



## FACES *of* HOME HEALTH

# Caring for Frail Elderly Patients in the Home

**S**utter Health, based in Sacramento, California and serving Northern California, partners with its home care affiliate Sutter Care at Home, to provide high-quality palliative and care management services to persons with advancing illness. Sutter Health's Advanced Illness Management (AIM®) program first began as a home health palliative care program in 2003. Over the past four years, Sutter Health has been expanding the AIM program into a continuous care management model, serving persons who suffer from advancing chronic conditions with a sustained palliative care and care coordination approach that supports the patient and family while they are on a home health service, and following their episode of care. An AIM patient's team can help coordinate the patient's transition from hospital to home care, work with the patient's family and any additional caregivers to inform them and provide support for the patient's condition, teach the patient how to manage their own health through medication management, recognition of symptoms, and more. AIM patients remain in the program either through the end of life or until transferred to hospice care.

### Continuity of Care for Patients

One of the ways the AIM program seeks to reduce unnecessary hospital admissions is through coordinated care.

Sutter utilizes a virtual care team across settings to provide high-quality care to patients, especially the frail elderly. The following are the key components of the AIM program:

- **Working within the five pillars to care for patients.** The five pillars are: advanced care planning with emphasis on keeping personal goals front and center to all care, medication management, follow-up care coordination, red flag identification and symptom management plan development, and use of a personal health record and other patient engagement tools. These pillars are the focus of the AIM program's mission to unite a patient's care needs with his/her goals.
- **Identifying at-risk patients.** Patients with high symptom burdens and indications of advancing illness are eligible for the expanded AIM care management program. This segment of patients shows signs of clinical, functional, and/or nutritional decline, and frequently rebound to the emergency department or hospital for services. For this population of patients, the burden of living with advancing illness is clearly evident. These patients are often not expected to live more than 12 months and have large care teams—many see 10 or more physicians and specialists. Weekly physician visits become more and more necessary to help manage symptoms.
- **All members of the care team are trained to communicate using the same method to support care coordination.** Betsy Gornet, Chief Advanced Illness Executive at Sutter, said each team member is trained the same way and regardless of their role on the team, follows the five care pillars, and reports out updates (verbally and in written form) using the SBAR format, to establish consistency. This method is used in team conference, in peer-to-peer

communication, and with physician communication. That consistency helps the care team and physician focus on what is changing for the patient and what needs are most important. The AIM team members also teach and encourage patients and families to use an SBAR format when they talk with their physician. The intention is to simply focus effective communication on those things that will improve the quality of their life. Relationship building amongst all care team members facilitates better care coordination. According to Gornet, the AIM team is a virtual team comprised of clinicians who may work in patients' homes, or a physician group, or in the hospital or through phone-based telesupport. The team comes together at weekly case conferences and hand-off care to their peers as the patient's needs change. "The fact that we have team members across organizations invites an additional layer of relationships that doesn't exist in one setting instances," said Gornet.

- **Continued support through telesupport for each patient better engages patients and boosts confidence for patients and caregivers in managing the symptoms and health needs in the home.** Following the completion of a home-based service such as home health services, the patient is transferred to a telesupport team member who is connected to that patient's physician. Once a patient's home health appointment ends, telesupport allows future care teams to easily access patient data if the patient needs in-home or additional services again. Telesupport continues the five pillars of care established by the AIM program, and call frequency depends on a patient's status; if a patient is struggling, for instance, call frequency will increase, however, if a patient is hitting his/her marks call frequency may stay the same or decrease. The notes for these calls are accessible by the physician in real time if they're on the same EHR and, if not, the same day when notes are faxed. If a more urgent need is identified while on the phone, the telesupport nurse works with the patient's physician to determine the best next step.

- **Tailored plans that meet the needs of each patient lead to reduced risk of unnecessary hospitalization.**

The AIM program has seen a 60 percent reduction in hospitalizations per the AIM utilization metrics for 90 days pre/post enrollment. Additionally, Sutter has seen a 33 percent reduction in Emergency Department visits, and a 67 percent reduction in Intensive Care Unit Days for AIM patients.

- **Emphasis on patient self-management enables patients and families to feel more comfortable in their own care and in the care of loved ones.** Gornet said AIM patients are actively engaged to understand what to do if they experience certain symptoms, and learn how to talk to physicians. Making frail, elderly patients a vital part of their own care increases their awareness of warning signs and allows them to feel more stable in their homes.

