CPCPracticeSpotlight59

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care

Providence Medical Group – Glisan, Portland, Oregon; multi-specialty; 13 providers; 9,723 patients

Situation: Providence Medical Group (PMG) – Glisan has offered home visits with a Family Nurse Practitioner (FNP) to patients on an as-needed and regularly scheduled basis since spring 2014. These visits provide increased support and expanded access for patients whose struggles to come to the office for appointments could compromise their health.

Innovation: Physicians at PMG's Glisan office refer patients to **Patricia Green, FNP,** for a home visit for multiple reasons. This includes patients who have frequent hospitalizations or who have ongoing medication issues that need monitoring. Other patients may need more support with their chronic conditions or they are bed-bound and cannot easily travel to the clinic without extensive arrangements and support from family. Another group of patients referred to this service includes those whose behavioral health needs in tandem with debilitating chronic conditions make a trip to the clinic an overwhelming event. To avoid the stress, these patients may inadvertently opt out of the health care system, causing their conditions to worsen until they need emergency care or hospitalization.

Green spreads her visits over two days per week, averaging seven visits per day. Her schedule is a mix of routine visits with high-risk patients who need to be seen frequently and patients with acute needs requiring short-term episodic care.

Her office-on-wheels is a wireless-enabled laptop and a rolling bag stocked with clinical supplies. Clinical supplies in Green's rolling bag include a blood pressure cuff, a pulse-oximeter, otoscope, glucometer, venipuncture kit, testing materials for labs (swabs and urine cups/hats) and supplies for wound care and immunizations.

Connected by a hotspot created on her smart phone, Green can access patients' records in EPIC for an up-to-date summary of the patient's recent care, including labs and meds. During her visit, she will complete a home visit summary, a template with more detail than a regular visit that allows her to document the patients' living situation and conditions, other resources/services patients have in their homes and what needs/assessments they may need to remain safely in their current environment. The information is encrypted when transmitted, ensuring patients' privacy.

Benefits and outcomes: Home visits foster a continuity of care from the clinic setting to the home setting (reducing the need for an outside provider). The care is less expensive with a nurse practitioner who collaborates with the physician who has a long-term relationship with patient. The physician can easily refer for home visit, and then the patient can seamlessly return to physician care at the clinic as needed. Also, home visits provide a clear picture of the patient's home environment, which also supports improved quality of care.

Further, adding home visits to Glisan's care management strategy has likely contributed to the practice's significant improvement in unplanned readmissions for Medicare beneficiaries. To date, the practice's four-quarter average has dropped from 203 to 40.

Lastly, Green reports patients tell her they are highly satisfied with home visits. Having a nurse come to them alleviates the stress of managing transportation and appointments, and they get the care they know they need to stay in their homes.

How Home Visits Bridge Gaps

Patient A – When this patient refused to go to her scheduled appointments, concerned family members contacted her primary care physician, who requested Green make a home visit to rule out a medical or behavioral health cause. The NP's examination included labs, which were normal. During the visit, Green noted that despite the patient's declining ability to care for herself and other safety risks, the patient was adamant about remaining in her home. Green engaged the practice social worker to provide resources and options for the family, such as wrap-around care from palliative services and home health. Green continues to visit the patient monthly. Albeit not a long-term solution, these interim safety-net measures respect the patient's wishes and values while keeping her engaged with her primary care providers for care management.

Patient B – This patient with mild dementia was seen in the office for a skin tear resulting from a fall. Knowing transportation was a barrier for this patient who lived alone, the physician asked Green to visit the patient to assess and treat the wound toward healing. At Green's first visit, she assessed the patient had developed cellulitis and thus prescribed an antibiotic. However, this only moderately improved the patient's symptoms, and the culture taken at Green's next visit showed multiple resistant bacteria. This required either an expensive oral medication or IV antibiotics administered through a PICC line at a skilled nursing facility. Weighing costs and potential strain on the patient, the patient's family opted for the oral antibiotic, and Green made more frequent visits until home health visits could begin 10 days later. To prevent future falls, Green helped the patient's family set up wrap-around PT/OT services for strength and home safety, and the practice's social worker has arranged for community resources to provide more support for the patient. This patient is on Green's slate of regularly scheduled patients for consistent monitoring of her conditions.

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CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.1: Access and Continuity
- 1.2: Planned Care for Chronic Conditions and Preventive Care

CPC Change Driver 2: Enhanced Accountable Payment

- 2.1: Strategic Use of Practice Revenue

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

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