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Individual approach required for effective dementia care

Gather personal information that goes beyond OASIS

[Editor's note: This is the first of a two-part article that discusses best practices for the care of patients with dementia. This month we look at an overview of the challenges presented by dementia patients and techniques that improve care. Next month, we will look at additional tips to increase patient compliance and ways for home health workers to handle the stress of dementia care.]

About 70% of people with dementia or Alzheimer's live at home.[1] This is significant for home health managers, because it means that many elderly patients for whom they provide care may have dementia, in addition to the diagnosis for which home health is ordered.

Recently released home care practice recommendations for the care of dementia patients by the Alzheimer's Association in Chicago combine reviews of literature, as well as input from a variety of associations. "The home care practice recommendations are the fourth in a series of best practice publications the association has produced to support quality care in different settings," says **Elizabeth Gould**, MSW, director of quality care programs at the Alzheimer's Association. Other publications discussed care in nursing homes and assisted living facilities.

EXECUTIVE SUMMARY

Confusion, agitation, and an unwillingness to cooperate are just a few of the behaviors associated with dementia that pose extra challenges for home health employees trying to care for patients. Although dementia is rarely identified as a primary diagnosis for admission to home health care, it must be recognized and incorporated into the care plan for the nurse to be able to provide effective care.

- Get to know the patient's hobbies, habits, and behaviors at admission, so visit times and types of visits can be adjusted to the patient's schedule.
- Don't overwhelm the patient with a lot of information at one time. Give instructions in short, clearly worded phrases.
- Share information about what techniques work with the patient's family or primary caregiver, so they can use them, as well.

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"We know that many patients for whom home health is provided have dementia, even if we don't have specific data," says **Mary St. Pierre**, MGA, BSN, RN, vice president, regulatory affairs for the National Association Home Care and Hospice in Washington, DC. "It is important that home care clinicians understand the special needs of dementia patients, even if dementia is not the primary diagnosis."

"Making sure that clinicians understand dementia is important for several reasons," says **Peter Notarstefano**, director of home and community-based services for the American Association of Homes and Services for the Aging in Washington, DC. "Although home health reimbursement is related to the post-acute care service, staff members spend time dealing with the behavior that is related to dementia," he explains. Not only can dementia affect compliance with treatment protocols, but it can also affect how easily clinicians and aides can provide services, he says.

"Each patient is different, so it is important to learn as much about the patient in the initial assessment as possible," says Notarstefano. "For example, find out if the patient experiences sundown syndrome, so you know to avoid late afternoon or early evening visits," he suggests. Also, be sure to include the primary caregiver in the assessment process, he says.

"The educational process for a dementia patient is different, because you need to include the caregiver in all teaching," says Notarstefano. "The clinician should also look for ways to make the caregiver's life a little easier," he suggests. Once the patient is discharged from home health care, the caregiver will appreciate any suggestions that clinicians can make to help them better care for their family member. "Sometimes, a social work visit can be requested to help the caregiver identify community sources for respite care or other assistance," he says. Clinicians and aides also can make sure they share tips on how to improve acceptance of bathing, dressing, or other activities of daily living with the caregiver, he adds.

Use tool to gather info

In addition to the OASIS [Outcome and Assessment Information Set] information collected during the initial visit, clinicians can use a tool developed by the Alzheimer's Association to gather information about the patient's habits and behaviors that might affect care, says Gould. *(See resources, p. 15.)* "The family and the patient can answer questions, and the clinician can also add personal observations that can help all team members develop a successful, individualized approach to caring for the patient," she says. Sharing information among team members is critical, because each member might observe different behaviors or different reactions to situations, she adds.

Establishing trust is key to successful interactions with a dementia patient, says Gould. "Start each visit by acting as a guest, so the patient will assume the role of host," she suggests. Be mindful of the patient's routines, so you don't interrupt

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their schedule and so that you visit at a time of day that is good for the patient, she says. "Also, if possible on the first visit, arrive with a friend of the patient or a family member, or even use a name of a friend to establish a bond and be less threatening," she recommends.