Health Information Technology (HIT) plays a prominent role in Sutter's AIM program. Gornet stated that just to run the day-to-day IT portion of the program, five or six different systems are used, with 16-17 different systems being used to gather total utilization and cost of care information. The HIT systems help keep all team members informed and in-the-loop through increased accessibility to information about the patient.

The goal of the AIM program is to connect the services and support a patient needs with their personal goals. In utilizing a tailored plan of care for each patient, the AIM team can more efficiently coordinate with all members of the patient's care and support team. Gornet sees improved communication daily between patients and care teams. She says they have even seen specialists writing notes to other specialists in patients' personal health records and putting the patient in the middle of physician-to-physician conversations that he or she may never have been privy to before. This, coupled with enrollment for the remainder of a patient's life (or until admission to hospice), allows for greater synergy in the care of the frail, elderly patients and ultimately a better care experience for older Americans in their homes and outside them as well.

# SNAPSHOT: Chronic Conditions Among 2011 Medicare Home Health Beneficiaries



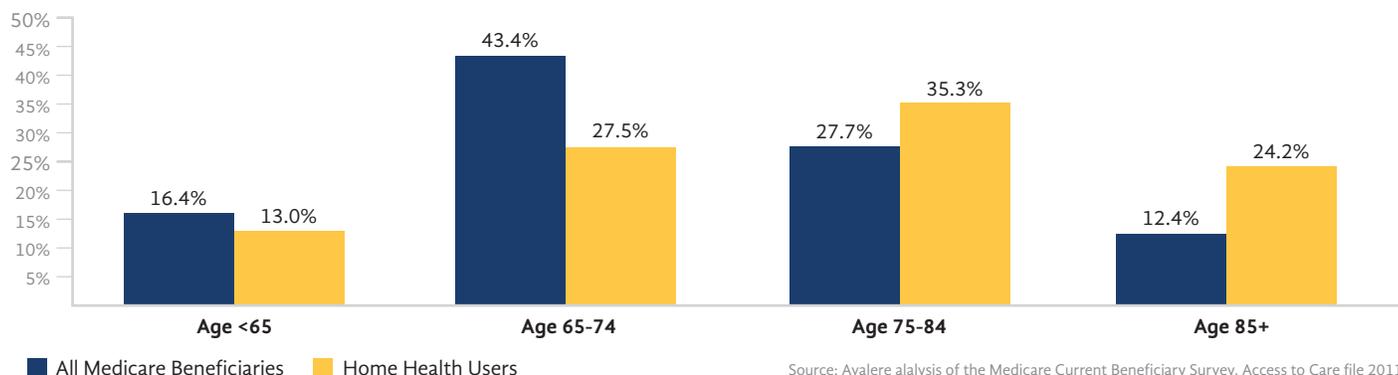
National trends for home health care reveal that the patients receiving the Medicare home health benefit are older in age and often suffer from multiple chronic conditions. The following information, taken from the 2013 Home Health Chartbook, reveals basic demographic information using 2011 Medicare claims data for the patients receiving home health care services under the Medicare program. You can find the full analysis and past years of data at <http://ahhqi.org/research/home-health-chartbook>.

## Medicare home health care providers in the United States serve a sicker and older patient population than the overall Medicare program.

- In 2011, 24.9% of home health beneficiaries were age 85 or older (compared to 12.4% of all Medicare beneficiaries).
- 83.2% of home health beneficiaries have three or more chronic conditions (compared to 60.5% of all Medicare beneficiaries).
- 45.8% of home health patients described themselves as “being in fair or poor health” (compared to 26.6% of all Medicare beneficiaries).

## Demographics of Home Health Users

Chart 2.1: Age Distribution of Home Health Users and All Medicare Beneficiaries, 2011



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011

## Chronic Conditions and Age by Home Health Beneficiaries

Generally speaking, home health users are more likely to be older than other Medicare beneficiaries, and have multiple chronic conditions. As you can see in the table below, nearly one-in-four home health users is over the age of 85, and 83.2% have three or more chronic conditions. Less than 50% of Medicare home health users are married, and 39.6% are widowed. Accordingly, these patients need greater amounts of care and additional resources in order to maintain their health.

Additionally, compared to all Medicare beneficiaries, Medicare home health users are more likely to have a yearly income of below \$25,000 per year, with 62.5% of home health users earning less than that mark. Over one-third, 34.8%, of home health users have incomes below 100% of the Federal Poverty Level (FPL), compared with just over one in five (22.0%) Medicare beneficiaries. Overall, home health users are more likely to be poorer and more fragile, requiring additional support services and attention to properly manage their care.

