status outcomes of clients; (4) fostering indepen-

¹ VNS CHOICE is sponsored by the Visiting Nurse Service of New York, the largest not-for-profit provider of home and community-based services in the U.S.

dence and improving or delaying declines in functioning; and (5) reducing Medicaid expenses in a cost-effective manner. In 1997, New York State launched a larger initiative to improve the financing and coordination of chronic care services for the frail elderly population integrating its prior demonstration. The Long Term Care and Financing Act of 1997 created a new category of health maintenance organization and provided a flexible model of managed LTC that permits different plans to structure a program model consistent with their organizational capabilities.

Managed LTC programs receive a capitated per member per month payment from Medicaid and are responsible for providing comprehensive care management, authorizing and arranging for capitated services, and coordinating all services, both capitated and non-capitated. Covered services include a wide array of home and community-based services designed to help individual enrollees remain in their home and community for as long as is safely possible, substitute services such as home delivered meals, social day centers, and institutional services when appropriate. Medicare services such as primary and specialty physician care, diagnostic testing and laboratory, inpatient care, and emergency room services are not covered by the program; however, managed LTC programs are required to coordinate services across all providers and settings. (Table 1 provides a list of the services covered by managed LTC programs.) A summary of VNS CHOICE utilization data illustrates the range and utilization of community services arranged by care team clinicians. Table 2 presents an overall picture of community service utilization by VNS CHOICE members.

Managed LTC programs are responsible to coordinate and provide care management for covered and non-covered services.

Table 1
Medicaid Managed Long-Term Care Covered and Non-Covered Services

Covered Services:	
<ul style="list-style-type: none"> • Skilled Home Health Care including: <ul style="list-style-type: none"> - Nursing - Rehabilitation Therapies - Social Work - Nutrition - Paraprofessional Services • Ambulatory Health Services including: <ul style="list-style-type: none"> - Dentistry - Optometry - Podiatry - Audiology 	<ul style="list-style-type: none"> • Personal Care • Outpatient Rehab Therapies • Home Delivered Meals • Adult Day Services (Social and Medical Day Models) • Chore Services (housekeeping, cleaning, laundry etc) • Prescriptions • DME/Supplies (Includes ambulatory aids such as a walker, bathroom safety equipment such as grab bars, a raised toilet seat and commode, wheel chairs, a hospital bed, incontinence products, oxygen and respiratory equipment, and surgical supplies such as foley catheters and ostomy supplies) • Personal Emergency Response Systems • Respiratory Therapy • Scheduled Medical Transportation • Environmental Modifications (home safety modifications or improvements such as a wheelchair ramp or grab bars) • Assisted Living (Optional)
<ul style="list-style-type: none"> • Nursing Home 	
Non Covered Services:	
<ul style="list-style-type: none"> • Services Covered by Medicare • Physician (Primary and Specialty) • Hospital Inpatient Care • Diagnostic Testing and Lab Services • Emergency Room • Ambulance 	<ul style="list-style-type: none"> • Certain Medicaid Services including: <ul style="list-style-type: none"> - Mental Health Services - Substance Abuse Services - Family Planning Services

SOURCE: New York State Department of Health. Managed Long Term Care Contract. Internet address: http://www.health.state.ny.us/nysdoh/man_care/mltc_contract.pdf

Table 2
Percent of VNS CHOICE Enrollees Using Community Services: 2004

Service	Members Using Service	
	Percent	
Nursing	100	
Home Health Aid	92	
Social Work Services	90	
PERS	83	
Transportation	77	
Physical Therapy	57	
Dental	15	
Nutrition Counseling	10	
Social Day Care	9	
Vision Care	9	
Chore Services	4	
Meals	4	

NOTES: VNS CHOICE is sponsored by the Visiting Nurse Service of New York, the largest not-for-profit provider of home and community-based services in the U.S. PERS is Personal Emergency Response System.

SOURCE: VNS CHOICE Managed Long Term Care 2004 Annual Managed Care Operating Report.

