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# HomeCall

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- HomeCall, Inc. is a state-licensed, Medicare-certified, and JCAHO-accredited home health care company. One of the larger home health providers in the mid-Atlantic region, HomeCall, Inc. operates in Maryland and Virginia. The company offers qualified professional and paraprofessional services to its clients and is designed to be an alternative to institutional treatment and care. Headquartered in Frederick, MD., it also has 13 offices throughout its service area.

# Comprehensive Homecare Services



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## **HomeCall offers qualified, professional medical staff members for home careservices including:**

- Skilled Nursing, Physical, Speech and Occupational Therapy,
- Private Duty Nursing
- Medical Social Work
- Home Health Care Aides
- Nutrition Consultation

## **Advanced Homecare Technology :**

- Personal Emergency Response System/Main Street Messenger
- HomMed Monitor - Monitors vital signs daily in your home
- MedPartner-Medication management tool to assist medication compliance
- Anodyne Therapy for Peripheral Neuropathy

## **Specialized Nursing Services including:**

- IV (Intravenous) Therapy
- Maternal/Infant Care
- Home Phototherapy for Infants with Jaundice



# Total Number Of MAHP Monitored Since Program Started

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The Program Started in May of 2003 with just 7 monitors.

Since that time we have monitored over 800 lives.



## Why we chose this product

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- Ease of use for Client and Staff
- Clinical Support Given by HomMed
- Technical Support Given by HomMed
- Exclusive Rights
- Outcomes
- Peripherals



# CHALLENGES WE FACED

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- Train the staff: HomMed played a big part in Training the trainers.
- Staff buy in.
- MD buy in.
- Distribution and Returns of equipment.



## GOALS

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- **To provide education about specific disease processes and support the clients and their family through frequent contact via phone calls. These calls allow us to give the client/caregivers the knowledge they need while decreasing visit utilization.**
- **To communicate effectively and timely with member's health care providers; to facilitate appropriate care and follow-up when potential risks are identified.**
- **Reduce the number of hospital admissions, other related medical cost and improve/maintain the clients over all health.**



## TARGET DIGNOSIS

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- Coronary Artery Disease = CAD
- Congestive Heart Failure = CHF
- Diabetes
- Asthma
- Hypertension
- Wounds
- Transplants



# Results 2005

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## ■ Improvements

- 25% Were given diet education they lacked.
- 16% Increased compliance with Sodium Limits
- 50% Blood Pressure returned to the range set by MD
- 41% Gained knowledge of HA1c test.
- 93% Had no prior diabetic teaching
- 88% Showed an increase in diabetic compliance while in the program
- 92% Blood Sugar improved while in the program
- 9 Months was the average stay in the program
- 23% of the clients lost weight, 7% = 4 LBS, 3% = 3% LBS, 3% = 16 LBS, 3% = 36 LBS, 3%= 97 LBS
- 23% of the clients who smoked stopped smoking while in the program
- 89% of the clients were compliant with the use of the monitor
- 50% decrease in ER visits.



# Telephonic Case Management

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**Through telephonic case management enrollee's will receive skilled assessments, education, information and support related to their disease process. These interventions will assist the enrollee to slow/prevent future complications of the their disease and reduce medical cost.**



# Criteria For HomMed Placement Case Management

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## Using referrals and/or the Predictive Modeling Tool

- **Congestive Heart Failure**

All members admitted to an acute care facility with a primary diagnosis of Congestive Heart Failure are a mandatory referral. All N.Y.H.A. Class II, III, IV and valve disorders will be eligible for the HomMed program.

- **Coronary Artery Disease**

Coronary Artery Disease associated with Hypertension, Diabetes, Congestive Heart Failure, or Renal Insufficiency. Coronary Artery Disease and Obesity as defined by B.M.I.

- **Diabetes Mellitus**

A diagnosis of Diabetes Mellitus with Obesity as defined by B.M.I. and/or renal insufficiency or Congestive Heart Failure.

# HomMed For Pregnancy Induce Hypertension

Total WeeCall Population Monitored in 2005 = 37

## WEECALL HOMMED GUIDELINES FOR PREGNANCY INDUCED HTN/PREECLAMPSIA

<b>Criteria:</b>	Patient's exhibiting signs/symptoms and/or diagnosed with PIH/Preeclampsia.
<b>Medical Diagnosis:</b>	642.03 Hypertension complicating pregnancy, childbirth, and the puerperium 642.23 Other pre-existing hypertension complicating pregnancy, childbirth, and puerperium Unspecific hypertension complicating pregnancy, childbirth and puerperium
<b>Related Nursing Diagnosis:</b>	<ul style="list-style-type: none"><li>- Altered tissue perfusion related to vasoconstriction of blood vessels</li><li>- Fluid volume deficit related to fluid loss of subcutaneous tissue</li><li>- High risk for fetal injury related to reduced placenta perfusion secondary to vasospasm</li><li>- Social isolation related to prescribed bed rest</li><li>- Potential for skin breakdown R/T decreased mobility</li><li>- Potential for muscle atrophy from decreased mobility</li></ul>
<b>Outcome:</b>	Control and/or decreased disease progression; thus, reducing the number of premature births.

