The Unique Role of Private Duty in Chronic Care Management

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Objectives

› Review of statistics surrounding chronic disease
› Describe Care Transitions and the Private Duty Agency Role in Care Transitions
› Discuss the role of Private Duty Agencies in preventing avoidable rehospitalizations
For Purposes of this Presentation

- Private Duty is the broad term we will use for agencies that provide in-home aide services – either public, third-party or private pay
- Non-medical home care
- Companion/sitter services

Regardless the term...we must emerge!

Chronic conditions

- Chronic conditions are conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living. They include both physical conditions such as arthritis, cancer, diabetes, COPD, heart failure, and HIV infection. Also included are mental and cognitive disorders, such as ongoing depression, substance addiction, and dementia.
Multiple Chronic Conditions

- MCC are concurrent chronic conditions. In other words, multiple chronic conditions are two or more chronic conditions that affect a person at the same time. For example, either a person with arthritis and hypertension or a person with heart disease and depression, both have multiple chronic conditions. (US DHHS)

Functional limitations with MCC

- People with MCC also are at greater risk of poor day-to-day functioning. MCC contributes to frailty and disability. Functional limitations often complicate access to health care, interfere with self-management, and necessitate reliance on caregivers. (US DHHS)
Let’s Start Thinking Beyond Our Traditional Care Giving Roles…

- Medicare covers 50 M people age 65 and over and younger adults with disabilities—(Kaiser Family Foundation, Medicare’s Role and Future Challenges (2012))
- People with chronic conditions are more likely to have preventable hospitalizations and other poor outcomes. Most people with chronic conditions have private insurance (54%). Others have Medicare or Medicare with supplemental insurance (20%), Medicaid (11%), or other insurance 6%). Some are uninsured (8%). (Chronic care – making the case for ongoing care – Robert Wood Johnson)

The Prevalence of Chronic Conditions

- The number of people with chronic conditions is rapidly rising. Between 2000 and 2030, the number of Americans with one or more chronic conditions will increase 37 percent, an increase of 46 million people.
- Some 28 percent of Americans have two or more chronic conditions and they are responsible for two-thirds of health care spending.
- In the Medicare program over two-thirds of the expenditures are for beneficiaries with five or more chronic conditions. (Chronic care – making the case for ongoing care – Robert Wood Johnson)
The Impact of Chronic Conditions

- We can expect to see more adult children in their 60s or 70s with chronic conditions of their own, caring for a parent age 90 years and older. – AARP

Ref: Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving

Projected Costs of Chronic Diseases

- Cancer is the second leading cause of death in the United States, exceeded only by heart disease. (CDC)
- Among U.S. residents aged 65 years and older, 10.9 million, or 26.9%, had diabetes in 2010. (CDC)
- Estimated Diabetes Cost in the United States–Total (direct and indirect) $174 billion (CDC)
- Medical expenses for people with diabetes are more than two times higher than for people without diabetes. (CDC)
Hypertension

- Hypertension is a chronic disease that poses a risk for cardiovascular disease and increases the risk of heart attack, stroke, kidney disease, and heart failure. Data from 2007–2010 indicate that 33% of adults 20 and older—an estimated 78 million—in the United States have hypertension.

(Medscape Nurses– Home Blood Pressure Monitoring)

Heart Disease and Stroke

- Death rates alone cannot describe the burden of heart disease and stroke. In 2010, the total costs of cardiovascular diseases in the United States were estimated to be $444 billion. Treatment of these diseases accounts for about $1 of every $6 spent on health care in this country. As the U.S. population ages, the economic impact of cardiovascular diseases on our nation's health care system will become even greater.
Chronic Disease and Non-adherence

- Patient’s can undo a month’s worth of expensive and intensive care just going home and going about their normal routines (John Charde MD, VP Strategic Development, Enhanced Care Initiatives, Inc (April 2006)

- Non-adherence contributes to:
  - Increase in number and length of acute care visits (25% of hospitalizations due to medication errors)
  - Increase in ED visits
  - Unnecessary changes in treatment
  - Overuse of scarce and expensive medical resources
  - Loss of productivity and decreased quality of life

  Hence, the need for our enhanced care enriching roles!

