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Home based Care

Principles & Proceedings.

Home based Care

Most of the home bound elderly suffer from multiple chronic diseases , are non ambulatory and need interdisciplinary care .

Home based care consists of :
Doctor consultation
Nursing care
Physiotherapy , Occupational therapy
Psychologist, Counselors
Dietitians
Social workers
Home health aides.

Home based Care for seniors

Home based care catering mostly to seniors with psychologists , physiotherapists and nurses working along with doctors as a team . Short procedures , dressing of wound etc will be done at home . Later collection of specimen for laboratories will be done.

In case of emergencies Telemedicine may be available.

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- Much needed for seniors , specially of age more than 70 yrs and young patients with chronic diseases specially neurological diseases.
- A way to prevent recurrent hospitalizations .
- Allows early & safe discharge of patients from hospital.
- Ideal care for patients : Builds trust and satisfaction.
- Team care is possible for chronic diseases.
- With the availability of modern technology excellent monitoring of patients is possible even at home.

Overview on Home based care

- **Guiding principle is to provide "the right care, for the right patient, by the right provider, at the right time, with the right tools."**
- **Four major questions to answer** in defining the practice:

1. What is the main mission?
2. What is the target population and geographic service area?
3. What is the practice and team structure?
4. What are the financial options for sustainability?

Common factor is the need for 24/7 clinical access for patients and family members.

Steps of integration of care

01 **Primary care office practice** with G.P/Internists/ Geriatricians, Pediatricians, Gynecologists, Palliative care physicians, Psychologists, Dietitians, Physiotherapists under one roof.

02 Integrate Primary care with **Telehealth**

03 **Home based care** for the elderly supplemented with Telehealth & Old age homes

04 Strengthening **Secondary Health care** by developing District hospitals, Day care centres

1.Mission

- Reduce expenses
- Provide preventive and palliative care to the target population

2 A .Patient Population

Four major types:

1.Elders (65 and over) with severe chronic disabling disease

2.Younger disabled persons affected by neurologic or mental health disorders

3.Post-hospital populations (without long-term primary care)

4.Convenience populations in home, office, or hotel settings

2 B . Geographical area

- Radius be limited to a 25–30 min driving time.
- Individual visits can be less than 15–20 min apart on a particular day.
- Boundaries beyond a 30-min driving radius may be worthwhile for high population density opportunities, such as retirement communities

3 A .Dedicated HBPC Team versus Extension of Office Practice

Building a dedicated HBPC team has the advantage of

- setting a clear mission
- building a team focused on a single goal
- developing infrastructure for unique clinical and business aspects of home-based medical care

Early steps to develop a dedicated HBPC team include:

- Make your practice known in the local health-care community and neighborhoods (e.g., primary care practices, polyclinics, hospitals, hospice agencies, senior housing communities).
- Determine which practice partner entities are available to serve the target population (e.g., pharmacy, durable medical equipment delivery, skilled home health agency services, home-based personal care services,subspecialty physicians specially psychiatry, neurology, nephrology, laboratory services, telemedicine including psychologist & dietitian).

- Hire core team members (physicians, nurse , physiotherapist/occupational therapist, and office coordinators) with start- up funding from a sponsoring health system, philanthropy, or private investment.
- Build strong administrative infrastructure support for financial practice management and data analytics.

More modest approach

- To start a home-based medical practice from an existing office-based practice. This can start with clinicians who make visits to previous office patients that are now homebound. After-hours coverage relies on the on-call service/telemedicine of the office practice.

Challenges

- Difficulty providing urgent visits when needed, as an office schedule limits flexibility.
- Increased on-call demands due to greater care needs of home-based patients.
- Practice of home-based medicine requires a distinct skill set for clinicians and administrative staff.
- Building a home-based primary care service from an office-based practice can be a starting point, but the team should set specific milestones to determine when to create a subsidiary or independent HBPC team.

Long-Term Primary Care versus Short- Term or Episodic Services

- The long-term approach commits to coordinate medical and social services for a population of older patients across settings and over time, from the home to the hospital, and to hospice. Such an HBPC team assumes responsibility for a high-cost and ill population and is accountable for clinical and cost outcomes of the population. These teams generally offer 24/7 phone access to clinical staff, urgent visits when needed, and coordination of social and medical specialty services.

Community based practice

- One advantage of being a community-based practice includes being closer, to the patients, families in the neighborhood.
- Such proximity encourages close working relationships and a shared mission to keep elders at home, rather than bringing them to the hospital.
- However, being community-based does remove the health system's safety net on the financial end. This means that practice survival depends on volume productivity, the results of contracts, and effectiveness of the internal financial systems.

Future option

- A future option may be to base an HBPC team in a skilled nursing facility (SNF) within a large integrated system.
- Most patients in an HBPC practice are close to being nursing home eligible, and patients discharged from subacute rehabilitation programs following a hospital stay are a good source of referrals.

