Penn Medicine's Home Care and Hospice Services

Alignment, Collaboration and Innovation Across the Care Continuum

The Trident of Successful Organizational Leadership in an Integrated Healthcare Delivery System

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University of Pennsylvania Health System

Penn Medicine

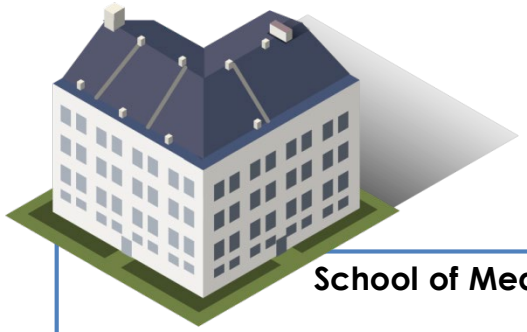

PHILADELPHIA
CITY OF
BROTHERLY LOVE


LOVE

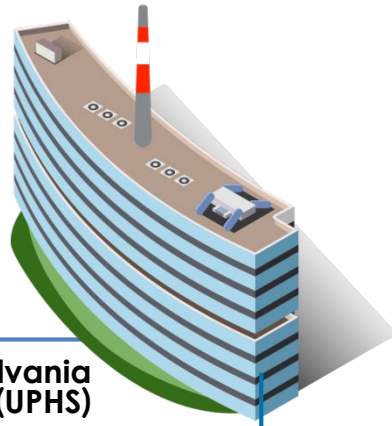

PHILADELPHIA
EAGLES


PEPSI
PAT'S
KING OF
STEAKS
Italian Market
PAT'S
STEAKS
GENO'S
STEAKS

Penn Medicine



School of Medicine



University of Pennsylvania Health System (UPHS)

Health System Clinical Components

- Clinical Practices of the University of PA (CPUP)
- Hospital of the University of PA (HUP)
- Penn Presbyterian Medical Center (PPMC)
- PA Hospital (PAH)
- Clinical Care Associates (CCA)
- Penn Home Care and Hospice Services (HCHS)
- Chester County Hospital (CCH)
- Lancaster General Hospital (LGH)
- Good Shepherd Penn Partners (GSPP)
- Princeton Health Care (Dec. 2017)

In 2018, *Forbes* even named Penn Medicine the country's top health care employer and sixth best employer overall

Penn Medicine Profile: Fiscal Year ‘18

Penn Medicine	Total
Licensed Beds	2,989
Revenues	$6.1 Billion
Adult Admissions	118,445
Outpatient Visits	4,123,729
Home Care visits	450,000
Births	16,160
Employees	39,400

Five hospitals located in Philadelphia, Chester County, and Lancaster, Pennsylvania
Multiple ambulatory sites in PA and NJ
Merger with Princeton Health Care December, 2017

Penn Medicine is setting course for the future of health care

A future that's patient centered.

A future that solidly integrates the continuum of care.

A future that contains costs, and sustains quality.

Penn Home Care and Hospice Services is helping move the needle on all these goals.

Penn Home Care and Hospice Services

Penn Care at Home

- Specialties in Cardiology, Oncology, Neurology, Orthopedics, Diabetes
- Telehealth monitoring
- ADC 1900

Penn Home Infusion

- Intravenous medications and other complex therapies
- Services include oncology, pain management, infectious disease, cardiology and nutrition
- 24/7 infusion pharmacy
- ADC of 1400

Penn Wissahickon Hospice

- Palliative care, pain management and counseling
- **Caring Way program** provides palliative care for patients actively seeking curative treatment
- Hospice ADC 250
- CW ADC 220

Inpatient Hospice at Rittenhouse

- State-of-the-art 20-bed hospice care
- 24/7 visiting hours
- On-site cross-functional staff

4,765 average daily census

1200 employees

Penn Home Care and Hospice Services

Neighborhood Health

- Home Health Services
  - 63,000 visits/year
  - ADC - 350
- Senior Link Program

Neighborhood Hospice

- Home Hospice
  - 54,000 days of care
  - ADC 110
- 22 bed inpatient hospice unit

Princeton Home Health and Hospice

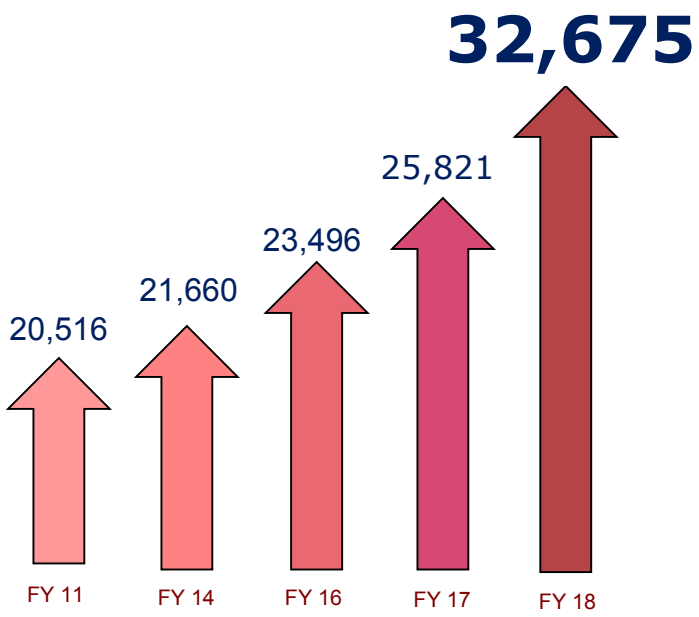
- Home Health
  - ADC 405
- Home Hospice
  - ADC 70
- Caregivers
  - ADC 60

Care Shift to the Home

- Value based purchasing
- Readmission penalties
- Bundle payments
- Insurance site of care shift for infusion therapy
- Shift of appropriate patients from Skilled Nursing Facilities to Home Health
- Aging demographics and increase of chronic disease