Don't rush through the visit, suggests Notarstefano. Take time to talk with the patient and explain what you are doing before you do it, he says. Be ready to slow down, or talk about something else to distract the patient, if he or she seems to be getting anxious, he adds.

"It is especially important to recognize each dementia patient as an individual," says St. Pierre. Don't treat a dementia patient as a child who doesn't understand what is going on; instead, take time to find out exactly how much the patient comprehends and how to best include the patient in the care, she suggests.

Including the patient can take many forms, says Notarstefano. "An aide can ask a patient to set the table while the aide prepares lunch," he says. "Easy activities that are safe for the patient to perform and give them a sense of participation will improve the relationship," he points out. Asking patients to sit in the kitchen and talk about their favorite meals or recipes while the aide prepares the meal also makes the patient feel included.

Make sure that inservices address dementia so that all clinicians and aides understand all of the symptoms and behaviors, says Notarstefano. "Many times a clinician will attribute confusion to dementia, but you can't assume that all confusion is dementia-related," he says. "Dementia progresses slowly, so if a clinician or aide notices a sharp increase in confusion or other symptoms in a short period of time, further assessment is needed," he says. Infection, certain medications, or an increase in blood sugar levels in diabetic patients can all increase confusion, he points out. "This is why it is important to get to know each dementia patient and be aware of the individual."

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1. Alzheimer's Association. 2009 Alzheimer's disease facts and figures. *Alzheimer's and Dementia*. 2009; 5(3):234-270.

RESOURCES

To download a free copy of "Personal Facts & Insights" to use as an information gathering tool for dementia patients, go to http://www.alz.org/carefinder/support/documents/personalfacts.pdf.
To download a free copy of the Alzheimer's Association's Dementia Care Practice Recommendations for Professionals Working in A Home Setting, go to http://www.alz.org/national/documents/Phase_4_Home_Care_Recs.pdf.

SOURCES

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Improve retention rates by making safety a priority

Job satisfaction correlated to safety issues

[Editor's note: This is the second of a two-part article that discusses the safety of home health employees. Last month, we looked at the types of workplace hazards home health employees face in patients' homes. This month, we look at how improving employee safety can affect recruitment and retention of employees and specific actions to take when an employee reports an unsafe situation.]

Why should a home health manager pay close attention to employee safety? Not only are there legal and ethical reasons to do so, there is also the fact that employees who feel safe in their work environment are more likely to remain in their job.

"As home health nurses grow older, it becomes more important to make sure that they are satisfied with their jobs and stay with the agency, because it is difficult to replace their experience and knowledge," points out **Robyn R.M. Gershon,** MHS, DrPH, associate dean of research resources and professor at the Mailman School of Public Health at Columbia University in New York City. High turnover at a home health agency is not only

expensive, but it also can create more dissatisfaction among employees, as other staff members are asked to cover more patients, she says.

One study shows a negative correlation between threatened verbal or physical abuse, environmental exposures to cigarette smoke or unhealthy homes, and household job-related risks to both job satisfaction and retention, Gershon says.[1] Other issues that home health employees identify as issues in the job, such as transportation and travel, or the type of work that is done, do not present a significant correlation to retention. "It is clear that violence — or the potential for violence — are issues that affect the employee's plan to stay with the agency," says Gershon. If a home health agency can develop safety policies that are specific to home health and ensure that all employees understand that the agency takes their safety seriously, the opportunity to retain employees increases, she says.

Be sure your policies address the process to report a safety issue, the actions that are taken after a safety incident or report, and the options for resolving the safety issue, says Gershon. Safety policies should address a range of issues, including infection control and personal security, she adds. *(See right, for steps to take after an employee report.)*

Just developing policies is not enough to reassure employees, suggests **Norma R. Anderson**, RN, MSN, CNL, DNP(c), nurse educator, University of San Francisco School of Nursing and author of "Safe in the City," a study of workplace danger in home health.[2] "Safety policies and protocols needs to be reinforced through yearly safety training classes and daily reminders that safety is important," she says. "A continuous focus on employee safety makes employees feel valued."

