

IMPLEMENTATION OF A NURSE-DRIVEN FRAILTY SCREENING TO IMPROVE ACCESS TO HOME-BASED PRIMARY CARE

A DOCTOR OF NURSING PRACTICE PROJECT

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SCHOOL *of* NURSING

BACKGROUND

HOME BASED PRIMARY CARE (HBPC):

Continuous in-home primary & palliative care from an interprofessional team that provides routine and urgent care services to homebound adults with high healthcare utilization due to multiple chronic conditions.



SIGNIFICANCE

- Proactive care tailored to patient preference & needs
- Vigilant patient monitoring
- Targets avoidable utilization, complications, and medication errors
- Provides access to care for “invisible homebound”

HOME-BASED PRIMARY CARE



Compassionate, Cost-Effective Care for the “Invisible Homebound”

WHO ARE THE “INVISIBLE HOMEBOUND”?



2 MILLION

frail, seriously ill and home-limited older adults unable to visit physicians' offices

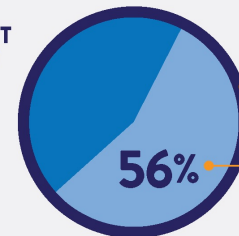
HBPC IS PREVENTIVE MEDICINE

Vigilant patient monitoring, care management and preemptive interventions help



- ✓ Prevent chronic conditions from getting worse
- ✓ Avoid unnecessary emergency department visits and hospitalizations

U.S. PATIENT CARE COST



WHAT IS HOME-BASED PRIMARY CARE (HBPC)?

Teams of HBPC professionals that deliver appropriate primary or palliative care in the home according to patient preferences

A new standard of care for high-risk, medically vulnerable homebound adults



HBPC IS COST-EFFECTIVE

Proactive, preemptive care targets healthcare's major cost drivers...

- Re-admissions
- ED visits
- Avoidable complications
- Medication errors



... for the invisible homebound who account for about half of the costliest 5% of patients and are responsible for out-of-control healthcare costs

\$1.6 TRILLION
spent on patient care in U.S.

\$909 BILLION
spent on people living with both chronic conditions and functional limitations

PROVEN BENEFITS

- Reduces avoidable utilization (hospitalizations, ED visits)
- Improves Patient/Caregiver Satisfaction
- Reduces Cost
- Decreases Mortality

PROVEN BENEFITS FOR PATIENTS AND PAYERS

VETERANS ADMINISTRATION STUDY

9,425
Newly enrolled
HBPC patients

10.8%
Lower annual
Medicare costs

83% Highest ever patient
satisfaction scores²



HBPC END-OF-LIFE CARE PROGRAM

in Wheaton, IL



DECREASED
MORTALITY
RATES

Most patients spent **0** time in the hospital in last 3 years of their lives³

HBPC PROGRAM in the Washington, D.C. area

20% FEWER
emergency department visits

27% FEWER
skilled nursing facility stays

23% FEWER
specialist visits

9% FEWER
hospitalizations³

HBPC PROGRAM at 6 Philadelphia academic and community hospitals

3 MONTHS

OF POST-HOSPITALIZATION
HOME CALLS

CUT READMISSIONS BY

MORE THAN 50%



HBPC: THE RIGHT THING TO DO

New standard of care should be an essential benefit in all health plans

- Provides vulnerable and underserved patients access to continuous care
- Alleviates social stressors
- Preempts avoidable emergency department visits and hospitalizations
- Improves patient satisfaction
- Achieves better outcomes at lower costs



The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults

FINANCIAL ANALYSIS

YEAR #3			3 Year Total
Unit savings	# Units	1 Year Savings	
\$ 15,200.00	60	\$ 912,000.00	\$2,736,000
			\$1,000,000
Net Savings			\$1,713,010
Return on Investment (ROI)			85%
\$ 15,200.00	626	\$ 9,515,200.00	\$19,942,400
Net Savings			\$17,919,410
Return on Investment (ROI)			886%

