Teaching Transitions of Care through (Post Discharge) Home Visits
Faculty

- Session Coordinator: Linda V. DeCherrie, MD – Mount Sinai School of Medicine
- Faculty Present:
  - Rachel Miller, MD – University of Pennsylvania
  - Christina R Whitehouse, NP – University of Pennsylvania
  - Bruce Kinosian, MD – University of Pennsylvania
  - Justin P. Lafreniere, MD – Johns Hopkins University
  - Theresa Soriano, MD, MPH – Mount Sinai School of Medicine
- Other Contributing Faculty:
  - Ania Wajnberg, MD – Mount Sinai School of Medicine
  - Debbie Dwiderski, MD – Montefiore Medical Center
Session Outline

- Introduction
- Home visit logistics
- 3 transitional care educational programs that include home visits – Inpatient, outpatient and interdisciplinary focused
- Table exercise (each participant can attend 2 tables)
- Wrap up and evaluations
Polls

- Please get out a phone that can text to help answer these questions
Goals of Transitional Care Curriculum

- Transitions and handoffs in medicine have received a lot of recent discussion.
- Re-admissions are important to look at for a patient safety and reimbursement perspectives.
Teaching transitions of care

- Residents and students do not witness the transition of patients from inpatient to outpatient.
- Important to allow trainees to learn about transitions in an experiential way to enhance their learning.
Home Visits - Logistics

- Home visits incorporated in many transitional care models
- In primary care: Routine, urgent, post-discharge, consultative
- Unique CPT codes: 5 codes for new visits; 4 for revisits
- Another set for assisted living/adult homes (domiciliary)
Medical Home Visits

- Can be done by MD, NP, PA
  - For trainees, faculty may be present or act as preceptor
- Must document medical necessity for every home visit
  - Home safety evaluation
  - Recent fall at home
- Ongoing home visits usually require meeting Medicare Homebound Rule
## 2012 Fee Schedule for Housecalls

<table>
<thead>
<tr>
<th>Type of HomeVisit</th>
<th>CPT code</th>
<th>Face-to-face time (min)</th>
<th>2012 Medicare Allowable ($)</th>
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<tr>
<td>NEW PATIENT</td>
<td></td>
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<tr>
<td>Problem focused</td>
<td>99341</td>
<td>20</td>
<td>54.12</td>
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<tr>
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<tr>
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<td>Comprehensive</td>
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<td>ESTABLISHED PATIENT</td>
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<tr>
<td>Comprehensive</td>
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<td>171.21</td>
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</table>
What to bring on visits

- Bag (rolling, backpack, over the shoulder bag)
- Stethoscope
- Ophthalmoscope, otoscope
- BP cuff (various sizes)
- Pulse oximeter
- Thermometers
- Gloves
- Hemoccult cards, developer, lubricant
- Pocket-talker/ amplifier
What to bring on visits

- Tongue depressors, swabs
- Blood drawing materials
- Specimen cups
- Simple dressing materials (gauze and tape)
- Ear curettes
- Sharps container
- Instant hand sanitizer
- Soap and paper towels
Other possibilities at home

- Procedure:
  - I&D
  - Arthrocentesis
  - Wound debridement
- EKG machine
- Smart-phone diagnostics
- Home radiology
- Home lab services
- POC testing
- Nail clippers
- Impedance cardiography
- Bladder scanner
Patient supplied materials

- Scale
- Glucometer
- Dressing materials
- Peak flow meter
Technology

- Laptop/tablet computing
  - Broadband/wireless access to EMR
- Clinical: EKG, pulse ox, bladder scanner, point-of-care labs
- Radiology: usually private service
- Telehealth
Travel

- Taxi
- Car
  - Providers’ or programs’
  - Gas/mileage reimbursed
- Mass transit (bus, subway)
- Foot
Safety

- **Formal policies & procedures:**
  - Detailed Home Care Security Policy
  - Safety lecture every 1-2 years given to staff by a Personal Safety Consultant
  - Main office or contact aware of visit schedule
  - Visits confirmed with patients/families

- **Program-specific:**
  - Providers must tell someone else they are making home visits
  - Updated cell phones
  - Visits in AM
  - Paired visits (trainee-trainee; faculty-trainee) or with staff escort
  - Never take stairs in public housing
Safety

- Trainee orientation
  - Instructed to be aware of environment
  - If providers feel uncomfortable → leave

- Rare safety breaches:
  - Pet bites most commonly reported
Transitions of Care
PILOT YEAR 2009

- 1st Monday of the month— “Transitions of Care” didactic session
- ½ of Internal Medicine interns randomized
- Post-discharge home visit- Piloted in 2009 with Naylor- Transitions of Care Nursing Team
- Last Monday- Reviewed DC summaries/instructions
- Debriefing for those who went on visits
- Evaluation
Transitions Home Visit

