HOME CARE AIDES:
ESSENTIAL PARTNERS IN CHRONIC DISEASE MANAGEMENT AND TRANSITIONAL CARE COORDINATION

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PRESENTATION OUTLINE

• Part One – Overview of Innovations Center relative to Transitions

• Part Two – Review of HCA Transitional Care Inservice Training

• Part Three – Sharing Success Stories
**PART ONE: ACA – AFFORDABLE CARE ACT**

- 2010 – Patient Protection & ACA signed into law
- Significant reform of nation’s health care system
- Changes include extending health care coverage
- Changes take effect over a period of years through 2019

**IC MISSION**

SEEKING MODELS THAT DELIVER BETTER HEALTHCARE AND BETTER HEALTH AT REDUCED COSTS

- **BETTER HEALTHCARE = QUALITY**
  - Improve individual patient experiences
  - Safety, Effectiveness, Patient-centeredness, Timeliness, Efficiency, & Equity
- **BETTER HEALTH = Address underlying causes of poor health**
  - Lack of preventative care
  - Poor nutrition
  - Physical inactivity
  - Behavioral risk factors
- **REDUCED COSTS – Lower cost of care by improving care**
PARTNERSHIP FOR PATIENTS

Two Goals:

➢ Keep patients from getting injured or sicker.
   2013 – 40% reduction of preventable hospital acquired conditions.

➢ Help patients heal without complication.

COMMUNITY BASED CARE TRANSITIONS PROGRAM - CCTP

➢ Created by Section 3026 of The Affordable Care Act

➢ April, 2011 - CMS announced funding opportunities to community partnerships

➢ Allows for testing of models for improving care transitions for high risk Medicare patients.

➢ Partnership for Patients – 2013 goals:
   o Reduce hospital readmission rates by 20%
   o Reduce hospital-acquired conditions by 40%
PART TWO:  
HCA TRANSITIONAL CARE TRAINING

The HomeCare Aide’s Learning Objectives:

To understand:
- the importance of effective transitions of care in the aging population
- gaps in care & barriers to healthy outcomes in the aging population
- transitional care coordination models
- the aide’s role is supporting patient’s involvement with Transitional Care

CARE TRANSITIONS......

- Refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

Examples: Hospitals, sub-acute and post-acute nursing facilities, the patient’s home, primary and specialty care offices, outpatient clinics, and long-term care facilities
COMMUNICATION FAILURES IN "HAND-OFFS"

- Medication discrepancies
- Discharge plan does not convey important next steps for patient
- Discharge instructions are inadequate
- Patient returning home without essential equipment
- Lack of appreciation for weakness of patient’s support system
- Poor patient self-management due to cognition (health literacy)

CARE TRANSITION GAPS RESULT IN:

- Unnecessary ER visits
- Increased readmission to hospitals
- Poor chronic care disease management
- Lack of preventative care
- Increased risk of falls (poor medication mgt.)
TRANSITIONAL CARE
DESIRED OUTCOMES

- Reduction in adverse drug events
- Reduction in patient harm related to medical errors of omission
- Reduction in unnecessary healthcare encounters
- Reduction in redundant tests & procedures
- Achievement of patient goals & preferences
- Improved Patient understanding of & adherence to treatment plan

EVIDENCE-BASED CARE TRANSITION MODELS

- Care Transitions (CT) – “Coleman Model”
- Transitional Care Model (TCM) – “Naylor Model”
- BOOST – Better Outcomes for Older (adults through) Safe Transitions
- GRACE – Geriatric Resources for Assessment & Care of Elders
- Guided Care
- Bridge
COMMON CARE TRANSITION THEMES

- Transitional Care Staff
- Interdisciplinary Communication/Collaboration
- Patient Activation
- Enhanced Follow-Up

NAYLOR’S TRANSITIONAL CARE MODEL

Naylor’s model includes a Transitional Care Nurse providing oversight for 1-3 months:
- Pre-discharge: Daily Hospital visits
- Post-discharge services include home visits, physician visit & telephone support.

Components include:
- Medication Reconciliation & Management
- Patient & Caregiver Understanding
- Facilitation of Patient Self-Management
- Transitional Care
THE COLEMAN MODEL

- Coleman Care Transitions Intervention (CTI)
  - 4 week process designed to empower & support patients to take more active role in their health care
  - Includes one hospital and one home visit, along with series of follow-up phone calls by designated coach
  - Coach (nurse, SW, or community worker) – primary role is to “coach, not do”
  - Proven effective intervention - patients had lower re-hospitalization rates @ 30 days and @ 90 days

