Changing the Model of Care for Home-Based Primary Care

Ayanna “Mickie” Whitfield

College of Nursing, East Carolina University

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Main Points

- Implementing the Whole Health model of care will require extending the standard times for patient encounters.

- A new role, Whole Health Champion, should be established to facilitate communication regarding Whole Health updates. These champions will act as on-site resources for their designated healthcare teams. Additionally, they will serve as intermediaries between the Home-Based Primary Care teams responsible for implementation and the leadership overseeing personnel, policy, and procedural decisions.

- Home-Based Primary Care team members need internet access while in the field for real-time access to the electronic health record.

- The Personal Health Inventory expresses the patient's goals while broadening the focus of the patient's encounter to what matters most to them.

- Home-Based Primary Care team members can be introduced to the Whole Health model of care by completing the online training specific to primary care providers. However, they will also need specific training on the Whole Health tool that will be used.

Purpose & Background

The quality improvement project was developed in response to the need for a process and a tool to implement the Whole Health model of care into Home-Based Primary Care. The Home-Based Primary Care team, the program's patients, and their caregivers played a crucial role in this project. Once the process was defined, the Home-Based Primary Care team was the key user. They utilized it for enrolled patients and new admissions into the program. The process was
shared with Whole Health leadership and other Home-Based Primary Care teams for implementation at different sites across the organization.

Methodology & Results

A convenience sample was used to implement this quality improvement project. Before the project, the Home-Based Primary Care team was unfamiliar with the Whole Health model of care and needed to learn about the tools available to implement it into their practice. The chosen tool needed to be available in the Electronic Health Record and printable form for use in the field. The tool that was chosen was the Personal Health Inventory. The process of the Home-Based Primary Care team implementing the Whole Health model of care first required the completion of an online course for primary care providers by the team. A follow-up session focused on administering the Personal Health Inventory by Home-Based Primary Care team members was done to ensure the team felt secure in administering the tool in patients' homes. This included a one-page cheat sheet as an off-line resource in the homes of Home-Based Primary Care patients. Patient assignments were made based on their visit schedule. Patients who were able to communicate their goals were the priority. Patients who required skilled care outside their homes or were too ill to participate were excluded. Caregivers of Home-Based Primary Care patients were also allowed to participate. This was based on the finding that exploring what is important to caregivers positively impacts them and the health experience of the patient (Schwabenbauer et al., 2021).

The printed tool was made available to the team so that they could take it into their assigned patient homes. The process of initiating the Personal Health Inventory was not complete until the information was entered into the patient’s electronic health record. This is also how the
team was made aware of the patient’s goal. Finally, the team evaluated progress toward the goal during interdisciplinary team meetings where the patient's care plan was discussed.

At the end of the project, 43 patients and seven caregivers had an active Personal Health Inventory.

**Strengths & Limitations**

The Home-Based Primary Care team was a strength of the project. They undertook additional responsibility to learn and introduce a different care model to the patients on their caseload. Since implementation was a priority, there was already a leadership team in place for Whole Health. This team served as a resource and sounding board for the project at its inception and during project development.

A significant limitation of the project was the need for more access to Electronic Health Records in the field. This required the team to initiate the tool once on paper while in the patient's home and again when they returned to the office, where the data was entered into the Electronic Health Record. The Home-Based Primary Care program has a standardized visit schedule for all team members. This schedule did not allow room for more than two visits for the nurse practitioner or physician associate and only one for the remainder of the team members during the 11-week implementation phase. Meeting a health goal requires a process that cannot be completed in one patient encounter.

**Implications and Conclusion**

Completing the Personal Health Inventory on paper and then in the Electronic Health Record is a duplication that can be erased if the Home-Based Primary Care team has internet access in the field. This is achievable with agency-issued mobile hot spots. Implementing the Whole Health model of care will not only require a change in how care is delivered but will also
require additional personnel. A Whole Health Champion will be crucial to the program's success. This person will communicate with the Home-Based Primary Care team doing the implementation work about outcome measures that guide leadership in making decisions to support the Whole Health model of care expansion. These decisions include extending the standard time for visits, lowering the caseload expectation, making the Personal Health Inventory a standard part of the program admission packet for all Home-Based Primary Care teams, and possibly creating multiple Home-Based Primary Care teams at all sites.

Patients have more access to knowledge now than in the past. This new knowledge fosters strong opinions about their healthcare, with an expectation that those opinions will be heard and acted upon. The Whole Health model of care permits patients to have a voice in their healthcare by making them an active member of their healthcare team. The organization prioritized implementing the Whole Health model of care to replicate the positive experiences seen by mental health patients (Bokhour et al., 2022). Although the Whole Health model of care fills up time during the encounter, Home-Based Primary Care teams can better partner with patients enrolled in the program to optimize their health when it is practiced.
References
