Examining the Evidence, Establishing the Framework, Embracing Change

Joanne Handy, Co-chair
National Advisory Council

What will happen today

- Overview of work by National Advisory Council (NAC) and staff
- Draw on your expertise to continue this work and move forward

We all have home care stories

- Personal
- Professional
- Examples of excellent care
- Examples that underscore the challenges we face

Where we began…

- National Stakeholder Meeting January 2007
  - Understand the current state of geriatric practice in home care
  - Participants
    - Home health agencies
    - National associations
    - Quality improvement organizations
    - Accrediting organizations
    - Foundations

Conclusions from National Stakeholders Meeting

- Need for and commitment to
  - Address gaps in quality affecting older adults
  - Effective care management

Establishing a National Framework for Geriatric Home Care

- To build a framework
  - for practice guidelines
  - that will shape the provision of home care and
  - recognize the integral role of caregivers.
- Funded by the John A. Hartford Foundation

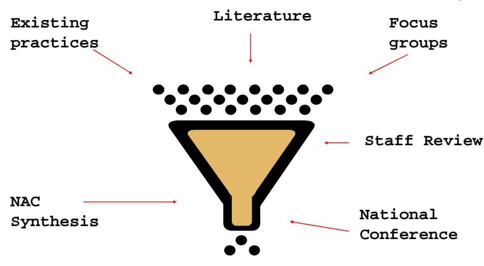
Geriatric Home Care

….services provided to older persons in their home regardless of payment source that are designed to address the health conditions, risks or goals that are associated with advancing age.

Priority Areas

- Medication Management
- Physical Function
- Pain
- Cognitive Function
- Palliative, Advanced Illness Care
- Care Coordination

Geriatric Home Care Framework Project



The Framework

Insights in Current Practice

- 3 Regional Focus Groups
  - Multi disciplinary
  - Urban & rural

Rewards

- Supporting autonomy, choice, and safe function of older adults at home
- Practicing comprehensive and individualized care
- Opportunities to contribute to the field through teaching an practice

“its helping people stay where they want to be at the last phase of life”

“having the honor of supporting people in their own homes”

“promoting aging in place…we don’t fix and cure (we) provide wellness and quality of life”

Gaps and Difficult Aspects

- Uncoordinated, fragmented care
- Lack of older person/family involvement
- Workforce: sheer lack of numbers
- Workforce: Lack of geriatric training
- Limited guidance for quality improvement efforts
- Funding and policy decisions leading to practice gaps

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"And then in real life, what happens next? Where is the follow-through, where is the reassessment, where is the monitoring of tolerance or improvement or adverse events?"

"emperor's new clothes aspect..we're acting like we're putting all these new programs (to improve care) in place and we don't have a workforce to care for people"

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Making Home the Hub of Excellent Care for Older Adults

Mary Naylor, Co-chair
National Advisory Council

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Who are we caring for?

- Data from OASIS National Repository
  - All patients 65 and older
  - 5.5 million initial assessments
  - Medicare and Medicaid

Data part of larger study funded by Assistant Secretary for Planning & Evaluation

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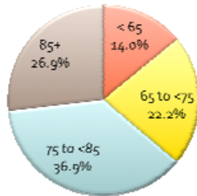
Age at Initial Assessment



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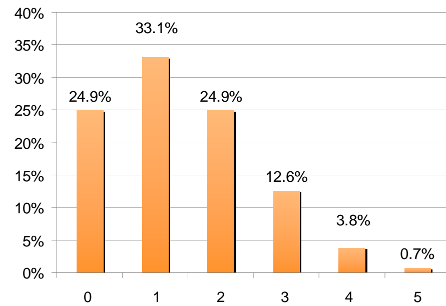
Number of Chronic Conditions



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Frequency of Chronic Conditions

Chronic Condition	%
Hypertension	29.7
Diabetes	20.7
Arthritis Musculoskeletal	15.6
Heart Failure	12.3
Chronic Pulmonary Disease	11.8
Acute Myocardial Infarction	11.1
Cardiac Dysrhythmia	8.7
Stroke or Late Effects CVA	8.3
Dementia	4.3
Neurological	3.8
Alzheimers: Cerebral Degeneration	2.8

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What Adds to Complexity of Care for Older Adults in Home Health?

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Sensory and Communication Impairment

Vision Impairment	26.3%
Hearing Impairment	40.4%
Impaired Verbal Expression	31.9%

Physiologic Problems

Dyspnea	64.6%
Daily or Constant Pain	52.1%
Obese	13.8%
UTI	8.1%
Urinary Incontinence or Catheter	38.3%
Bowel incontinence	12.0%

Mental and Emotional Status

Cognitively Impaired	36.1%
Confused or Nonresponsive	43.9%
Memory Deficit	15.1%
Impaired Decision Making	14.8%
Daily Anxiety	16.3%
Depressed Mood	18.9%

Physical Functioning

Dependent in:	
• Bathing	90.2%
• Transferring	73.8%
• Ambulation	88.4%
• Management of Oral Medications	58.5%
Mean # of ADLs and IADLs	6.8 (range 0-14)

Living Arrangements

Lives Alone	29.5%
Lives with Spouse	37.5%
Lives with Other Family	26.9%
Lives with Paid Help	8.9%

Charge for Today: Realize Home Care's Potential

Create home care that is:

- Relationship-centered
- Team-based, interdisciplinary, collaborative
- Evidence-based
- Individualized and culturally sensitive
- Communication-focused
- Longitudinally-focused

Next Sessions

- Work group sessions
  - Assignments: right side of folders
  - Room names: on sticker
  - Staff at the doors to direct you
- Return here for lunch and afternoon
  - Summary of group
  - Next phases