3 B . Practice Structure

- Skilled medical clinicians who can provide intensive management of serious chronic illness
- Continuity of care across settings (e.g., home, hospital, skilled nursing facility, or hospice)
- 24/7 access for urgent clinical triage and decisions and caregiver support Mental health services
- Compassionate end-of-life care
- Mobile electronic health record (EHR)

- A practice should develop a plan for managing growth as patient volume expands, as a team of several clinicians approaches capacity of 250–300 patients. A focus on a relatively small subgroup of a highly targeted population and a high annual attrition rate, with annual mortality rate for the population that approaches 20–25 % percent

3 C. Team structure

- A team includes:

1. Medical services

(a) Mobile labs and ECG
(b) Mental health
(c) Subspecialty services e.g neurology,nephrology.
(d) Hospice care
(f) Private ambulance and wheelchair van transport
(g) Inpatient rehab
(h) Skilled nursing facilities (SNF)
(h) Durable medical equipment delivery

2. Social support services

(a) Family caregiver support, counseling

(b) Patient and caregiver education (Short live lectures of 45 min-1 hr/ Lectures available through website of 15 min modules)

(c) Minor home modifications

(d) Nursing home placement and specialist visit

- There needs to be simple access for new patients, with a single phone number and engaging office staff who answer the phone, determine if the prospective patient is appropriate for the practice (has difficulty leaving home and has a reliable caregiver/contact person), and start the intake process.
- In having an in-person orientation at the practice's administrative office for the family caregiver.

- The goal is to prevent medical and social crises and thereby avoid unneeded hospitalizations or nursing home stays. Unstable patients are to be seen urgently within 24 h.
- Routine visits occur every 1–8 weeks to stay ahead of any instability. Office staff should confirm visits only 1 day ahead of time and offer flexible 2-h time windows (AM or PM) to the patient and caregiver.

- All medical care comes from a physician/nurse dyad
- The physicians perform new patient visits, see the patient every few medical visits, and also provide telemedicine in odd hours
- The nurse performs a majority of the house calls for chronic visits.
- The patients and families need a single number for 24/7 phone access.
- Each clinician carries a “black bag”

Financial Options for Long-Term Sustainability?

- Additional aides such as tests for ECG, Sugar may be added.
- Surgical/dressing items to be supplied by us to the patient
- Plans to add labs & tests in future
- Physiotherapy/occupation therapy to be offered as an addition
- Tie ups with hospitals for post hospitalisation care patient
- Supply of medicines to patients

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Palliative Care

Principles

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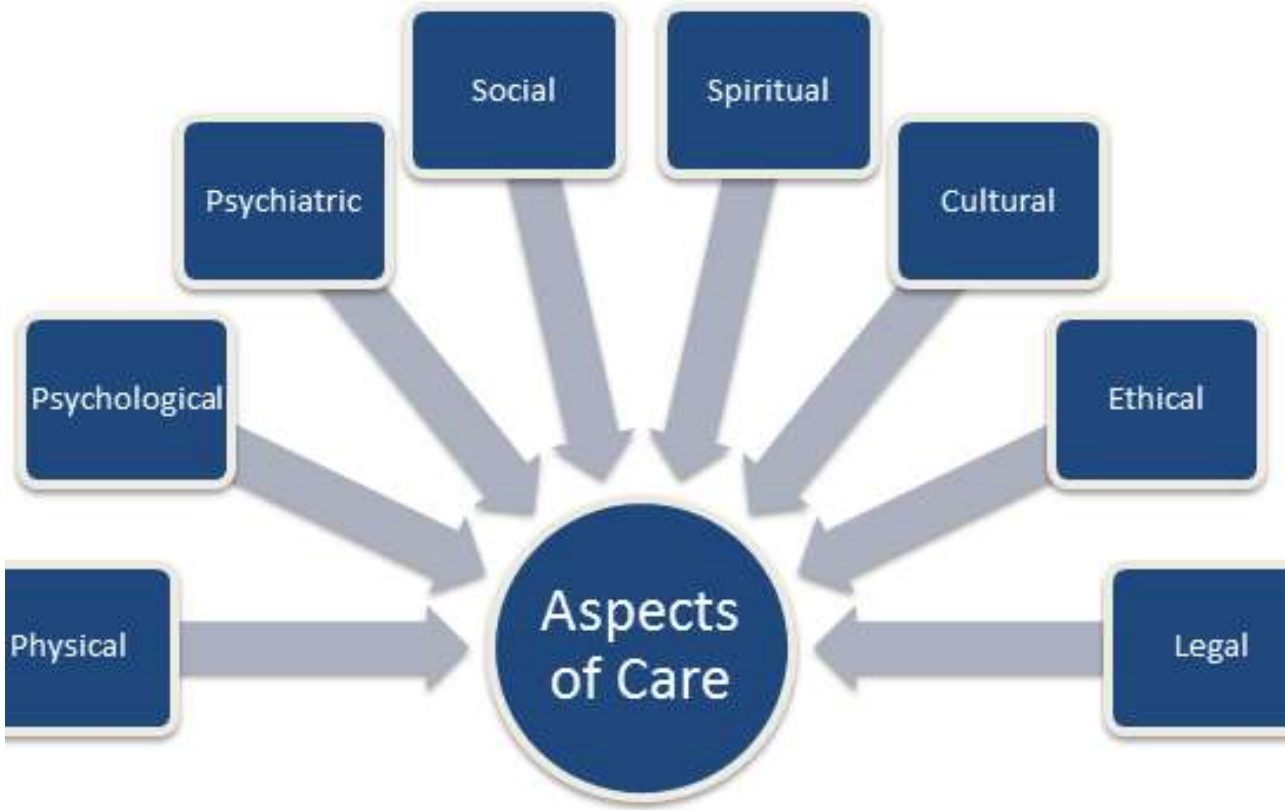
Palliative Care

