There Is No ‘I’ in ‘Safety Net’

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For Felicia Barrow, whose illnesses over the last 20 years include HIV, Hepatitis C, hypertension, osteoarthritis and breast cancer, no single health expert nor course of treatment could weave a true safety net of care. It takes a *team*.

At the center of Mrs. Barrow’s team is Felicia herself; her needs, her feedback, and her participation are essential. Then, working collaboratively and across all facets of her daily life, she is supported by a nurse-led team of health professionals who make sure she gets to her doctor’s appointments, maintains good baseline health, fully understands and complies with her medications, and successfully overcomes the depression and anxiety that can result from isolation.

Each week, a registered nurse — who is in constant communication with Mrs. Barrow’s doctor — visits her to conduct physical assessments, reconcile complex medication regimens, manage multiple chronic illnesses and facilitate care transitions across settings to keep her healthy. Her certified home health aide helps her with shopping, cleaning, bathing, and getting out, whether to the park or a doctor’s appointment. And a social worker connects Mrs. Barrow to support groups when she is depressed, assists with crucial Medicaid/Medicare and disability paperwork, and, during the hottest summer on record, helped her successfully apply for an air-conditioner for her stifling public-housing apartment.

“It’s not only medical,” Mrs. Barrow says of her care. “The team helps with everything, with *life*.”

The Right Care For Our Times

We all want our health care delivery system to be more efficient, less costly, and better able to meet each patient’s holistic needs. We know that reigning in the mounting costs of re-hospitalization, emergency care and other often preventable interventions is essential to building a better system for patients, providers and payors alike. I’ll delve more deeply into these and other critical issues at the center of the budget sequestration crisis in my next post, but it is important to recognize that cost effective team-based solutions *are possible now*.

Thought and practice leaders, including the Institute of Medicine, the, and the Robert Wood Johnson Foundation, through initiatives such as Improving Chronic Illness Care (ICIC), are calling for and developing exemplary models of and best practices in collaborative, interprofessional care. The Centers for Disease Control and Prevention recently recommended home care-centered, team-based care for hypertensive patients, based on strong evidence that it improves blood pressure control. Visiting nurse-led teams have been shown to improve patient outcomes in cases of multiple chronic conditions, and the National Diabetes Education Program recommends collaborative, multidisciplinary care to treat diabetes.

Our organization's managed long-term care health plan, VNSNY CHOICE and those of other innovative leaders such as Kaiser Permanente are proving that experts can work together to advance care for the most vulnerable Americans in the ultimate laboratory: daily life. These teams include home- and community-based nurses, home health aides, behavioral health experts, doctors, hospitals, discharge personnel, rehabilitation therapists, social workers, bereavement counselors and nutritionists, all working together with the patient's physicians.

Earlier this year, New York State took a bold step to make team-based care — in the form of managed long-term care — mandatory across the state for Medicaid beneficiaries who need long-term care services in the community. These are some of the most medically-fragile New Yorkers, who, with very limited resources, struggle with such chronic (and often multiple) conditions as diabetes, obesity, hypertension, congestive heart failure, depression, isolation and anxiety.

No longer will they receive care in an ad hoc or episodic fashion. Rather, when New York State residents who depend on Medicaid need long-term care, qualified health professionals will guide and supervise their health, convening medical, behavioral, dental and social care around the patient. In the case of our Medicaid MLTC health plan VNSNY CHOICE, which served as a model of efficiency for New York State's Medicaid reform, a nurse-led home- and community-based *team* will weave that vital safety net.

Building a Better Safety Net

There is no safety net when our health care system incentivizes unnecessary tests through a fee-for-service model.

There is no safety net when Provider A does not talk to Provider B and no one takes into account that a patient cannot get to the clinic for a follow-up, does not understand medication instructions, or thinks her dementia symptoms are just a part of "getting old."

We need teams to build and maintain that safety net. We need collaboration.

Without a team, health services for a New York policeman with sickle cell anemia, forced by disability to retire in his mid-50s, might have stopped with wound care, which was how he first came to be cared for by our organization. But, noting his depression and isolation, the nurse tending the wound brought in a behavioral health counselor, who is reconnecting him to the outside world. This includes helping him resume a beloved hobby by finding affordable photography equipment, as he sold his in the depths of his depression.

Without collaboration and follow-up, an 80-year-old great-grandmother with diabetes and hypertension cannot stick to her plan of care because she keeps coming home from the store with canned and prepared foods high in sugar and sodium. So, across the Bronx, care teams are doing more than *suggesting* healthy meals to their clients. Registered dieticians and home health aides who are part of our MLTC health plan team literally accompany patients to corner bodegas to shop for fruits, vegetables, skim milk and other healthy ingredients.

And rehabilitative therapy alone can achieve only so much for a 70-something widow in Queensbridge who cannot leave her apartment or even check her mail because of chronic obesity. But with the help of a highly skilled nurse-led team, which includes a dedicated social worker who made it her mission to get her patient enrolled in an intensive weight loss program, our Queensbridge patient can embark on lifestyle changes that greatly improve her quality of life, safety and outlook for the future.

Letters to the Future

Early in my career, I was part of a team who cared for a young father with ALS, or Lou Gehrig's Disease, as his body shut down bit by bit. Nurses and therapists monitored his feeding tube, responded to emergency breathing problems, conducted range-of-motion exercises, and managed his pain. A home heath aide helped him with daily needs such as cleaning, eating and staying safe in his home.

One detail of this early experience serves as an example of the profound impact that team-based care can have on not just a patient but a "life," as Mrs. Barrow says. At the end of every day, the aide sat by this young man's side as he — unable to move — dictated letters for his small children to read when they were older.

Our home care team provided the continuity, trust and comprehensive care necessary to meet the human needs of this very sick father and his family.

It is an experience I will never forget.

For more on caregiving, click here.

For more by Mary Ann Christopher, click here.