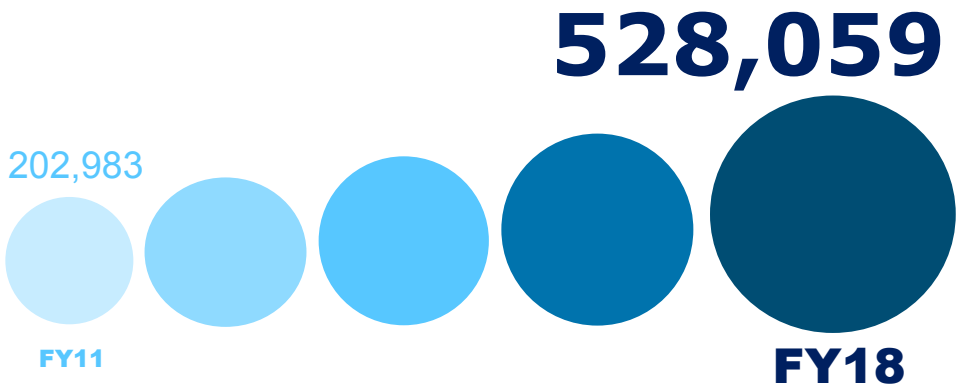
Valuable Growth for Penn Medicine

PHCHS Admissions



Referrals have increased 25% over five years

HCHS Visits



NHA joined PHCHS 7/1/2018. Princeton Home Health and Hospice not included in statistics.

HCHS works with the rest of Penn Medicine to build out the continuum of care

We're integral to Penn's strategic direction

- Partnering with the Office of the CMO, Service Line leads, and Primary Care - HCHS manages Penn Medicine Continuity Services.
- We're a key player in Penn's bundled payment initiatives.
- Long history of leadership of strategic system-level committees like the Transitions Steering Committee and the Post-Acute Care Partnership.

We're standardizing on the same clinical pathways

- We're working with the service line disease teams to follow standard clinical pathways, starting with Heart & Vascular, Oncology, Neuroscience and Musculoskeletal.

We innovate clinically

- Telehealth
- Penn Innovation Center
- Automated FU phone calls
- Caring Way
- Hospital at Home

We're a clinical partner to the rest of UPHS

- Consults, goals-of-care conversations, field rotations.
- We identify trends with our health system partners—readmissions tracers and case conferences
- We review real-time readmission feedback—and take action with our hospital counterparts.
- We have the same electronic records—and actively share information.

The future of post-acute care is Continuity

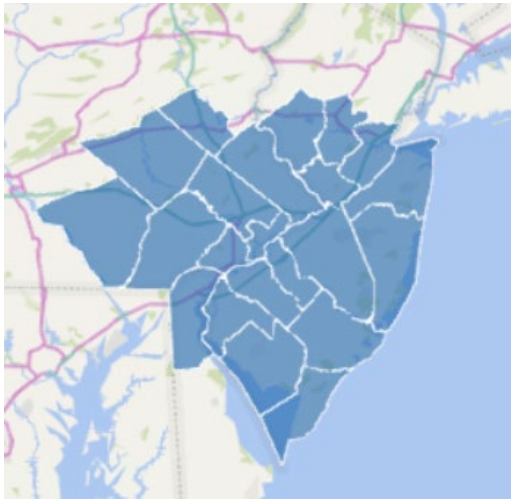
The aim of Penn's Transitions-in-Care model is to keep patients **healthy and safe** across the **continuum of care.**

Penn will build on a **growing set of interventions** that help integrate the care continuum with a focus on building continuity across UPHS

Risk Stratification	Interdisciplinary Care	Closing the Loops	Getting Information to the Right Place	Followup Programs & New Payment Models
• **Risk assessment linked to interventions** • **Real-time readmission feedback**	• **Shared clinical protocols** across the continuum • **Patient & family education** • **Med rec** across the continuum • **Goals of care conversations**	• **Referrals to post-acute services** • **Followup appointments & slots** • **Followup phone calls** • **MyPenn Pharmacy**	• **PCP contact info** • **Discharge summary to next provider** • **Loopback communication & trouble-shooting** • **Same EMR across Penn Medicine**	• **Integrated platform of wraparound programs** • **Care connectors** • **Bundled payment experiments**

Vision and Strategy for Care in the Home

- **Standardized and coordinated clinical care model in the home across Penn Medicine's regional service area**
- **Integration will enable the development and implementation of innovative clinical care in the home to all Penn patients**
- **Strategic suite of services in the home to align with Penn Medicine Hospitals, Service Lines, and Penn Medicine Medical Group goals**
- **Creation of meaningful capacity across inpatient hospital settings by lowering readmission rates and reducing the overall cost of care**



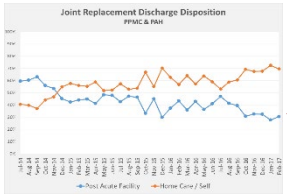
Benefit of an Integrated Home Based Service Model

- **Leverage Technology– shared clinical information and outcomes across all Penn Medicine Home Based Care providers and consistent clinical documentation in PennChart**

- **Accountability for Outcomes – centralized ability to measure and manage performance**

- **Implementation of Best in Class Clinical Team – access to educational programs and specific clinical competencies to develop and support clinical staff in the home and community**

- **Standardized Patient Experience – clinical excellence and coordination regardless of patient geography and care needs**

