



Developing New Models: Integrating House Calls and Team-Based Care Into Primary Care



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Key Players

Renaissance Family Practice (RFP)

Health Policy Institute (HPI)

Beginnings

Fall, 2014

Started “from scratch”

Presentation Outline

Patient Case Study

Process of Care

Lessons Learned



Case Study: Emma

Patient

Emma Jenkins, 74 yo

Female

History

Advanced COPD, AFib,
heart failure, DM II, sleep
apnea, anxiety,
dehydration, previous
smoker



16 different medications

Overwhelmed with managing herself, yet struggling with allowing for family member involvement

Frequent errors with important medications (digoxin, warfarin)

Wasn't requesting refills once they ran out

Unable to afford respiratory medications

Case Study: Emma

Team-Based Outreach Call Program

Identified Social Concerns/Needs

Walks, bathes, and dresses independently

Routine errands (groceries, etc) are too taxing

No longer driving

Lives with daughter & son-in-law; family grocery shops and cooks

Reluctant to trust others with her care

Office without permission to speak with family members

No living will or DPOA established



Case Study: Emma

Team-Based Care
Outreach Program

ER Utilization

	C O P D	CP	Benign Tremor	Dyspnea	Knee Pain	Pulmonary Embolism	UTI	Toe Nail Avulsion	HF	Dizziness	Afib RVR	Total
2014	8	2	1	1	1	1						14
2015	9	3	3	2			1	1	1	4	1	24
2016	8		1									9