Effective care management for community, institutional, and medical care has a direct impact on the program's ability to provide services in a cost-effective manner. Poor medical outcomes often result in increased utilization of capitated services. As an example, VNS CHOICE found that care

management time and the functional needs of members traditionally increase following a hospital stay. As such, managed LTC programs have the incentive to reduce costs by providing enhanced care management that avoids a hospital admission if possible, reduces the hospital length of stay, and likelihood of multiple hospital admissions.

Individuals enrolling in a managed LTC program require medical, psychosocial, environment, and supportive long care services. Enrollment is voluntary and enrollees may disenroll from the plan at any time. Typically, managed LTC programs serve an elderly population, although the lower age eligibility limit is set at age 21. Individuals may enroll in a managed LTC program if they live in the plan's service area, are nursing home eligible as defined by a standardized assessment tool, have LTC service needs that are expected to continue for at least 120 days, can remain safely in their home at the time of enrollment, are eligible for Medicaid,

and under the care of a community physician who is willing to collaborate with the managed LTC program.

Enrollment in managed LTC has grown steadily in New York State. As of May 2005, 15 managed LTC programs enrolled 12,565 individuals. A majority of all managed LTC enrollees (84 percent) are enrolled in one of the seven New York City-based plans. Since September 2002, the first month the New York State Department of Health reported overall enrollment in managed LTC, enrollment has increased 55 percent throughout New York State and 57.8 percent in New York City (New York State Department of Health, 2005).

VNS CHOICE MANAGED LTC MODEL

VNS CHOICE has a service area of the five counties of New York City, and began enrolling members on January 1, 1998. To date, the program has served 6,900 nursing home eligible Medicaid beneficiaries, with a current membership of approximately 3,800 enrollees.

During the initial development and implementation, the program faced a series of challenges. In order to provide enrollees with a range of services and providers that adequately addressed individual care needs, the program needed to develop and build a network of community providers. Managed LTC was a new model and many provider organizations were unfamiliar with the regulatory and contracting requirements. In fact, many providers within the current network had never contracted with a managed care entity. The organization worked over time to educate community providers about managed LTC, the opportunities that the model provided for them and for their constituencies, and established collaborative relationships with individual community-based

organizations and providers. Today, the program has a sizable network of more than 120 community-based organizations throughout New York City. These include 20 providers of paraprofessional home care services, 25 providers of social adult day services, 27 nursing homes, 17 home delivered meals programs, and 21 car and ambulette² services. VNS CHOICE has a specialized provider relations team who develops, supports, and manages ongoing business relationships with each of these network providers. Each provider's qualifications are verified prior to their joining the program's provider network. The wide array of network providers offers members a choice regarding the community services they would like to receive and of the individual providers who offer these services. Member satisfaction surveys completed several times throughout the year in a language spoken by members demonstrate their satisfaction with the flexibility of the service delivery system.

Consistent with its service area, VNS CHOICE serves a diverse multicultural population characterized by complex medical, psychosocial, and LTC needs. The program has experienced low levels of disenrollment, on a monthly basis less than 2 percent of the prior month's membership. The average length of membership for members who disenroll from the program, with more than 50 to 60 percent of disenrollments due to member death, is approximately 3 years. (Table 3 provides a demographic profile of VNS CHOICE members.)

VNS CHOICE information systems track up to five diagnoses per member and, on average, members have five clinical diagnoses. In addition, the average member has a high rate of functional deficits.

² Motor vehicle that is specifically designed, constructed, or modified and equipped and intended to be used for transporting persons who require the use of a wheelchair.

Table 3
Demographic Profile of VNS CHOICE Members

Demographic	Percent
Age¹	
65-74 Years	25
75-84 Years	46
85 Years or >	29
Sex	
Female	77
Male	23
Ethnicity	
Hispanic	33
Black	28
White	23
Asian	14
Language Spoken	
English	46
Spanish	32
Chinese	12
Russian	4
Home Environment	
Lives Alone	41
Lives with Family	39
Lives with Spouse	23
Primary Caregiver	
Have Primary Caregiver	75
Daughter/Son	51
Spouse/Significant Other	11

¹ Average age is 80.