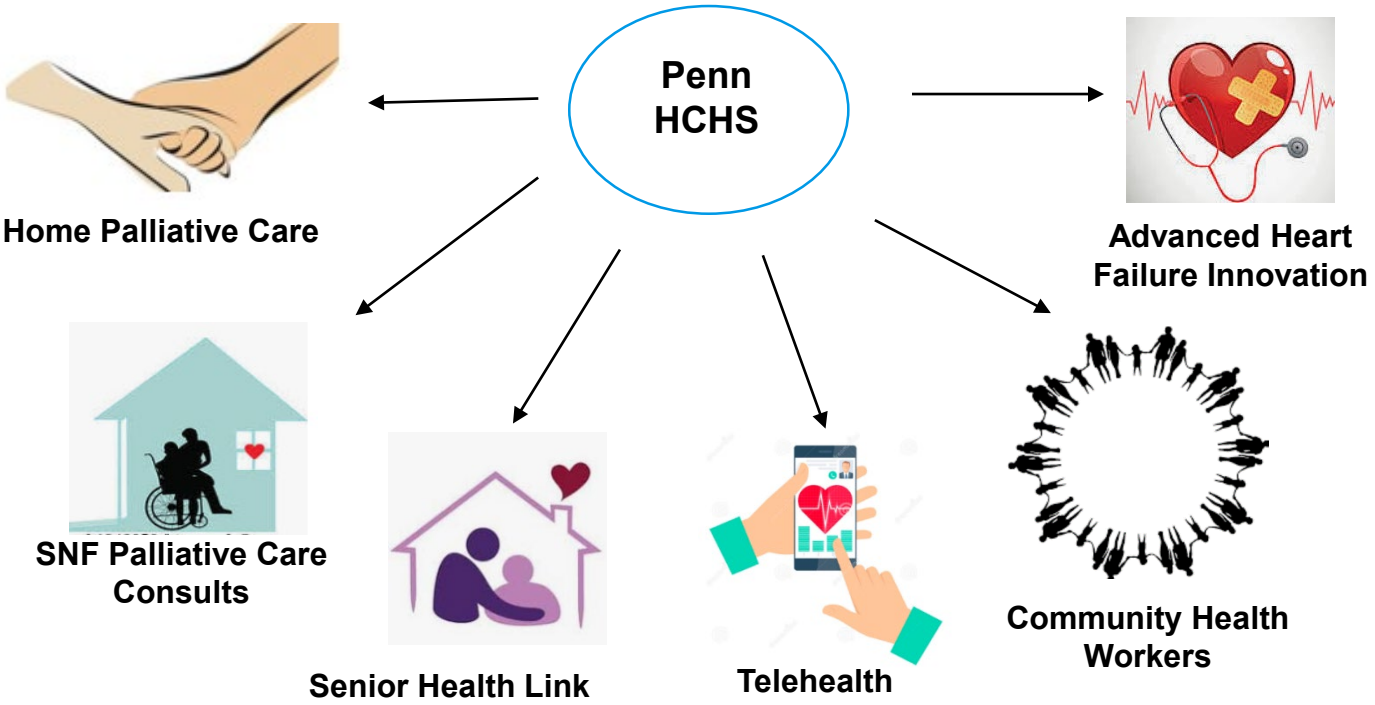


- **Execution of Clinical Pathways – ensure adherence to service line and disease team clinical pathways in the home**

- **Economies of Scale – consolidation of administrative and clinical support functions to support clinical operations**

Collaboration Beyond Traditional Home Health

- Scope of services extends beyond traditional Home Care / Hospice to best meet unique patient needs and align with health system goals
- Partnerships with multidisciplinary Penn Medicine teams to provide leading-edge care in the home and community



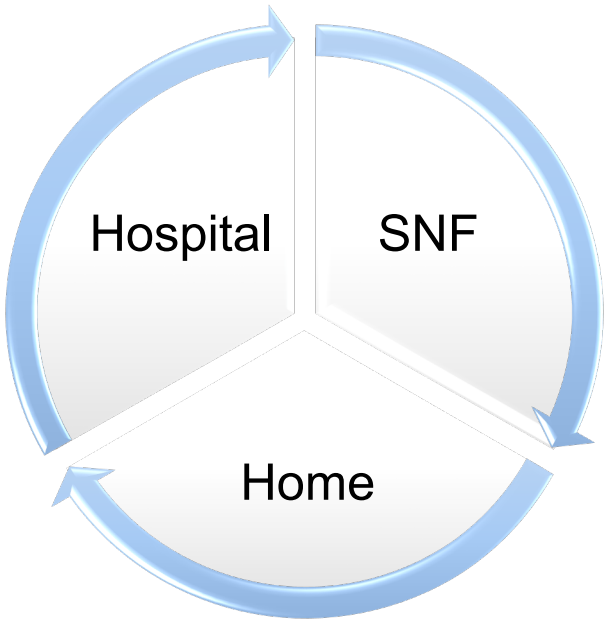
Palliative Care

Community-Based Services and Innovation

Case Study: Mr. M

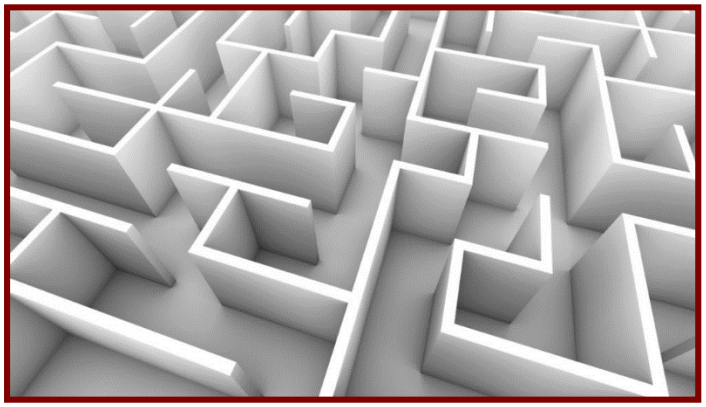
72 year old male with metastatic prostate cancer, early dementia, and multiple recent falls at home

- Admitted to the hospital after fall
- Discharged to a skilled nursing facility
- Struggled with delirium and pain control
- Refused to work with physical therapy
- Transferred back to hospital for UTI
- Ultimately discharged home with wife
- Increasing difficulty getting to oncology clinic for appointments and treatment
- Caregiver stress and isolation



What are Mr. M's needs?

