PROMOTING EXCELLENCE IN GERIATRIC HOME CARE

JULY 9TH, 2008

IMPLEMENTATION APPROACHES FOR FRAMEWORK PRIORITY AREAS AND STRATEGIES

CARE COORDINATION, MANAGEMENT & TRANSITIONS WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- Home care is currently episodic and is part of a fragmented, uncoordinated health care system
- To show cost-effectiveness, need to be able to track the dollars over time and through the entire health care system
- Necessary changes seem overwhelming. It is not clear how to streamline processes and eliminate duplication
- Care planning is multi-disciplinary, but it needs to be inter-disciplinary. Providers may not be trained to work collaboratively in a truly integrated way
- Incentives are misaligned (e.g. readmissions can be advantageous for hospitals—they represent revenue)
- There are no incentives for MDs to facilitate transitions across care settings
- Lack of standardized data across settings limits understanding and comparisons
- There is no valid criteria that can be used to determine which patients benefit from case management
- Many care coordination interventions are too complex and comprehensive to implement

2. Three Strategies Ranked as Most Urgent to Implement

- Design robust measures of transitions and integrate these into national measurement/quality improvement efforts
- Form policy work groups, lobby for reform to re-align incentives and reimbursement systems to promote coordination of care
- Define evidence-based, eligibility criteria for case management

3. Three Strategies Ranked as Easiest to Implement

- Use existing care planning tools but add ongoing review and revision capabilities and reminders until better systems are implemented
- Look at currently integrated systems such as Kaiser and the Department of Veterans Affairs for best practices
- Form policy work groups, lobby for reform to re-align incentives and reimbursement systems to promote coordination of care

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MEDICATION MANAGEMENT WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- In home care, the care team is dispersed
- Teams often don't share the same medical record for a patient – lack of computer systems or multiple non-communicating systems
- Pharmacist is not always incorporated into the care team
    - Can be difficult to identify pharmacists with geriatric expertise (and there are not enough)
- It is difficult to identify complex patients that are most appropriate for referral to a consultant pharmacist
- How does the pharmacist communicate his/her concerns and what are the communication protocols? (i.e., do they talk directly to MD or through HHC nurse?)
- Lack of reimbursement for care coordination
- Limited training for team members regarding how to individualize assessments/plans
- Patients and caregivers are not always included in medication reconciliation, assessment and planning
- Patients are not always able to pay for medications
- Current quality measures (e.g. management of oral medications) are not comprehensive indicators of medication problems and care planning

2. Three Strategies Ranked as Most Urgent to Implement

- Make a single reconciled medication list the standard of practice which:
    - includes both patient report and all prescribed medications
    - requires constant monitoring and periodic updates
- Increased geriatrics training across home care workforce
- Increased communication between team members regarding medications using case conferences or electronic communication

3. Three Strategies Ranked as Easiest to Implement

- Make a single reconciled medication list the standard of practice
    - includes both patient report and all prescribed medications
    - requires constant monitoring and periodic updates
- Collect all necessary patient information for medication reconciliation in the first few days of home care
- Increased communication between team members regarding medications using case conferences or electronic communication

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COGNITIVE FUNCTION WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- Help people overcoming the fear of the label "dementia"
- Identifying contributing factors to cognitive impairment that can be addressed and include these in the care plan
- Lack of agreement on what competencies are needed to provide high quality care and current lack of education about cognitive function in most disciplines
- Risk of not being able to address identified impairments due to lack of resources.
- Families are confused by fragmentation of the system
- Lack of employer support and resources particularly for women who are family caregivers and have economic needs of their own
- Impact of cultural diversity and literacy on views of cognitive impairment.
- Lack of information about cognitive function communicated during transitions, particularly when patients are admitted to home care
- Lack of standards for assessing and managing cognitive function
- Differences across states in regulations related to safety and scope of practice
- View that home care is not supposed to address cognitive function as this is rarely the primary reason for home care
- Challenges working with MDs who don't view cognitive issues as their concern

2. Three Strategies Ranked as Most Urgent to Implement

- Get data that illustrates interactions and effects of Cognitive Function on other outcomes in order to advocate for change; Develop evaluation design for Cognitive Function interventions (make sure we have good evidence)
- Mount a national campaign to include mental/cognitive status information at beginning and end of care in EVERY SETTING
- Launch a public-private media/social marketing campaign to address stigma; Treat cognitive impairment as a public health issue; Frame the issue in terms that don't scare people; work to find terms /concepts; Address the whole person and present cognitive impairment as one aspect

