South Florida Hospital News and Healthcare Report
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How to make the most of a post-discharge home visit waiver for chronic care patients

by: Accountable Care Options LLC

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For a select group of doctors associated with Next Generation Accountable Care Organizations, Medicare has increased the number of post-discharge home visits to nine in 90 days from two in the first 30. That greatly benefits primary care

physicians with patients suffering from chronic conditions. Best practices make the most of these opportunities to promote patient independence and reduce the likelihood of re-admittance. [Highlight that the “select group of doctors” are physicians associated with Next Generation ACO’s]

In our experience with this program, as a Next Generation Accountable Care Organization, we are conducting three visits for patients in relatively good health. For those with chronic health problems, an additional six visits allows the primary care physician to order follow-ups when the patient’s health declines and to address longer-term needs.

Once a member of our Transitional Care Team conducts the first home visit, the information is reported to the primary care physician for follow-up orders. We try to schedule an appointment with the primary care physician during that visit. If the patient demurs, after we submit that paperwork to the doctor’s office, it’s up to the primary care office to schedule the office visit.

When the patient’s health is unstable, the transitional care team schedules another home visit under the guidance of the primary care physician. These evaluation and management visits tend to be more akin to social service encounters because the registered nurse or ARNP, in concert with a behavioral health professional, is trying to determine whether it is safe for the patient to live independently at home or whether to bring in additional caregivers to assist with activities of daily living. The evaluation and data are reported to the doctor for further follow-up.

One critical question is: Can the patient stay in the home, or has the individual progressed to the point where an assisted living facility might be a better choice? That cannot be answered until the patient is settled in the home. Sometimes, problems don’t present themselves within the 30-day window

that Medicare provides for two visits for physicians who are not part of a Next Generation ACO. [non-sequitur. I believe the waiver allows for nine visits within ninety days and they might all be provided in that 30 day period.

In every patient contact, whether medical or social service focused, the primary care physician receives a full report with recommendations and a plan of care as to which services are needed. The plan must be patient-tailored. If the individual needs to be moved to an assisted living facility, the doctor schedules an office visit with the patient and his or her family.

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