One percent of our nation is struggling for health. Not financial health or political fortune. But plain and simple health. These are the elderly, frail, long-term care patients whose struggle every day to live as independently as possible with their complex health conditions makes them the costliest 1 percent in the nation to care for.

Traditionally, these elders of our community would be in nursing homes. It’s a necessary solution, certainly in some cases, but only when the patient’s needs truly dictate that level of care.

Today, CenterLight Health System in New York City is changing that tradition and finding more ways to provide the care patients need in their own homes. CenterLight’s perspective is unique since the nonprofit organization serves more than 9,000 patients a day as both a provider of health care services and an operator of managed care.

Clive Fray, a 70-year-old resident of the third floor of a large, brick
apartment building in the Bronx, is one of those 9,000 patients and the larger 1 percent. “I feel very happy to be where I am,” says Fray. “This is my place. This is my home.”

Fray’s home, however, is not your average apartment in the city. He lives in Scheuer Gardens, which is operated by CenterLight Health System, and is enrolled in CenterLight Healthcare’s Program of All-Inclusive Care for the Elderly (PACE). PACE is funded by the federal Centers for Medicare and Medicaid Services as a way to promote coordinated care for dual-eligibles in the home.

Living in his own apartment, receiving care in his building with nurses and therapists who come to him, he couldn’t be happier.

For Fray and others’ care, there are two key ingredients that are intimately intertwined: nurses and that all-important coordination. At CenterLight, nurses are really the “hub” in a “hub and spoke model” of care. They are the caregivers who meet with the patient first; understand their medical, physical, social, emotional, and cultural needs; and build a care plan around those needs. As a bridge joining physicians, therapists, and social workers, the nurse is the one coordinating with the other team members to deliver care.

Whenever possible, CenterLight’s nurses plan that care at the patient’s home or at locations close to them, in their communities. Here are a few examples of how the organization is providing care in the home so that patients’ quality of life is as good as it can be:

PACE

Long-term care patients often fare better at home. That’s the mantra behind PACE, a model that is gaining national exposure and is active through 82 programs in 29 states. CenterLight operates the largest and one of the oldest PACE programs in the nation. Serving more than 3,000 patients a day, CenterLight’s PACE program offers therapeutic recreational activities as well as primary medical care to patients at centers close to their homes throughout the metropolitan New York area. A small percentage who live in nursing homes are also able to be part of the PACE program.

“As a bridge joining physicians, therapists, and social workers, the nurse is the one coordinating with the other team members to deliver care.”

PACE allows the nurse, as a member of an interdisciplinary team, to develop coordinated care plans for patients. This means bringing physicians, therapists, social workers, patients and families around the table to determine how to best care for that patient, ensure no duplication or adverse interaction of the recommended care, and keep patients living as independently as possible. All of it is funded under a capitated model, where an insurer pays a certain amount per patient per month.

The results add up to create a better quality of life for patients. In fact, only 6 percent of CenterLight’s PACE patients live in nursing homes, as opposed to roughly 50 percent of a proxy nursing-home-certifiable population in Medicaid fee-for-service. And hospital days are lower for these patients due to a better understanding of what they need and an effort to keep them healthy and not just treat ailments as they arise.

Diversity

New York is the most diverse city in our nation, so CenterLight has added a unique component as a focus of its care: diversity and cultural difference.

“In creating care plans that are unique to our patients, we know that they have needs and preferences that have nothing to do with physical ailments,” says Alvin Empalmado, assistant vice president of clinical operations. “Instead, they have everything to do with whether or not they are being treated with respect and whether their cultural preferences are being appropriately incorporated into their treatment plan.”

What better place to deliver that care than in the communities in which they live, which are largely organized around their ethnic backgrounds.

For example, at the East Harlem PACE center, more than 250 patients are seen on a regular basis. Most of them are Hispanic; however, a group of six Korean patients recently became PACE members, utilizing the facility daily. This led the site director, Eileen O’Brien, RN, to hire a Korean translator just so that these six individuals can understand the PACE doctors’ advice and participate in the activities more fully.

Cluster Care

In offering PACE to patients, CenterLight began realizing opportunities to be more effective in care as well as more efficient with nurses’ time. The solution is a Cluster
Care program, which lets a nurse and nurse aide focus on small groups of patients that live in their own apartments in CenterLight-sponsored housing. A similar concept has several patients sharing an apartment and the assistance of an aide.

This focus also lets nurses see the small changes in their patients’ health, and determine how to best meet their patients’ needs before they become an issue.

“Cluster care and shared housing really make a difference for our residents,” says CenterLight Healthcare PACE Director Ginette Sangosse. “These are people who wouldn’t be able to live on their own if they didn’t have someone on the premises they knew they could call on in an emergency.”

**Telehealth**

In recent years, telehealth has gained significant momentum in the health care industry, particularly in home care settings. In 2010, the Long Term Home Health Care Program, also operated by CenterLight Health System, instituted the practice, which allows monitoring of patients for daily blood pressure and blood glucose through web-based platforms that provide real data. This means the patients do not have to go in to a clinic or physician’s office to have these basic vitals taken.

“Telehealth lets us see how patients are faring in between nurses’ home visits,” says Joan Mitchell, telehealth manager. “Are they taking their medications and complying with prescribed regimens? Is there a dangerous day-to-day variability in glucose or blood pressure, even though periodic averages appear acceptable? If we can answer these questions, we can know how to keep them healthy rather than needing, for example, a trip to the ER.”

To make telehealth even more effective, telecare nurses at AMC Health work in collaboration with CenterLight’s home care nurses to ensure timely and appropriate responses to issues that emerge for patients on telehealth. Motivational Interviewing (MI) is used when counseling a patient. MI’s tenets are molded on an approach to care management that sees the patient as a partner and develops care plans that are negotiated, not dictated. Equally important, MI methodology emphasizes the power of incremental successes over grand life changes.

The results from telehealth are remarkable. In 2011, for patients on the program with diastolic hypertension at baseline or standard clinical guidelines, average improvement translated into nearly a 29 percent reduction in risk of cardiac events and a 20 percent reduction in risk of stroke. Daily telemonitoring and timely responses helped in improving patients’ health status.

Adds Mitchell: “There’s no need to wait anymore until the next quarterly blood test or clinical evaluation. Patients and care managers can receive proof that they are making progress toward improved health care outcomes on an ongoing basis.”

**Where Health Care is Headed**

Coordination. Patient-centered. Focused. CenterLight truly believes that these are the words that will define health care for years to come. So the organization is already down the path in making those hallmarks of care.

“We are, first and foremost, providers of care to our patients. We put them at the center of everything we do. We measure our success based on the contribution we can make to improving and maintaining the quality of their life,” says Joseph Healy, chief operating officer of CenterLight Healthcare. “At this stage in their lives, to have the best life possible while living independently in their community, the 1 percent of seniors with complex health issues needs a variety of services that can only be provided by an organized team. Helping them achieve that is what we are all about.”

To learn more about CenterLight’s continuum of care options, and specifically more about their home care options, visit www.centerlight.org.

**About the Authors:** With over 25 years of nursing leadership in healthcare, Mary Wehrberger, vice president of clinical operations, oversees all of the clinical services and operations functions to assure quality, cost-effective care to CenterLight Healthcare’s 7,200 members in 14 PACE and 5 Select programs in eight counties.

Florence Marc-Chard is a registered nurse with over 30 years experience in home health care administration. As vice president of home care services at the Center for Nursing and Rehabilitation, for CenterLight Health System, she serves geriatric and AIDS patients in the boroughs of Brooklyn, Bronx, Queens and Manhattan.