

Focus On:

Home Health Care

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EVERGREEN Rounds

Specialty care highlights for physicians

Winter 2009

Update on Home Health: The Ultimate Patient-Centered Care

Evergreen Home Health offers one of the most extensive and successful home health programs in the Puget Sound region. Along with the regular disciplines of nursing, physical therapy, occupational therapy, speech therapy, medical social work and home health aides, Evergreen offers in-home mental health – one of the only local programs to do so. Evergreen Home Health's full complement of services, including collaboration with Evergreen Hospice and Palliative Care, leads to seamless transitions in care.

As for outcomes, the numbers tell the story. Among the five largest home health agencies serving King and Snohomish counties, Evergreen Home Health has:

- the lowest percentage of patients (18 percent) needing re-admission to a hospital;
- the highest percentage of patients (82 percent) staying at home after an episode of home care ends; and
- a tied ranking for the lowest percentage of patients (17 percent) who need urgent, unplanned care.

Eligibility for Home Health

Home Health nurses have tremendous scope, working in the field as our community's frontline clinicians.

"Home health patients must be homebound, have a physician's referral, and need skilled care, assessment or instruction," says Kay Broadgate, RN, a home health nurse for 20 years. But beyond those three key criteria to be eligible for home health, the patient population is widely diverse.

"The majority of our patients are geriatric, while the younger set typically includes patients with a chronic illness such as MS, or acute trauma or postoperative status," says Broadgate. "We do a lot of wound care and post-op care after joint replacements, and have certified wound specialists for complex wound cases. We also provide care for a significant number of cardiac patients, both acute and chronic, and work closely with the congestive heart failure clinic at Evergreen."

"Home Health covers a very broad spectrum," says Broadgate. "I love it because there's no better way to make an impact. We sometimes have

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Home Health: Physical Therapy

"We're the physician's eyes and ears in the patient's home," says Pam Green, PT, a physical therapist who's been a home health clinician for 15 years. "Patients can't hide things from us the way they can when they just see a doctor for 20 minutes."

Green, who won Evergreen's "clinical service star" staff award in fall 2008, has seen a wide range of patients and lifestyles over the years.

"We see a fair number of older people who have been hospitalized and are deconditioned and weak," she says. "We also see a fair number of patients after knee and hip joint replacement, and neurological patients with MS or stroke." Less common are younger patients after an injury at work or car accident.

"Home health patients have to be homebound, which means it's a 'great and taxing effort' for them to get to medical treatment elsewhere," she says. "My goals are to get people safe and independent in their homes and, ideally, help them no longer be homebound, so they can access their community and the rest of the world."

PT Techniques in the Home

Physical therapy techniques in the home include exercises for strength, flexibility, range

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Telehealth: Monitoring Patients at Home

Evergreen Home Health offers a unique Telehealth program in partnership with Evergreen Healthline. Patients use a home monitoring device to track weight, blood pressure and other symptoms, and a nurse reviews these daily readings and calls the patient or physician, if needed, for any unusual readings. Patients can phone the 24-hour call center, staffed by RNs, for further questions and health education.

Telehealth services can be provided with or without home health care and are free to the patient. To be eligible, patients must have a working phone and be willing to use the tabletop monitoring device (or have a caregiver help them). For more information on Telehealth, call 425.899.2941.

Evergreen Home Health: By the Numbers

- 57,000 patient visits a year
- 700+ patients on the average daily census
- 400+ patients a month admitted to care

- 70 nurses, with 58 in the field
- 33 physical therapists
- 13 occupational therapists
- 4 medical social workers
- 4 home health aides
- 3 speech therapists
- 3 clinical educators
- 2 wound specialists

Evergreen: Top 5 Percent Nationwide for Clinical Excellence

Evergreen Hospital Medical Center is among the select group of hospitals to receive the HealthGrades 2009 Distinguished Hospital Award for Clinical Excellence – one of only four hospitals in Washington to earn this distinction. HealthGrades is the nation's leading provider of independent hospital ratings. Visit www.evergreenhealthcare.org to see the full listing of Evergreen's services recognized for excellence.



The Ultimate Patient-Centered Care, continued from page 1

a tendency in hospitals and clinics of walking in and telling patients what to do. But in home care, the patient drives the care plan and its goals, in collaboration with their physician and clinicians.”

“We give patients a head-to-toe assessment at every visit, and if anything changes, we call that in.”

– Kay Broadgate, RN, Evergreen Home Health

A Physician's Eyes and Ears

Because “skilled care” includes assessment and instruction as well as hands-on care, Home Health clinicians become a physician's eyes and ears in a variety of ways.

