

Advancing the Agenda for Home Healthcare Quality

**Lessons from the Science of Improving Function: Implications for Home Care
Executive Summary**

Dorothy Baker, Ph.D., RNCS
Research Scientist/Scholar
Internal Medicine, Geriatrics
Yale University School of Medicine

Prepared for the Advancing the Agenda for Home Healthcare Quality Meeting
Center for Home Care Policy and Research
The Visiting Nurse Service of New York
March 31 – April 1, 2005

THE ISSUE

Since implementation of the Outcome and Assessment Information Set (OASIS) in 1999 and the advent of publicly reported patient outcome indicators, home care agencies have an increased emphasis on improving the functional abilities of their older patients. These policy changes were based on research findings that the most accurate predictor of home care utilization is the patient's ability to perform essential activities of daily living (ADLs), such as bathing, dressing, transferring, toileting and feeding, and to manage community life (e.g., money management, traveling to places out of walking distance, managing medications, cooking, cleaning, and doing laundry). Traditionally, however home care clinicians have not uniformly focused on improving functional outcomes.

PAPER OBJECTIVES

The purpose of this paper is to summarize a series of randomized clinical trials and demonstration projects where home-based clinicians tested strategies to efficiently and effectively improve the functional abilities of their older patients. Understanding the results of this work can provide a foundation for evidence-based home care practice. In addition to suggesting the content of the assessments and interventions, administrative and clinical processes of care which foster the translation of research protocols into clinical protocols are suggested, based on those which were found to be successful in the research projects.

FINDINGS

Behavior Change Strategies

Improving functional ability requires intervention with the intent of changing behavior. Clinicians, like their patients, must find ways to integrate new behavior patterns into daily life to reach the goal of improving functional outcomes. The stages of change model has been widely tested and successfully used to engage both older adults and clinicians in clinical and research settings. It helps

clinicians avoid practice patterns that create "noncompliant" patients. The model is easy to comprehend, and clinicians can match their interventions with readiness to change levels found in their patients.

The Cascade to Dependency

To move patients to the action necessary to improve functional outcomes, home care clinicians must provide a compelling lesson in basic physiology. Research has thoroughly documented the hazards of immobility and consequent functional decline for hospitalized and community dwelling older adults. The changes typical of aging, when combined with physical or chemical immobilization or remaining sedentary, unwittingly initiates a cascade of events that can become irreversible for older patients.

Multifactorial Etiology of Geriatric Syndromes

Inactivity is one major risk factor contributing to functional decline. Further, research has shown that the etiology of geriatric syndromes is multifactorial. Geriatric syndromes are characterized by the compilation of incremental deterioration in multiple domains, which finally accumulate and produce negative outcomes. The concept of multifactorial etiology is not common knowledge and challenges the dominant paradigm that illness has an immediate, single cause which should therefore, be amenable to a single, quick, medical solution.

Multifactorial Interventions for Geriatric Syndromes

Multifactorial problems require multifactorial intervention as verified by successful research interventions which simultaneously reduce multiple risk factors. Delirium, falls and functional decline have been successfully reduced by multifactorial interventions. These studies identify a common set of risk factors as the multifactorial etiology of complications of hospitalization, as well as falls and functional decline in the community.

Restorative Model of Home Care

A multifactorial restorative model of home care integrates medical treatments for acute disease and personal care for ADL dependencies, with rehabilitative interventions to improve functional outcomes. In the restorative care project, work groups of researchers, home care nurses, rehabilitation therapists and aides identified agency policies, misconceptions of older adults and their caregivers, and practice patterns that impede patients' progress toward functional independence. Interactions between staff, patients and families revealed the origin of expectations that aides "do for" patients. The role of the aide was redefined as providing a setting in which patients can safely practice self care skills to manage themselves at home. A practical method was developed to set goals and specifically define the role of the home health aide, prompting incremental movement toward patient independence in order to prevent physical deconditioning and emotional dependence. Intervention patients used fewer nursing, therapy and aide visits and were discharged sooner than usual care patients. OASIS discharge scores on self-care, home management and mobility were significantly better among intervention patients and fewer of them reported pain.

TRANSLATING RESEARCH INTO HOME CARE PRACTICE

A Clinical Approach to Practice Change

The stages of change model is useful for engaging practicing clinicians and their patients in the process of implementing new behaviors. Presenting information in a manner that matches the person's stage of change is essential. In addition several advantages exist to using lay language to communicate a clinical story. Use of lay language reduces potential barriers between the disciplines (nursing, therapy and aides) and between providers and the older adults they are serving. This helps create a spirit of teamwork among all participants, which is essential to efficiently and effectively intervene in multifactorial geriatric syndromes.

A Systems Approach to Practice Change

Administrative involvement and system support help remove barriers to practice change. Management of geriatric syndromes requires a systems approach to deliver interventions coordinated across multiple departments. If all departments do not share a common goal, clinicians find themselves working at cross-purposes. To improve efficiency, a single consistent message should be presented by marketing, administration, intake and front line staff. To redefine the role of the home health aide, in the restorative care project, it was essential to rewrite descriptions provided in agency written materials, and for staff to collectively practice delivering the new message. Staff reluctance to test new innovations was encountered, based on a fear that a practice change could result in patient complaints and administrative reprimands.

IMPLICATIONS FOR HOME CARE

Geriatric syndromes that concern home care clinicians and patients, such as functional decline, falls, and delirium share common risk factors that can be reduced by assessment and intervention by home care clinicians. Particular emphasis should be placed on increasing patients' physical activity. If systems of care are redesigned to help clinicians address these risks, the payoff can be substantial in terms of patient and staff satisfaction as well as improved functional and economic outcomes.