Implementation of Home-Based Palliative Care with CRNPs

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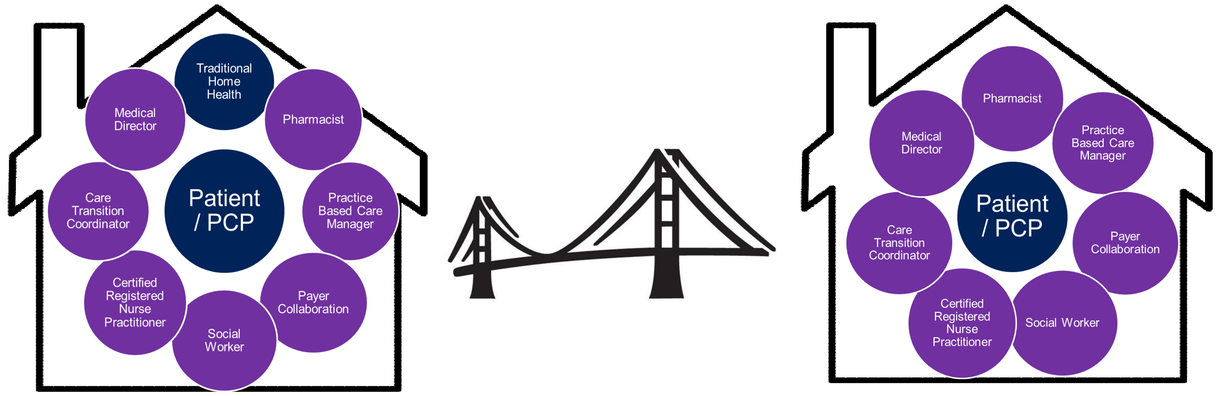
Payer Provider Collaboration

- Patient identification
- Resource allocation
- Education/Communication
- PCP participation
- Documentation
- Facilitation of information
- Patient engagement
- Measures of success
- Patient Satisfaction

Bridging the Gap



Home Transitions
(Enhanced Traditional Home Care)

Advanced Illness Care

As an Integrated Delivery and Financing System (IDFS), the University of Pittsburgh Medical Center (UPMC) and the UPMC Health Plan identified gaps in care provided to seriously ill patients at home including breakdown in communication across the health care team, limited scope of traditional home health services and inconsistent follow up for patients with serious chronic illness. A collaborative effort between the UPMC Palliative and Supportive Institute (PSI), the Health Plan and the system-owned home health agency was developed to support two new payer/provider models of care in community. At the core of both models is a palliative care trained CRNP who visits patients in the home and collaborates directly with the patient's Primary Care Physician to minimize the burden of serious chronic illness, establish a value-based plan of care, and prevent unnecessary emergency room visits or re-hospitalization. A "Home Transitions" program leverages resources available within the home health team and enhances services with the CRNP, a pharmacist, and medical director. The "Advanced Illness Care" program is designed to support patients with life-limiting illness/ poor prognosis and is provided by a CRNP and a team of specialty-trained clinical social workers.

Summary:

This payer provider collaboration has been in place for 12 months. During this time, we admitted approximately 1,500 patients into these program. We have completed approximately 1,600 home based CRNP and Social Worker visits for these two programs. Simultaneously, we maintained a comparison group of patients to compare the outcomes and this data that will include our identified measures of success and patient satisfaction. Identification of the appropriate patients for these enhanced services was developed by the collaborative team and also included a readmission risk score. The development of the assessment tools for the CRNP included enhanced medication reconciliation, in-home advanced assessments, early detection of changes in condition, and recommendations to enhance patient's plan of care and medical treatment in collaboration with the patients PCP. In addition, both the CRNPs and the SWs introduce Goals of Care conversation and Advance Care Planning, including POLST completion, where appropriate. The SW function has been highly successful and instrumental in this program with a focus on the social economical needs for these patients.