Hospitalizations

2014: 5

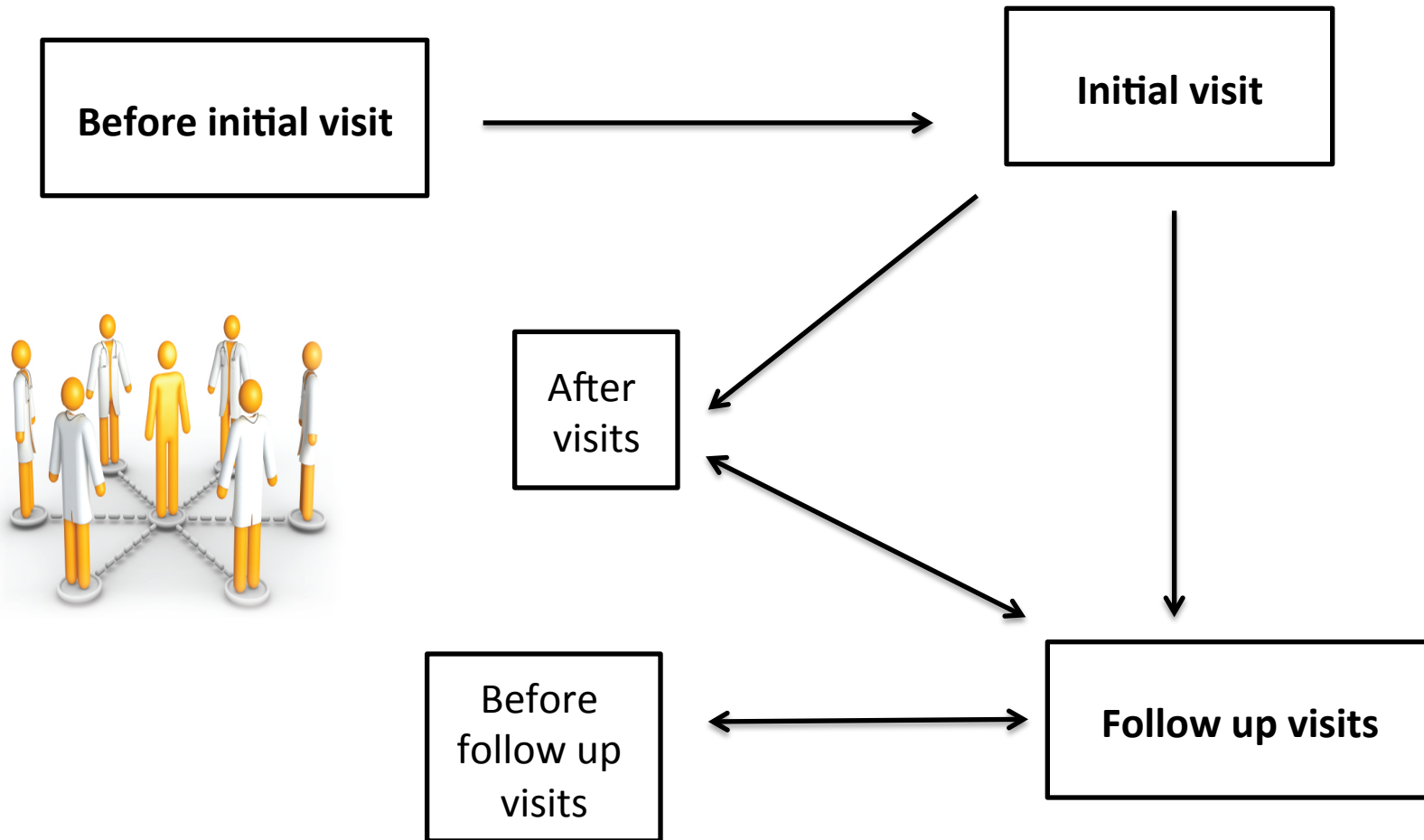
2015: 5

2016: 1



Home Visit Process of Care: Overview Continuous Care

Team-Based Care
Outreach Program



Home Visit Process of Care: Before Initial Visit

Team-Based Care
Outreach Program

I. Referral received

Typical referral sources

Emma 2015 referrals:

- Hospital F/U x 5
- ER F/U x 1
- NP self-referral x 1

Emma 2016 referrals:

- PCP/NP x 5



Home Visit Process of Care: Before Initial Visit

II. NP identifies time frame for home visit

III. Patient scheduled by office

IV. Chart Review

V. Consult team member(s), if appropriate

Emma: discharging provider contacts NP & advises 24-f/u; concern for stability d/t med noncompliance



Home Visit Process of Care: Initial Visit

Team-Based Care
Outreach Program

I. Establish trust with patient/family

Emma

Listening to stories about her grandchild

Emma's family

Eye contact

Warm hand shakes



II. Assess/prioritize medical and psychosocial needs

Emma

Medical

Prevent COPD exacerbation

Rate control Afib

Prevent fluid overload

Ensure stable blood sugars

Monitor renal function

Psychosocial

Lack of trust for others with her care

Poor medication management

Home Visit Process of Care: Initial Visit

Team-Based Care
Outreach Program

III. Contact team members from visit, if necessary

Emma

Consult PCP. Patient self-stopped digoxin – restart?

IV. Address pressing priorities

Emma

Medical

Restart digoxin

Extend prednisone taper

Increase lasix

Psychosocial

Route refills for missing meds

Assess patient's barriers to allowing others to participate in her care

V. Review follow-ups with patient

VI. Identify parameters for when to seek care (office vs ER)

Home Visit Process of Care: Before & After Each Visit

Team-Based Care
Outreach Program



I. Develop a unified care plan and coordinate care

Team member involvement always varies, based on patient need

Care plan based on patient's goals of care; includes plan of care and next steps



Care coordination can be extensive for the complex patient

Home Visit Process of Care: Before & After Each Visit

Team-Based Care
Outreach Program

Emma Unified Care Plan Feb, 2016

Team: PCP, NP, PharmD

Medical:

Mild COPD & HF exacerbations

Medication adjustments

Psychosocial:

Patient barriers to allowing others to support her care

More open to allowing daughter to manage PO meds

Still wanting to self-manage respiratory medications

Not yet willing to allow for RN COPD

Educator home visits

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Emma Care Coordination Feb, 2016

Office staff to contact home health: RN monitor respiratory status & draw labs, SW consult to initiate meals on wheels

Office staff to process order for CPAP nasal pillow and new glucometer

PharmD visit to review respiratory medications & med plan for self-administration; PACE

PCP office visit in 4 days to assess stability and PO med management with family

Home Visit Process of Care: F/U Visits

Team-Based Care
Outreach Program

I. Assess/address needs, using unified care plan as a guide

Emma's Progress

Medical: Cardiac and respiratory status

Psychosocial: Daughter filling pill boxes?

Psychosocial: Did patient complete her paperwork for PACE?

Psychosocial: Respiratory med self-administration plan?



Home Visit Process of Care: F/U Visits

Team-Based Care
Outreach Program

II. Assess/address new developments

Identification of Emma's COPD triggers

Son in law smoking in house; patient reluctant to address with family

House without air conditioning; overheating & dehydration causing dyspnea



Home Visit Process of Care: F/U Visits

Team-Based Care
Outreach Program

III. Motivational interviewing to establish goals of care

Emma

Desiring a smoke-free house and air conditioning in her bedroom; would like help talking with family about this

Becoming comfortable with her new PCP; would like to continue with him

IV. Review follow-ups

V. Identify parameters for when to seek care

VI. Charting in EPIC





Home Visit Process of Care: Ongoing

I. Developing trust with patient, family and colleagues

II. Periodic correspondence with team members about patient facilitators/ barriers to goals of care

III. Periodic discussions with patient and family to address symptom changes and progress with goals of care



Home Visit Process of Care: Ongoing

Team-Based Care
Outreach Program

IV. Refine team member process of care and communication strategies

Emma: improving team communication with office triage to avoid unnecessary ER visits