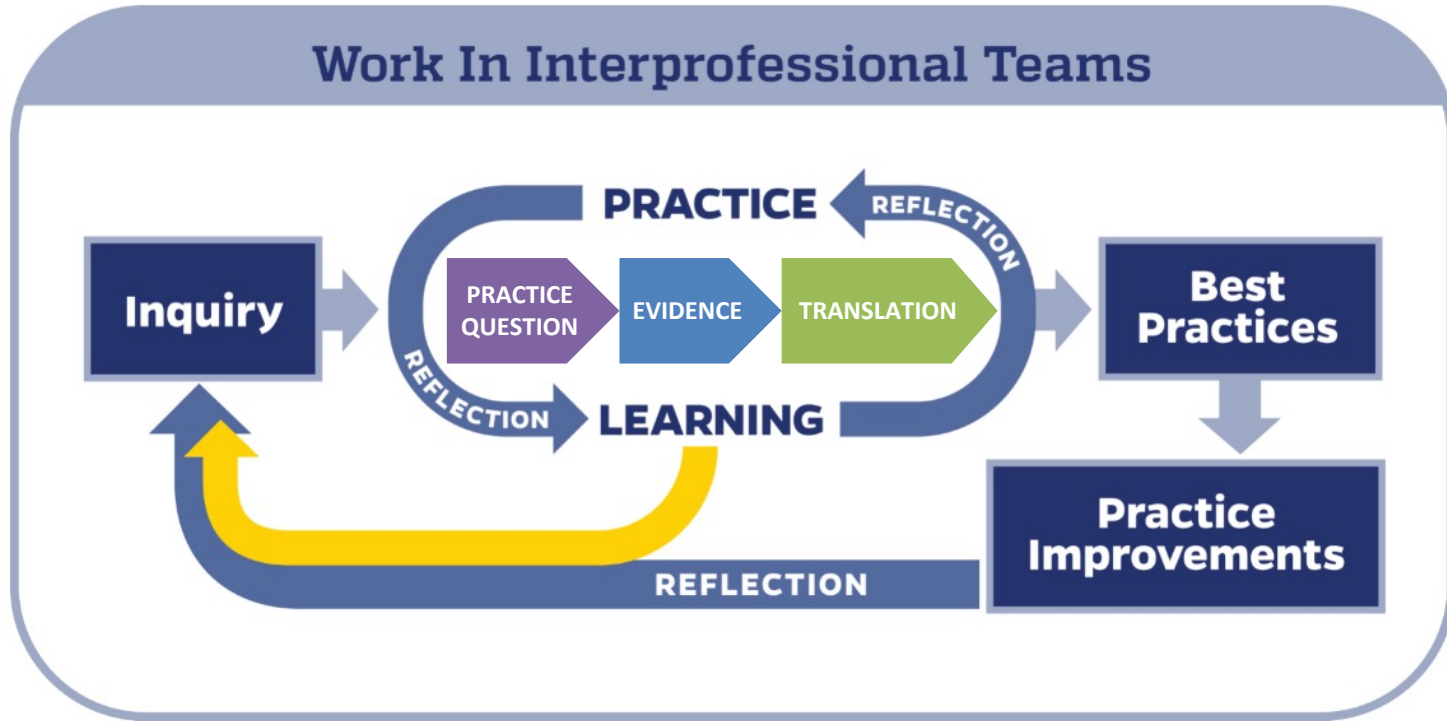
Comparing the average cost of a HBPC program against the revenue generated in preventing hospital readmissions yields significant return on investment.

EQUITY AND INCLUSION

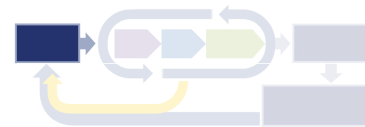
Ornstein et al., 2015 examined epidemiological trends for the United States' homebound population and found that:

- only **12% of the homebound population reported having access** to in-home primary care.
- Homebound individuals were **older**, more likely to be **female**, and of **nonwhite race** compared to non-homebound individuals.

JOHNS HOPKINS EVIDENCE-BASED PRACTICE MODEL




PROBLEM INQUIRY



What are current barriers to accessing HBPC at the practice setting?

- Lapse in care coordination existed from hospital discharge to enrollment in the HBPC program
- Lack of formalized process for identifying frail, homebound (HBPC eligible) patients prior to inpatient hospital discharge.
- Outpatient frailty screening with the Clinical Frailty Scale

CLINICAL FRAILTY SCALE

	1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally , e.g., seasonally.
	3	MANAGING WELL	People whose medical problems are well controlled , even if occasionally symptomatic, but often are not regularly active beyond routine walking.
	4	LIVING WITH VERY MILD FRAILITY	Previously “vulnerable,” this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities . A common complaint is being “slowed up” and/or being tired during the day.
	5	LIVING WITH MILD FRAILITY	People who often have more evident slowing , and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

	6	LIVING WITH MODERATE FRAILITY	People who need help with all outside activities and with keeping house . Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	7	LIVING WITH SEVERE FRAILITY	Completely dependent for personal care , from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
	8	LIVING WITH VERY SEVERE FRAILITY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a life expectancy <6 months , who are not otherwise living with severe frailty . (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

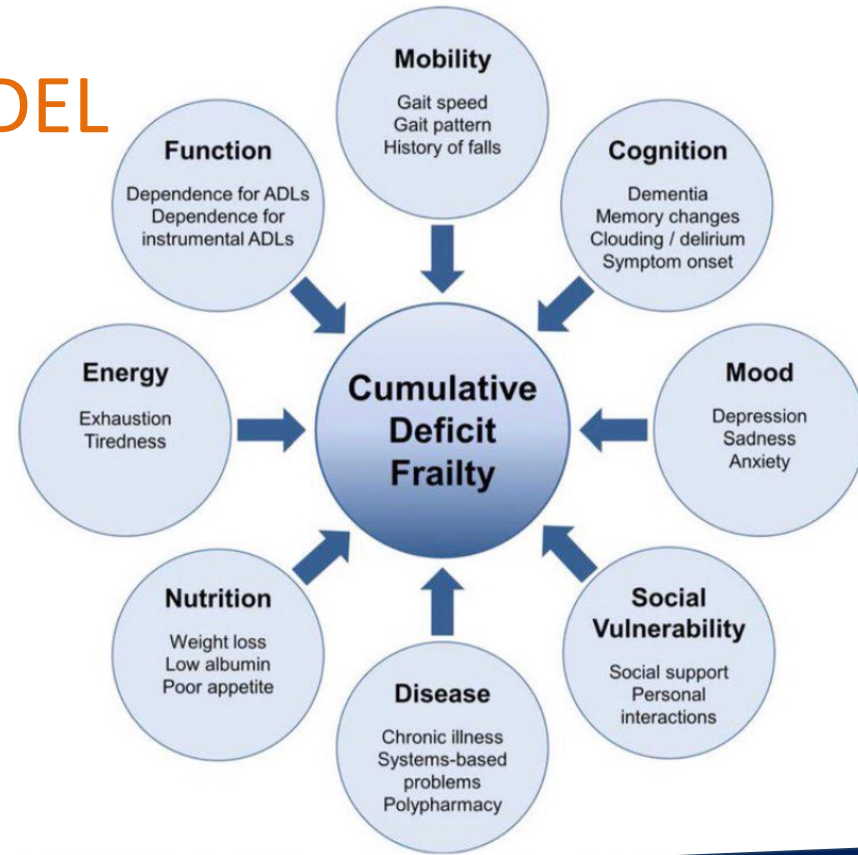
In **very severe dementia** they are often bedfast. Many are virtually mute.



Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

CUMULATIVE DEFICIT MODEL

Frailty is the result of an aging process in which the accumulation of age-related deficits predict poor outcomes.



PET PROCESS



I. Practice Question

1. Recruit interprofessional team
2. Define the problem
3. Develop and Refine EBP Question
4. Identify Stakeholders
5. Determine Project Leadership
6. Schedule Team Meetings

II. Evidence

7. Search for evidence
8. Appraise evidence
9. Summarize the individual evidence
10. Synthesize strength & quality
11. Develop recommendations

III. Translation

12. Determine fit of recommendation(s)
13. Create action plan
14. Secure support and
15. Implement action plan
16. Evaluate outcomes
17. Report outcomes to stakeholders
18. Identify next steps
19. Disseminate findings

PHASE I: PRACTICE QUESTION



I. Practice Question

1. Recruit interprofessional team
2. Define the problem
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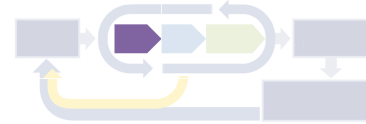
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INTERPROFESSIONAL TEAM RECRUITMENT



Inpatient: Acute Cardiology Unit

Nurses

Charge nurses

Cardiologists

Resident Physicians

Case Managers

Nursing Manager

Outpatient: HBPC program

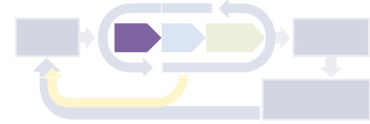
Nurse

Nurse Practitioner

Physician

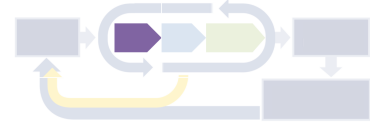
Pharmacist

DEFINE AND DEVELOP EBP QUESTION



Can the inpatient team use the Clinical Frailty Scale to improve identification of frail hospitalized adults to increase access to Home-based Primary Care?

PROJECT ORGANIZATION



- Identify Primary Stakeholders: Nurses
- Determine Project Leadership: Charge Nurses
- Schedule Team Meetings: Morning Huddles

PHASE II: EVIDENCE



I. Practice Question

1. Recruit interprofessional team
2. Define the problem
3. Develop and Refine EBP Question
4. Identify Stakeholders
5. Determine Project Leadership
6. Schedule Team Meetings

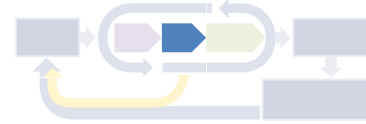
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EVIDENCE SYNTHESIS



Validity

The CFS had the strongest association to mortality and “discharge not to home” when compared to other frailty scales (Aucoin et al., 2020).

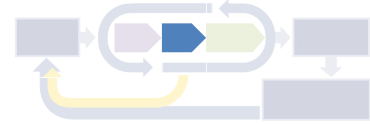
Utility

The CFS was the superior instrument for use in acute care patients in terms of speed and ease of use (Lewis et al., 2019).

Discharge Outcomes

Moderate to severe CFS scores were correlated to poor discharge outcomes (Kanenawa et al., 2021; Tew et al., 2021).

EVIDENCE BASED RECOMMENDATION



The evidence supported the use of the Clinical Frailty Scale to improve identification of frail hospitalized adults at risk for poor discharge outcomes in an acute care setting to increase access to effective discharge resources, like home-based primary care.

PHASE III: TRANSLATION



I. Practice Question

1. Recruit interprofessional team
2. Define the problem
3. Develop and Refine EBP Question
4. Identify Stakeholders
5. Determine Project Leadership
6. Schedule Team Meetings

II. Evidence

7. Search for evidence
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III. Translation

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METHODS & IMPLEMENTATION





FRAILTY QUESTIONNAIRE


For each question, please select all of the options that apply to you.


Two weeks **BEFORE** your current illness...

Q1. Did you need help with any of the following personal care?