“A doctor may have us go into the home for an assessment, and then call to give our report and make a request for the home health plan, with frequency of visits and goals of care,” says Broadgate. “It's a collaborative effort, though we operate strictly under doctors' orders.”

“We give patients a head-to-toe assessment at every visit, and if anything changes, we promptly communicate with the physician,” says Broadgate. “We also discuss what kind of communication the doctor wants, asking: Do you want us to call you every time with this, or is this what you're expecting? We establish parameters of normal limits for individual patients and keep the physician apprised of progress or decline, response to medications, and factors in the home that support or present barriers to established goals.”

Most Home Health visits, by their very nature, draw on a nurse's teaching skills. A homebound person who's just been diagnosed with diabetes, for instance, needs immediate, clear teaching on nutrition, the disease process, signs and symptoms to report, medications, glucose monitoring and resources available in the community.

Physicians often call in Home Health nurses to help clarify medication management. “Elderly patients have long lists of medications, so one of our roles is making sure everyone's on the same page with medications and whether they're working or not,” says Broadgate.

Patient safety and end-of-life care can also trigger a referral to Home Health. “If a patient's not safe at home, doctors will ask us to go out and do a home assessment,” she says. “Sometimes we find that patients aren't taking their medications, or they're becoming dizzy or confused. We may call in a social worker and get more in-home support going, or get the family more involved if another plan needs to be put into effect. We're on the patients' turf, so we get a really good picture of their support system.”

Case-Managed, Interdisciplinary Teams

With an RN as the case manager, Home Health's interdisciplinary care is made up of occupational therapy, physical therapy, speech therapy, social work and home health aides. Depending on the patient's needs, a physician can write orders to include all or some of these disciplines on the case.

“After joint replacement, for instance, we'll get an order for PT, OT and nursing, with the nurse monitoring the wound, post-op complications and pain control,” says Broadgate.

New technology in Home Health – the portable CoaguChek® meter – allows nurses to monitor “pro-times,” or prothrombin times, with a

simple finger stick. “Not every agency has these,” says Broadgate, “but they let us assess patients’ post-op response to anticoagulants, get on-the-spot Coumadin orders, do the instruction with patients in the home, and verify their understanding. We also all have laptop computers, so we’re highly computerized and mobile.”

In-Home Mental Health

Recent research on depression and dementia in the geriatric age group has brought the need for mental health care into sharp focus.

“We get a lot of referrals because we’re one of the only agencies providing in-home mental health,” says Broadgate. These clinicians are psychiatric RNs with special expertise in working with the elderly.

Major life changes and loss, especially loss of autonomy, are also common in older adults. “People don’t always transition gracefully,” says Broadgate. “The agency has a consulting psychiatrist and can consult as a team to manage these issues and recommend medication changes.”

An Immediate, Direct Impact

Ask a home health nurse what’s most rewarding, and you’ll likely hear that it’s having an immediate, direct impact on patients’ lives.

“Because you’re on their home turf, patients feel more in control,” says Broadgate. “They must be a participant in their plan of care; that’s where success lies. When you help patients identify their goals, their motivation is internal, not external.”

Home health is the epitome of patient-centered care. “You’re working with patients on a personal, one-on-one level,” says Broadgate. “There’s a lot of respect, and I love the eclectic aspect of it; it’s very exciting.”

Flexibility and a sense of humor are also key.

“Some days, you need a good pair of walking boots,” Broadgate says, “and it helps to be a dog lover.” ■

Physical Therapy, continued from page 1

of motion, balance, coordination, and gait training, as well as specific mobility training such as moving safely in and out of a bed or chair.

“We have ultrasound machines we can bring in when needed, but we’re primarily working with what we find in the home,” says Green. “We can’t bring parallel bars into patients’ houses for balance exercises, so we use the kitchen counter. We put small objects on the floor for people to step over for balance training, and we teach them how to make a small ankle weight out of a couple of cans of corn in a small grocery bag.” Especially for elderly patients, these and other simple solutions, such as making a homemade heat or ice pack, make good sense since they’re inexpensive and not intimidating.

“You’re thinking on your feet and using what you have, trying to be as creative as you can,” says Green. “You don’t want to send the family out to spend \$80 on something they won’t use anyway.”

The Home Health team can facilitate getting any necessary, Medicare-covered equipment, such as a walker or hospital bed, into a patient’s home. They can also direct patients to resources for other equipment, such as a bedside commode or bath bench, that Medicare doesn’t cover.

