# DEVELOPING A RESIDENCY HOME VISIT CURRICULUM

Megan Malgeri, MD
University of Vermont Medical Center, Burlington, VT
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# WHY DID WE ADD THIS TO OUR PROGRAM?

- We recognized the richness of the process of providing care in the home
- We felt supervised visits with a preceptor would add quality to our program (structure and safety to home care, immediate feedback on performance)
- Optimizes care for our clinic's population
- Home visits from MDs are generally declining[1, 12], yet home health care is one of the fastest growing industries. In full spectrum family medicine training, we need to provide residents confidence and exposure.
- People are being discharged from hospitals earlier, and home visits are shown to reduce hospitalization and need for nursing home care[2, 4, 5, 9, 10].

# NO LONGER A FORMAL ACGME REQUIREMENT

ACGME language (below) currently allows options for which non institutional care option to pursue. We still felt this was a great learning experience, and wanted to develop a formal program around home care.

I.D.1.d) Long-Term Non-Institutional Care Services

Non-institutional care services, such as home care, day care, residential care, transitional care, or assisted living, must be included in the program. (Core)

I.D.1.e) Ambulatory Care Facilities

One or more of the following must be included in the program: (Core)

I.D.1.e).(1) a nursing home that includes sub-acute and long-term care; (Core);

I.D.1.e).(2) a home care setting; or, (Core)

I.D.1.e).(3) a family medicine center, internal medicine office, or other outpatient setting. (Core)

# FIRST THINGS FIRST

Performed a literature review

- Student Teachers in Family Medicine (STFM)
- Resident Curricular Resource (RCR)
- Primary literature (PubMed search)
- Film Rx: The Quiet Revolution http://video.pbs.org/program/rx-quiet-revolution/
- Discussed with local provider who had home visit only practice experience
- Discussed with providers and residents for feedback

# NEXT STEPS

- Lit review helped formulate ideas for implementation of the program:
  - ½ day with preceptor carves out time for this type of visit smoothly
  - Some programs used MDs, APPs, or behavioral health specialists as preceptors
  - We assigned one MD to create this curriculum, allowing autonomy, flexibility of scheduling and design
  - Several programs with HV curricula preferred resident-driven patient selection to add meaning to experience
  - 2-4 patients in a half-day, depending on complexity and travel time

# RESIDENT INPUT

- Requested resident input—whenever a program involves residents, it is important to obtain their perspective.
- Residents in our program wanted initially one preceptor, to allow for ease of coordination
  - They preferred to draw first from their patient panel vs the whole clinic population
  - They wanted 1x 4 hour session per month vs more, due to multitude of resident demands

# DETAILS

- When to do this?
  - We chose resident's outpatient residency clinic month, which allowed for greatest scheduling flexibility. Another option: the month after inpatient service to allow for continuity after complex discharges.
- Who precepts?
  - Resident and faculty input helped to guide formulation
  - Faculty did not want to add this to their responsibilities
    - Residents preferred single vs multiple preceptor format for clarity and attending familiarity/expertise
    - One of our program goals was for direct supervision for enhanced resident feedback and for billing, an MD needs to precept residents, so we chose an MD preceptor vs NP or behaviorist.
    - We had funding for one MD to have 0.1 FTE devoted to developing this program and developed the program so this attending would also be the preceptor.

# FORMAL SET UP AT OUR CLINIC

- 1-2 x 4 hour sessions with supervision from one dedicated home visit attending preceptor
- Residency administrator coordinated schedules and placed 1-2 residents per month who were on outpatient continuity clinic to participate in home visits.
- When 2 residents participated, each had 1 x 4 hour session per month
- When 1 resident participated, he or she had 1 x 4 hour session. To add acute home visit access for our clinic, we also froze one hour at the end of another clinic day during that month for the resident. If a patient needed a home visit outside of the 1x 4 hour session later that month, this slot was filled. If no one in the clinic needed a home visit, the frozen hour was opened up for outpatient office visit care.
- Carpooling to the visits to allow for immediate feedback, enhanced safety
- Pharmacist performed med-reconciliation before visit
- We coordinated visits with our social worker or home health care team when applicable
- We could bill based on time, due to attending presence (HV 25, 40 and 60 minutes)

# BILLING

With home visits, as with OV, if an attending is present for the duration, you can bill on time, or on complexity.

With home visits it seems best to bill based on time spent in the encounter (25, 40, 60 minutes) and attest that this was a home visit, the exact number of minutes we were engaged together and in patient's home, and that I was present for entire visit and agree with the note the resident has written.