 Using the toilet



 Getting dressed



 Bathing/Showering



 Walking

**Stop here if you have selected any of the options above.*

Q2. Did you need help with any of the following activities?



 Going outside



 Handling Money


 Taking Medications


**Stop here if you have selected any of the options above.*


Q3. Did you feel constantly tired throughout the day?


 Yes


 No

Q4. Did you feel that you were walking slower than usual?


 Yes


 No

CLINICAL FRAILTY SCALE

Quick guide to scoring the CFS after completion of questionnaire

QUESTIONS	CLINICAL FRAILTY SCALE
Q1	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">ALL 4 ticked → CFS 7-8 Severely Frail</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">1-3 ticked → CFS 6 Moderately Frail</div>
Q2	ANY ticked → CFS 5 Mildly Frail
Q3 Q4	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">YES for either → CFS 4 Pre-Frail</div> <div style="border: 1px solid black; padding: 5px;">NO → CFS 1-3 Robust</div>

Rockwood K, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ*. 2005;173(5):489-495. doi:10.1503/cmaj.050051.

If your patient scores a 6 or greater, they may be eligible for Home-Based Primary Care

- Weekly educational sessions utilizing handouts
- How to document CFS score EMR designated flowsheet
- How to refer to HBPC
- Defined a CFS score of 6 or greater as potentially eligible

METHODS

Handout #2

(redacted)

The **at Home Program (VaH)** is a home-based primary care program for older adults living with complex medical concerns and needs, who are confined to their homes ("homebound") due to medical, functional, and/or cognitive difficulties.

Through two years of service, VaH has decreased hospitalizations and emergency department visits among participants in the program by nearly half.



For more information, view Patient Programs at [.com](#).

The program offers comprehensive, person-centered primary care for older adults with complex morbidity that is responsive and equitable. VaH utilizes intensive care coordination, and medication management to provide primary care to individuals who experience difficulties in access to care.

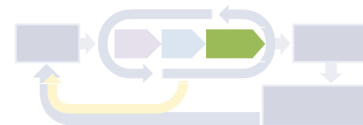
How does this program benefit my patient?

- **For homebound persons**, home-based primary care (HBPC) is a model that has been shown to improve quality of care and patient satisfaction by bringing primary care directly to patients' homes.
- HBPC programs have also significantly **reduced** participants' need for **emergency department visits and hospitalizations**.
- **Regular House calls** are provided to streamline care and prevent avoidable acute care utilization.
- **Caregiver Support** and **education** is delivered through house calls, and referrals to existing community providers.
- **Advance Care Planning** is offered to document and support participants' care goals.

Potentially eligible participants must meet Medicare criteria for "homebound" status, which Medicare defines as "You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury."

Persons living with dementia and multiple chronic medical conditions are particularly prone to being homebound, but VaH can be considered for any homebound adult with complex health needs for whom the usual sources of care are not working.

For example, homebound persons struggling with multiple hospitalizations and emergency department visits often benefit from VaH's coordinated model of care in the home.



METHODS: PROJECT SCHEDULE



Content Outline	Description of Learners	Setting	Education Details
Week 1: Education Session 1 Handout review	Staff nurses, nursing case manager, acute cardiology LIPs	Inpatient Unit	Staff nurses completed screening flowsheet in EMR, findings presented to case manager
Week 2: Education Session 2 Handout review	Staff nurses, nursing case manager	Inpatient Unit	Staff nurses completed screening flowsheet in EMR, findings presented to case manager
Week 3: Education Session 3 Handout review	Staff nurses, nursing case manager, acute cardiology LIPs	Inpatient Unit	Same as prior + eligible patients were discussed in discharge rounds
Week 4: Education Session 4 Handout review	Staff nurses, nursing case manager	Inpatient Unit	Same as prior + eligible patients were discussed in discharge rounds

METHODS



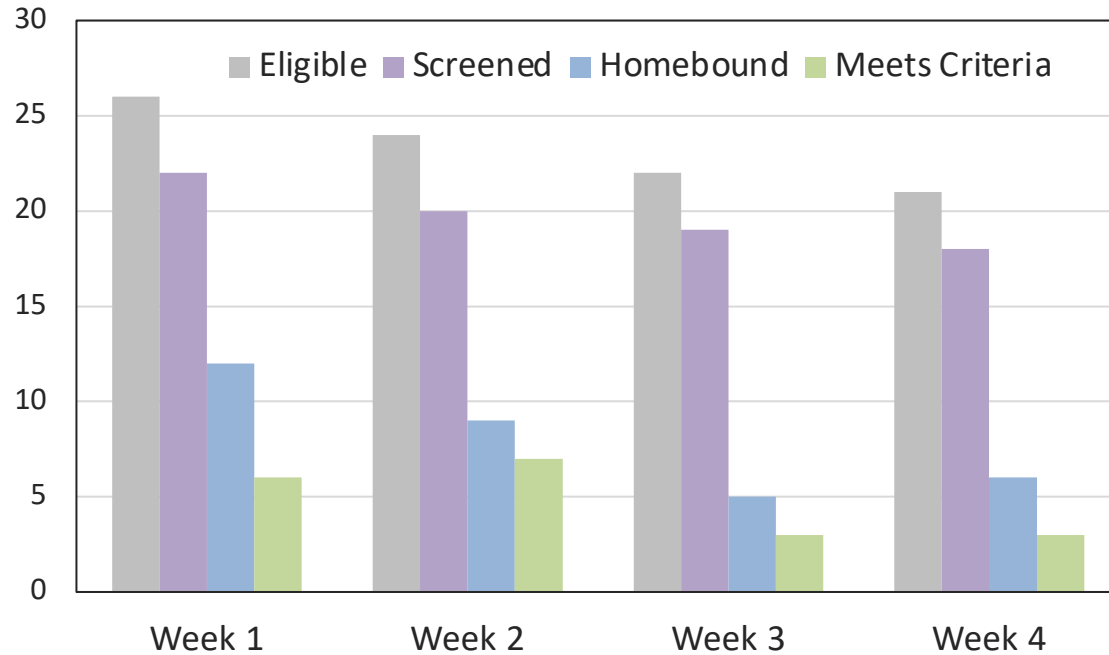
- Prospective chart audit to ensure CFS completion
- Weekly review of identified patients with the unit-based nursing case manager
- Referrals tracked prospectively during the project period and 1 month post project