USING COLEMAN’S FOUR PILLARS OF CARE AS A BUILDING BLOCK FOR EDUCATING AIDES

- Medication Self Management: patient is knowledgeable about meds & has a med mgt system; inclusive of med reconciliation and simplification
- Personal Health Record (PHR): facilitates guided communication & ensures continuity of care planning; introduced during hospital visit & used throughout program
- Medical Care Follow Up: patient empowerment to schedule and complete follow-up visits after discharge
- Red Flags: patient knowledgeable about indicators that suggests their condition is worsening & how to respond
MEDICATION SELF MANAGEMENT

Goal: Patient is knowledgeable @ meds and has a med mgt. system

Home Care Agency CLINICAL Activities
- Importance of understanding meds and having a system in place
- Reconcile medications after any handover-identify & correct discrepancies
- Assist with med simplification & support manageable system
- States vary with regards to Scope of Practice for Home Care Aides

HOME CARE AIDE ACTION STEPS – MEDICATION SELF MANAGEMENT

Med errors and noncompliance are major risk factors for rehospitalization. The HCA’s role is to observe, remind, reinforce, and report; the HCA does NOT administer medication.

- Ask the patient if they took their medication for the day, as a general reminder.
- Call the supervisor/nurse if any medications are missing/not taken/unusual reaction to medications reported/observed.
- Encourage the patient to write down their questions in preparation for the nurse’s and MD’s visit.
- Remind the patient to take their medication list to the appointment with MD
PERSONAL HEALTH RECORD (PHR)

- Goal: Patient understands & utilizes a PHR to facilitate communication and ensure continuity of care planning across settings.
- Patient manages the PHR
- Sample PHR available at: www.qualitynet.org

Home Care Agency Activities:

- Explain PHR & its components
- Review & update after any handover
- Encourage pt to update and share with PCP and/or specialists at F/U visits

HOME CARE AIDE ACTION STEPS -PHR

*The HCA should be familiar with factors/barriers that may prevent the patient from achieving their goal.*

- Review patients personal health record with their permission, and encourage them to keep it up to date
- Ask the patient what their goal is and the steps they are presently working on with the nurse or therapist.
- Ask the patient how you can help him/her to achieve the goals.
- Report to your supervisor/nurse or the therapist if there is a lack of progress toward the goals or any barrier (pain, emotional factors, safety and financial issues) in achieving the goals.
- Reinforce good practices with the patient and the family.
MEDICAL CARE FOLLOW UP

Goal: Patient schedules & completes F/U visit with PCP/specialist. Pt empowered to be active participant with these interactions.

Home Care Agency Activities:
- Emphasize importance of F/U and need to provide PCP with recent health status information.
- Practice and role play questions for PCP/Specialist

HOME CARE AIDE ACTION STEPS - MEDICAL CARE FOLLOW UP

The HCA should encourage the patient to be an active participant in their care
- Ask the patient when their next MD appointment is.
- Reinforce the importance of keeping the scheduled appointment.
- Remind the patient about their upcoming appointments and to take their Personal Health Record, medications and list of concerns to the appointment.
- Encourage the patient to write down their NON-emergent questions to the nurse, therapist or the doctor to be asked on the next nursing/medical appointment.
- Encourage the patient to call the nurse or therapist if there are problems with the patient getting to appointments. Report this to your supervisor/nurse.
**RED FLAGS = ACTION PLANS**

Goal: Patient knowledgeable about indicators when condition worsening and how to respond.

**Home Care Agency Activities:**
- Collaboratively develop an emergency care plan (ECP)
- Discuss signs & symptoms of impending changes in health status
- Reinforce whom to call and when

**HOME CARE AIDE ACTION STEPS – RED FLAGS = ACTION PLANS**

*It is the HCA’s responsibility to familiarize oneself with each patient’s action plan and to follow the specific instructions.*

- Ask the patient if they received a written action plan regarding their care and obtain their permission to review it.
- Remind the patient and caregiver about the action plan every visit.
- Ask if they have any symptoms and refer to the patient action plan to see if their complaints require a call to your supervisor/nurse. Report any signs or symptoms.
- Identify and report any acute changes while caring for your patient.
**Sample CHF Zone Tool**

**GREEN ZONE: ALL CLEAR**
- No shortness of breath
- No swelling
- No weight gain
- No chest pain
- No decrease in your ability to maintain your activity level

**GREEN ZONE MEANS:**
- Your symptoms are under control
- Continue taking your medications as ordered
- Continue daily weights
- Follow low-salt diet
- Keep all physician appointments

**YELLOW ZONE: CAUTION**
- Weight gain of 2 or more pounds in 24 hours or 5 lbs in 7 days
- Increased cough / new cough at night
- Increased swelling
- Increase in shortness of breath with activity
- Increase in the number of pillows to sleep
- Weakness / Dizziness
- Decreased appetite

