CURRENT PRACTICES IN HIGH-TECH HOME CARE pdf

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Affilations Almost Family, Inc. According to Kaushal, Almost Family, Inc. A common denominator in the workshop so far, said Kaushal, is that in home health care technologies can be value-added services that aid with patient centeredness, sustainability, and reimbursement. Telehealth can have a wide range of complexity, from the simplicity of the telephone all the way to the extreme complexity of smart homes. Providers, however, do not know the best way to provide evidence-based telemedicine, he said. From the patient perspective, telehealth can range from being as simple as a telephone call, joining an online support group, or obtaining health information and self-management tools online to having email and online communication with health care providers. From the provider perspective, telehealth can range from the use of electronic health records and remote monitoring of vital signs and symptoms all the way to doing consultations and patient visits by video. Technology can be helpful to teams of caregiversâ€”physicians, nurses, therapists, social workers, and others, all of whom are delivering some aspect of careâ€”by creating vital links that facilitate communication, coordination, and improved collaboration. Almost Family does this not only by following an evidence-based medical care plan but also by paying attention to functional issuesâ€”ambulation, bathing, transfer, and so onâ€”in what is a highly regulated industry. Meanwhile, home health care takes care of people with complex and multiple chronic conditions e. The collaboration benefits include, for example, the ability to target visits and interventions to the patients and at times when they are the most needed and to tailor self-management training and health education for both patients and caregivers. For hospitals, they can reinforce the discharge plan, allow the hospital to recognize key indicators for readmission, contribute to the stabilization of patients after hospitalization, and generally support care transitions. The communication component encourages good communication and relationships with discharge planners. For the system as a whole, telecommunications applications have the potential to gather and compile useful data so that health care systems can learn more about what home health care applications produce the most desired outcomes, Kaushal said. To test the impact of telehealth, his company worked with two of its partners, Medtronic and Cardiocom, on a month study of some patients with congestive heart failure. The intervention involved post-acute care and post-episode calls, used an interdisciplinary team approach, and created some champions in every study market. The study demonstrated the positive effects of telehealth on hospitalization rates and patient satisfaction and reduced day hospital readmission rates to about half the national average What Almost Family learned from this study, Kaushal said, was that it was not only technology or communication, coordination, and collaboration that made the difference but also the need to align staff, standardize care processes around clinical best practices, and then conduct focused training for clinicians around those processes. These best practices involved patient education as well. According to Kaushal, positive outcomes like these can lead to organizational growth in several ways: Kaushal noted several lessons from the experience, including the following: Sites that had strong clinical care champions had the best outcomes. An integrated hospitalâ€”physicianâ€”home health care approach to the delivery of care produced the highest number of enrollees. Operational planning program design; incorporation of new programs into ongoing operations; leadership support; broad stakeholder involvement; and definition of clear goals, timelines, and deliverables is important. Vendor systems must be scalable. Monitoring of the communication between the members of the team and clinicians in the field directly improved patient care. A focus needs to be placed on communication that takes into account the situation, background, assessment, and recommendation the SBAR approach. Success is different for different people, including different patients. In the future, Kaushal believes that when standardization begins to occur and reimbursement is aligned with value, innovation will be accelerated if telehealth applications show that they can improve the quality of health care and not just save costs so that systems do not have to rely solely on local execution. The workshop brought together health care researchers, technology researchers, industry, and government to discuss a series of questions around four