- 1) Pain and delirium management
- 2) Psychosocial and caregiver support
- 3) Advance care planning and goal setting
- 4) Complex care coordination across settings



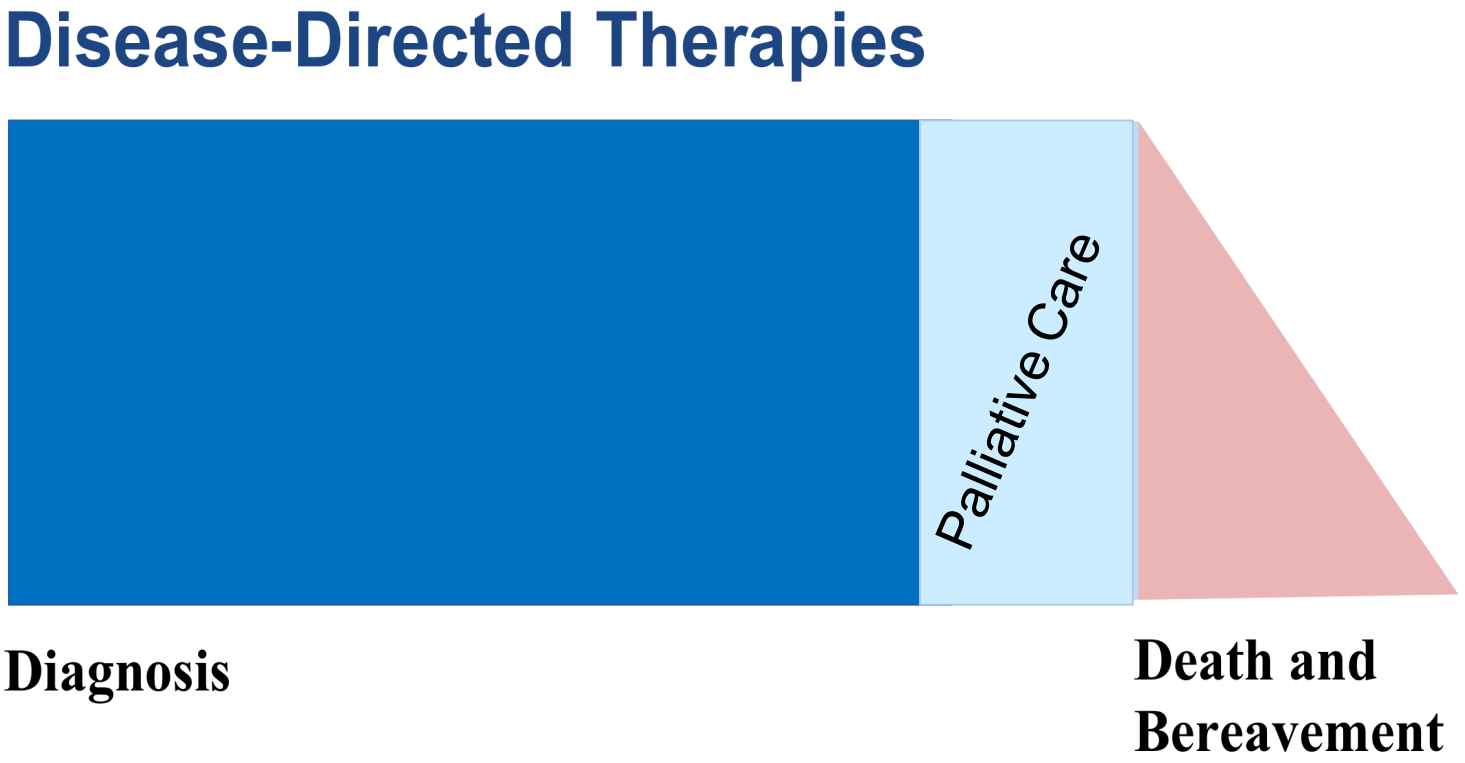
What is Palliative Care?

From the Center to Advance Palliative Care (CAPC):

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.

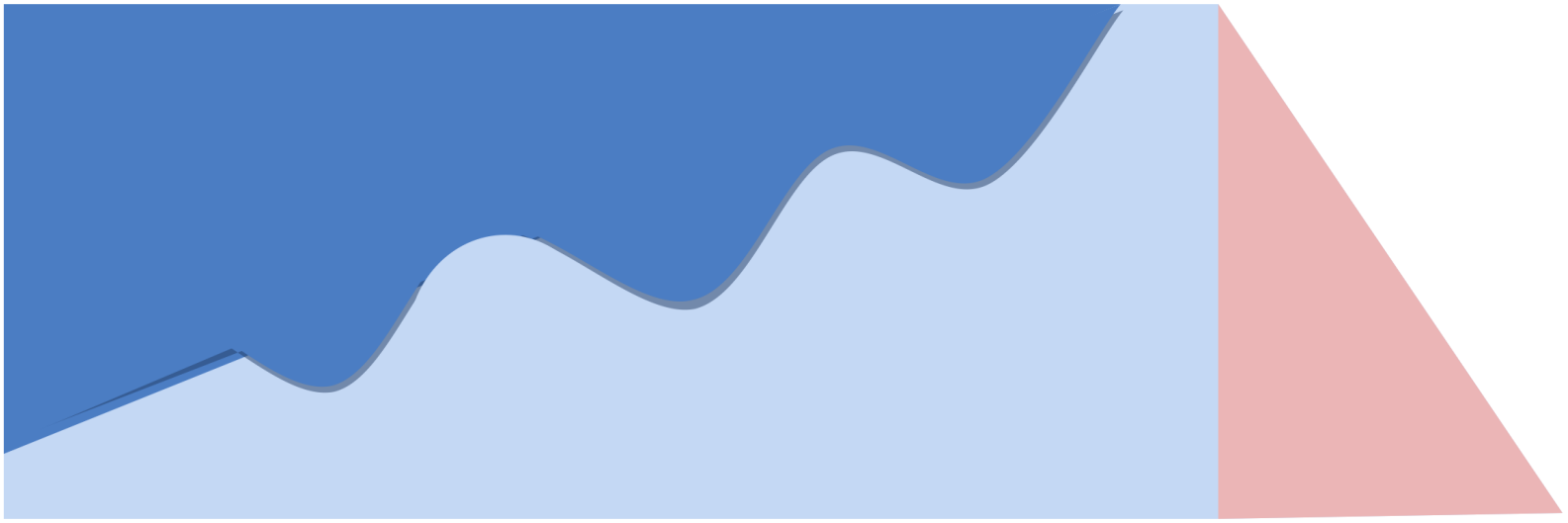
The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Old Model of Palliative Care