Have You Heard?
Hospitals Are Being Penalized for Certain Readmissions

- Reducing Hospital Readmissions – Oct. 1, 2012–CMS will rank hospitals based on 30 day readmission rate for Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN); in 2015, the program will expand to include more conditions

- Poor performing hospitals will have all Medicare payments reduced by an amount equal to value of payments for excess readmission. MedPac 2012
The term "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. (Eric Coleman)

Patients with chronic disease move frequently from one health care setting to the next.

The result is often poor communication, errors, and duplication of services.

Hospitalization, emergent care, poor outcomes, high cost, dissatisfaction, disengagement

(Patty Upham, RN, Director-First Health Home Care - AHHC NC 2012 Annual Convention)

And...errors can also occur during care transitions in our own agencies (substitute aides; weekends; etc.)
Mismatched Communication

**Provider Process:** Giving information

**Patient Process:** Understanding, remembering, and acting on information

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**What is at stake?**

- The risks to older adults during care transitions are well established, and can be associated with poor outcomes as well as costly yet avoidable hospital readmissions and emergency room use.

- Risks include *medication errors, duplicative tests, lack of coordination, poor communication among professionals across settings, problems in the timeliness of care, and lack of access to vital home and community based services.*

  *(Family Caregiving and Transitional Care: A critical review—Gibson, Kelly, Kaplan)*
Rehospitalization

- In the United States, 19.6 percent of people with Readmission following an acute care hospitalization is a costly and often preventable event. During 2003 and 2004, almost one-fifth of Medicare beneficiaries – more than 2.3 million patients – were readmitted within 30 days of discharge (Jencks et al., 2009). are rehospitalized within the first 30 days of discharge. The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and care becomes more fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that the Centers for Medicare & Medicaid Services (CMS) measures. (CCME)

How can your agency help?

- Hospital readmission is also disruptive to patients and caregivers, and puts patients at additional risk of hospital-acquired infections and complications (Horwitz et al., 2011)
- Some readmissions are unavoidable, but readmissions may also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care
So What Does This Mean?

No longer can we just give care – we must engage with other providers to demonstrate that we too can assist patients with chronic diseases and that private duty has a role in preventing ED use and hospital admissions! We must be Care “Enrichers”!

A part of the *Valued Village*

The best personal care or companion services may not be enough to keep your client out of the ED, Hospital and/or nursing home...we must do more!
Do you have checklists, assessments, screening, communication & education tools on the following key conditions: Depression; Congestive Heart Failure; Diabetes; COPD; Falls; Pain; Medication Management; Dyspnea

Do you have data on local hospital readmissions and ER use? Do you know where your local hospital stands with CMS as related to readmission rates? Will your local hospital be penalized?


Do you have marketing materials for referral sources demonstrating your commitment to Chronic Disease Management such as:

- Your client ED use;
- Your client hospital readmission rates;
- Your client satisfaction rates; and,
- Your client fall incidents; etc.
Private Duty Go Forth!

Are you preparing and training staff in:
- Chronic disease management
- Patient centered care
- Patient and/or staff coaching
- Health Literacy
- Observation, Recording & Reporting?

Of course at their level of understanding and level of responsibility!

Are you Prepared to Take the Next Step?

- What would your staff think about an emerging agency role?
- Do the nurses or other supervising staff have questions about their new roles in chronic disease management? What would the in-home staff think about embracing their full potential?
- Does the agency have resources to take on these new challenges?
- What will be the cost/benefit? To the agency? To the Community? To the client?
For Example – the Aide as an Agency Team Member in Post Acute Care

We all know:
• The Aide is a valuable member of the Home Care Team in providing care and in observations that are noted during time spent with a client as well as reporting the observations to the supervisor and or family for follow up as needed.
• But, do we use the aides to their full potential? Or, are our aides just task oriented and everything is ok as long as they check off the correct box?