topics: How should technologies be designed for the aging population that wants to age at home? People who want to age in place are a diverse population, so should technologies be designed for the entire aging population or the 5 percent? What kind of sensing innovations are needed? The design of sensors and the development of algorithms and precise timing to make them useful are tough, so what information should sensors be conveying? How can people be helped to use technology to identify potential transition periods, and how can they be helped through health care transitions? How can nonâ€”health care technologies be used to support health? Nilsen noted that the workshop started from the assumption that technology could enhance health outside of hospitals and nursing homes by improving and sustaining health and increasing the quality of life; by allowing people to live at home longer; by reducing health care costs, especially the cost of unnecessary hospitalizations and rehospitalizations; and by reducing the strain on the health care workforce and on family caregivers. The workshop participants found that it was hard to talk to each other, Nilsen said. The people involved with technology wanted to see more investment in basic science, the people involved with health care wanted better technology now, and participants in general tended to focus on the technologies relevant to their own particular area of expertise. The technologists tend to think that all health care professionals are clinicians, she said, and the clinicians tend to think that all people involved with technology are programmers, but many partitions exist in both fields. Such a rethinking implies a balance between personalization and universal design, as well as stronger human factors research to support that balance. She gave as an example the glucose monitor, saying that glucose monitors are often not designed for people who have diabetes because they have tiny buttons and even smaller type. The new technologies developed must be useful to the patient, the caregiver, and the care team by giving them actionable data useful to them, Nilsen said. Other technologies that can serve everyone include, for example, tablet computers that have very simple operating systems for people who have never used computers. Furthermore, although users can take advantage of the health care applications that operate on tablet computers, they also can use the tablets for email and social networking. In other words, Nilsen said, the technology is designed so that people can use the technology in the way in which they intend to use it, with health care woven in. Ideally, integrated technologies free up time for conversation. For the long term, the health care system will need both more personalized technology and evidence-based, generalizable solutions that can be adapted to individual needs, Nilsen said. Another difficult question applies to monitoring technologies and, especially, cameras. Nilsen asked whether those technologies are there to keep an eye on the person so that the family knows what the individuals is doing and whether they are safe, or whether they are there to help the person be independent longer. This is one of the facets of obtrusiveness that George Demiris raised earlier. Randomized clinical trials may still have a place for the evaluation of specific outcomes and the development of best practices. According to Nilsen, the following developments are needed to evaluate the evidence: Workshop participants were able to make comments and ask questions of the panelists. The following sections summarize the discussion session. Technologies that are too obtrusive are less acceptable, she said. One of the ways to find this out, she suggested, is through better human factors engineering and testing of the usability of a technology throughout the development process. Brady further noted that FDA has a guidance for industry related to premarket concerns. The guidance asks industry to consider the design, the users, and the physical environment in which a device will be used. Cindy Krafft, American Physical Therapy Association, said that some of the technologies in development have great potential to support patient functionality and activities of daily living. Krafft gave the example of a case in which telehealth was used to report weight on a daily basis. However, she noted, home health care nurses need to be sure that patients can get on and off the scale by themselves; often, they cannot, which can lead to inaccurate data reporting. Rehabilitation has been a great beneficiary of technological advances, Nilsen said, in part because technology can provide data between in-person visits. She gave as an example a program funded by the National Science Foundation in which physical therapists remotely gathered data from a Wii Balance Board. Incentives Krafft noted that a tremendous opportunity exists to expand rehabilitation therapies to prevent patient decline and keep patients out of higher-cost care. Unfortunately, she said, the current payment methods discourage the widespread use of rehabilitation methods that might replace a reimbursable therapy visit. Demiris agreed that telehealth and

similar technologies raise a concern that they will be used to replace actual visits. They could be a great convenience for patients and families, or they could result in a diminution of services. In the early days of telehealth, he said, advocates emphasized that these services would be an add-on they would not replace visits , but later it became clear that, if that were true, they would not be cost-effective. Rather than visits lost or visits added, it is important to think about the effective coordination of the services needed to achieve agreed-upon outcomes. Technology is only one tool among many in service redesign, he said. Nilsen agreed, saying that rehabilitation technologies are often useful in providing data between in-person visits. At Almost Family, Inc. Each patient needs a plan of care that is integrated across clinical disciplines, that includes the appropriate technology, and that each discipline is following. Of the 10 visits, half can be telehealth visits. To measure productivity within Almost Family, Inc. With this system which is still being tested , staff who are paid per patient visit do not feel penalized for telehealth visits, he said. Bowles, Visiting Nurse Service of New York Research Center and the University of Pennsylvania School of Nursing, said a further step would be to think about ways to reward clinicians who become more efficient. She described a randomized trial that she led in which the nurses were asked to replace some in-person visits with visits via the use of video technology. The trial found that nurses who were efficient could save time. They were then assigned additional patients, however, and so got more work. She said that one way to overcome that disincentive might be to base rewards on patient outcomes and counting telehealth encounters into the productivity standards rather than just the number of patient visits per day. Evaluating New Technologies Bruce Leff, Johns Hopkins University, questioned whether randomized controlled trials are really a robust method for evaluating these technologies. Technologies are not used in isolation, he said, but are used in the context of people, processes, and the planning of care. They are implemented in a very specific setting with a specific clinical team and social milieu. Moreover, trials take a long time and are very expensive. Demiris acknowledged these challenges, adding that the technology itself may become outdated, given how long it takes to plan and carry out a randomized trial. Furthermore, technology does not operate independently of everything else. Nilsen listed other kinds of trialsâ€”optimization trials, adaptive trials, and continuously evolving trialsâ€”that can be considered for the evaluation of technology. Moreover, ways to shorten the amount of time required for traditional randomized trials may exist. NIH is working on speeding up subject recruitment, for example, as well as shortening the time needed to obtain outcomes.