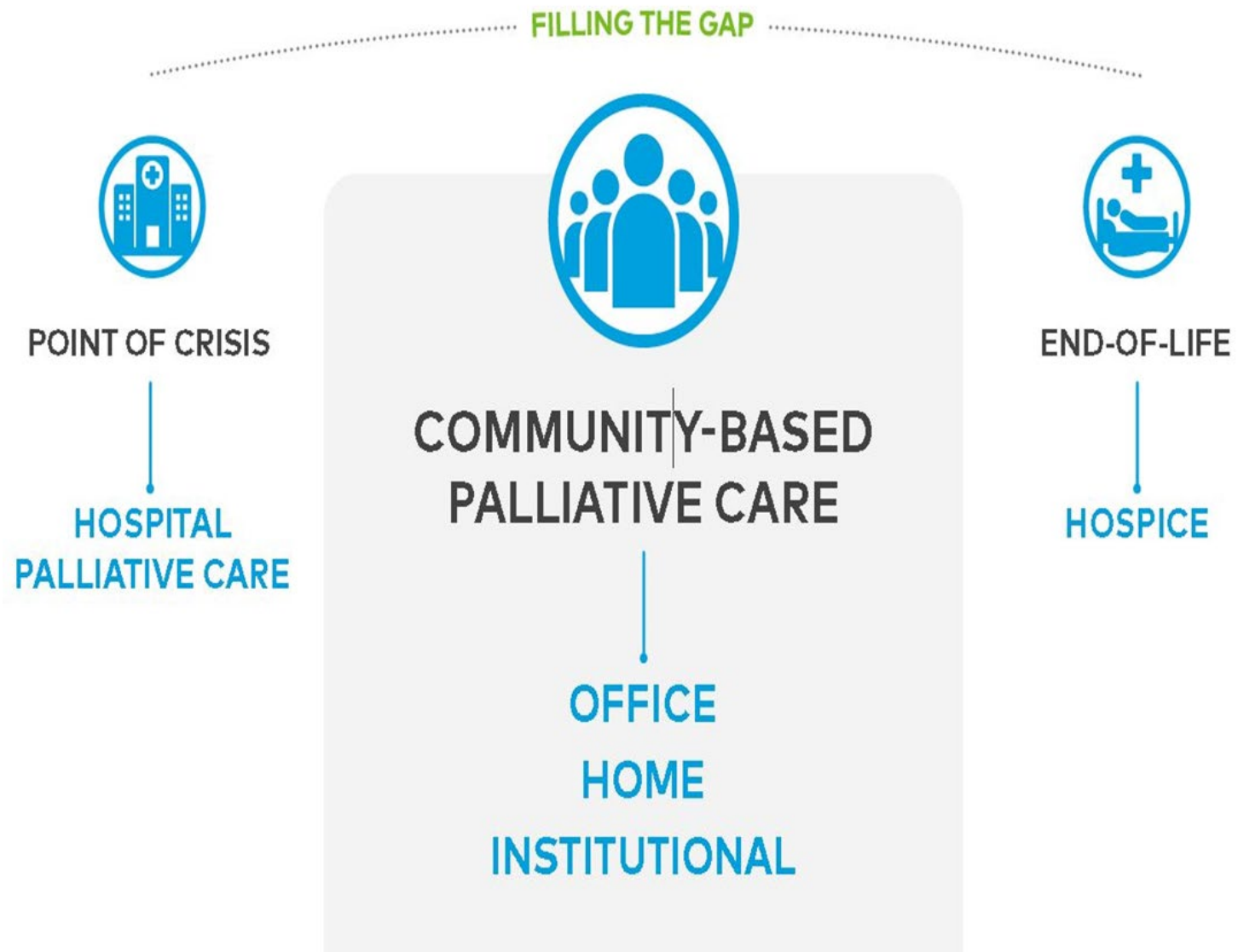
Current Model of Palliative Care

Disease-Directed Therapies



Mr. M could have received palliative care in all settings

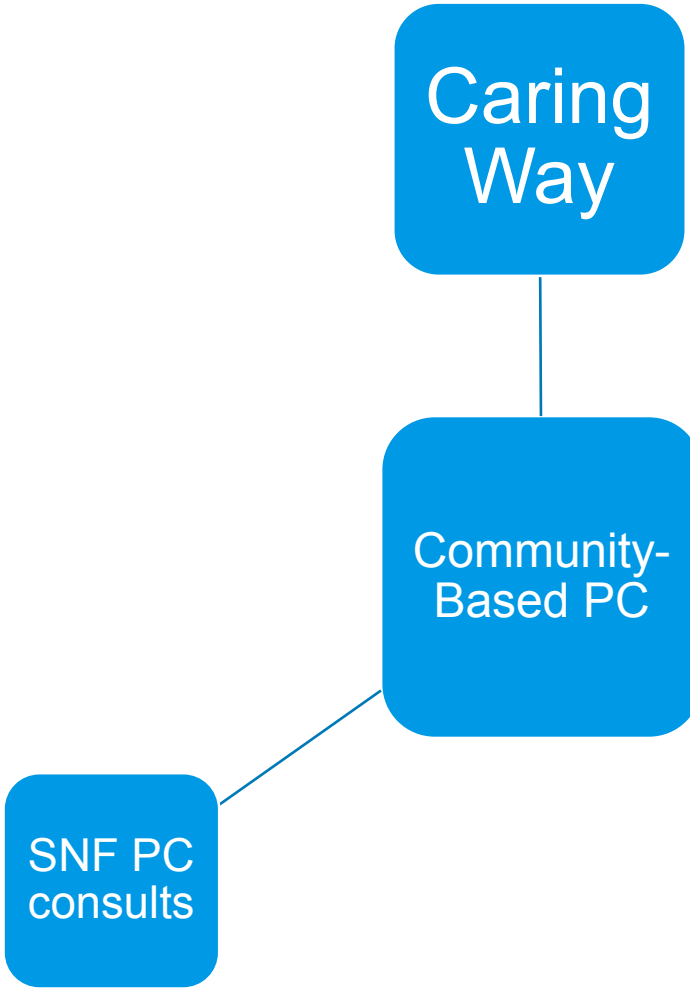
Where should palliative care be delivered?