NOTE: VNS CHOICE is sponsored by the Visiting Nurse Service of New York, the largest not-for-profit provider of home and community-based services in the U.S.

SOURCE: VNS CHOICE Key Clinical Indicators Report (January-December 2004.)

Table 4 provides a description of the functional and clinical characteristics of VNS CHOICE enrollees.

VNS CHOICE was designed around the several key principles initially identified in the New York State Department of Social Services (1996) request for proposal. These building blocks are consistent with the State's initial objectives for managed LTC, including consumer choice, involving the member and his/her family in the care planning process, improving or stabilizing level of independence and functional status, and collaborating with community

providers and facilities to provide fully coordinated care. These objectives are interwoven into all aspects of a member's care.

The care team philosophy and interdisciplinary team model integrates concepts that demonstrate the patient-centered focus of the program: comprehensive service delivery which addresses the social, environmental, physical, and medical needs of individuals while integrating both acute and LTC services; collaboration between interdisciplinary care team clinicians, members, caregivers, physicians, providers and facility staff; and continuous coordination of care, which addresses the multiple health and community services needs of the program's population.

Through the program's care management model, enrollees in effect receive a care manager for life, a nurse consultant who serves as the single point of contact for all services regardless of setting. Following an initial assessment by the nurse consultant care manager, he/she identifies and coordinates the need for clinical interventions by members of the care management team including social workers, rehabilitation consultants (physical therapist), nurse practitioners, and nutritionists. The nurse consultant also identifies and arranges for services through which the member may benefit, such as home health aide hours, meals on wheels, time spent at a local day center, and preventive services such as appointments with a community audiologist or optometrist. Ongoing communication and discussion between members of the care team, either through formal case conferences or informal consultations, presents clinicians with a consistent opportunity to monitor the changing health status of enrollees with the goal of preventing acute exacerbations, and slowing the rate of functional decline wherever possible.

Table 4
Functional and Clinical Characteristics of VNS CHOICE Members: 2004

Assistance with Activities of Daily Living ¹	Percent
Grooming	78
Dressing Upper Body	87
Dressing Lower Body	94
Bathing	97
Toileting	53
Transferring	77
Ambulation	95
Eating	82
Assistance with Instrumental Activities of Daily Living²	
Light Meal Preparation	91
Transportation	98
Laundry	99
Housekeeping	99
Shopping	99
Telephone	43
Top Primary Diagnoses	
Hypertension	19
Diabetes	14
Osteoarthritis	9
Congestive Heart Failure	6
Chronic Ischemic Heart Disease	5
Cognitive Impairment	
Moderate Cognitive Impairment	46
Severe Cognitive Impairment	8
Urinary Incontinence	
Members with any Urinary Incontinence	55
Pain	
Members for Whom Pain Interferes with Daily Activities	35
Medications	
Average Number of Medications Taken Per Member Per Month	7.7
Percent of Members Requiring Assistance with Oral Medications	70

¹ Of the 8 listed, the average member needs assistance with 5.3.

² Of the 6 listed, the average member needs assistance with 5.3.

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SOURCE: VNS CHOICE Key Clinical Indicators Report (January 2004-December 2004).

These principles are put into practice during every care team visit through the establishment, evaluation, and modification of priorities, goals, and interventions regarding the health and emotional status, level of physical and functional performance, and cognitive status of individual enrollees. Members are continuously assessed for changes in health status, sensory and cognitive impairments, depression, anxiety, functional difficulties, and

the prevalence of pain that interferes with daily activities. It is this cycle of continuous care management and care team collaboration that effectively alerts clinicians and community physicians to areas of improvement, stabilization or decline in health or functional status. The Center for Health Care Policy and Research, the research arm of the Visiting Nurse Service of New York, collects and analyzes data gathered during all assessment and

Table 5
Clinical Interventions on the Functional and Clinical Status of VNS Members: 2004

Status	Members Who Could Improve in This Activity and Did Show Improvement	Members Who Could Remain Stable in the Activity and Did Remain Stable
Functional		Percent
Dressing Upper Body	20.4	53.8
Dressing Lower Body	15.8	55.9
Bathing	19.8	54.5
Toileting	34.8	67.1
Transferring	21.4	68.6
Ambulation	10.1	73.2
Clinical		
Pain	49.6	69.6
Cognitive Impairment	37.1	63.0
Dyspnea	36.1	64.9
Confusion	36.6	66.4

NOTES: Percents based on the number of members who had both an initial assessment and the most recent (January-December 2004) assessment. VNS CHOICE is sponsored by the Visiting Nurse Service of New York, the largest not-for-profit provider of home and community-based services in the U.S.