3. Three Strategies Ranked as Easiest to Implement

- Provide support and tools for home health teaching and training about cognitive function similar to prior Quality Improvement Organizations (QIOs) campaigns on other topics
- Piggyback on the attention to medications/safety issues as an approach to incorporating cognitive function into assessment
- Require home health visits to people with cognitive function issues as part of training in all disciplines

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PHYSICAL FUNCTION WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- Lack of specialized physical, occupational and speech therapy
- Complacency among health professionals; lack of commitment to best practices when improvement in physical function may take a long time or when decline can only be slowed, not stopped
- Under-reporting of falls. Patients unwilling to tell health care professionals.
- Difficulty involving family beyond the initial interaction
- Resistance among health care professionals to learn about best practices in other areas and support patient treatment (e.g., nurses learning about and reinforcing physical therapy principals)
- Inconsistency of patient assessment across disciplines
- Lack of a standardized assessment of patient engagement
- Problems in the physical environment (e.g., hazards in the patient's home that cannot be easily addressed)
- Difficulty motivating patients, particularly people who are sick and frail

2. Three Strategies Ranked as Most Urgent to Implement

- Implement standardized training that includes an overview of:
    a. Frequently used assessment tools
    b. Common interventions used to promote physical function
    c. Approaches to monitoring and measuring functional status and progress
- Partnering with registered Dieticians as nutrition is important to physical function
- Timely access to primary care evaluation and assistance in addressing barriers to physical function (e.g. fatigue, medication side effects)

3. Three Strategies Ranked as Easiest to Implement

- Implement a standardize protocol for training
- Focus on patient preferences. Negotiate a care plan based on patient goals.
- Establish best practices for communication with patients and families at home care discharge about continuing physical activity and ways to maintain physical function

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CHRONIC PAIN MANAGEMENT WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- Pain is not static and requires ongoing monitoring, reassessment and changes to care plans
- Patients often do not understand pain management and fear side effects of pain medications
- Providers may resist prescribing medications that are federally regulated or that have negative side effects
- Patients report using different terms (e.g., discomfort) that may not lead to an accurate pain assessment
- Perception of pain differs across people and may be different for patients, caregivers, and clinicians
- Pain management is rarely standardized in health care settings
- Non-pharmacology pain management takes time and effort that may be hard to accommodate in clinician schedules
- The home care episode may be too short to resolve pain management issues
- Home care clinicians may have limited pain management experience

2. Three Strategies Ranked as Most Urgent to Implement

- Bundling payment and services to allow and encourage a holistic approach to chronic care services that include pain management
- Improve interactions among home care clinicians and patient about pain through better training and education and assessments of health and pain literacy for both providers and patients
- Encourage home health care leadership and policy makers to make pain management a priority and to support regulatory and practice changes

3. Three Strategies Ranked as Easiest to Implement

- Increase provider education about chronic pain management strategies
- Improve communication and patient education about pain management at times of transitions and provide incentives for successful pain
- Improve home care clinician interaction with patients by assessing patients' health literacy and understanding of pain management

PALLIATIVE CARE & ADVANCED ILLNESS MANAGEMENT WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- Hospice is not well understood by patients, families, and some providers
- Lack of understanding of what constitutes palliative care and how this differs from hospice
- Need to clarify how Advanced Illness Management (AIM) differs from hospice and palliative care
- Patient and families are often reluctant to discuss serious illnesses and end-of-life care and decisions
- Providers are often uncomfortable initiating discussions with patients and families about advance care planning
- Home care clinicians often function in silos; it can be difficult to assemble a team for AIM or end of life care outside of hospice
- Difficulty making the business case for this type of care. Lack of reimbursement outside of the Medicare hospice program

2. Three Strategies Ranked as Most Urgent to Implement

- Need to build new models (e.g. AIM) based on evidence and evaluate these new programs
- Lobby for reimbursement for palliative care and AIM
- Develop strategies to train the staff in how to initiate discussions and communicate with patients regarding their goals and expectations in the context of serious illness
    - Develop standardized tools and approaches that can be used within the providers' time limitations

3. Three Strategies Ranked as Easiest to Implement

- Implement "bridge programs" to identify the potential need for AIM or end-of-life care at the outset of treatment
- Develop strategies to train the staff to communicate with patients regarding goals and expectations
    - Develop standardized tools and approaches that can be used within the providers' time limitations
- Create a forum to share best practices on palliative care in home care with physicians- including MDs, hospitalists, nursing home MDs, community MDs so they can support care at home. Identify and use teachable moments to discuss what can be done to manage comfort and symptoms.