Community-Based PC at Penn Medicine

- **Developed under Penn Homecare and Hospice Services**
  - Smooth transitions to hospice at home
  - Right patient to right program
- **Close collaboration with inpatient palliative care programs**
  - Bidirectional handoffs and referrals
- **Data driven program development**
  - Identification of high priority populations for health system
    - Readmission rates
    - Bundles
- **Partnership with service lines on palliative pathways**

Community-Based PC at Penn Medicine



Home Health license
RN, LPN, SW, chaplain, NP, HHA
ADC approx. 200 patients
TJC certified

New service in 2018
PC NP consults and follow-up visits
Emphasis on goals of care and transitions

Home and inpatient hospice
High acuity (VADs, pressors, transfusions)
ADC approx. 250 patients

Caring Way: Exemplary PC at Home

- **Winner of the 2018 "Circle of Life Award"**

- **Multiple strategies to promote interdisciplinary teamwork**
  - Frequent case conferences and team meetings
  - Physician and nurse practitioner support
  - Social work, chaplain, and child bereavement services
  - Joint visits with hospice to ease transitions
  - Close collaboration with hospital PC teams

- **Unique use of technology**
  - Telehealth monitoring
  - Same EHR as rest of Penn Medicine for transparency
  - Online Advance Care Planning tool that uploads to EHR

Program Case Study: Heart Failure

Partnership between Cardiovascular Service Line, Caring Way, and Penn Center for Innovation

Hospital of the University of Pennsylvania

Chester County Hospital

Presbyterian Hospital

Pennsylvania Hospital

450

INPATIENT DEATHS PER YEAR FROM HEART FAILURE

▼ **50%**

reducing hospitalizations by 50% in the last year of life

▼ **3,262**

acute care days/year

▼ **$13 million**

in care costs/year

Fact finding: Cardiology and Palliative Care

Assumption	Facts
Hospitalizations are necessary for symptom management and HF exacerbations	Patients prefer to maximize time at home Symptoms can be managed at home
Hospice can't actively manage HF medications	Optimal HF management is the best palliation for symptoms Homecare and hospice clinicians can be trained to provide HF care
Palliative care is difficult to find in the outpatient setting	No PC clinic for non-oncology patients Home PC services are available but not well understood by providers