OUTCOMES



Week	Eligible	Screened	Mean Frailty Score	Homebound	Meets Criteria
1	26	22	4.91	12	6
2	24	20	4.90	9	7
3	22	19	4.11	5	3
4	21	18	3.94	6	3
Total	93	79	4.49	32	19

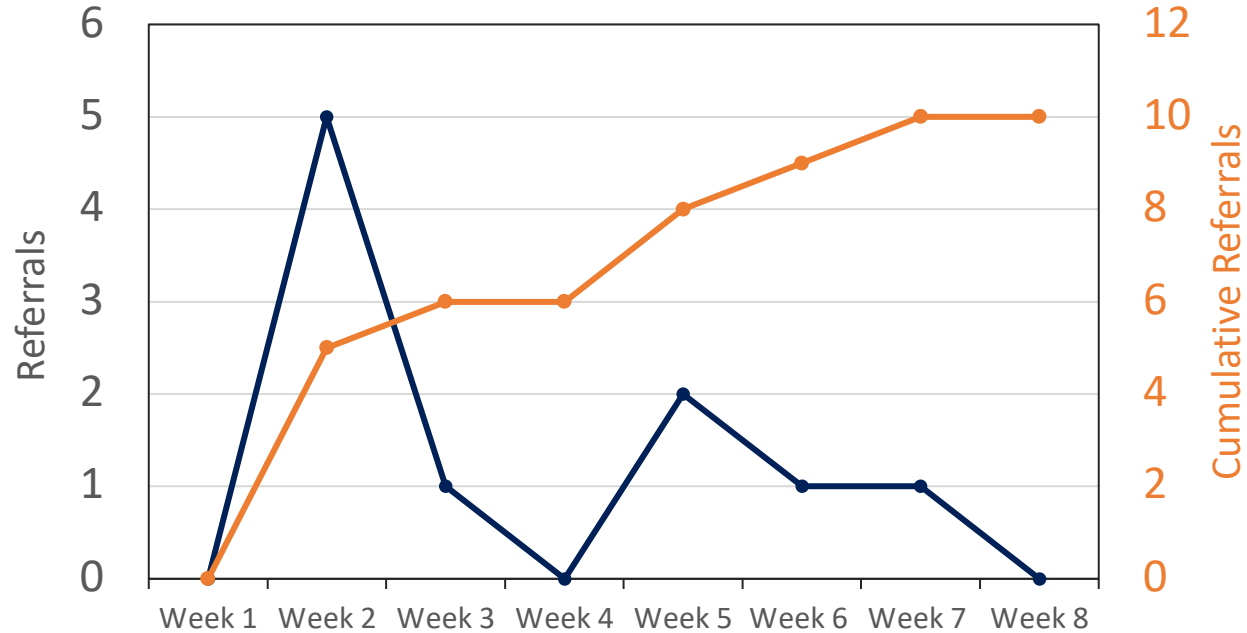
OUTCOMES



OUTCOMES



Referrals By Week





DISCUSSION

- Referrals increased significantly during the study period
- Successful adoption of the CFS tool by inpatient nursing staff
 - 85% adherence rate
- Increased nursing staff confidence in frailty identification
- Project accessed a population most likely to benefit from frailty screening
 - 40% screened as homebound
- Including specialized nursing roles for intervention was a success
 - 8 referrals from case management, 1 from NP, 1 from HF navigator

NEXT STEPS & SUSTAINABILITY



- Integration with interdisciplinary discharge rounds and admission database
- Implementation on additional inpatient units
- Foster long term collaboration between inpatient/outpatient providers for improved care coordination & transitions of care

REPORT & DISSEMINATE FINDINGS



- UVA SON Submission (Libra) and Poster Presentation
- Journal of the American Geriatrics Society (JAGS)
- Poster Presentation AGS Scientific Meeting May 2023
- UVA Health 2023 EBP Symposium

DNP PROJECT TEAM

- ❖ Regina DeGennaro, DNP, CNS, RN, AOCN, CNL
 - Faculty Advisor
- ❖ Justin Mutter, MD, MSc
 - Practice Mentor
- ❖ Halima Walker MSN, RN, CCRN
 - Practice Mentor
- ❖ Sarah Craig, PhD, RN, CCNS, CCRN-K, CHSE, CNE
 - 2nd reader

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- ❖ David Egley, RN
- ❖ Ivora Hinton, PhD, Coordinator, Data Analyses and Interpretation, UVA SON
- ❖ David Martin, Health Sciences Library Clinical Data Research Specialist
- ❖ Ethan Heil, PE, Graphic Design, Emotional Support



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QUESTIONS?