# RESIDENT EVALUATION

Based on Milestones and with home visits we are able to evaluate on some otherwise difficult to evaluate milestones (these are what we chose, but more are applicable if needed):

PC-2-Cares for patients with chronic conditions

PC-3-Partners with patient, family and community to improve health…

PC-4-Partners with the patient to address issues of ongoing signs, symptoms…that remain unclear…

PBLI-1-locates, appraises, assimilates evidence from scientific studies related to patients' health problems

PLBI-2-Demonstrates self-directed learning

PROF-3-Demonstrates humanism and cultural proficiency

C-1-Develops meaningful, therapeutic relationships with patients and families

C-2-Communicates effectively with patients, families and the public

SBP-3-Advocates for individual and community health

SBP-4: Coordinates team-based care

# PRECEPTOR EVALUATION FROM RESIDENTS

Likert scale Inadequate to Outstanding

1. Behaves professionally, respectfully and is generally a good role mode

2.Knowledge base for the provision of outpatient care

3. Provides useful and appropriate feedback on my performance

4. Constructive/critical feedback is given tactfully and respectfully

5. Is efficient and is mindful of the time constraints I have as a resident physician

6. Allows me adequate autonomy to develop and maintain my patient-doc relationship during encounter

7. Provides adequate (not too much but not too little) oversight in my patient care plans

8. Do you have any feedback or suggestions for improving our home visit curriculum?

# COLLECTING DATA

We collected data in a pre-home visit survey and again a year later in a post-home visit survey

Confounded by graduating seniors being hard to reach and incoming interns being in the mix during the post-survey. However, it was possible to identify who had completed a home visit as part of the program and who had not, despite the shifting demographic

Small numbers: 18 ppts in pre-survey, 16 in post survey. Of 16 in post survey, 8 had completed home visit program and 8 had not. Despite challenges, still provided qualitative data

We added in a burn-out question in the post-survey data, as home visits may reduce burn out by adding meaning and forcing a slower pace.

# SURVEY RESULTS

- Increased percentage of residents who had completed home visit from 83% to 100%
- 44% said home visits have changed their practice. More (50% of those in this new program) felt this had changed their practice as compared to 37.5% of those who had done home visits beforehand
- Limitations of home visits: most listed were time, lack of electronic resources and reimbursement challenges. Safety was of minimal concern (6%)
- Reasons to visit the home:
  - residents noted psychosocial context most consistently (>60% of residents noting this in open response answer context).
  - Other issues noted consistently: when there are barriers to care, building trust, and strengthening patient-provider relationship
- What residents wanted to gain: highest respondent answers: perspective on patients' lives, broadening psychosocial context, becoming more efficient/effective at home visits.
- Residents noting they wanted to gain an increased comfort with home visits decreased from 23% to 6%, indicating increased comfort with this scope of practice.

# RESULTS CONTINUED

- 100% of residents feel there is a role for MD/APPs in home visits
- For those who had completed home visits, their confidence in addressing psychosocial determinants of health increased
- In the after-survey, the only residents to say they did not plan to include home visits as part of their practice were in the group who had not completed home visits with our program.
- We did not have before vs after data, but 56% of our residents denied burnout, only 6% were completely burned out.
- Interestingly, more residents who had completed a home visit program were burned out than those who had not (62.5% vs 25%) but with 8 residents who had completed and 8 who had not, the numbers are too small to make much of this data. Additionally, likely more G1s were in the group who had not completed a home visit, due to the timing (autumn) to the survey. G1s just starting residency are less likely to be burned out, which may be confounding the data. Regardless, this would be something to watch with adding more tasks to residents.

# LESSONS FROM THE ROAD

- Residents are so busy, they often will not plan ahead to arrange for home visits without personal reminders. Even with this, their panels are small, so they most often came up with only one patient to visit. Thus the program should develop a list of patients who would benefit from a home visit.
- Preceptor/administrator needs to check-in with status of scheduling to ensure visits are scheduled.
- Keep in mind visit location and distance between stops to obtain a reasonable route. We have not found a way to automate this.
- We didn't have a way to add access for an acute home visit if needed in our clinic, we froze a one hour session at the end of a separate clinic day for the resident on home visits. Thus, if a patient needed a home visit outside of the 1x 4 hour session that resident had or at a different time than the session, we could schedule a home visit in this frozen slot. If no one in the clinic needed a home visit, the frozen hour was opened up for outpatient office visit care. If two residents were on home visits in a month, the two separate 4 hour sessions added that acute access so we did not then freeze the 4-5 pm clinic slot during those months.

# LESSONS FROM THE ROAD

- Setting up a clinic list based on need
  - This is difficult—still not automated for us
  - We use an EPIC patient list that one provider keeps updated
  - We use sticky notes to put in address for coordinating destinations, main patient issue, and goal date for HV
  - We need a back-up/emergency scheduling/fill in system if the attending for home visits is gone
  - Use clinic resources even if out of clinic:  we have pharmacist med rec, and have coordinated with home health agency, social work, medical students sometimes attend home visits.
  - Carpooling is an efficient, immediate way to provide quality prep before visit and feedback after a visit

# ONGOING IMPROVEMENT

- We are now working to automate as much as we can and make it sustainable
- Need more functionality of EPIC to allow more information such as address, primary problem, or sharing of sticky notes about home visit information
- Linking this as a service for recently hospitalized patients, expanding to provide formal precepted care for high utilizers, and then to patients at other clinics in our practice group, and even expansion to migrant farm workers at local farms are possible next steps.
- With more funding, it may be possible to bring a pharmacy student and social worker on every home visit.

# RESOURCES


1. AAFP Practice Profile Survey, May 2005
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