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SOURCES

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How to address a report of a safety issue

Take report seriously; document follow up

Ensuring employee safety requires more than a set of policies and procedures. It requires immediate action and thorough investigation once an employee reports an unsafe situation, says **Robert W. Markette Jr.**, an attorney with Gilliland & Markette in Indianapolis.

Take each report seriously, says Markette. Although the issue may seem minor, be aware that most cases of violence in home health were preceded by warning signs that the home health employee didn't report, or didn't view as serious, he explains.

Make sure that employees know that they don't have to stay in the home if they feel threatened, says Markette. "If the patient or a member of the patient's family yells at the employee or threatens them in any way, they should leave and let their manager talk to the family," he says.

There are gray areas in which some home health nurses use their own judgment, admits Markette. "Some patients with dementia will threaten others, curse, or yell — and the behavior is related to the disease," he says. "Older, more experienced nurses will often take the behavior in stride, but younger nurses or aides may not be prepared to handle the situation," he says.

Regardless of the situation, once an employee reports that he or she doesn't feel safe, a manager must investigate, says Markette. "If there is violence or a threat of violence, suspend service while you investigate," he suggests. "After the investigation, a manager and another person from the agency should visit the family," he says. The agency should always send two people to meet with the family, with one person having the authority to make decisions and the other person as a witness to the meeting. The purpose of the meeting is to identify the issue, outline the results of the investigation, and discuss the actions that will be taken to resolve the issue. The employee

involved in the report should not be present, he says. "All of these points should be included in a letter that will be given to the family," he says. A family member or the patient must sign a form acknowledging receipt of the letter, he adds.

In some cases, the agency might ask a family to fix unsafe conditions in the home, make sure that family members or friends who threatened or made the employee feel unsafe are not at the home when the employee is there, or confine a dog during the employee's visit, says Markette. "If the family and patient agree to the conditions, resume service," he says.

There may be cases in which patients or family members don't want certain employees based upon race or gender, and that prompted the threatening language, says Markette. "An agency cannot assign employees based upon race or gender," he emphasizes. If the family or patient insists upon certain gender or race, then the agency will have to discharge the patient, based on the family's unwillingness to provide a safe environment, he adds.

Dementia patients can present challenges, but Markette suggests that the agency try to assign more experienced nurses to them if there is no real potential for violence. "If you do make a staffing change after an investigation, be sure to point out to the employee who filed the complaint that it is not a reflection on the employee's performance; it is related to being able to serve the patient," he suggests.

If the patient and family don't address the issues outlined in the letter, it is appropriate to send another letter informing them that due to their inaction, your agency must discharge the patient, says Markette. Although agency managers are reluctant to appear to abandon a patient, it is acceptable to discharge a patient when there is clear evidence and documentation that providing care places the home health employee in a potentially dangerous situation, he says.

Finally, after the report has been investigated and issues have been resolved, be sure to communicate with the employee who initiated the complaint, says Markette. "Explain the process and the results thoroughly, so that the employee knows the complaint was taken seriously."

SOURCES

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2010 may bring new career opps for CMs

Value of care coordination is being recognized

Now is a good time to be a case manager, leaders in the field report. New opportunities are opening up for case managers as the country struggles with ways to provide optimal health care for everyone while minimizing soaring costs for care.

"Care coordination, case management, and safe transitions of care can only help save health care dollars. More and more, case management is being recognized as a valuable service and people are beginning to understand how the care coordination piece benefits the bottom line," says **Margaret Leonard** MS, RN-B, C, FNP, senior vice president for clinical services at Hudson Health Plan in Tarrytown, NY, and president of the Case Management Society of America (CMSA).