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APPENDICES

- Structure slide Phase I
- Structure slide Phase II
- Evidence Search and Appraisal
- Teaching Plan
- Limitations and Ethical Considerations
- Financial Analysis

PHASE I: PRACTICE QUESTION

Step 1: Recruit interprofessional team

Step 2: Define the problem

Step 3: Develop and Refine the EBP Question

Step 4: Identify Stakeholders

Step 5: Determine Project Leadership

Step 6: Schedule Team Meetings

PHASE II: EVIDENCE

Step 7: Conduct internal and external search for evidence

Step 8: Appraise the level and quality of each piece of evidence

Step 9: Summarize the individual evidence

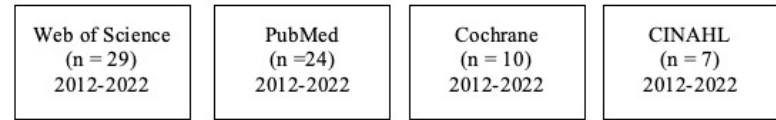
Step 10: Synthesize overall strength and quality of the evidence

Step 11: Develop recommendations for change based on evidence synthesis

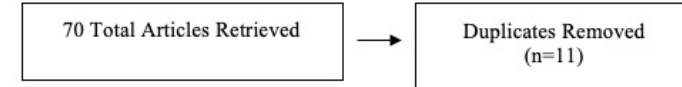
EVIDENCE SEARCH

- 70 articles identified from 4 databases
- 22 excluded due to non-relevance to PICOT question
- 19 excluded for using alternate frailty screening (not CFS)
- 9 Excluded for not addressing discharge outcomes

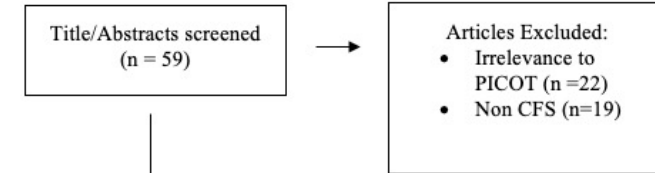
Identification



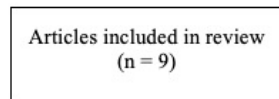
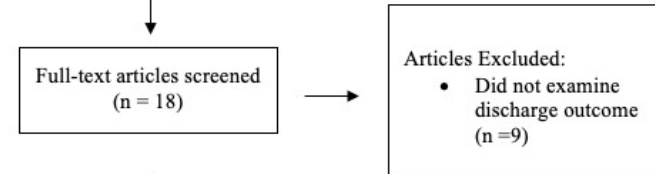
Screening



Eligibility



Included



STEP 8: EVIDENCE APPRAISAL

Study (Author, Year)	Study Design	Level of Evidence
Aucoin et al. (2020)	Systematic Review and Meta-Analysis	II, A
Church et al. (2020)	Scoping Review	III, A
Curtis et al. (2018)	Retrospective cohort study	II, A
Juma et al. (2016)	Prospective cohort study	II, A
Kanenawa et al. (2021)	Retrospective cohort study	II, A
Lewis et al. (2019)	Prospective cohort study	II, A
Mazzola et al. (2022)	Retrospective cohort study	II, A
McLeod et al. (2016)	Exploratory Case Series	III, A
Tew et al. (2021)	Prospective cohort study	II, A
Wharton et al. (2019)	Retrospective cohort study	II, A

STEP 15: TEACHING PLAN

Content Outline	Weekly Objectives	Project Objectives
Week 1: Information Session 1	1, 2	1.) Integrate frailty nursing knowledge into the acute care environment. Incorporate interrelatedness of frailty and poor discharge outcomes.
Week 2: Information Session 1	1,2,3	2.) Demonstrate ability to create a CFS score using an EMR flowsheet.
Week 3: Information Session 2	1,2,3	3.) Demonstrate skill in application of the CFS score to referral to HBPC.
Week 4: Information Session 3	1,2,3,4	4.) Use the CFS to guide prioritization and clinical decision making to assign appropriate discharge interventions.

LIMITATIONS



- Critical staffing days correlated to a significant drop in referrals from the unit staff
- Proportion of homebound patients decreased from 46% in week 1 to 29% in week 4
- Intervention may be less generalizable to populations with lower incidence of moderate to severe frailty
- Unexpected barrier to intervention was the misconception that only physician providers had the authority to place a referral to HBPC

ETHICAL CONSIDERATIONS

- Ensuring the patient & family understand the implications of HBPC referral
- Respecting the patient's choice of primary care provider
- Patients who are referred but then screen as ineligible for HBPC

Frailty, dementia raise mortality risk for older Americans after surgery

In the first study of its kind, Yale researchers found striking differences in the mortality rate of older Americans within a year of having major surgery.

