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Transitional Care Medical House Call: A Pilot Project

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Rationale

- Vulnerable, homebound older adults are highly susceptible to unplanned 30-day hospital readmissions.
- Costly for the health care system ($6.2B in '97 to $2.8T in '12).
- Transition of care programs complemented with home-based primary care delivery improve health care outcomes for this population.

Purpose/Aims

- Implement medical house calls as component of transitional care management (TCM).
- Measure patient outcomes.
- Correlate predictors of 30-day unplanned readmission.

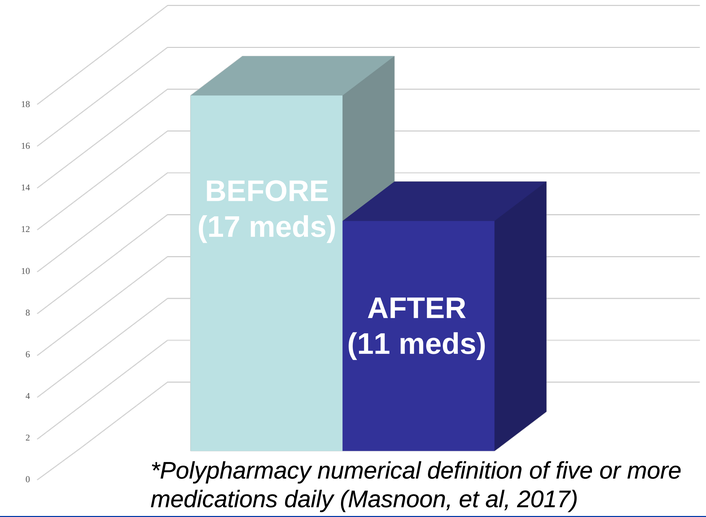
Supported by: Senior Care Clinic House Calls
www.SeniorCareClinic.org

Methods

- Convenience Sampling (*N=145*)
- Medicare beneficiaries >65 y.o. discharged from SNF to home.
- Home visit by provider with prescriptive authority, a Nurse Practitioner (NP).
- Tracked & analyzed point-of-care concerns:
  - ✓ Unplanned 30-day hospital readmission: 19.2%
  - ✓ Days to see patients: 8.5
  - ✓ Common LACE Index scores 11-15 *(M = 12.6; SD = 2.9)*
  - ✓ Prescriptions required: >50%
  - ✓ Number of comorbidities (co-existing disease conditions): 2
  - ✓ Days to see Primary Care Provider (PCP): >14 days
  - ✓ Polypharmacy* (see graph)

Results

- Polypharmacy*: statistically significant reduction from 17 to 11 *($z = -7.497$, $p < .001$)*



**Polypharmacy numerical definition of five or more medications daily (Masnoon, et al, 2017)*

Clinical Relevance

Older adults discharged from a higher level of care benefit from TCM through medical house calls by a NP within 14 days after discharge by significantly reducing polypharmacy and managing readmission risk.

Reference: Masnoon, et al. (2017). *BMS Geriatrics*. DOI 10.1186/s12877-017-0621-2