All of the health care reform bills that were introduced in Congress include the concepts of care coordination, care management, and safe transitions of care as cost and quality essentials for health care, Leonard says.

In addition to giving input on health care reform proposals, CMSA has been asked to provide language for a model case management act, she adds.

The Case Management Model Act is not a bill, but rather a document that educates legislators and regulators to help them define criteria for care coordination, case management, and transitions of care. It includes case management standards of practice, which contain a list of criteria that must be met before someone can call himself or herself a case manager, Leonard says.

"I feel good about the health care reform measures as they apply to case management. I think they will open up new avenues of practice for us. I don't think primary care physicians or other providers who don't already have case managers on staff will not go start hiring them until something is decided about health care reform including the realignment of incentives; but once we get past

this hump, we're not going to see any problems with nurses and social workers getting positions," Leonard adds.

Nancy Skinner, RN, CCM, agrees that case managers will have new opportunities in the future.

"It's going to be a whole new world for case managers. The case manager is going to become a consultant who helps the patient, the family, and caregivers have quality of life through the end of life," says Skinner, a consultant for Riverside HealthCare Consulting in Whitwell, TN.

Some of the opportunities for case managers will depend on what the final health care reform legislation looks like, Skinner says.

For instance, the idea of a patient-centered medical home is under discussion, and is likely to involve case managers in some way, Skinner says.

However, there's still no agreement on how physicians will be reimbursed for providing the extra services to patients, she points out.

"In today's economy, we truly need to focus on appropriate case management, but it all depends on the funding. I believe that case managers will become a part of primary care practices, but it may take as long as five years to determine how the patient-centered medical home is going to be organized and how case managers will participate," she says.

The incentives have to be aligned appropriately for primary care physicians to add case managers to their practice, Leonard adds.

"We can't ask primary care physicians to provide care coordination and not receive increased reimbursement. They're going to have to hire staff, and the government is going to have to reimburse for it," Leonard says.

The medical home model includes case managers who work with physicians to manage the care of patients, something that is sorely needed, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

"The health care system has become so complex that people need someone to act as their advocate. As physicians are forced to decrease the time they spend with patients in their office, and more responsibility shifts to the patient and family members, people need someone to guide them in making the right choices and following their treatment plan," Mullahy says.

Case managers can help people understand their diagnosis, make informed choices about treatment options, prevent complications, and save money at the same time, Mullahy says.

"However, the average person doesn't understand how much help a case manager can be, and that's why we need to educate them," she says.

Case managers based in physician offices can help patients understand how to manage their condition, how it will improve their quality of life if they do, and what could happen if they don't, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"We hear so much about noncompliant patients who don't fill their prescriptions and don't take their medications correctly, but there is very little education that occurs at the doctor's office level when a new prescription is ordered or a new diagnosis is made. Patients need to be educated about how to adhere to their treatment plan, and case managers are the right people to do so," she says.

Sometimes patients can't afford their prescription and need help looking for alternatives, Kizziar points out.

"Doctors decide what is appropriate and rarely ask if the patient can afford it. I think people leave the doctor's office without the knowledge they need to make the kind of decisions they need to make. This is another opportunity for case managers," she says.

Whatever happens with health care reform, it is likely to be more and more difficult for middle-sized and smaller employers to continue to provide the same kind of health care coverage they do today, and that is likely to create opportunities for case managers, Kizziar points out.

She sees opportunities for case managers either as consultants on a contract basis or as employees who can help employees navigate the health care system, she says.

"As more and more people shop for health care benefits, case managers have an opportunity to share their expertise and act as consultants to employees to help them make wise decisions," she says.

Being a health care educator and advisor to help employees navigate the health care maze is an opportunity case managers haven't had in the past, she says.

"I have believed for a long time that case managers should inform the health care consumer about how to make better decisions and how to be compliant. This is going to be even more impor-

tant in the future," Kizziar says.

The complex health care system and the emphasis on efficient and effective care already is creating opportunities, Mullahy points out.