By Jim Shelton | OCTOBER 19, 2022

JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
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VOL. 79, NO. 5, 2022

THE PRESENT AND FUTURE

JACC STATE-OF-THE-ART REVIEW

Interventions for Frailty Among Older Adults With Cardiovascular Disease



Heart, Lung and Circulation (2020) 29, 1187–1194
1443-9506/19/\$36.00
<https://doi.org/10.1016/j.hlc.2019.10.007>

ORIGINAL

Frailty in Elderly Patients Undergoing Cardiac Surgery Increases Hospital Stay and 12-Month Readmission Rate



Impact Factor: **2.645**
5-Year Impact Factor: **2.956**

JOURNAL

Available access | Research article | First published online December 18, 2019

Frailty Is Associated With Early Hospital Readmission in Older Medical Patients

Home Based Primary Care to Reduce Hospital Readmissions: Financial Analysis

Caitlin Burchfield MSN, APRN, AGPCNP-BC

Kimberly Miller MSN, APRN, AGCNS-BC, CDCES, BC-ADM

University of Virginia

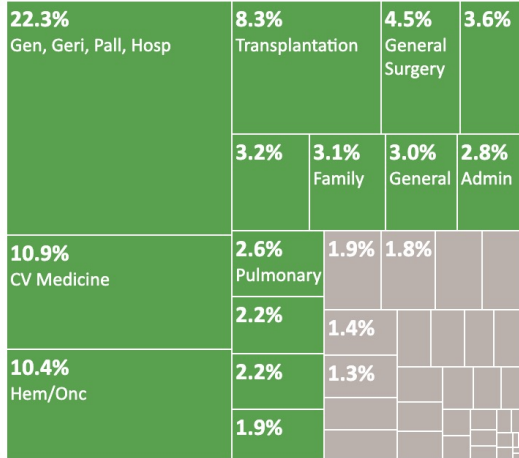
GNUR 8670 Financial Analysis



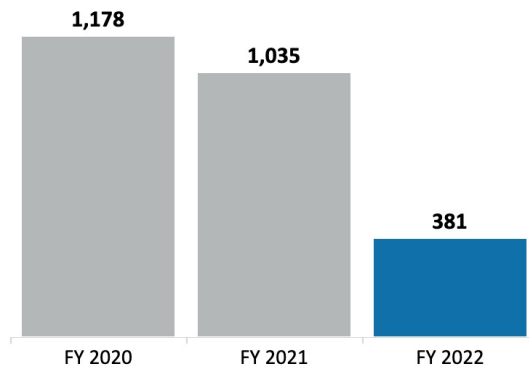
SCHOOL *of* NURSING

Early Hospital Readmissions

Percent of Total Readmissions



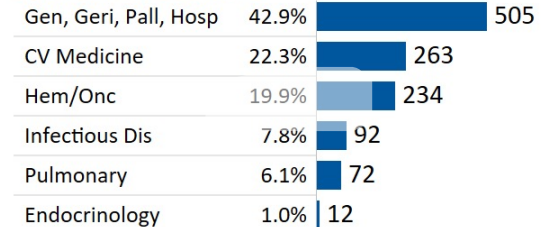
By Fiscal Year Readmissions



Medical Center
Daily Huddle Dashboard, July 1, 2019 - November 29, 2021
■ Current FY ■ Prior FY