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Patients Have the Right to Contacts to Help Clients Find a High-Tech Home Care Provider Acknowledgments The authors wish to acknowledge the support of those individuals and organizations whose contributions served to make this project a success. Ursula Springer, President, and Bill Tucker, Managing Editor at Springer Publishing Company, for expressing initial interest and providing ongoing support for the preparation of this manuscript. Jean Hurkin-Torres, our Production Editor, was most skillful in moving the manuscript to publication with minimal delay. Cook; and Project Officer, Dr. The support of the Andrus Foundation made possible the performance of the initial research on which this book is based. His chapter in this volume is an important contribution to this analysis. Susan Reisman Kaye edited earlier versions of the professional and consumer guides to high-tech home health care that chapters 11 and 12 are based on. Susan also assumed lead responsibility for researching and updating the literature review presented in chapter 2. Her work, as always, is first rate. Our original team of field interviewers, coders, data entry personnel, and transcribers performed in yeoman-like fashion throughout the course of the original research project. Tembeka Ntusi and Patricia Schumann deserve special mention for the significant contributions they xi xii Acknowledgments made in performing selected in-person and telephone data collection and data processing tasks. Mary Katherine Kraft provided helpful consultation in statistical processing during the course of the original research. Our thanks extend to various individuals within the Bryn Mawr College and Graduate School of Social Work and Social Research community who assisted in the administrative, budgetary, and technical execution of the project. Included here are Ruth W. His staff also participated in reviewing drafts of the survey questionnaire used in conducting the research reported in this book. We extend our sincere thanks to the cooperating executive directors and coordinating site staff at the participating Pennsylvania and Delaware home health care agencies. The willing participation of the staff and patients at the local agency sites and the executive directors comprising the national sample of home health care agencies in this investigation was, of course, of crucial importance in carrying out this analysis. Their capacity to give of themselves and share their organizational, professional, and personal experiences in home health care was pivotal in bringing our research to a successful conclusion. However, the simple fact that home care is such an attractive health care option may have proven to be as influential as any factor, including its cost savings qualities, in the ultimate decision to expand in-home care Applebaum, As the health care system continues down the path toward a capitated, prospective payment system, home health care is likely to be the commonly preferred route not only for patients but also for those who are expected to foot the bill. The home care service industry has grown from a mere 1, such programs in to more than 20, currently. In the context of a home care boom, the structure, auspice, and service repertoire of those organizations delivering in-home services remains diverse, with help provided to millions of individuals confronted by chronic health conditions, acute illness, terminal illness, and permanent disabilities each year. However, of the 20, operating organizations, more than 8, home care agencies are noncertified and include home care aide organizations and hospices National Association for Home Care, These programs remain outside Medicare for various reasons, including the likelihood that they do not provide the kinds of services that Medicare covers or do not provide skilled nursing care, which is required for reimbursement of home care services under Title XVIII of the Social Security Act. Just as home care organizations have proliferated in recent years, so have hospices. Hospice programs provide palliative rather than curative care for the terminally ill and their families including medical, social, emotional, and spiritual services. The outlook for growth in hospice care, like home care, is strong given increases in the aging population, the increasing number of persons with AIDS, rising health care costs, and the attractiveness of the hospice care philosophy, which emphasizes holistic, patientfamily, in-home centered health care delivery. Between and the total number of hospices participating in Medicare increased from a mere 31 to 2, In , an additional hospices were operating but were noncertified Hospice Association of America, The proportion of

