Introduction

- Hotspotting is a program focusing on providing interprofessional care to patients with complex medical and social needs using a patient-centered approach.
- Hotspotting program provides an opportunity for students from various healthcare programs to coordinate and offer individualized interventions to reduce ED admissions in “high-utilizers.”
- Our team consisted of students from: physical therapy, medicine, pharmacy, and occupational therapy programs.

“I’m always on the go”: Who is RS?

- When our team met RS, an 80-year-old gentleman, our first impression was “go-getter.” Despite his difficulty with ambulation, transportation, and other medical conditions, we were struck by his optimism and cheery knit sweaters. Although RS spent several decades incarcerated, upon serving his time he immediately reconnected with faith and spirituality. He currently attends Protestant, Catholic, and Jewish services. He is constantly attending various services, spending time at community centers, or volunteering. Unfortunately, his extensive list of co-morbidities and frequent hospital admissions prevent him from living life to the fullest.
- PMH: CHF, T2DM, GERD, HTN, HLD, OSA, obesity, chronic venous insufficiency, cellulitis, and blindness of left eye
- Hospital admissions: RS was admitted to the hospital several times a month for diabetic related wounds, chest pain, and suspected elder abuse.

Barriers

Interpersonal
- Inability to provide aid for community activities
- Inability to aid in his goal to reconnect with family
- RS had a criminal record that made it very hard to place him in certain care facilities

Systemic
- Scheduling conflict
- Lack of Epic access for some team members
- Inability to reach head-caregivers to ask about missing medication

Team
- Communication
- Team roles and responsibilities not clearly defined
- Coordinating appointment and home visits while members of our team were away on clinical rotations

Outcomes

Pre-Intervention Utilization | Post-Intervention Utilization
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ED | 2 | 0
ICU | 1 | 0
Inpatient admissions | 3 | 0
Inpatient days | 16 | 0
Outpatient visits | 6 | 8

Estimated Cost: $63,500 Estimated Cost: $4,000

Our Approach & Interventions

1. Bridged the gap in communication between RS and care team
   - Contacted his nurse, doctor, and pharmacy to establish goals of care

2. Aided in medical organization
   - Organized medication vials into two separate bags: as needed and daily

3. Provided calendar for RS
   - Placed calendar in a visible location and instructed RS how to efficiently organize appointment dates

4. Patient education
   - Pending enrollment into Diabetes Education program
   - PT exercises to address his long-standing neuropathy
   - Phone education to allow him to set alarms for daily medication and appointment reminders

5. Housing
   - RS is now living in an assisted care facility in South Philadelphia where he receives help from caregivers ~8 hrs/day

6. Transportation
   - RS has a new transportation company (ABBI Express & logistics LLC) that was recommended by his caregiver; this service meets his various needs and he is very satisfied with it

Take Away Points

- A thorough home visit can provide more nuanced context to patients’ medical conditions
- All patients are deserving of the highest standard of care, even those who may have committed morally reprehensible acts
- RS was very grateful for our service and appreciated the time we spent with him at home
- Interdisciplinary teamwork helps bridge gaps in communication and can improve the patient’s trust in health care. Our team utilized GroupMe chat to communicate regularly
- Hotspotting was a valuable opportunity to practice interprofessional teamwork before we embarked on our professional careers

Acknowledgments

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