SOURCE: VNS CHOICE Key Clinical Indicators Report (January-December 2004).

reassessment visits. Table 5 presents a snapshot of the effects of clinical interventions on the functional and clinical status of VNS CHOICE members.

On enrollment, members are assigned a nurse consultant care manager who, from the point of enrollment, functions as the primary contact for a program enrollee. Nurse consultants, in collaboration with members of their interdisciplinary care team, engage in ongoing collaborative care management to coordinate and communicate clinical assessments, and develop appropriate interventions that meet a member's medical and LTC needs.

Although nurse consultant care managers are experienced clinicians when hired, the program has developed a series of training programs to ensure that all care managers are well prepared to meet the extensive requirements of managed LTC. Clinical staff receive training in care management for members in the community, hospital and nursing home and participate in a geriatric curriculum designed to promote comprehensive care for a geriatric population. Topics covered through the geriatric curriculum include cognitive assessment and mental status of older

adults, depression, dementia and delirium, medication management, falls risk assessment and prevention, nutrition, pain management and advance care planning. New topics are continually added to the geriatric curriculum to address staff needs.

Clinical guidelines developed by VNS CHOICE and based on current evidence-based standards of practice, are used by care managers to ensure consistency in clinical practice. As developed, the guidelines generally include disease symptoms in the elderly, medical management standards, treatment and medication goals, geriatric considerations, common complications, and member education standards. Examples of specific guidelines developed by the program include dementia, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, depression, and congestive heart failure. In addition, the program has adopted prevention standards and monitors and facilitates access to preventive services, such as influenza and pneumonia vaccines, routine screening tests such as cholesterol and osteoporosis, diabetes management screening, and mammograms. Care managers work with members and their physicians to ensure

compliance with these standards. Member education accompanies all related screening and immunizations.

Pharmaceutical care is an important component of the care management process and one that helps clinical staff provide an enhanced quality of care and higher level of safety to program members. As front-line clinical managers, nurse consultants play a vital role in the strategies and practices designed to promote good medication management. Through close contact with program members, care coordination during periods of transition from the community, hospital and nursing home, regular visits to the home, and a continuous review of medications, nurse consultants are in a unique position to identify medication errors and respond quickly to signs of an adverse drug reaction, recognize drugs considered inappropriate for an elderly population, and monitor compliance with medication utilization.

CARE MANAGEMENT

VNS CHOICE focuses on member choice by including members and their families in the development of a care plan that reflects their care preferences and willingness to use substitute services, such as home delivered meals and adult day care, to the extent possible. Care planning and collaboration begins from the point an individual enrolls in the program, and continues through the member's enrollment period. Through a cycle of regular assessment and reassessment, care managers address changing medical and LTC needs and focus on efficient use of resources, prevention strategies, promotion of independence and autonomy, and close monitoring and management of chronic diseases (Figure 1).

Advance care planning is an important component of the program because most members remain with the program for life.

The program's goal is to assure that members receive care according to their wishes. Mindful of the various cultural and religious beliefs held by individual enrollees, nurse consultant care managers and social workers discuss advance directives and end of life planning with all members. These discussions ensure that member wishes are carried forth even in situations where a member may be unable to communicate his/her wishes.