"More and more third-party administrators are bringing case management and disease management programs into their organization. Employers are starting to look at opportunities for case managers. Hospitals are advertising for nurse navigators to help patients navigate their way through the health system and to manage their care once they are discharged," Mullahy says.

With the current emphasis on readmission rates, case management responsibilities in the acute care setting are likely to expand, and extend into the community, Skinner says.

"The focus on readmissions is going to increase the value of case managers and create a greater need for case management," Skinner says.

Data compiled by the Centers for Medicare & Medicaid Services (CMS) show that about 20% of patients responding to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) replied no when asked if anyone told them what they needed to do at the next level of care, Skinner points out.

"As health care reform rolls forward, I see case managers taking a role after patients are discharged from the hospital to help prevent an adverse event that could result in a rehospitalization," Skinner says.

For instance, heart failure is a major cause of rehospitalization within 30 days of discharge, Skinner says.

"Case managers can have a significant role in working with these patients to prevent readmissions. I predict that in the near future CMS will announce an intention to modify or discontinue payments for readmissions within 30 days. If and when this occurs, hospitals are going to have to develop a case management program for heart failure patients after discharge, or they're going to lose reimbursement from Medicare. Case managers in acute care are going to have to pick up a much greater role in transitions of care," she says.

Skinner predicts that in the future, case managers will work in every health care environment where there is a transition of care — skilled nursing facilities, long-term acute-care hospitals, home care agencies, and hospices.

"As patients move from one level of care to another, it's going to be the responsibility of the facility discharging them to give them the tools they need to be successful at the next level," she adds.

The aging baby-boomer population is going to be the catalyst for change, she adds.

"I can see case managers working in clinic environments and educating patients on what is wrong, what the patient needs to do, and why it is important," Skinner says.

For instance, joint replacement patients could benefit from having a case manager work with them before surgery, during the hospitalization, and after discharge, she adds.

Case managers can help with transitions of care by facilitating communication between providers and making sure providers at each level of care have all the information they need to treat the patient.

"Many times, patients are seeking care from many different providers who don't always communicate with each other," Leonard points out.

For instance, if a patient is hospitalized or sees a specialist, the family doctor may not know what has been going on.

With the current system, if the primary care physician refers a patient to a specialist, that doctor should get the information back to the primary care physician. It doesn't always happen because no one is responsible for sending the information or ensuring that the primary care physician receives it, Leonard points out.

"In the future, because of the economy, many different levels of providers are going to pop up. We've already seen patient navigators and care coaches," Leonard says.

The new types of providers may be less skilled and less educated than the clinicians who provide direct patient care, but they're also less expensive, she adds. This means it will be more economical to hire a less skilled person to do jobs that don't need the expertise of a licensed clinician.

"Case managers are likely to be the people who will have oversight over the less expensive health care worker. The National Quality Forum has suggested in their work, which was published for public comment, that the care coordination team has to be led and overseen by a licensed health care professional. I don't think the public is going to let that idea die. They want to feel protected in what they are doing," she says.

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Want to spend more time interacting with patients?

Here are two opportunities to consider

Case managers went to nursing school to take care of people, something they find themselves doing less and less in most practice settings, **Catherine Mullahy**, RN, BS, CRRN, CCM, points out.

"Nurses like to feel like they are making a difference for patients, that they are part of the solution to their patients' health care issues. Case managers who spend a huge amount of time with their heads in a chart or talking to insurers aren't feeling good about what they are doing. Instead of spending time with patients, they're spending time on paperwork and business issues," adds Mullahy, president and founder of Mullahy & Associates, a case management training and consulting company.

In the future, as people need more and more help navigating the health care system, case managers are going to have the opportunity to have much more personal and face-to-face contact with patients, she says.

Direct-to-consumer case managers and guided care nurses already are providing face-to-face case management and developing a close relationship with their clients, she adds.