Palliative care is an approach that improves the quality of life of patients as well as families facing a life threatening illness through the prevention and relief of suffering.



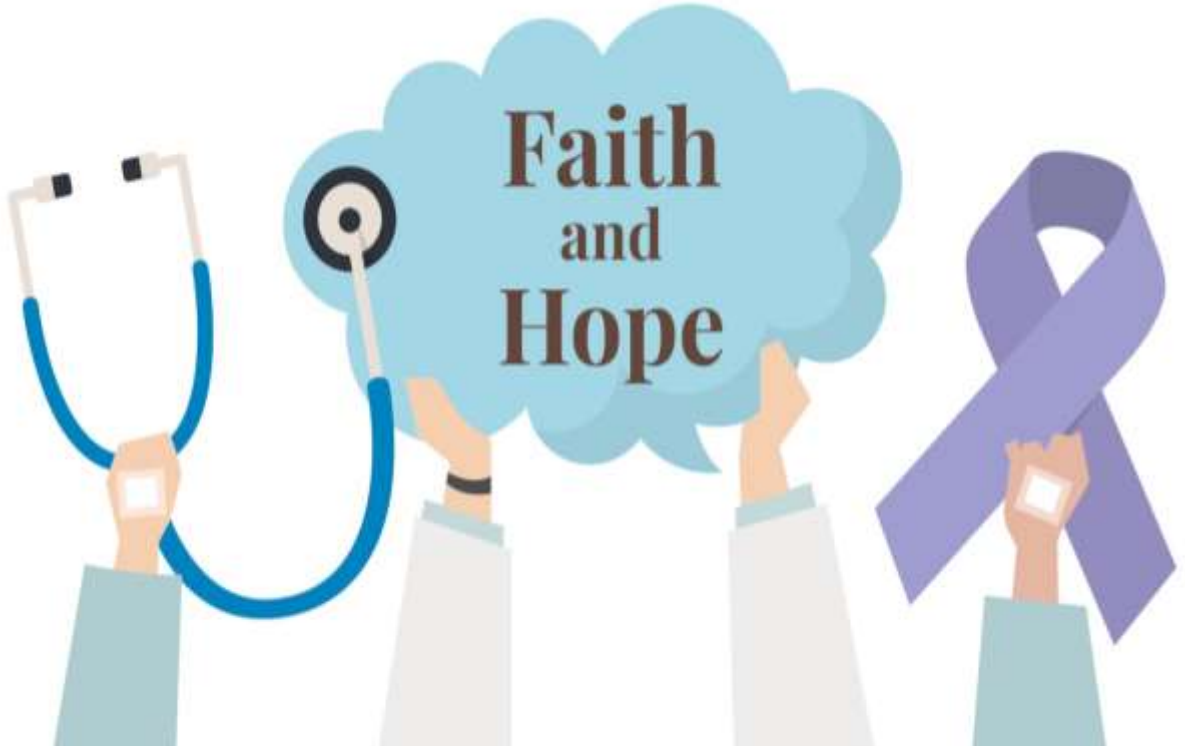
There is extensive overlap between home-based primary care and home-based palliative care . For patients with refractory pain, complex depression , anxiety or need for conflict resolution around goals of treatment specialty palliative care in home is appropriate.

Home based palliative care demonstrated increased satisfaction , fewer hospital admission and emergency department visits, and lower costs.

Palliative Care

Provision of home based palliative care as a stand alone facility to manage:

- Pain
- Depression
- Loss of appetite
- Shortness of breath and other difficult to control symptoms
- Helping the patient/caregivers in understanding the disease
- Caregiver training



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- Identification of patient centered goals of care
- Family support
- Prognostication of disease so that unnecessary treatments/procedures are avoided.
- Maintaining mobility of the patient as far as possible with physiotherapy , nursing care as needed
- Telemedicine when needed to help sudden problems

What we can Do?

- Electronic Health Record System for Home Based Care
- Develop Home based care & Palliative care infrastructure
- Develop in-house laboratories to supplement Home based care
- Develop education and training modules for care givers

Thank You