FY 2020 | 1,178 mortalities

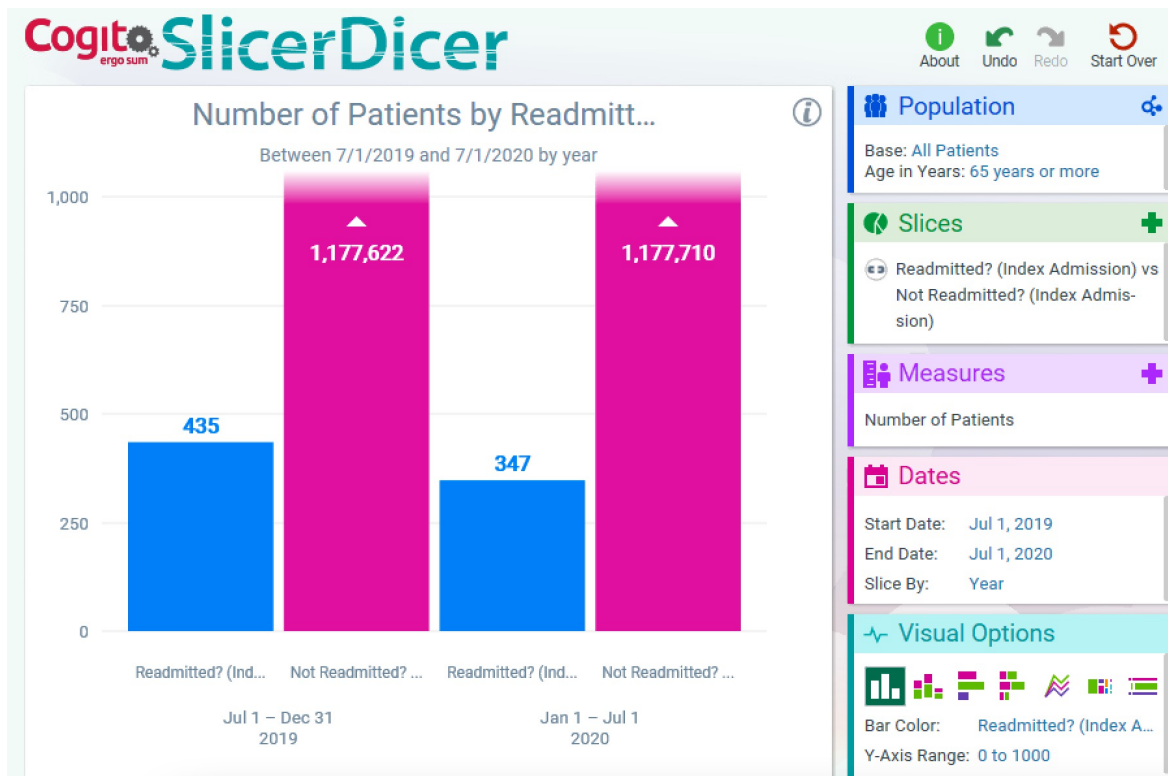
By Physician Division



Counts of readmissions broken out by Physician Divisions. Physician and department services based on discharge provider and location of prior (index) admission.



Early Hospital Readmissions



HBPC Program Cost Analysis

PROGRAM COSTS	NOTES	YEAR # 1			YEAR #2			3 Year Total
		Unit Costs	# Units	Extended Cost	Unit Costs	# Units	Extended Cost	
Salary Expense								
Medical Director	1 FTE (national average)							
Salary Expense		\$ 175,000.00	1	\$ 175,000.00	\$ 175,000.00	1	\$ 183,750.00	
Benefit	26% of base salary	\$ 45,500.00	1	\$ 45,500.00	\$ 45,500.00	1	\$ 45,500.00	
Pharmacist	1 FTE (national average)							
Salary Expense		\$ 125,000.00	1	\$ 125,000.00	\$ 125,000.00	1	\$ 131,250.00	
Benefit	26% of base salary	\$ 32,500.00	1	\$ 32,500.00	\$ 32,500.00	1	\$ 32,500.00	
Nurse Practitioner	1 FTE (national average)							
Salary Expense		\$ 100,000.00	1	\$ 100,000.00	\$ 100,000.00	1.5	\$ 155,000.00	
Benefit	26% of base salary	\$ 26,000.00	1	\$ 26,000.00	\$ 26,000.00	1.5	\$ 39,000.00	
Nurse Coordinator	1 FTE (national average)							
Salary Expense		\$ 80,000.00	1	\$ 80,000.00	\$ 80,000.00	1	\$ 84,000.00	
Benefit	26% of base salary	\$ 20,800.00	1	\$ 20,800.00	\$ 20,800.00	1	\$ 20,800.00	
							\$63,440.00	
Total Expenses							\$2,022,990.00	

HBPC Program Revenue Analysis

PROGRAM REVENUE ESTIMATE	NOTES	YEAR # 1			YEAR #2		
		Unit savings	# Units	1 Year Savings	Unit savings	# Units	1 Year Savings
Cost avoidance due to reduction in readmissions	VAH enrolled 75 patients in inaugural year, and reduced hospitalization by 80%. $75 \times .80 = \# \text{ units}$	\$ 15,200.00	60	\$ 912,000.00	\$ 15,200.00	60	\$ 912,000.00
Initial Grant Funding Year 1		\$1,000,000.00	1				
Projected cost savings after enrollment expansion	If VAH expanded coverage to all readmissions age 65+. In 2020 there were 782; thus, $782 \times .80 = \# \text{ units for year 2\&3}$	\$ 15,200.00	60	\$ 912,000.00	\$ 15,200.00	626	\$ 9,515,200.00

Return on Investment

YEAR #3			3 Year Total
Unit savings	# Units	1 Year Savings	
\$ 15,200.00	60	\$ 912,000.00	\$2,736,000.00
			\$1,000,000.00
Net Savings			\$1,713,010.00
Return on Investment (ROI)			85%
\$ 15,200.00	626	\$ 9,515,200.00	\$19,942,400.00
Net Savings			\$17,919,410.00
Return on Investment (ROI)			886%

ASSUMPTIONS

- Cost projection assumes all staff are full time, fully benefited, receiving 5% salary increase per year, and that the team will add another part-time NP in year 2.
- Salary/FTE information obtained by combining data from public databases and national average information. (Salary.com, 2021), (U.Va. Faculty & Staff Salaries, 2021).
- Average Medicare readmission will continue to cost approximately \$15,200 per admission over next 3 years, based on national average data. (Weiss et. al, 2021).
- Scenario #1 assumes readmission reduction will remain the same, Scenario #2 assumes VAH will increase enrollment to cover serviceable UVA population.

Outcomes & Impact

- "In its inaugural pilot year at UVA, the Virginia at Home program reduced hospitalizations by approximately 80%, and emergency department visits by approximately 50%." (*Virginia at Home Program, 2021*).
- The Virginia at Home Program has the potential to improve patient care while generating significant revenue for the medical system.

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