Guided care nurses

Guided care nursing gives RNs an opportunity to do what they went to nursing school for in the first place, says **Kathleen Trainor Grieve**, RN, BSN, MHA, CCM, a guided care nurse from Johns Hopkins Healthcare who works at Johns Hopkins Community Physicians at White Marsh.

The guided care model was developed by an interdisciplinary team of clinical researchers at Johns Hopkins University to improve the quality of life and efficiency of resource use for people with complex medical conditions.

Guided care nurses work in the primary care setting to coordinate care for patients with chronic conditions and complex needs, working side by side with the primary care physician, and interact with other health care providers who treat their patients.

"We are partners with the primary care physicians, the patients, the families, and the specialists. We take a holistic approach to patient care and are truly part of the whole team," she says.

Unlike nurses in other settings, guided care nurses never lose track of their patients after a brief episode of care because they work with their patients on a long-term basis, usually for life, Grieve points out.

They develop a close working relationship with patients and their caregivers and meet with them in their homes as well as accompanying them to physician visits and visiting them in the hospital. They coordinate transitions between levels of care and providers.

"Some patients have said that working with a guided care nurse is like having a nurse in the family. Someone they trust is looking out for them and getting them the care they need," Grieve says.

Following an at-home assessment and evidence-based planning process, the guided care nurse monitors patients proactively, promotes self-management, smoothes transitions between sites of care, educates and supports family caregivers, facilitates access to community resources, and coordinates the efforts of health care professionals, institutions, and community agencies.

"Self-management is an important aspect of the program. We don't do things for our patient that they can do for themselves. We focus on helping them take charge of their own health," she says.

Guided care nurses come from a variety of backgrounds, Grieve says. Of the seven nurses in a three-year trial of the guided care nurse program at Johns Hopkins, one nurse had geriatric experience, another was an experienced home care nurse, and another had been a hospital-based nurse for only four years.

"It's not so much the experience nurses have had that make them a successful guided care nurse. It's their personal attributes," she adds.

For instance, guided care nurses have to be assertive when they need cooperation from the physicians, especially when they are just starting

with the practice.

"Doctors are all overworked and have limited time. You can't let it stop you when they tell you they don't have time to talk," she says.

Guided care nurses must complete a guided care nursing curriculum and pass a certification examination.

Direct-to-consumer case managers

Direct-to-consumer case managers are nurses who are independent business owners and contract with patients and/or their family members.

While the contract for the actual services may be with the patient, referrals may come from group medical practices, elder care attorneys, financial advisors, small employee groups, and others who are aware of the benefit of the services.

Their fees are paid by the person who hires them.

"There's a tremendous need for case managers to help consumers navigate the health care system. Direct-to-consumer case managers help patients understand their diagnosis, their treatment plan, their medications, and help when nobody else has the time to answer their questions. They are the patient's advocate and someone patients and family members can call on when they have questions and concerns," Mullahy says.

When patients are seeing five or six different doctors, they need a case manager who can go with them to their appointments, help coordinate the care, and ensure that all of the providers have the information they need to develop a treatment plan.

"This type of practice gives case managers an opportunity to work one on one with patients and to develop a close relationship with them. It goes back to the first generation of case management where the case managers spent time with their patients. Direct-to-consumer case managers can control their own caseload and decide the best way to handle their cases," she says.

Direct-to-consumer case managers are not employed by a managed care organization, a hospital, or another entity.

"They represent the patient's interest and only the patient's interest. They don't face the challenge that their employer may want something that conflicts with what they think is the patient's best interest," Mullahy says.

Geriatric case managers have been contracting with family members or elder care attorneys for a number of years and managing the care of elderly patients, often when their family members live in another state, Mullahy says.

Other case managers have gone into business to consult with patients who are undergoing cancer treatment or have complicated conditions, such as congestive heart failure or end-stage renal disease, she adds.

Direct-to-consumer case management is a growing field that is likely to increase in the future, but it's not for everyone, Mullahy says.

