HomeCare Program Delivers Coordinated Care to High Risk Patients at Home

HealthCare Partners Medical Group, Torrance, California

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HealthCare Partners believed that high risk patients could have better medical outcomes if cared for in a home setting using an interdisciplinary team approach that focuses on both the patient and his/her family and caregivers.

Case Study: HomeCare Program Delivers Coordinated Care to High Risk Patients at Home

To better care for its highest risk patients, HealthCare Partners Medical Group implemented a HomeCare Program in 2008. The program uses an interdisciplinary team approach to provide coordinated care to patients, with a focus on including the patient's family and caregivers. The goal of the program is to improve the quality of life and clinical outcomes for homebound and other high risk patients.

Patients are referred into the HomeCare Program by our primary care physicians, hospitalists, and specialists. To identify the initial group of patients to be seen as part of the HomeCare Program, HealthCare Partners also used a health plan stratification tool. The target population may not always be physically homebound, but may have complex psycho-social needs that require in-home management.

Services and goals of the HomeCare Program may include acute medical management after a hospitalization or skilled nursing facility stay, management of chronic medical conditions, assistance with complex social situations, advanced care planning, and a change in living arrangements for some patients.

The program's current staffing model includes two physicians, two nurse practitioners, one social worker, and two medical assistants to manage a panel of approximately 360-400 patients. A clinician initially sees each patient for a 90-minute consultation, and then the patient is seen monthly on a routine basis, and urgently as needed. Patients, families, and referring physicians are given 24/7 direct telephone access to the HomeCare team.

Clinicians are able to complete medical record documentation in the patient's home using a laptop with a wireless connection to our Electronic Medical Record system. The HomeCare team holds weekly meetings to review patient status, treatment, and progress, and to determine follow-up needs. Pharmacists, geriatricians, and behavioral health providers participate in the team meetings as needed.

To maximize the effectiveness of the HomeCare Program, the HomeCare team continues to work closely with the patients' primary care physicians, specialists, and hospitalist teams. The HomeCare team has access to a rich database of claims, pharmacy, and electronic

medical record data, which provides point-of-care evidence-based reminders for preventive and chronic care needs to enhance the clinical outcome for these high risk patients.

The program's success is measured on such dimensions as patient satisfaction, chronic disease measures (e.g., LDL, HbA1C, blood pressure, acute hospital admits, acute hospital days, ER visits, Urgent Care visits, and PCP visits), and overall cost of care compared to a control population.

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