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HOME CARE MEETS PRIMARY CARE

By Erin Graham | March 14, 2018

As primary care physicians work harder than ever, little time is left to manage patients who need them most: the frail and complex. Yet for those patients, 15 minutes in the exam room isn't enough – and getting to the exam room at all may be impossible.

"Our most vulnerable patients are the ones we don't see, who go from home to hospital to home to hospital," says Clive Fields, M.D., chief medical officer and co-founder of VillageMD, a national provider of primary care management services.

Those are the patients, says Fields, whose care is fragmented, delivered by "multiple single-modality providers – physical therapists, respiratory therapists, and so on – coming and going," with the onus on patients and their families to put all the pieces together.

So, Fields imagined an opposite scenario: hour-long visits in patients' homes with a consistent primary care provider. To make that vision a reality, he designed Village@Home, home-based primary care delivered by nurse practitioners. "Improvement in outcomes has been staggering," says Fields.

Primary care at home

Enrolling 300 patients a year in the Village@Home program, Village Family Practice, the company's flagship practice in Houston, has 20 to 45 percent fewer hospital admissions and readmissions than market average. Avoidable emergency department visits are 33 percent lower than market average.
And the practice is extraordinarily cost-efficient, with Medicare costs 20 to 40 percent lower and the cost per diabetic patient 16 percent lower than market average.

And it all relies on nurse practitioner Jennifer Burbridge's way with patients. As a Village@Home nurse practitioner, her focus is on building relationships and engaging patients in their own care.

"I didn't realize how many patients were falling through the cracks until I started doing these visits three years ago," says Burbridge. "I think sometimes people give up and just don't go to their doctors."

Her patients tend to have one or more chronic conditions: diabetes, chronic obstructive pulmonary disease, paralysis from a stroke or dementia. Or they're in transition, recovering at home following a hospitalization.

Caregivers as friends

Calling on five to seven patients on a typical day, Burbridge greets her patients and their caregivers as friends and knows their pets' names. Relationship-building is at the core of her care.

Over the course of her visit, she checks vital signs, does bloodwork, and reconciles medications. She checks for bed sores and treats urinary tract infections, and in doing so, reduces readmissions. And as an advanced care practitioner, she can prescribe medications on the spot, streamlining one of the knottier aspects of home-based care.

During the visit, Burbridge charts her notes directly into patients' EHRs on a smartphone or iPad, allowing the primary care doctor to see updates immediately. And most important, she doesn't need to cram all this into a 15-minute window, taking as much as an hour with each patient.

"We prevent patients from feeling like they are lost in the system."

"If I have any questions, I can go directly to that person's primary care physician and ask them what they want to do," she says. "I'll call the specialist if something is going on they should know about, or if the patient doesn't understand what they were told at their visit.

continued on page 2...

"I think patients feel good that there's a connection to their doctor through me," Burbridge continues. "It prevents patients from feeling like they are lost in the system."

A social worker helps Burbridge address psychosocial issues. And as the program has grown, a licensed vocational nurse has joined the team to take patients' phone calls, so the person on the phone knows them as well as Burbridge does.

Familiarity is the key to the program's success. "I'm not a stranger coming into the house," says Burbridge, "and that seems to be such a critical thing."

Pushing the home healthcare envelope

Home-based healthcare may be the frontline of reducing the cost of healthcare. The Centers for Medicare and Medicaid Services estimates that in 2014, house calls saved the system $25 million nationwide — an average of $3,000 per patient. By eliminating fragmentation in home-based care, the Village@Home model has the potential to increase those savings, Fields says.

And in building relationships with caregivers as well as patients, it offers a lifeline for 40 million lay caregivers in the U.S. today, 2.3 million of whom have had to quit their jobs to take care of their frail spouse or parent.

Taking time to talk with family members about logistical or insurance issues — or their own anxiety — is essential. "The biggest thing is to actually listen to caregivers and take the time to talk," Burbridge says. "It helps with their stress."

While VillageMD measures the overall improved outcomes of its patients, Burbridge sees its impact of patients and their families day in and day out. "This helps them have a better quality of life for as long as possible. I feel like I'm making a difference."

Erin Graham is a frequent contributor to athenaInsight