hospices that are Medicare-certified is increasing, while the proportion of noncertified hospices is decreasing. Given the focus of this volume on the evolving profile of in-home care, it is important to note that the majority of Medicare-certified hospice programs are home care agency based. Indeed, in-home Introduction 5 services that reflect the use of high-technology equipment and techniques represent one of the newest and most challenging developments in this expanding area of service delivery. This dimension of home care is, in fact, projected to expand at an especially rapid pace in the years ahead. As reported by the Hastings Center: The high-tech home care industry has rapidly and relentlessly erased, for increasing numbers of families, the boundary between hospital and home, between the intensive care unit and the living room. More and more patients now receive in the privacy of their homes highly sophisticated medical treatmentsâ€”ventilator therapy and artificial nutrition channeled through infusion pumpsâ€”that 20 years ago would only have been available in special care units Hastings Center, , p. Twenty years ago home care was depicted in exceedingly simplistic terms. This service category had little status in the professional community. Considered an ancillary service of low priority, workers occupied positions of exceedingly limited status in the health services sector. Today, the rapid expansion in the range of available in-home technologies has served to alter both the home environment and the nature of treatment provided to the functionally impaired older person. These developments appear destined to 6 Setting the Scene alter substantially the landscape of gerontological home care and, in particular, the legal, technical, and ethical organizational and training regimens to which home care personnel and their elderly patients are exposed. First, the home health care sector should not be interpreted as being totally immune to cuts in funding. More than a few politicians remain very concerned that the uncontrolled expansion of home care will ultimately translate into a whole new set of unanticipated and unmanageable costs accruing to tax-dependent programs like Medicare and Medicaid. Census Bureau, , cost containment enthusiasts remain unconvinced that increased use of in-home care will be accompanied in the long run by declining utilization patterns of other forms of health care and in particular long-term institutional care. Congress, concerned by the escalating costs, included a number of measures in the Balanced Budget Act meant to curtail expenditures, including an interim payment system that places a cap, or ceiling, on the amount Medicare will reimburse each home care agency. Another action taken by Congress by means of the Balanced Budget Act seeks to correct the tendency by some home care agencies to routinely provide clients with personal care services e. Government officials maintain that the new laws will serve to return home health care to the original intent of the programâ€”the provision of relatively shortterm services for patients in medical need of skilled nursing and therapy services. However, spokespersons for home health care organizations and consumers warn that such policies run the risk of harming the most vulnerable of patientsâ€”those who are very ill and in need of the most intense and costly services. Legislative proposals are being presented to hold the tide on the anticipated home health care cuts brought on by Balanced Budget Act changes in Medicare. The drama, which has potentially powerful consequences for the well being of home care organizations and their consumers, has not yet played itself out NASW News, April There are also cries that home health care is not adequately regulated so as to insure that quality, responsible care is going to be delivered in consistent fashion. Concerned observers point to the proliferating number of proprietary home care agencies that have entered the market obviously thinking that reimbursements for services rendered are lucrative. Akin to the nursing home scandals of the sixties and seventies, these critics predict the widespread occurrence of horrendous accounts of misuse of government funds and negligent care of vulnerable homebound older persons by greedy, profit-seeking home care organizations and their uncaring, poorly trained staff. In similar fashion, the quality of hospice care, a field of specialty introduced only 25 years ago, can vary, it is argued, considerably from one program to the next. Uniform, quality standards do remain less than fully developed, especially for home health care organizations offering end-of-life care. The absence of such standards led in part to the passage of the sections of the Balanced Budget Act impacting Medicare. While Medicare pays for much of the home care and hospice care in this country, being a Medicare certified agency does not, in and of itself, assure quality. Government officials continue to argue that the problems of fraud and abuse in home health care are significant, including improper charges to Medicare by home care organizations and, more recently, exaggerated threats to patients by organizations of reduced and discontinued benefits in the near