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Featured in This Issue:

Evergreen Home Health
12040 NE 128th Street, MS #103
Kirkland, WA 98034
425.899.3300



Kay Broadgate, RN
Evergreen Home Health

Kay Broadgate, RN, has been a registered nurse for 34 years and has been a home health RN for the last 20 years. She received her BSN from Seattle University and has also worked in acute care and ambulatory care. ■



Pam Green, PT
Evergreen Home Health

Pam Green, PT, has been with Evergreen Home Health for 10 years and was Evergreen’s “clinical service star” in fall 2008. She graduated from the U.S. Army’s physical therapy school and has worked in a variety of settings, including 18 years as a school PT in Michigan. ■



Connie J. Smith, MD
Co-Managing Physician,
Evergreen Senior Health
Specialists

Totem Lake Medical Plaza, Ste. 100
11521 NE 128th St.
Kirkland, WA 98034
425.899.6800

Connie Smith, MD, geriatrician and internist, received her medical degree and postgraduate training at the University of Washington. She is particularly proud of the comprehensive multi-disciplinary care provided at the Evergreen Senior Health Specialists clinic. ■

For Referring Providers

To refer patients to **Evergreen Home Health**, call 425.899.3300 or 800.859.0166.

To refer patients to **In-Home Mental Health**, call 206.923.6300.

To contact a physician at Evergreen:

- Call Healthline at 425.899.3000 and press “5” to skip the consumer options and reach the physician-only line (you won’t be prompted to press “5”).
- Consult the Evergreen Directory of Physicians and Services. Call Healthline at 425.899.3000 to have a copy mailed to you.

Creativity and Perseverance

From her years in the field, Green has a wealth of wisdom on how to connect with a variety of patients, establishing trust and making them comfortable with treatment.

“You have to meet people where they are,” says Green. “You have to be able to joke with them if that’s what they’re doing, or cry with them if that’s where they are, and then move them into doing what you want them to do. All of our home health clinicians are fabulous – nurses, PTs, OTs, speech therapists – with a high level of caring and professionalism.”

Every day, home health clinicians embody patience and perseverance. “It’s just you and the patient in the home, perhaps with a family member,” says Green. “So there’s a high degree of independence, with considerable problem-solving and thinking on your feet. You never know, when you knock on the door, what you’re going to find.” ■



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Editor: Rebecca Buffum Taylor
rounds@evergreenhealthcare.org

Evergreen Healthcare is a community-based health care organization with more than 800 staff physicians in over 50 specialties serving residents in the Puget Sound region. Evergreen’s clinical excellence and breadth of services are among the most comprehensive in the Pacific Northwest.

A Physician’s Perspective: Home Health Benefits

Connie Smith, MD, co-managing physician of Evergreen Senior Health Specialists, sees a wealth of benefits when referring patients to Home Health.

“Patients feel more secure with their treatment if someone’s monitoring them in the home,” she says. “We refer nearly 100 percent of patients with ongoing needs after hospitalization to Home Health, because that allows us to have another set of eyes and ears and monitor the problems they were treated for.”

Smith often refers to Home Health for patients in assisted living facilities and adult family homes. “Home health providers are really great at being a liaison, educating and helping caregivers feel more comfortable with treatment, since most caregivers in those facilities aren’t skilled nurses,” she says.

She commonly refers patients for acute conditions and wound care, as well. “They do a great job of treating a wound and monitoring progress with that,” she says. “If a patient has a new pneumonia, we’ll often refer to home care to go out and monitor the patient’s reactions to the medication, listen to the heart and lungs, and make sure everything is clearing up.”

“We refer to in-home mental health frequently for patients with dementia who are having behavior issues, hallucinations or depression, or are acting out – particularly if they’re in adult family homes or assisted living,” she says. “It helps to have someone there who can assess the situation, monitor medication responses, work with the staff, and educate them about these issues.”

“Patients feel more secure with their treatment if someone’s monitoring them in the home. We refer nearly 100 percent of patients with ongoing needs after hospitalization to Home Health.”

– Connie Smith, MD

Advice to Referring Providers

For physicians to get the most benefit from a home health referral, Smith offers this advice: “Be very specific about why you’re referring, so the home care nurses know what your concerns are,” she says. If a patient has congestive heart failure, for example, she advises a physician to write up a referral with these specifics: “Follow-up of congestive heart failure symptoms, daily weights, and monitor response to new medications,” with the new drugs clearly listed.

“Home care nurses utilize care pathways, but every patient’s needs are unique, so the more information the referring physician can give, the better quality report you’re going to get back,” Smith says. “The home care nurses are members of the team, so they need to be informed about what you’re thinking and what your goals are.”

Smith also emphasizes the need to set up open, clear communication with home health nurses.

“It’s a two-way street, and we need to communicate both ways, so that what we’re doing in our offices and what the nurses are assessing out in the homes are compatible,” Smith says. “Also, nurses can often provide important information about what’s going on in the home, so if, for example, you’re having trouble helping a patient control diabetes, the nurse can often give you real insight into why that’s happening.” ■