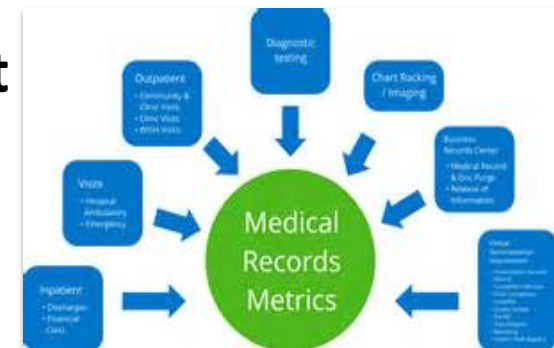


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V. Review of the evidence for best practices/gaps in the evidence



VI. Longitudinal data collection to demonstrate proof of concept (Health Policy Institute)



Lessons Learned Thus Far: Trust

Team-Based Care
Outreach Program

I. Buy-in takes time and is developed through trusting relationships

Committed leadership willing to take risks, and site champions for each discipline, help to build and support trust



Trust was identified as a a core team-level attribute in a San Diego team-based, interdisciplinary program targeting high-risk utilizers (n = 28; \$3.5 million in public expenses 2010). The pilot demonstrated a **reduction in 67% of total costs** after 3 years (National Center for Interprofessional practice and Education, 2016).

National Center for Interprofessional Practice and Education, 2016.
Project 25: Doing whatever it takes to care for homeless super users.
Manuscript submitted for publication.

Lessons Learned Thus Far: Trust

Team-Based Care
Outreach Program

Two months ago, Emma began allowing her daughter to completely manage her PO medications. Since that time, INR levels have remained therapeutic (vs. 17 sub- or suprathreshold levels in 2015)

The office now has Emma's permission to speak with her family members about her care

Emma now allows the COPD RN Educator to visit her in the home to routinely review use of respiratory medications



Lessons Learned Thus Far: Unification

Team-Based Care
Outreach Program

II. Care must be continuous, with unified care plans and goals

In an interdisciplinary, home based VA primary care program for complex patients (n= 9,425), the development of **patient-centered, unified, team-based care plans were identified as fundamental to the success of the program** (Edes et al, 2014). **Hospitalizations** in this program were **reduced by 25%**.

After ongoing conversations between Emma, her care team, and Emma's family, Emma's house is now smoke-free, and her son in law installed an air conditioner in her bedroom



(Edes et al, 2014. Better access, quality and cost for clinically complex veterans with home-based primary care. Journal of the American Geriatrics Society, 2(10), 1954-1961. DOI: 10.1111/jgs.13030)

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Lessons Learned Thus Far: Patient-Centered Collaboration

**III. Interprofessional,
collaborative practice is
vital to successful care
with complex patients**



As a team, we
help one another
understand and
work out the
process of care for
each patient



Team composition
varies with each
patient, depending
on patient need
(SW, PT, PharmD,
PCP, NP, OT, RN,
Specialist)



Lessons Learned Thus Far: Patient-Centered Collaboration

Team-Based Care
Outreach Program

Current successful **home-based primary care** models targeting complex patients have adopted an **interdisciplinary approach** that is **flexible** and **responds to the needs of the patients** (Boling & Leff, 2014)



Emma is now in routine contact with her PCP and NP. Emma's family members are now steady participants in her care.

Boling, P. & Leff, B. (2014) Comprehensive longitudinal health care in the home for high-cost beneficiaries: A critical strategy for population health management. *Journal of the American Geriatrics Society*, 62 (10), 1974-1976. DOI: 10.1111/jgs.13049

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Examples of Challenges That Lie Ahead

Team-Based Care
Outreach Program

Devoted efforts to understanding & addressing over-utilization of resources

Re-educating patient/family on proper use of the ER

24-hour immediate access to primary care providers who all have knowledge of unified care plan?

24-hour on-call coverage is fundamental to the success of interdisciplinary home-based primary care for complex patients (n=722). The study revealed a **17% reduction in total Medicare costs over a two year time period** (DeJonge et al, 2014).

Emma

“I need to be able to trust that, if I call the office, my concerns will be addressed quickly.”



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Final Thoughts

When asked her for her thoughts on recent increased access to an interdisciplinary primary care team, Emma responded:

“The increased contact gives me the chance to be heard. I know that I am better taken care of when I have more time to be heard.”