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IMPLEMENTATION APPROACHES FOR FRAMEWORK PRIORITY AREAS AND STRATEGIES

GUIDELINE IMPLEMENTATION WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practice

- Practice and behavior change is intrinsically very difficult
- Evidence is necessary but not sufficient to insure the application of best practices
- Not enough community-based research is available that is directly applicable
- Long lag time from research results to community application
- The science behind how to implement guidelines is young and not well developed
- Once implemented, sustaining best practices over the long term is a challenge
- Some people or agencies will volunteer to implement new approaches, others will not and these groups are different and need different approaches
- Guidelines don't specify which interventions work best in which settings
- Access to guidelines and research can be limited, particularly if agencies are small and do not have education and quality improvement resources
- How guideline implementation relates to quality improvement is not always clear
- There is often no systematic way to keep guidelines up to date

2. Three Strategies Ranked as Most Urgent to Implement

- Map guidelines to outcomes and provide incentives to encourage improvement in currently reported outcomes
- Partner with academic institutions to offer certification programs or other educational programs for home health care managers that emphasize how to manage practice change
- Build an integrated approach to guideline implementation into assessment, care planning and decision support systems

3. Three Strategies Ranked as Easiest to Implement

- Partner with academic institutions to offer certification programs or other educational programs for home health care managers that emphasize how to manage practice change
- Translate guidelines into formats that are specific to practice processes
- Provide interactive, innovative tools and training modules for staff

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INCREASING PATIENT AND FAMILY INVOLVEMENT WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- The fragmented health care system and competing incentives make self management and family care giving difficult
- Patients and families lack information on services in general and home care specifically
- Providers are not always sure how to involve patients and families given their time constraints for planning and education
- It is not always easy to understand patient and family priorities or meet their expectations
- Insurance coverage or other payment sources often do not match patient and families' needs for services, particularly for long-term care
- Family caregivers may not be available or may "burn-out" and be unable to provide ongoing care
- Providers lack knowledge about family caregiving and do not have good tools to assess patient and family capabilities to manage care
- Technology presents promising ways to support patients and families, but people need to build the skills to use these technologies
- Diversity (cultural, ethnic, socioeconomic, etc.) requires that providers individualize support

2. Three Strategies Ranked as Most Urgent to Implement

- Need to implement transitional care (starting before discharge if a patient is hospitalized) that addresses patient and family needs for information and skills
- Improve separate assessment of both caregiver and family's knowledge and capacity to provide care
- Overcome patient and family isolation by creating a support system using a variety of tools such as web-based information and community resource centers

3. Three Strategies Ranked as Easiest to Implement

- Use of tools to improve caregiver/provider communication (such as "Next Step in Care"), particularly at times of transitions and to facilitate medication reconciliation
- Education of patients and families as well as provider about what can be realistically expected from services and self management
- Work to overcome patient and family isolation using available resources

MAKING THE SYSTEM WORK: POLICY AND REGULATORY SYSTEMS WORKGROUP

1. Challenges and Barriers to Implementing Recommendations and Best Practices

- Medicare does not cover all the services that many home health patients need
- Home care is very dependent on Medicare and Medicaid payment. As a result practice is driven by the payment policies of these programs
- Lack of incentives in payment and regulation for high quality care and care coordination
- Conflicting approaches to quality assurance from different regulators
- The information needed to make many policy and regulatory decisions is not easily available

2. Strategies Ranked as Most Urgent to Implement

- Support funding approaches that encourage integration (including Medicare/Medicaid) such as the current Special Needs Program or new models of managed care for people who are seriously ill
- Promote coordination by:
    - Creating incentives for care coordination
    - Developing measure of care coordination
    - Including documented success at care coordination in the conditions of participation for Medicare, Medicaid and other payers
- Require organizations receiving money from managed care to require specified levels of geriatric training for their clinicians
- Require geriatric content in the professional licensure process for all appropriate specialties and professions
- Support national initiatives that promote high quality home care (example given: the Independence at Home program)
- Create measures of quality, processes and outcomes that are the same across all settings in the healthcare system to allow comparisons across settings and better understanding of patient trajectories