future. Still other difficulties challenge the trend toward home care expansion. Both home care and hospice coverage, while expanding through Medicaid, Medicare, and private insurance, can be difficult to access, negotiate, and subsequently secure by the novice consumer. The requirements and 8 Setting the Scene rules of eligibility may be complex and difficult to interpret and comprehend. Uninformed consumers without personal advocates but instead with a tendency toward passivity and confusion when dealing with formal community programs, government entitlements and benefits, and the ever present small print, may become demoralized and withdraw from the process of securing needed services. The vast majority of older adults, regardless of their potentially falteringly health, prefer, if they had the choice, to remain in the familiar environs of their own homes rather than being relocated to nursing homes, homes for aged persons, or even the residences of their relatives. Public opinion polls and health care service utilization research have repeatedly confirmed that individuals with disabilities wish to receive care at home if it is possible Applebaum, More than ever before, technology-enhanced services and equipment make it possible for even the most incapacitated older adult to do just that. By the year , it is estimated that the 65 and older population will comprise The number of those aged 65 or older could double between and Health Care Financing Administration, In January of , The Census Bureau has projected by the year as many as one in five Americans could be over 65 U. Department of Labor, Introduction 9 State and federal payers, the private insurance sector, and those citizens who pay for substantial portions of their health care out-of-pocket will continue to exert cost containment pressure on the health care industry. At the same time consumers want high quality care and convenient access to the latest in health care innovation including technological advances in home-based service delivery. We argue that the technological revolution in home-delivered services, while progressing extremely rapidly, is proceeding without adequate systematic analysis of the comparative experiences of high-tech providers and their consumers. Nor do we think such analyses, even when they are performed, are figuring in prominent enough fashion in the development of best-practice approaches to planning, implementing, and operating high-tech home health care programs. Information, which reflects current practice in high-tech home care, is critically needed to help inform the growing number of multidisciplinary professional personnel engaged in the planning, administration and delivery of this category of service. Unfortunately, the knowledge base on this topic remains underdeveloped, rarely drawing on applied research depicting current high-tech home care practice. This volume was designed to contribute in part to filling this very gap in the professional and multidisciplinary long-term care and in-home service delivery literature. The primary purpose of this volume is to offer the reader convenient access to much needed information about the unique benefits, drawbacks, and challenges of importing high technology into the homes of older persons and the disabled. We believe this book is unique in its purposeful combination of both a descriptive report of research-based observations from the front-lines of home health agency operation and interpretive analyses of major issues, policies, and practices informing the delivery of high-tech home health services. Its unique quality is further reinforced by the fact that it proceeds to translate or reframe the research and analysis into concrete guidelines and recommendations for professional practice in home health care. The prescriptions for practice contained within this volume are intended to be of particular value to a wide range of home health care personnel. Content will be relevant to those agency planners arid administrators, managers, and supervisors who are considering engaging in or have recently implemented a hightech service program in their organization as well as in-home direct service providers such as occupational, speech, and physical therapists; nurses; social workers; and home health aides that are likely to work with patients receiving high-tech care. Section I introduces the reader to the field of high-tech home health care. It scans the historic and contemporary literature in home health care and aging and highlights significant developments and factors expected to influence the manner in which the home health service sector is likely to evolve in the context of the technology boom in health care. Section II of the book reports on two streams of home health research conducted by the authors. Findings from both a national survey of home health care executives and an intensive local field study of direct service providers and older consumers of home health care are presented. Chapter 3 presents dominant profiles of both providers and consumers of traditional and high-tech home health care. Chapter 4 describes the experience of providing high-tech in-home services. In chapter 5 the

experience of receiving high-tech home care is considered by providers and by older consumers themselves. Chapter 6 addresses issues pertaining to the rights of the home health patient. Finally, chapter 7 explores the impact that the introduction of high technology methods, services, and equipment is having on the structure and function of the home care organization. It should be noted that the research reported in Section II and content presented elsewhere in the volume focus on the experience of providing home health services for primarily older adults. Indeed, the home health industry predominantly serves an aging population of individuals experiencing declining health. The emphasis of our research was on the intersection of high-tech home care and the older adult population. We realize, however, that other populations of consumers need and benefit from home health care services including the developmentally disabled, individuals with AIDS, pregnant women, sick children, accident victims, and others. The reader should realize that much of what is said herein, while referring to older adults, will have direct relevance and application value to other age groups who are beneficiaries of the interventions offered by home care organizations. Section III introduces the reader to in-depth discussions of a series of crucial professional practice topics and issues in high-tech home health care. This section considers the legal chapter 8 , ethical chapter 9 , and financial reimbursement chapter 10 dimensions of service. Section III also presents concrete professional practice guidelines for organizing and Introduction 11 delivering high-tech care chapter 11 and effectively informing consumers of the availability of such services chapter

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3: "Current Practices in High-Tech Home Care " by Lenard W. Kaye and Joan K. Davitt

It is a unique combination of both a descriptive report of research-based observations from the frontlines of home health agency operations and interpretive analyses of major issues, policies, and practices informing the delivery of high tech-home health services.

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The authors bring to the forefront evidence-based current home care practices, such as ventilator therapy and artificial nutrition infusion pumps, and develop them through complete discussions of legal, ethical and administrative issues they entail.

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