Home Care: the next frontier of pediatric practice

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Home Care: the next frontier of pediatric practice

Goldberg et al  J Peds 1994
125:686--90
Talking Points

• Why Home Care?
• Types of programs/services
• Community based care vs inpatient
• Care Coordination/Medical Home
• What is my role?
Why Bother?

• Home based services may not be for every child or every family

• Benefits include:
  • Lower cost
  • Decreased hospitalizations
  • Decreased ER visits
  • Increased family satisfaction
  • Increased quality of life
Community Based Services

- CHHA
- LHCSA
- Long Term Home Healthcare
- Katie Beckett
- Day Programs—Day Hab; Schools; ADHC
- EI & preschools
- Outpatient Rehab
- Respite
- DME
Home Care Players

- DPS/manager/supervisor
- Nurse coordinator
- Therapist
- Paraprofessional
  - Home Health Aide
  - Homemaker
- DME /supply coordinator/PSC
Home Care has become heavily regulated and the Physician is a key component in the agency’s compliance with regulations and essential to their operation and financial success

Don’t forget Stark laws
Differences from inpatient

- Who are your eyes and ears?
- Who are you communicating with?
- What are time frames
  - Lab tests
  - XRay
  - Office visits
- Contingency and emergency planning
Components for Parent & Doc to consider

• Case Manager
  • Provided by whom (DOH; EI; Medicaid; OMR/DD; Home Care)

• Insurance/Financing
  • Who is helping you manage entitlements/coverage etc
  • Letters of necessity

• DME
  • Feeding utensils, bath chairs, special car seats, walkers, hospital bed, wheelchairs, seating, vans, lifts, pumps, respiratory equipment, monitors
Components for Parent & Doc to consider

• Home evaluation
  • Equipment, space, safety, feasibility
  • Modifications needed

• School issues
  • IEP or 504
  • Services at school

• Service transitions such as EI to CPSE etc

• Recreation
Components for Parent & Doc to consider

- Clothing—adaptive
- Transportation
- Support groups/extended family
- Dental issues—is there a dentist identified
Dear Dr. Simpser,

We understand you are considering sending your pediatric patient home from the hospital. We have a number of suggestions for how we can work together for the benefit of the child, their family, as well as each other. Please review the following items and by all means please contact us with any questions, comments or modifications. We really mean it. Please call us anytime; day or night. We cannot stress enough ......
Communicate
Communicate
Communicate

Sincerely,

Kid Friendly Home Care
The Doc & Home Care
Getting Started

• Establish relationships with agencies over time based on your own experiences and your colleagues recommendations

• Don’t leave all the decisions to the discharge planner or social worker

• Consider initiating a phone call to agency yourself but certainly expect a phone call prior to initiation of services from nurse/case manager

• Insist that agency identify one primary contact for your patient. You identify the primary clinical contact for your practice (you or your physician extender)

• Be sure agency knows how to reach you/your practice off hours
Nurse Coordinator

- Treat the home care primary nurse as an extension of yourself
- Along with well trained parents, they are your eyes, ears and hands
- If you or parents are not comfortable with the primary nurse—either clinically or “personality” advocate for a change
- Recognize that you know the patient best—teach the nurse what you know—clinical, social etc
- Make clear your expectations re frequency of visits, level of communication you expect etc
Expectations: Yours

- Communication from nurse before and after initial visit
- Any significant change in status; urgent calls to avoid ER visits
- Nurse coordinator should inform you of other service agencies involved or other specialists
- Routine call q month or 2 month depending on chronicity
Expectations: Agency’s

- Home Care agency’s goals include quality care, compliance with regulations and margins
- You can help by being available as needed for care issues
- Sign and return 485s expeditiously
  - Initial, interim and renewal plans of care/orders
  - By regulation no services can be provided without a plan of care every 60 days from a physician—essentially like a prescription
  - Includes meds, frequency of nursing as well as rehab visits and paraprofessional services
Expectations: Agency’s

• Whenever you see the patient, call nurse to have her follow up on issues—avoid revisits

• Inform HC agency of referrals to specialists or other service agencies

• Inform HC of school or outpatient services patient is receiving
One More Thing

Sign the 485!

Right away—don’t set it aside

TODAY!!
Just in case you think this is asking too much listen to this story
Additional approaches

* **If you are a “heavy user”**

- Care coordination program in your practice
- Visit the “office” and establish relationship with leadership
- Consider being on the agency’s medical advisory board
- Consider regular case conferences with HC team either in person or by phone
How do you support parents

- Help develop portable medical/care summary or health care plan (both keep on file)
- Probe satisfaction with services/agencies
- Advocate for equipment & services; timely letters etc
- Single contact as much as feasible
- Navigate the system particularly specialists--“Interpret” recommendations
I have to do what?

• Prescribing Rehab services or DME
  • Get educated
  • Individualized
  • Requires communication & goal setting with multiple team members
  • Demand regular outcomes reports
  • What do schools do vs home or outpatient

*Peds 2004 113:6; 1836--1838*
Medical Home

- Accessible
- Family Centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally Effective
- www.medicalhomeinfo.org
Care Coordination

- Plan of Care—proactive, anticipatory, integrated
- Central record
- Share info --- everywhere
  - Other docs
  - Other community providers—home care; educational etc
- Family support/resources
- Help parents understand and navigate specialists
- Dedicated staff
Can you afford it?

Has anyone really done it?
PAAC

Pediatric Alliance for Coordinated Care
Palfrey et al  Peds 2004 113:1507--1516

- 6 practices; 40 kids per practice (Mass.)
- Dedicated PNP 8 hrs a week
- IHP for each child
- Local parent consultant (stipend)
- Very successful on multiple parameters
- Cost ~ $400 per child/year
Barriers

- Lack of knowledge
- Poor communication
- Need clearly defined roles
- Time to provide coordination, care etc
- Clinic & ER use
- Poor reimbursement
- Resistance to your role
- Language/cultural barriers
Challenging Cases

Cases where the specialists may be viewed as primary

- Cancer
- AIDS
- Short Gut

Pediatrician’s role can be supportive provided the specialist’s practice takes over the bulk of the Medical Home role

Never lose sight of your patient
Home and Community Based services can be cost effective and satisfying on multiple levels for all involved.

Quality of Life for child and family can be significantly improved.

The level of “Care” provided by the Pediatrician significantly affects the positive outcomes and success of a community based program for children with chronic illness.
Contact Info

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St. Mary’s Healthcare System for Children
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www.stmaryskids.org