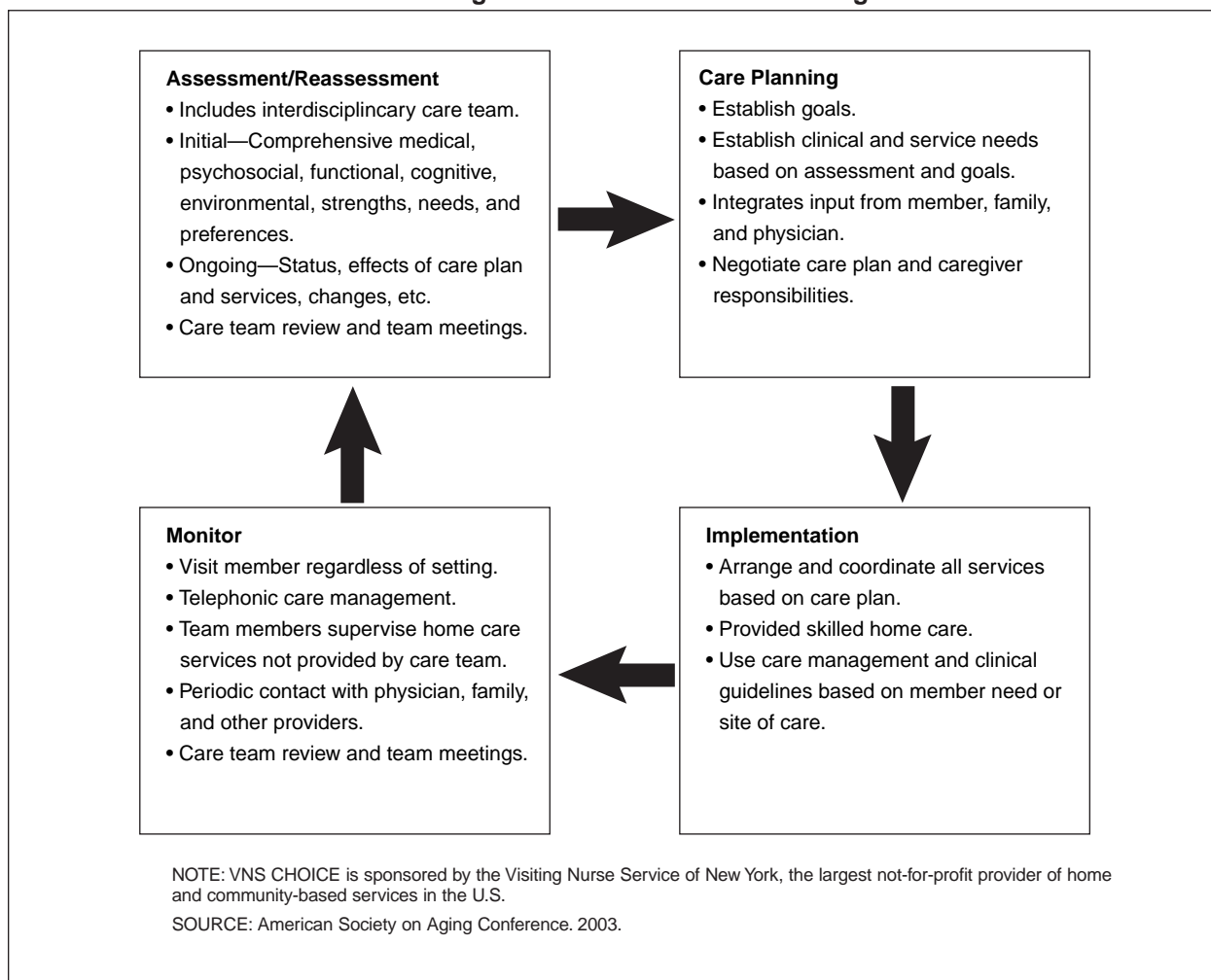
Community physicians are integrally involved in the development of a member's plan of care and are notified regarding changes in clinical status and care. Decisions regarding nursing home admissions are made jointly between the member, his/her family, and physician.

Coordination between clinical professionals within the interdisciplinary team occurs regularly. During team meetings and case conferences, clinical staff involved in the care of a member or a group of members discuss assessment findings, specific care needs, clinical problems, interventions, treatments, etc., of new enrollees and members with difficult clinical or psychosocial issues.