- Key points..
  - Medication reconciliation
  - Caregivers/support in home
  - Understanding of medical plan
  - Safety in the home - equipment/meds
  - Referrals - Home PT/OT, wound care, telehealth, SW
  - Who to call if issue
  - Follow up appointments with provider
Transitions of Care:
Didactic Themes

- Why we should care…
- Identifying Vulnerable Patients
- Communication
- Working with Interdisciplinary Team
- Home services & SNF
- Med reconciliation
- DC summary/instructions
Increased degree of confidence in:
- Identifying potential threats to a well executed transition between sites of care (p<0.001)
- Anticipating the consequences of a poorly executed care transitions (p<0.001)
- Knowledge of the community resources available to patients with chronic illness (p<0.001)
Transitions Ambulatory Education

Year 2 & 3

- Winter/Spring 2011 all internal medicine residents went on visit and nurse-educators expanded to PCAH
- Summer/Fall 2011 all internal medicine residents went on visit
- Pre-visit didactic session, post-visit debriefing, written short essay requested
Transitions Visits: Essays

- “I plan to be more inquisitive of patients’ home healthcare situations upon admission to the hospital as well as their goals for disease management.”
- “...highlighted importance of issues such as medication reconciliation and health education. This experience will help me improve my discharge planning process”
Transitions Visits: Essays

“I learned from the visit that in many ways, medically stabilizing our patients for discharge is the first step: continued maintenance of their health requires intense work from the patients, the nurses, and the doctors, even in the most ideal of circumstances.”
Future Directions

- SNF transitions visit!!!!!!
- Additional ½ hour to review discharge summaries/instructions
- Expand evaluation
The Aliki Initiative at Johns Hopkins Bayview Medical Center

An Inpatient Model for Teaching Transitions of Care Through Home Visits

Justin P. Lafreniere, M.D.
GIM Fellow, Medical Education
The Aliki Initiative: The Objectives

“Knowing the patient as a person”

- Performing careful care transitions
- Eliciting patient values, preferences and barriers to care (meds)
- “Seeing” the patient outside the hospital
The Aliki Initiative is funded through philanthropic donations by Mrs Aliki Perroti through the Johns Hopkins Center for Innovative Medicine.
The Aliki Initiative: The Challenges

- Patient selection
  - Which patients go to Aliki?
  - Which patients get a home visit?

- Resident concerns
  - “not enough patients”
  - “not my job”

- Medical student learning objectives
- Faculty training A MUST
- Time still limited
The Aliki Initiative: The Results

- Higher patient satisfaction\(^1\)
  
  (97% vs 47% percentile ranking, p<0.01)

- Higher resident\(^1\) and faculty satisfaction

  "I actually feel like a good role model when I am on this service, whereas other experiences can really feel demoralizing in that regard."

- Reduced HF readmissions\(^2\) (OR=.21 p= 0.04)

  - Despite a higher CMI

1. Ratanawongsa, N. J Gen Intern Med. 2011
Goals of Curriculum

- Improve resident’s understanding of the transition from inpatient to outpatient including medication reconciliation, follow up appointments, and knowledge of sites of post-acute care
- Improve discharge summaries
Transitions of Care Curriculum

- \( \frac{1}{2} \) day per week for 2 weeks during 4 ambulatory blocks (8 sessions for each intern)
- 6-8 interns per block
- 2 week block curriculum:
  - 1 didactic session
  - 1 post discharge visit in pairs
Didactic topics:

• Location and services at discharge
• Handoffs
• Discharge summaries
• Local and national models of TOC
Post-discharge visits

(Intern picks patient, visit patients in pairs)

- Home
- Subacute rehab
- Nursing home
- Acute rehab

Discharge (D/C) Summary Exercise

- One intern only reads d/c summary
- Both interns predict function, mental status of patient
- Review d/c summary together

- Symptoms
- Services
- Function
- Physical exam
- Medication reconciliation
- Care Transitions Measure (CTM-3)
Obstacles to Implementation

- Initially wanted to work with an inpatient team – but unable to reduce work to allow for post discharge visits
- Obtaining time in inpatient curriculum – noon talks etc did not seem best venue
- Finally obtained outpatient curriculum time
Outcomes

- Process Outcomes: 100% of interns in Year 1 and 2 conducted at least one post discharge visit at home and at subacute rehab.
- Qualitative Outcomes: discharge summary exercise:
  - Acknowledgement of the importance of the discharge summary for transitions of care
  - Realization of the importance of documenting the mental status and functional status of the patient
Table Exercise

- 3 tables: Inpatient, Outpatient, interdisciplinary
- Please go to one table for 20 min and then pick a second table for 20 min
Table exercise

Discuss:
- Current programs in Transitions
- Current use of house calls
- Barriers to using house calls
- Advantages to using house calls
- How can you measure impact of adding house calls

Fill out note card – commitment to change