## Demographics of Home Health Users

Table 2.9: Selected Characteristics of Medicare Home Health Users and all Medicare Beneficiaries, 2011

	Hispanic Medicare Home Health Users	All Medicare Beneficiaries
Over age 85	24.2%	12.5%
Live alone	35.6%	29.4%
Have 3 or more chronic conditions	83.2%	60.5%
Have 2 or more ADL limitations*	28.7%	10.6%
Report fair or poor health	45.8%	26.6%
Are in somewhat or much worse health than last year	41.3%	23.0%
Have incomes under 200% of the Federal Poverty Level (FPL)**	64.5%	48.9%
Have incomes under 100% of the Federal Poverty Level (FPL)**	34.8%	22.0%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2011.

\*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.

\*\*In 2011, FPL for a household of 1 was \$10,890, a household of 2 was \$14,710, a household of 3 was \$18,530, and household of 4 was \$22,350.

# BECOMING FAMILY: Working with Patients and Caregivers



**M**r. Robert “Bob” Martinez is an 81 year-old Sutter Care at Home and AIM patient who suffers from vascular disease, congestive heart disease, and recently had four toes amputated. Despite his health struggles, Mr. Martinez remains active in his dominoes game at the West Oakland Senior Center (of which he has been a player for 30 years), is an extremely gentle and passionate speaker, and dreams of seeing his extended family located throughout Colorado and New Mexico. He lives with his son Jimmy, his family caretaker.

The Martinez family first came to Sutter when Mr. Martinez’s wife received hospice care. Almost two years later, Mr. Martinez began a regular home health plan of care. Following a recent hospital stay, Mr. Martinez was placed in the AIM program, where he received home health services including Transitions and Telesupport. Mr. Martinez recently successfully

completed his in-home care plan with home health services. This tailored in-home support helped him avoid additional surgeries.

## Caring for Patients and Families.

Sutter doesn’t just work with Mr. Martinez on his rehabilitation, the team makes sure to include Mr. Martinez’s son Jimmy in their plan of care for his father. If Jimmy has a question about his father’s health he knows he can call a member of the Sutter team for guidance. Jimmy said a couple of times he felt overwhelmed managing his father’s condition; he called Sutter and was able to have nurses talk him through what needed to be done. In order to better manage his father’s condition, the Sutter team taught Jimmy how to properly change a bandage, manage his father’s medication levels, and other clinical tasks to care for his father.

## Making Lifelong Connections

The Martinez family has long trusted Sutter to help with their home care and hospice needs, so much so that the Martinez's consider their Sutter nurses and specialists members of the family. Jimmy, who has worked with Sutter in the care of both of his parents – including with the team's bereavement support staff after his mother passed away – agreed. "That's what they are, the Sutter Care team, family. That's something that will be in my heart forever."

Since the Martinez's had worked with Sutter before, both parties were able to pick up where they left off after Mr. Martinez's last hospital stay due a blockage in his veins.

With the addition of telesupport, at the end of Mr. Martinez's appointment with the home health team, Jimmy will still feel the same level of comfort knowing there's someone there to help if he needs it.

## Teaching Self-Reliance

Rather than simply assisting Mr. Martinez in his day-to-day care, Sutter's team of nurses and specialists taught Mr. Martinez and his son how to manage Mr. Martinez's various conditions and medications in order to best manage the high burden of his symptoms.

Sutter and the AIM program not only taught Mr. Martinez how to best care for himself, that self-reliance has paid off in his ability to travel. Recently, Mr. Martinez was awarded an opportunity through the Dream Foundation to take a trip-of-a-lifetime to visit his extended family near the Colorado/New Mexico border, giving him an opportunity to see many of his family members one last time.

Caring for frail and elderly patients requires a holistic, comprehensive plan of care that addresses the patient's physical, emotional, and mental needs, and often requires strong partnerships with a patient's family caregiver allowing them to be able to adapt to what the patient and family need most. Sutter's AIM program is tailored from the start of care through end of life to meet all of the patient's needs. In Mr. Martinez's case, this meant working with him and his son Jimmy to empower them to maintain an appropriate level of care for Mr. Martinez, while being there for the family at any juncture they needed.

***Update:** Approximately four months after conducting the interview portion of this profile with Mr. Martinez and his son, Mr. Martinez was admitted to Sutter Care at Home's Hospice program where he passed away seven and a half weeks later in his living room surrounded by his family per his wishes. Due to his advancing illness, Mr. Martinez was unable to make the trip to Colorado. However, the Dream Foundation instead flew two of Mr. Martinez's cousins to his home, prior to his death. Mr. Martinez was able to visit with both family members and passed shortly after his second cousin left.*

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