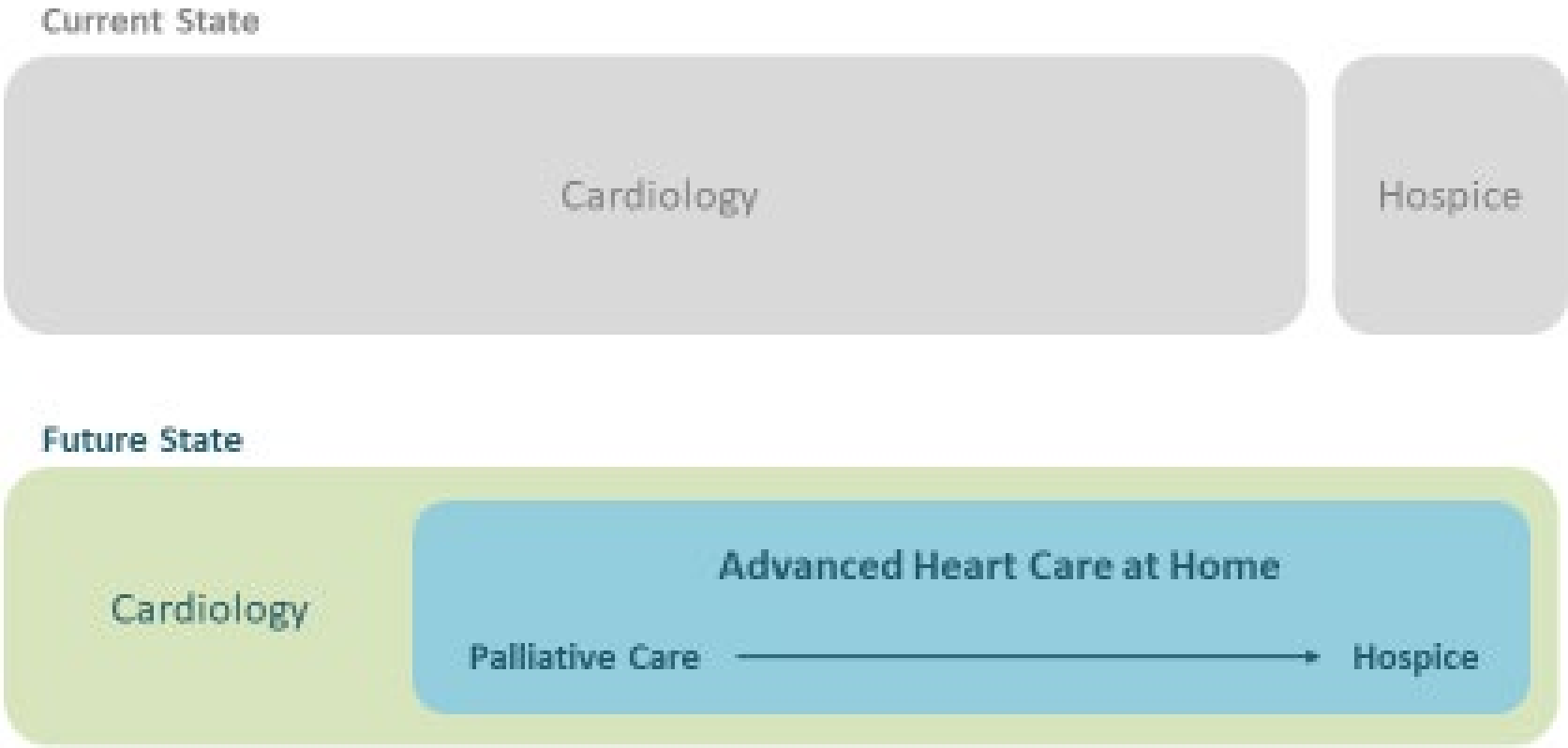
Advanced Heart Care

at home

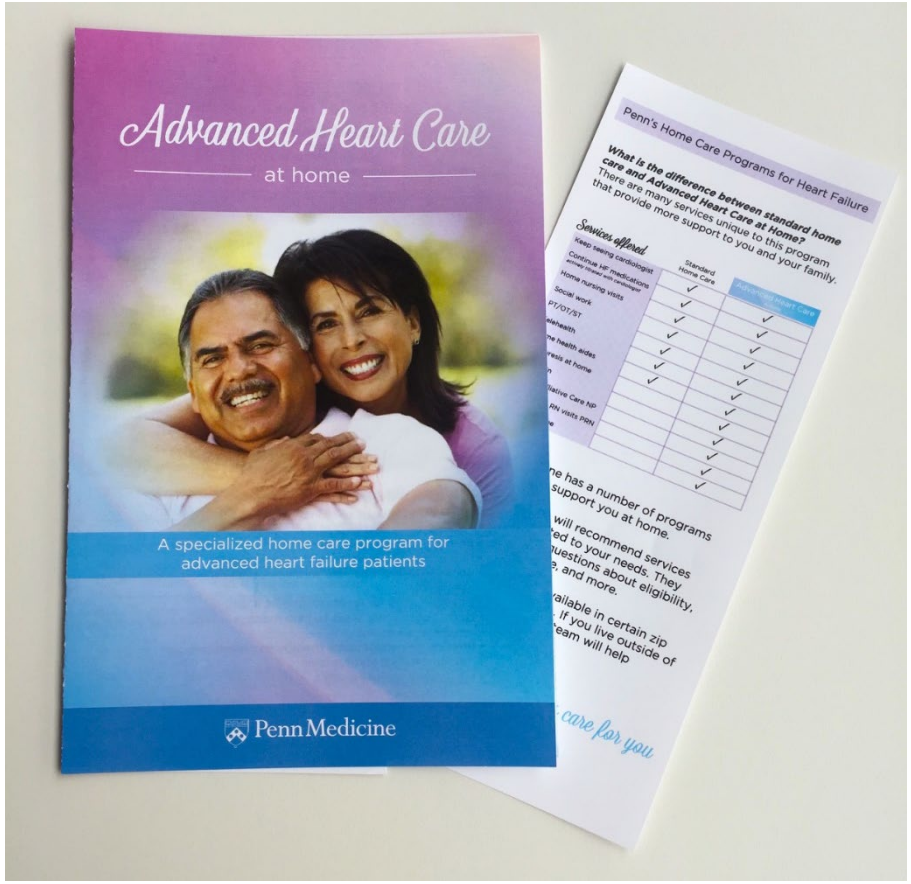
1. **Support cardiology care teams in referring appropriate patients to Advanced Heart Care at Home**

2. **Build a heart failure specific program within Caring Way and Penn Wissahickon Hospice**

Building a Shared Vision



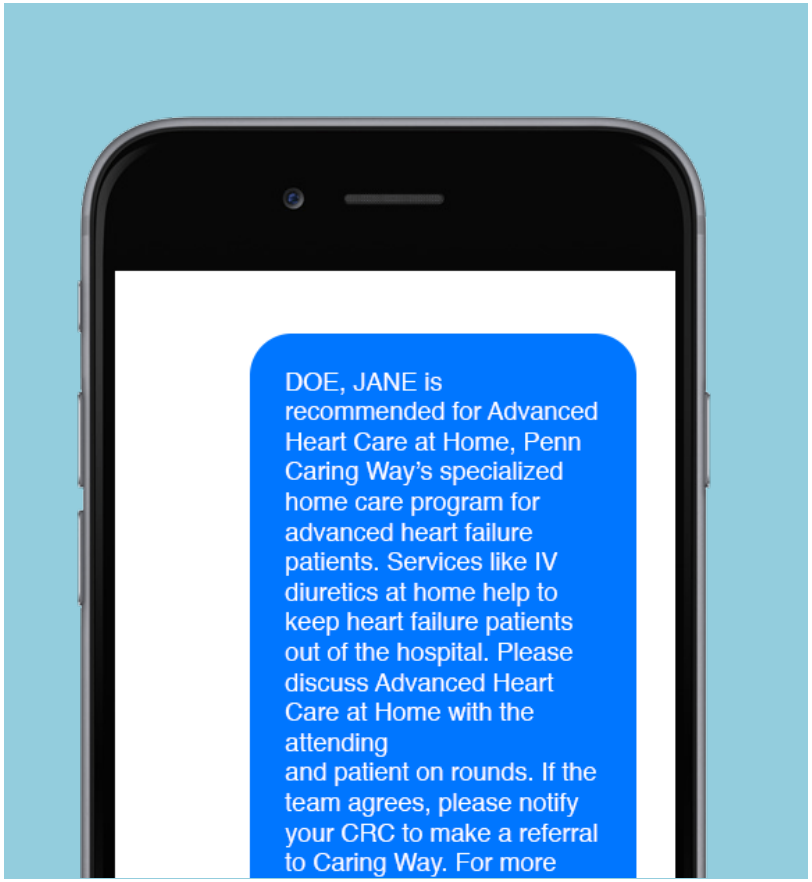
Advanced Heart Care at Home



Specialized Pathway Within Home Palliative Care and Hospice:

- Home nursing visits
- Heart failure meds & monitoring
- IV diuretics at home
- Palliative care NP visits
- Social work visits
- Support for family
- Telemedicine support
- Transitions to hospice at home

Nudging Referrals from Hospitals



Process

1. Identify inpatients using mortality risk score
2. Alert cardiology team using secure texting
3. Cardiology refers amenable patients