# Just Added MedPartner



- Using easy to understand voice commands and visual cues, MedPartner alerts the user at the correct time to take their medication, the number of pills and the appropriate bottle. MedPartner is AC powered and has battery backup in case of power loss.
- Voice prompts and green blinking LED lights indicate the correct bottle to select. A red visual prompt (blinking red LEDs) as well as a voice command alerts the user if the incorrect bottle is selected. A record is generated with each selection and can be automatically sent to the home health agency that is monitoring the user. This automatic record helps clinicians at the home health agency to assess user medication compliance.



# Goals For MedPartner

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- Track and Increase Medication Compliance.
- Correlate Compliance with Trend Results.
- Increase Teachable Moments.



## Responding to Vital Signs with Alerts

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- **Review client's daily trends (Monday thru Friday working hours)**
- **Contact client/caregiver to obtain additional subjective data and determine possible cause of alert. If necessary, ask client to repeat vital signs to support clinical data.**
- **Daily fax alerts to client's physician**
- **Notify client's case manager for appropriate follow-up via e-mail or if urgent, by phone.**
- **Document any intervention in the "Respond to Vital" comments window of "Tabular Trends" or under the "Current Status Screen".**



# Current HomMed Census

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## Total Cases By Diagnosis

- CHF = 40%
- CAD = 35%
- Diabetic = 13%
- Hypertension = 8%
- Remainder a mixture of other targeted DX

# Success Stories

## YES WE HAVE THEM!

- 58% of all success stories involve an alert that leads to MD intervention of a medication change i.e.: Increased Systolic or Diastolic reading that results in an increase in the clients Antihypertensive Medication.

Patient of the Baltimore City HomeCall was placed on the monitor on 1/03/06. He had a history of CHF, anemia, atrial fibrillation and pulmonary hypertension. On 1/26, heart rate was 161, 167 on retest. Patient was asymptomatic. On 1/27, HR was 42, 70 on retest, no symptoms. Heart rate was within parameters until 1/30, when it was 174. It was 44 on 1/31, 167 on 2/1, 173 on 2/2. MD was receiving faxed alerts and branch RN was communicating with the patient. HomMed manager was also following results. Vital signs were always normal at nurse visits and patient never had symptoms. An appointment was made with the cardiologist and patient was immediately admitted for atrial fibrillation. Cardio version was tried twice without success so a pacemaker was inserted and patient was sent home the next day. He feels "wonderful" and he and his wife are grateful that the problem was picked up by the HomMed monitor and he was able to receive prompt treatment before he had any serious complications.

Submitted by Peg Green RN, Senior Director  
Baltimore City branch of HomeCall

# Success Stories

- 63% of all success stories result in a behavior change that can slow the disease progression i.e.: following the prescribed diet after seeing the alerts when the client eats a meal with a high sodium content.

Patient is a 46-year-old African American male with very difficult blood pressure control issues. Had a CABG in 6/05 and BP when he started HomMed in August was 162/102, 174/110. He alerted daily for diastolic over 90 for 3 weeks as the case manager worked with him and relayed information to the physician. Patient had received extensive education from case manager before he began monitoring and received additional support and instruction in low sodium, low fat diet as he alerted, but he was then able to see the impact that his dietary indiscretion had on his blood pressure and weight readings because of the monitor. Medications were changed 4 times in the first few weeks and he began going to the gym at least 3 times weekly. BP has been below 120/80 82% of the time for the last month and never higher than 126/86. Although he has gained weight, physician agrees that he has gained muscle and is now fit.

Submitted by Paula Horley RN BSN  
Senior Case Manager

# Success Stories

- 17% of all success stories prevent an ER or Hospital admission i.e.:

Member had a little chest discomfort and dyspnea in church on Sunday and told case manager on Monday he thought it was due to the heat and that he was feeling much better. Case manager advised him to call physician even though he had not used any NTG. His BP dropped per HomMed on Tuesday evening and case manager called him Wednesday morning and asked him to recheck at lunch time. It was still low according to the HomMed readings but he was feeling better. He retested again that evening and BP was normal but he was dizzy the following morning and he told case manager that he had taken off the previous afternoon and slept for 3 ½ hours. He was still sleepy and BP was still low according to the HomMed readings in the morning. Case manager called PCP, they saw him that afternoon. He took his meds with him and they found that the pharmacy had given him someone else's meds, glyburide/glucofage instead of methyldopa, 3 weeks earlier. PCP told him he had to have a strong system to last as long as he did. Member was to take all his meds to the pharmacy to assure that no other mistakes had been made. Member thanked the case manager for following up on the problem.

Submitted By Pat Fagan RN, Case Manager