Care Management for Individuals in the Community

While more than 93 percent of enrollees reside in the community, the program has implemented a series of comprehensive guidelines to ensure consistent care management regardless of setting: community, hospital, or nursing home. Care team clinicians follow very specific guidelines and timeframes concerning initial and ongoing visits as well as telephonic care management for community members. More frequent visits or increased levels of telephonic care management are provided where clinically appropriate.

Figure 1
Continuous Care Management for All VNS CHOICE Program Members



Care management for a member residing in their home includes an array of interventions. Nurse consultant care managers represent the frontline of member care and play an integral role in the care planning process for all members. Within the team structure, nurse consultants assess the current needs of a member, coordinate care with clinical professionals on the interdisciplinary team, evaluate changing member needs and document these changes in the care plan, and communicate with community providers including physicians and hospital staff as well as the individual member and his/her family. Following an initial assessment by a nurse consultant, he/she

may identify the need for an intervention by a care team professional. Collaboration between members of the interdisciplinary care team attempts to address a range of care needs for the member as a whole.

For members who experience physical or functional difficulties, the nurse consultant may make a referral to a rehabilitation consultant for an assessment. Aside from providing traditional assessments and assisting members with their physical and functional difficulties, rehabilitation therapists explore opportunities to promote greater independence and maximize functionality for a program member. Often, assessments include a review of the living

environment to identify needed home modifications, such as grab bars in the bathroom or along a stairway or the removal of throw rugs to promote a safer living environment.

A nurse consultant assessment may also uncover the need for intervention by a social worker. In many instances, a social worker assessment may be necessary to evaluate the psychological, social service and environmental needs of a member. The social worker is in the best position to identify a member's eligibility for financial entitlements, alternate housing, if necessary, and discuss advance care planning to adequately address future care needs.

Nurse practitioners offer enhanced nursing care and consultation to a nurse consultant regarding a member with complicated clinical conditions. At the request of a nurse consultant care manager, nurse practitioners will visit the member and offer strategies for advanced clinical care. Nurse practitioners provide inservice clinical education to program staff, participate in case conferences and team meetings, and serve as a resource for nursing staff in the assessment and treatment of members with advanced health care needs.

Care Management in the Hospital

In New York City, the leading causes of hospitalization in the elderly include heart disease, malignant neoplasm, pneumonia, influenza, cerebrovascular disease, COPD, and diabetes. Managed LTC programs are at risk for all covered services which include: care coordination; home and community-based services such as skilled home care, personal care, durable medical equipment and medical supplies; prescription and over-the-counter medications; substitute services, such as social and medical day care, home delivered meals, and chore service; custodial nursing home; and select

ambulatory services including optometry, podiatry, audiology, and hearing aides. Acute care, whether covered by Medicare or Medicaid is outside of the benefit package. Managed LTC programs are responsible for coordination of all services and for third-party benefit coordination. The financial incentives of managed LTC programs are to ensure that members' medical and functional status' are well managed. Medically, the programs work to ensure that there are no or few exacerbations of chronic conditions, especially one that results in a hospital admission. Member hospitalizations result in deconditioning and functional decline, increased admission to nursing homes, and sustained higher costs for inhome community services.

While managed LTC programs are not at direct risk for hospital care, they do have incentives to both reduce hospitalization rates as well as to promote and manage effective care for hospitalized program members. On average, 30 percent of members have a sustained increased level of service needs following a hospitalization due to the underlying clinical reason for the hospitalization, as well as deconditioning that results from the hospital stay. By reducing admission rates and/or length of stay, and ensuring appropriate discharge planning, managed LTC programs both improve quality of care and outcomes for members, while being aligned financially with the interests of the program.

