A Clinical Pathway Providing Personalized Care Coordination for Socially at-Risk Patients with Multiple Chronic Conditions

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BACKGROUND

- Penn Presbyterian Medical Center "Presby" is the primary provider and safety-net hospital for a large swath of the city's most socially vulnerable residents. Medicaid patients at Presby, who only account for 20% of Presby Medicine Service admissions, represent 45% of patients with one readmission and 64% of patients with two or more 30-day readmissions. Most notably, only 26% of Medicaid patients were discharged with home health services, with the majority of patients being discharged with no additional services.

PURPOSE

- To develop an innovative clinical pathway to improve the care of socially at-risk patients with multiple chronic comorbidities admitted to the Penn Presbyterian Medical Center.

METHODS

- Using **design thinking principles**, our workgroup gathered **contextual insights** from patients, clinicians, and hospital executives using one on one interviews, focus groups and observations/ shadowing to identify areas of potential intervention.
- EHR-derived data from the Penn Data Store (August-October 2017) and **machine learning techniques** were used to determine a profile of patients at high risk of readmission.to Medicine Services.

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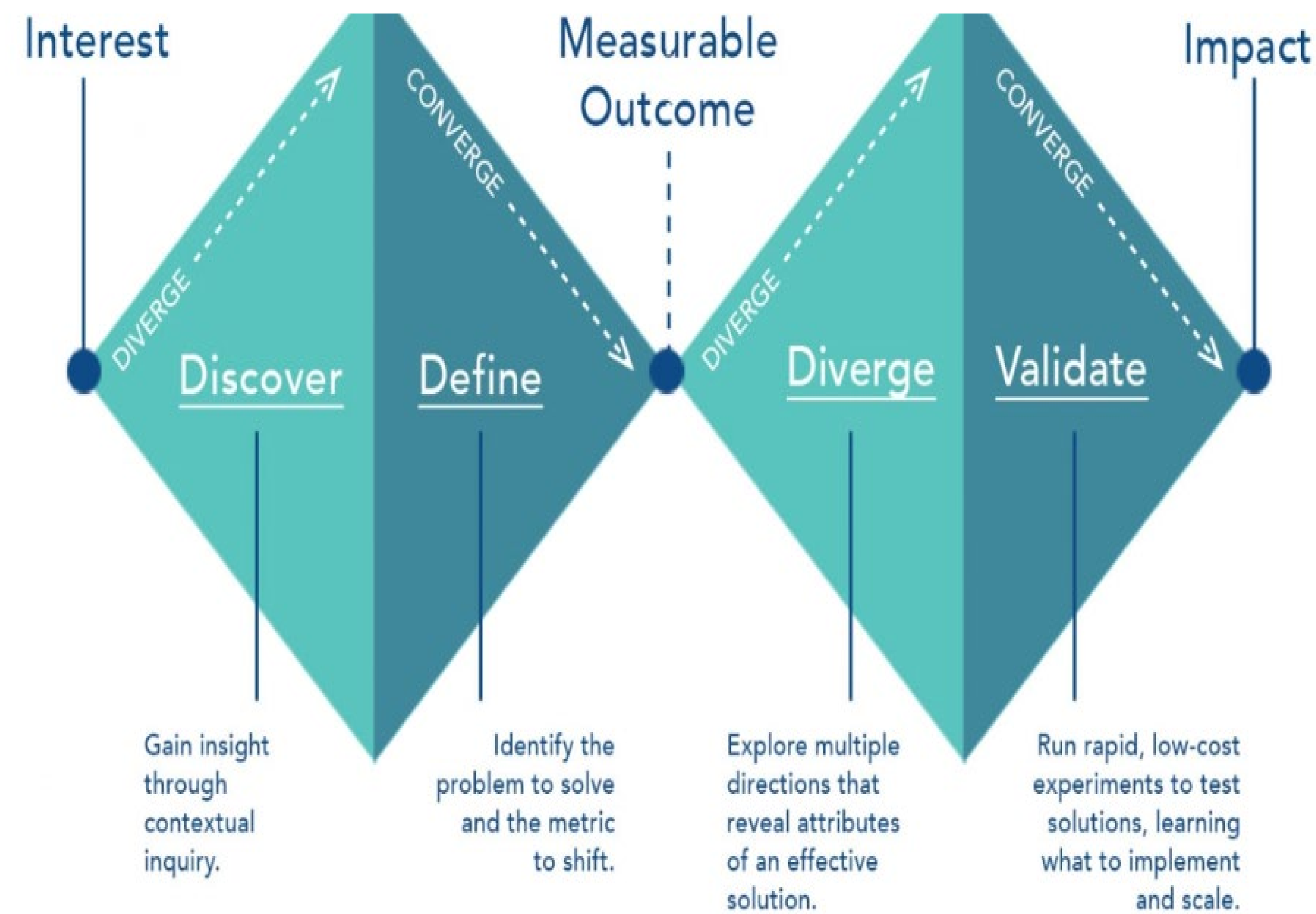
RESULTS



Characteristic	Total Sample (n=2,165)	0-1 Readmits (n=2,075)	Multiple Readmits (n=90)
Age, mean (SD)	63.6 (17.4)	63.7 (17.4)	61.5 (16.8)
Male, n (%)	1,065 (49.2)	1,018 (49.1)	47 (52.2)
Black, n (%)	1,375 (67.8)	1,293 (66.5)	82 (96.5) ***
Reside in West Philly, n (%)	997 (46.1)	939 (45.3)	58 (64.4) ***
Married, n (%)	681 (31.5)	671 (32.3)	10 (11.1) ***
Payer, n (%)			
Medicare	1,235 (58.0)	1,204 (59.0)	31 (34.4) ***
Medicaid	**519 (24.4)**	**461 (22.6)**	**58 (64.4) *****
Commercial	376 (17.7)	375 (18.4)	1 (1.1) ***
Comorbidities, mean (SD)	**5.3 (3.0)**	**5.2 (3.0)**	**8.5 (3.0) *****
ED Visits, mean (SD)	**2.7 (3.3)**	**0.5 (1.2)**	**3.7 (4.6) *****

How does THRIVE work?

01. COORDINATION

Your healthcare team begins developing your treatment plan upon admission and supports your return home.

02. TRANSITION

Your discharging physician will continue to supervise your care until you see your primary care provider.

03. COACH

A trained home care nurse will serve as your personal health coach walking you through your post-discharge plan of care.

IMPLICATIONS

- Using what we learned during the **discover** and **define** phases, we developed the **THRIVE** clinical pathway targeting Medicaid patients with multiple chronic conditions living in West Philadelphia.
- Rapid cycle testing of the **THRIVE** pathway will begin at Presby (4 South) during Spring 2019.
- Metrics to evaluate: reductions in readmissions, decreased time to PCP, improved communication between health care providers, improved continuity of care.

FUNDING

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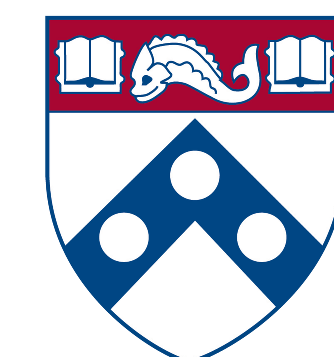

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