Observe, Record, Report

› The aide provides care and documents the completed tasks that are listed on the care plan.
› The aides should also note what they observe while doing those tasks and while spending time with the client.
› This important part of the aide’s role is called “Observe, Record, and Report” or ORR, for short.
Be sure to train aides on what observations to report according to the specific condition of the client such as low blood sugar symptoms with a diabetic or signs that a client with heart failure is starting to gain fluid and become short of breath, as well as other observations per the specific condition of the client.

For Example...Observe

- Changes in the client’s condition physical, mental, emotional
- Changes in the environment, or setting, that could affect the client’s health
- Changes in relationships with family and friends that could affect the client’s health
Which Includes:

Changes in the client's condition
- Signs of physical discomfort
- Changes in what the client can do
- Changes in behavior
- Changes in physical appearance

Changes in the client's environment
- Potential safety hazards
- Health hazards

Changes in relationships with family and friends
- Family or friends who used to visit regularly and don’t anymore
- Family or friends who suddenly start visiting regularly

Record and Report

- Different agencies will have different forms for documentation
- Train your staff regarding what type of “aide log” or “aide service note” to use
- Be sure to discuss with your staff the requirements for documentation, how to document deviations to the care plan (such as client refusing a task, etc.) and how to record observations
- Discuss frequently what to report, when to report, how to report and to whom to report
Hypertension–Home Monitoring

- Evidence supports the benefits of patient Home Blood Pressure Based Monitoring (HBPM) compared to office-based monitoring by providers alone. (Medscape Nurses–Home Blood Pressure Monitoring)
- HBPM is a method for patients to partner with providers with their self-care management.
- Is this something your Nurse Aide’s are helping with? Actually taking the B/P or assisting clients to take their B/P, helping the client to record and reporting abnormal findings to the supervisor or other designee.

So Many Chronic Conditions…Where to Start

- Fall Prevention
- Medication Improvement
- Patient Centered Care
How about Starting with Falls Prevention!

Falls remain the leading cause of injury and death for older Americans. Falls threaten seniors’ safety and independence and generate enormous economic and personal costs. CDC’s Injury Center monitors falls, fall-related injuries, and associated costs, reporting:

- In 2009, more than 20,000 older Americans died from injuries related to unintentional falls.
- In 2010, over 2.3 million older Americans were treated in emergency departments for nonfatal injuries from falls and more than 650,000 were hospitalized. CDC reports the death rate from falls among older adults has increased by 42% from 2000 to 2006.

How many clients do we lose to institutions because of multiple falls in the home?

Falls Prevention Resources

- This site has community based falls prevention guidelines – in English, Spanish and Chinese
  http://www.cdc.gov/HomeandRecreationalSafety/Falls/ pubs.html

- Fall Prevention Awareness training curriculum helps home health aides reduce falls and minimize injury to their clients by increasing their awareness of the risk factors for common falls and by enhancing their communication skills, A Joint Project of PHI and the National Council on Aging –
  http://phinational.org/workforce/resources/phi-curricula/ fall-prevention-awareness– go to resources and curricula, no cost

The curriculum consists of two three-hour in-service trainings. In addition, each session includes optional pre- and post-testing as well as warm-up and closing activities that can add an additional hour to the training.
For Your Marketing Data
How to Calculate the Incidence of Falls

- [http://nicheprogram.org/niche_encyclopedia-falls-fall_rates](http://nicheprogram.org/niche_encyclopedia-falls-fall_rates)
- [http://www.ahrq.gov/qual/nurseshdbk/docs/EllenbeckerC_PSQHC.pdf](http://www.ahrq.gov/qual/nurseshdbk/docs/EllenbeckerC_PSQHC.pdf)