"Just because someone is a wonderful case manager, they don't necessarily have what it takes to become a business owner and market their own services," she adds.

Offering your services as a consultant to consumers is fulfilling but is challenging because many case managers can't afford to go out on their own and lose the security of a weekly paycheck, she says.

Mullahy advises case managers who would like to try direct-to-consumer case management to keep their job and build up their practice in their spare time.

"I wouldn't advise anyone to leave the security of a job unless they have savings and other income," she says.

(Johns Hopkins is offering a six-week, 40-hour online guided care nurse course through the Institute of Johns Hopkins Nursing. For more information, visit www.ijhn.jhmi.edu.) ■

Program helps patients adhere to regimen

Members targeted have chronic conditions

Recognizing that patients who don't take medication for chronic conditions as prescribed are more likely to have poor control over their independence, Blue Cross has launched a program to coach people on medication adherence.

"We know that adherence to medication is an important part of managing a chronic disease. Members who have a chronic condition and don't adhere to their treatment have a greater potential for hospitalizations and outpatient care as well as a decrease in the quality of life," says **Kimberly**

Siejak, manager of population health and wellness for the Philadelphia-based health plan.

The medication persistence program, launched in July as part of the Independence Blue Cross Connections Health Management Program, targets members who have not been adherent in taking medications for coronary artery disease, heart failure, diabetes, and/or hypertension.

"We targeted these conditions because they often can be controlled with medication and patients typically experience long-term complications if they don't take their medication regularly," Siejak says.

Many of the patients in the program have heart failure, a condition that frequently results in rehospitalization, she adds.

"Often when heart failure patients are in the hospital, they are discharged with a new medication and they're not sure if it is different from the one they were taking before they were hospitalized. Our health coaches can contact them and discuss whether they were prescribed a new medication, if they have a follow-up visit scheduled with their physician, and to answer any questions they have," she says.

The health plan included hypertension in the program because people with hypertension may stop taking their medication and not experience any immediate symptoms and can experience severe long-term complications such as strokes, she points out.

Independence Blue Cross uses medical claims data and pharmacy claims data to identify members with chronic conditions and members who have been refilling their prescriptions for chronic diseases less than 50% of the time.

"We don't know what happens after members fill their prescriptions. We hope they are actually taking it. The data we use for this program do give us a measure of the refill rate, which may be a proxy for the member's medication adherence," she says.

The health plan's proprietary algorithm risk stratifies members into low, medium, and high risk categories. Each category receives a different type of outreach.

Health coaches also make outreach calls to patients with chronic conditions who have been discharged from the hospital to make sure they understand their discharge instructions.

"We want to balance our resources appropriately and reach the members where we can have the biggest impact," Siejak says.

Low-risk members are those who fail to refill only one type of medication. They receive periodic automated telephone calls that include the program's telephone number if they want to contact a health coach with questions or concerns.

Members at moderate risk are those who fail to refill two or more medications. Automated telephone calls give them an opportunity to transfer directly to a health coach.

"The health coaches love the calls they get when the members make the choice to speak with them. This means that something in the automated call has hit home with them. They are primed and ready to make changes. It can be a much different response from what they get from many of the outbound calls to members," she says.

The automated calls include general information about the medication types the members are taking, why it is important to take it as prescribed, and what complications may occur if they don't.

"We always ask the member to verify his or her identify before the system launches into the message," she says.

The automated calls encourage members to talk to a health coach or call their physician if they have any questions about their medication regimen.

"All of our interactions reinforce the members' relationship with their physician and encourage members to adhere to their treatment plan or talk to their doctor if they're having trouble with adherence," she says.

High-risk members receive an outbound telephone call from a health coach who educates the members about the importance of taking their medication and tries to engage them in health coaching to help them adhere to their physician's treatment plan.

Reasons the members give for not refilling their medication include side effects, forgetting to get it

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filled, and lack of information about why they are taking it.