Early results

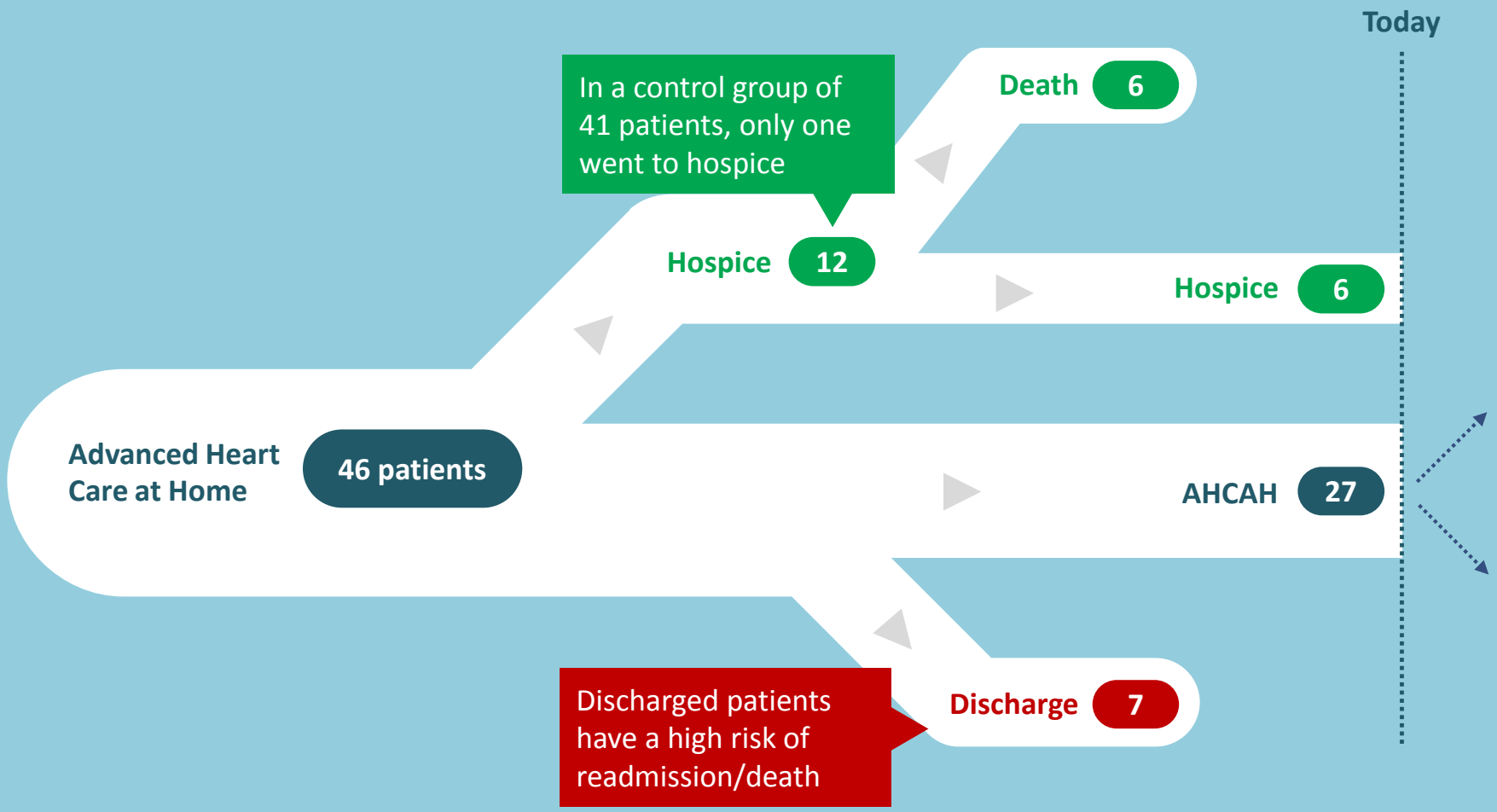
% HF inpatients referred to home palliative care:

0%
Baseline

▶

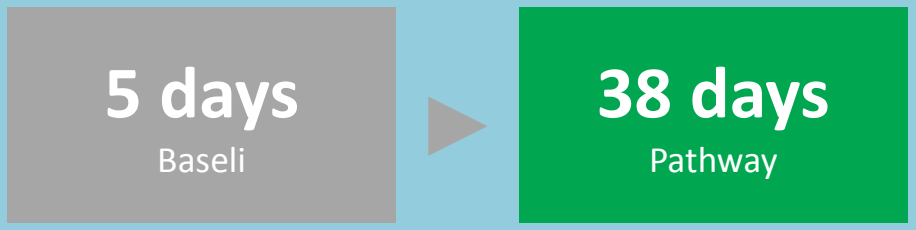
21%
Inpatient pilot

Early Pathway Outcomes

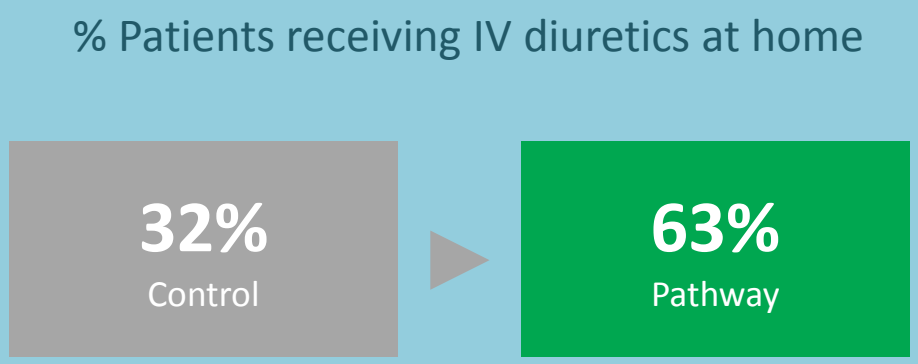


Early Pathway Outcomes

Average hospice LOS



Early Pathway Outcomes



Advanced Heart Care at Home: Next Steps

- **Randomized controlled trial to evaluated outcomes**
- **Discussions with payers – high level of interest**
- **Continued refinement of clinical pathway**
- **Ongoing heart failure education for front-line staff**

Potential to extend concepts to other progressive diseases:

Advanced Lung Disease

Hematologic Malignancy

End-Stage Liver Disease