- [http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No2May07/ArticlePreviousTopic/MeasuringFallProgramOutcomes.html](http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No2May07/ArticlePreviousTopic/MeasuringFallProgramOutcomes.html)

Medication Improvement

- Know the state regulations and Board of Nursing regulations regarding the aide’s role in assisting a client with medications such as reminders and observation
- Instruct the aide in their role in reporting and what to report to the supervisor if the client refuses to take their medication or appears to have taken more than prescribed
- And, be especially watchful at transition times – when med errors are most likely to occur
- Identify when clients need more medication assistance than your agency staff can provide and assist in locating those resources
Medications – The Dangerous 4

- Briefly, the researchers found that there were almost 100,000 emergency hospitalizations for adverse drug events every year in adults aged 65+ from 2007–2009. Half of the hospitalizations were in patients 80 and older. Almost two-thirds were due to unintentional overdose:
  [http://www.champ-program.org/blog/?p=1590](http://www.champ-program.org/blog/?p=1590)
- Warfarin, insulin injections, antiplatelet drugs including aspirin, and oral hypoglycemics – these four medications/med classes were responsible for two-thirds of these hospitalizations, with warfarin accounting for 33% of admissions.

Medication Improvement

- Instruct the aides in their role in reporting side effects of medications that they observe – especially high risk medications—warfarin—signs of bleeding; diabetic mediation—signs of hypo or hyper glycemia; other medications and side effects

(What difference could your agency make if concentrated especially on the Dangerous 4?)
Nutrition

- How does your agency assist clients with nutritional needs—meal preparation, therapeutic diet meal preparation, assist with eating, monitoring client eating and food availability (observe, record, report), grocery shopping, other?
- Is this something you market to your community partners?

Person Centered Thinking In Chronic Disease Management

- Involving the client in the plan of care
- Reflective listening to the client to find out their motivation for change
- Appropriate staff training for the person’s condition, knowing what to observe, record and report for the client as well as performing the needed tasks
What is Self-Management?

- Empowering & preparing patients to manage their health
- Focusing on patient’s central role in care
- Promoting self-responsibility
- Organizing resources: internal and community

Some Things to Think About
What will Keep My Clients Home?

- Friendly callers to check on your clients by telephone?
- Agency sponsored caregiver support groups?
- Revamping your marketing plan to include your best data and commitment to chronic disease management?
What will Keep My Clients Home?

› Investing in staff education to prepare them in their new roles and demonstrate your agency excellence – like in person centered thinking; coaching/supervision; or Alzheimer's training

Resources

› Discharge check list for client’s—
  http://caretransitions.org/documents/discharge_checklist.pdf—

› http://www.champ-program.org/page/100/geriatric-care-transitions-toolkit

**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
- No decrease in your ability to maintain your activity level

**YELLOW ZONE: Caution**

- Weight gain of 3 or more pounds in 2 days
- Increased cough
- Increased swelling
- Increase in shortness of breath with activity
- Increase in the number of pillows needed
- Anything else unusual that bothers you

**YELLOW MEANS:**
- Your symptoms may indicate that you need an adjustment of your medications
- Call your home health nurse and/or physician.

**AGENCY NAME**

**PHONE NUMBER**

(Please notify your Home Care Nurse if you contact or go to see your MD)

**RED ZONE: Medical Alert**

- Unrelieved shortness of breath: shortness of breath at rest
- Unrelieved chest pain
- Wheezing or chest tightness at rest
- Need to sit in chair to sleep
- Weight gain or loss of more than 5 pounds in 2 days
- Confusion

**RED MEANS:**
- This indicates that you need to be evaluated by a physician right away
- Call your physician right away or call 911

**Additional Resources**

- **Private Duty, Chronic Disease Management Resource Guide**
- **Community Based Care Transitions programs**

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
One Last Thought...

“You have to learn the rules of the game. And then you have to play better than anyone else.”

Albert Einstein

Questions & Thanks!

- Discussion
- Thoughts
- Go Forth!