Most members have a drug prescription plan, so cost is often not a factor, except in the case of Medicare beneficiaries who may have hit the donut hole in their prescription plan or who are having difficulties with copays.

"Sometimes when patients are prescribed a beta-blocker after a heart attack, they don't understand why they should continue taking it since they have completed cardiac rehabilitation and are feeling fine. They don't understand the risk in not taking it," Siejak says.

The health coaches discuss the individual issues with the member and emphasize the importance of taking the medications. They can also provide tools and resources to members to help them understand and keep track of their medications.

During the telephone call, the health coach works with the member to set goals for medication adherence and to develop strategies for meeting the goals.

They help the members prepare for a follow-up visit with their physician by discussing what questions the member should ask the doctor and what concerns they may want to bring up.

"The goal is to interact with the members and educate them to understand why it's important to adhere to their medication plan and to be an active partner with their physician," she says.

The health coaches work with the members to determine if they need follow-up calls and to set up a convenient time.

"The program is very member-centric. If the member seems to be doing well, the health coach may make only one telephone call. If someone is having a lot of problems, the health coach may call on a regular basis," Siejak says.

The health coaches, who are employed by a vendor with which Independence Blue Cross contracts, are health care professionals with 10 to 15 years experience. About 90% are registered nurses. The others are pharmacists, registered dieticians, and respiratory therapists who are called in when patients have specialized needs in their field.

The health plan conducts monthly data mining to identify members who are not filling their medication.

"We have checks and balance to monitor outreach efforts so the members don't get the same kind of calls over and over," she says.

In most cases, the same health coach works with the member but since the program is staffed

CNE QUESTIONS

17. Why is it important to make sure home health employees are familiar with dementia care best practices, according to Peter Notarstefano, director of home and community-based services for the American Association of Homes and Services for the Aging in Washington, DC?
    A. Medicare reimburses well for care of dementia patients.
    B. Home health nurses don't treat enough patients with dementia to develop an expertise.
    C. Dementia affects the ability to provide effective care.
    D. It is frequently the primary diagnosis for admission to home health.

18. What is an important first step to establish a good relationship with a dementia patient, according to Elizabeth Gould, MSW, director of quality care programs at the Alzheimer's Association.
    A. Establish trust.
    B. Offer to do everything for the patient.
    C. Give the patient complete control over every decision. D. Keep the visit short and quick.

19. What two key issues for agency managers are affected by an employee's perception of violence or potential for violence in the workplace, according to Robyn R.M. Gershon, MHS, DrPH, associate dean or research resources and professor at the Mailman School of Public Health at Columbia University in New York, NY?
    A. Accreditation and licensure
    B. Reimbursement and quality of care
    C. Patient satisfaction and referrals
    D. Recruitment and retention

20. How should a home health manager handle an employee's report of unsafe conditions in a patient's home, according to Robert W. Markette Jr., an attorney with Gilliland & Markette in Indianapolis, IN.
    A. Evaluate the credibility of the employee before proceeding.
    B. See if any other employees have complained about the same patient.
    C. Begin an investigation immediately.
    D. Ask an attorney for advice on how to proceed.

Answer Key: 17. C; 18. A; 19. D; 20. C.

by health coaches 24-7, if a member calls in the middle of the night or on the weekend, his or her health coach may not be at work.

The health coaches work on the same platform, which gives the coach who talks with the member the ability to access member information and leave information for the primary health coach.

"Greater than 80% of the time, the member talks to the same health coach," she says.

Since the medication persistence program was launched in July, 2009, the health plan has targeted 12,402 members with at least one automated outreach. About 90 of those members have been engaged in one-on-one health coaching. ■

BINDERS AVAILABLE

HOSPITAL HOME HEALTH has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail binders@ahcmedia.com. Please be sure to include the name of the newsletter, the subscriber number and your full address.

If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at www.ahcmedia.com/online.html.

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CNE OBJECTIVES

After reading each issue of Hospital Home Health, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CNE INSTRUCTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **March** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■