HEARTS: THE GEAUGA CENTER FOR HOME CARE

PREAMBLE

"…whatever houses I may visit, I will come for the benefit of the sick…."
Physician home visits can be traced to ancient Greece when the Hippocratic Oath, quoted above, provided standards of care. For centuries, rural American medicine was practiced by doctors making house calls on horseback. Modern times have centered medical care in offices, clinics, hospitals and long term care facilities. Home centered medical care has suffered the atrophy of disuse.

Nursing, on the other hand, has had a time-honored commitment to care in the home. Visiting nurses have kept alive the value of **aging-in-place** by serving the frail and chronically ill at home.

Family **Caregivers** occupy 25% of the American households and shoulder the lion's share of daily care. They have always been the largest unpaid work-force in the country.

What has yet to occur is teaming up of **physician, nurse and caregiver**, in the home, to coordinate their individual skills into a holistic and seamless plan of care for the patient.

RATIONALE

With millions of frail and chronically ill senior citizens either homebound or too disabled for easy access to medical care, the need for safe, timely, effective, efficient and equitable home-centered health care is greater then ever. Home care may be described as the "renewed frontier" of care giving. For centuries the home served as the primary site of care relying on the expertise of daughters, mothers and grandmothers. In modern times, advances in technology, the increasing cost of care, shortened hospital length of stays increasing risk of hospitalization and nursing shortages have made the home a necessary, safe and practical option for care. With our nation's aging demographic trend, the need for homecare will expand. Today, 6% of 65 year olds need assistance with daily activities and that number expands to 21% of 85 year olds.

A cadre of clinicians in nursing and family medicine will need to be trained in modern-day, technological homecare as a necessary expansion of their clinical responsibilities in patient care. Academic leadership is essential to accomplish this goal with commitment to service, education, research and community outreach.

VISION: HEARTS PLANS TO…

1. Assist in the establishment of an endowed Professorship in Home Care (at Case Western Reserve University School of Medicine-Department of Family Medicine) to create the unique body of knowledge with defines **Home as a Place of Care.**

2. Assist in the creation of curricula in schools of medicine, nursing and social work, to educate a cadre of **Home Care Clinicians** who will work in teams.

3. Promote the education of healthcare providers-current and future-to include the home as one of their centers for care. The curriculum will include home health care technology, advanced information systems and team orientation.

4. Teach Home Centered Care in community sites and on-site in the **Classroom-of-the-Home.**

5. Integrate the family caregiver into the home health care team and promote that role as **home health manager.**

6. Encourage the development of **physician-directed, nurse-led** education teams to assure the application of care competencies in the home.

7. Encourage the **integration** and **coordination** of existing services in the community to create a seamless system of care.

8. Facilitate **continuity of care** with family physician, nurse, family caregivers, home health care agency and other service professionals.

9. Promote research that advances the quality of care through the **Laboratory-of-the-Home.**

10. Embrace forward looking **principles of performance improvement** to include the evolution of clinical ethical standards, best practices and bench mark of care.

11. **Communicate** success in this endeavor to the **academic world** through publications and presentations and to the **local community** thorough print media and television.

SERVICE: The Home Health Care services initially embraced by the Geauga Center for Home Care services will be modeled after Chesterland Family Practice. Its 18 year experience in delivering home care formally integrates and schedules home visits into the routine of hospital and office practice. This has been accomplished by a physician-directed, nurse-led care team. (**Other family practices in the community will be encouraged to expand their activities to include Team Home Care.**)

HEARTS will assist in coordination of community services for the family and health care providers, thus maintaining the viability of the home as the key setting for care. This could include social work, nutrition, pharmacy, physical and occupational therapy, alternative integrated therapies, dental, pastoral, hospice, and maintenance, repair and remodeling services. Keeping the family physician and nurse in continuity with the patient and family is the essential goal of **HEARTS**.

EDUCATION: The center will utilize education and communication as primary ingredients in achieving its goals. The Center will sponsor classes that bring together family physicians, nurses, caregivers and other health care providers and students of medicine and nursing, around **Home Health Care Team Model.** Central community sites have been identified and timing of classes will be appropriate for work schedules of the participants. Learning by interactive case-based study using home care situations currently active will make the education reality based. Through this educational crucible, protocols, guidelines and pathways of care will evolve to establish standards of best practices and ensure there consistent application. Curriculums will then be developed in schools of medicine, nursing and allied health sciences.

CLASSROOM-OF-THE HOME: The critical component in education and development of Home Health Care is not at the center but in the home. The center will, therefore, coordinate continuity of care visits by students to allow longitudinal education in the home. The team education approach involving the individual, the family, the family physician, nurse and caregivers, provides a unique learning experience that will become a model for future educational purposes. These visits allow student to participate in the new model of physician-nurse-patient-caregiver team care that makes the classroom-of-the-home a reality.

RESOURCE CENTER: The center will promote education at all levels and include a library and internet resources to catalog county, state, regional and national resources dedicated to quality care in the home. The skills of observation, recording, and internet communications provided by the Home Health Care Team will promote the development of virtual networks of family based home health care managers. The quality of home care will then be able to achieve its highest standards.

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