**YELLOW ZONE MEANS:**
- Your symptoms may indicate that you need an adjustment of your medications
- Call AGENCY NAME at XXXXXXX

**Your Nurse’s Name:**

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**Instructions:**

_________________________

**RED ZONE: MEDICAL ALERT**
- Unrelieved shortness of breath: shortness of breath at rest
- Wheezing or chest tightness at rest that is not relieved by medication
- Chest pain not relieved by medication
- Need to sit in a chair to sleep (if this is a new symptom for you)
- Weight gain or loss of more than 5 pounds in 2 days
- Confusion

**RED ZONE MEANS:**
- You need to be seen by a physician right away
- Call your physician right away

**Physician:**

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**Number:**

25

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**ZONE TOOLS**

- **Everyday – Clinician Reviews Health Management Recommendations with Patient.** Patient Follows Recommendations
  - Green Zone – Patient is Stable. HCA continues to monitor Patient activities and to watch for changes or symptoms.
  - Yellow Zone – Symptoms increase or change. HCA reports to Supervisor.
  - Red Zone – Emergency Situation. Take immediate action!
ADULT-LEARNER CENTERED TRAINING ACTIVITIES

- National Patient Safety Foundation Patient Tools
- Personal Health Record (PHR)
- Home Care Aide Action Steps
- The Big Ten Fact Sheets
- PHI Body Systems Game
- Case Study Activity
NATIONAL PATIENT SAFETY FOUNDATION
PATIENT TOOLS

The following four handouts are available online at: www.npsf.org

Also available:
- Patient Safety Curriculum
- Tools & Resources
- On-line Learning Center
- Other Programs

Helpful Patient Tips

A READMISSION IS WHEN:
I am admitted to the hospital after being discharged for the same diagnosis (condition)

I CAN HELP PREVENT A READMISSION BY:
- Understanding My Discharge instructions
- Know what I need to do before and after I leave the hospital
- Ask questions early and often
- Ask when I do not understand my follow-up care instructions
- Arrange for the support and follow-up care I will need post discharge

Knowing My Diagnosis (Condition):
- Understand my main medical problem or condition
- Know the potential complications and who to call if I need assistance
- Learn how my condition impacts me and my family

Managing My Medications
- Understand my post-discharge medications, and if they are different than before admission
- Keep a current list of my medications, including over-the-counter and herbal medications (note any allergies)
- Bring my current medication list to appointments and review the list with my doctors
- Update my medication list when my medications change
- Take my medications as directed
- Understand what medications to take and when, and why it is important to take my medications
- Know the reasons for taking my medication and how they help with my condition
- Let my healthcare providers know if I am having problems taking my medications

Following Up with My Care: Things to Do
- Be sure to communicate with my primary care provider
- Ask my healthcare team to help me find a primary care provider if I don’t know one
- Schedule and go to all my follow-up appointments
- Keep a medical journal and bring it to all my appointments
- Tell my primary care physician and other providers that I was admitted to the hospital
- Ask my provider if they have received all of my test results and medical reports
- Ask questions at the follow-up visit about what I need to do and why I need to do it
- Understand and follow my post-discharge activity and dietary plans

Protecting Myself from Infections
- Avoid people who are sick
- Wash my hands often
- Learn how to care for my surgical site

Developed for Patient Safety Awareness Week by the National Patient Safety Foundation® www.npsf.org
**My Information Poster Discharge Patient Tool**

**Information about me and my follow-up appointments**

**Instructions**

1. Complete this tool before I go home, with help of a nurse or doctor.

2. Display this tool in my home where I will see it every day.

3. Share this information with my family members, providers and others who help me with my care.

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**FOLLOW-UP APPOINTMENT #1**

- **Where:**
- **Date/Time:**
- **Reason for Visit:**
- **Things to Bring (e.g., my current medication list):**
- **Questions to Remember:**

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**FOLLOW-UP APPOINTMENT #2**

- **Where:**
- **Date/Time:**
- **Reason for Visit:**
- **Things to Bring (e.g., my current medication list):**
- **Questions to Remember:**

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**My Diagnosis (Condition):**

- My main medical problem is

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**A FEW IMPORTANT THINGS (for additional tips review the Helpful Patient Tips sheet):**

- Become familiar with the signs and symptoms that I should know about immediately.
- Know when and how to call when I have questions or concerns.
- Make arrangements for my care at home.
- Order equipment and supplies that I will need at home.
- Understand follow-up care plan and schedule all necessary appointments with my providers.
- Learn how to take care of my surgical or wound site.
- Make sure all test results and records are sent to my primary care provider.
- Take steps to protect myself from infection.
- Carefully follow my post-discharge activity and dietary instructions.
- Understand my post-discharge medications, and know if they are different than before admission.
- Make a list of all medications and take it.