For the care team clinicians, hospital care management is an extensive and time-consuming process. On average, according to plan administrative data, the care team spends approximately 200 percent more time on care management in a given month for a hospitalized member than for community-based members without hospitalizations. The focus of care team interventions is to improve and stabilize the member's health status, aid in the return of

the member to the community, and facilitate an effective and smooth transition among and between settings of care—from the community to hospital and, following hospital discharge, from the hospital to a nursing home or back to the community. On admission to the hospital, care managers provide the facility with information concerning the member's medical history, medications, and contact information. This is an especially important role for members without family supports, and those who do not speak English. By bridging care settings and providing information to the hospital and physicians, care managers help to prevent duplication of services, identify lapses and delays in treatment that may affect the timely discharge of the member, ensure that advance directives are respected, and collaborate with hospital staff regarding the discharge of the program member.

Nurse consultants work with the hospital to plan for the member's return to the community or to a nursing home. For members returning home, supplies and equipment are ordered so that, on discharge from the hospital, the member has the services they need. Additionally, the availability of caregiver support and need for additional home health aide services, rehabilitation therapy or increased nursing visits is evaluated. For an admission to a nursing home for a short term or permanent placement, the nurse consultant consults with the member, his/her family, the community provider, and nursing home staff to ensure a smooth transition to the nursing home.

Hospital care management strategies implemented by the program have yielded positive results. VNS CHOICE data collected around hospital utilization demonstrates that care management can influence member hospitalizations. According to internal administrative data, from the 4-

year period 1999—2003, VNS CHOICE has experienced a reduction in hospital admissions and days per thousand for its members. Over this 4-year period, hospital days per thousand decreased 15 percent, and admissions per thousand by 10.8 percent. These data represent the change in rates for all members enrolled during this period of time.

Care Management in the Nursing Home

For VNS CHOICE members, post acute short-term rehabilitation therapy is the primary reason for a nursing home admission; however, as of 2005, 7 percent of the plan's members reside in a nursing home as a permanent resident. For these members, the plan remains responsible for both care management oversight and for the costs of the nursing home care. The program's goal is to manage transitions and provide continuity of care across all settings for its institutionalized members. Care managers identify the need for a nursing home admission due to conditions such as deterioration in health status, lack of caregiver support, or a condition in the home that leads to an unsafe environment for the member. Decisions regarding a nursing home admission from either the community or hospital are collaborative in nature. Care managers discuss the need for a nursing home placement and available options with the member, caregiver, care team clinicians, and community physician.

As is the case with hospitalized members, for individuals in the nursing home, care team clinicians serve as an advocate for the member and monitor the member while in the facility. On admission, information concerning the member's medical, social and environmental history and individual care preferences is shared with facility staff. Care managers participate in

nursing home care team care planning meetings, review the member's medical record, verify that changes in medical status have been addressed in a timely manner, and monitor progress toward the achievement of goals as agreed on by the nursing home.

CONCLUSION

Since the first year of program operations, VNS CHOICE has been refining and redefining care management strategies, interventions, and guidelines to better address the needs of its members. Even in those settings where the program has collaborative responsibility only, care management guidelines and strategies have had a positive effect on the medical and long-term health status of members. Over the last 7 years, the program has successfully collaborated with individual member physicians to improve the functional and clinical status of enrollees while promoting an enhanced level of medication management. Coordinating with community providers shapes the care plan for individual enrollees. Care managers have encouraged members to use services that can substitute for traditional home care, such as home delivered meals, social day center, and environmental modifications. Transportation is a key covered benefit to ensure that members have easy access to their community physicians and ambulatory service providers such as dentists, optometrists, podiatrists, and audiologists.

Through a series of guidelines and protocols, the program provides care management for members in the community, hospital, and nursing home and effectively manages transitions among and between settings and providers. By developing collaborative working relationships with hospitals (which are not included in the net-

work of contracted community providers) and nursing homes, the program has become increasingly effective in executing its care management roles in these settings.

Managed LTC brings together home and community based services, institutional-based LTC and traditional medical care through an array of comprehensive care coordination strategies which focus on prevention, the treatment and management of chronic illness and related complications and LTC service needs. Managed LTC programs are helping to reshape the relationship between chronic illness and supportive LTC service providers for a population with multiple medical, social, environmental, and LTC service needs. The outcome of managed LTC is a coordinated approach to care that addresses a wide array of medical and LTC service needs for a medically complex and functionally at-risk population.

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