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10/16/2013
PERSONAL HEALTH RECORD (PHR)

The following handout is available online at: www.homehealthquality.org

SAMPLE PHR HANDOUT
SAMPLE PHR HANDOUT (CONTINUED)

HCA ACTION STEPS ACTIVITY:

- The Home Care Aide's Role in Transitions of Care - Suggested Action Steps

As a Home Care Aide, you can fulfill your role in assisting the health care team in managing patient care and preventing rehospitalizations by understanding which patients are high risk and why. You are an important part in taking action to improve the risk for hospitalization, as well as falls and pressure ulcers.
HCA ACTION STEPS

THE BIG TEN: KEYS TO KEEPING CONSUMERS AT HOME

1. Congestive Heart Failure (CHF)
2. Chronic Obstructive Pulmonary Disease (COPD)
3. Diabetes
4. Pneumonia
5. Myocardial Infarction (Heart Attack)
6. Kidney Disease
7. Parkinson’s Disease
8. Urinary Tract Infection (UTI)
9. Falls
10. Skin Care
**The Big 10**

**Keys to Keeping Consumers At Home**

**Cerebral Heart Fall-Out HD**

**Definition:**
CHF is due to the heart's inability to pump enough blood for the rest of the body's needs. Fluid backs up into the lungs, legs, and sometimes the whole body. CHF is the most common reason for people 65 and older to go to the hospital.

**Diagnosis and Risk Factors:**
CHF can be caused by a number of factors including: Cardiovascular Disease, Elevated Blood Pressure, Lung Disease, Heart Valve Disease, or Valvular Heart Disease/Infective Endocarditis. Thyroid Disorders, and Heart Damage due to alcohol, drugs, infections, or obesity.

**Signs and Symptoms:**
- Shortness of breath
- Persistent or increased wheezing or coughing
- Sleep more than usual or need to sleep
- Increased swelling in the feet, legs, and abdomen
- Decreased weight
- Fatigue

**Best diet recommendations:**
- Maintain a low sodium diet
- Good fats: 20% to 30% of daily caloric intake
- Do not add salt when preparing meals
- Be especially careful with canned, frozen, and prepackaged foods

**Care Tips:**
- Assist consumer to use back support
- Avoid high salt foods

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**BODY SYSTEMS GAME**

- Developed with resources from "Providing Personal Care Services to Elders and People with Disabilities" Personal Care Services Curriculum from PHI available online at: [http://phinational.org/training/resources/pcsc/](http://phinational.org/training/resources/pcsc/)
- Easy-to-use and game to educate Home Care Aides on Anatomy and Physiology
BODY SYSTEMS GAME

- Body System Illustrations
- Body System Cards
  - What It Does
  - Main Parts
  - Common Problems
  - Common Diseases
  - How You Can Help
  - Observe and Report

CASE STUDY: TRANSITIONAL CARE FROM HOSPITAL TO HOME

- Anna, who lives with Freddie, was admitted to the hospital with shortness of breath and the diagnosis of pneumonia, on top of her history of Congestive Heart Failure.
- Both Anna and Freddie, and Freddie, Jr. were provided instruction at the hospital about new medications and diet before discharge. Anna was directed to make an appointment to see her physician two weeks after discharge.
- Freddie, Jr. reminded Anna to make her appointment when she returned home. She had difficulty reaching the scheduler, and finally got a visit for three weeks after discharge.
- When asked, Anna informed Freddie, Jr. that she was taking her Lasix (water pill) provided to her from the hospital. Anna didn't inform her son that after taking the 3 day supply from the hospital, she never filled the prescription. She was feeling much better and thought the expense of the prescription was unnecessary.
- Anna noticed her swelling legs, but didn't want to bother the busy doctor before her three week appointment.
- After 11 days, Anna was readmitted to the hospital for shortness of breath, marked edema (swelling) of the lower legs, and weight gain of 25 pounds. Anna's hospital stay went well, but her stress level was high, blood pressure was elevated, so another drug was added to her regimen.
- While Anna was in the hospital, her spouse Freddie was admitted for another stroke. After Anna's discharge, she found it easier to eat fast foods and frozen dinners, as she juggled visits to the hospital to visit Freddie.
CASE STUDY ACTIVITY

- Discuss areas in which some situations could have been prevented:
  - Medication system
  - Follow-up care with physician
  - Red Flags: What is the problem, what do I need to do, why is it important?

- What are the actions that the aide could take in reporting?

HOME HEALTH VNA’S EXPERIENCE

- Identifying the Need
- Training
- Implementation
- Further Development of Program
- Successes to Date
ASSOCIATED HOME CARE EXPERIENCE

- Identifying the Need
- Training
- Implementation
- Further Development of Program
- Successes to Date

QUESTIONS?
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