

# Geisinger at Home

## Program Growth Discussion

**Geisinger**

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# Population Health at Geisinger



**1980's**  
**Utilization  
Management**



**1992 - 2011**  
**Disease  
Management**

- Tobacco Cessation
- Asthma
- DM, HTN, CAD
- COPD, HF
- Case Management



**2005-2006**

- Proven Care®
- ProvenHealth Navigator®
- Case Managers in Primary Care Practices



**2007-2010**

- SNF redesign
- Telehealth for HF & TOC



**2013**  
**Special Needs  
Unit**

- Behavioral Health
- MSWs
- Community Health
- Women's & Pediatric CM



**2015-2016**  
**Embedded CM  
in Specialty  
Practice**

- Nephrology
- Cardiology
- Pulmonary
- Emergency Departments
- Biologic Care Pathways
- Community Paramedicine Program

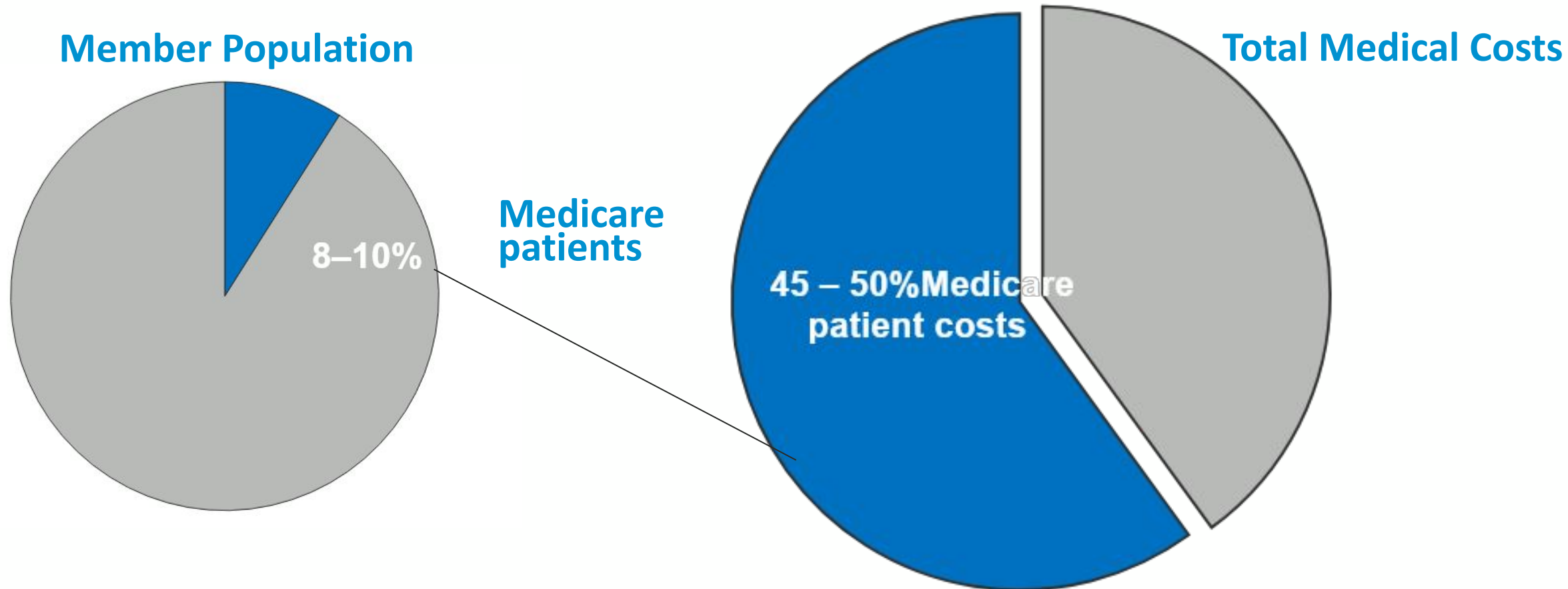


**2018-2019**  
**Primary Care  
Redesign**

- Geisinger at Home
- Community Palliative Care
- In-home Video Connectivity
- 65Forward

# Cost of Care

Small percentage of population drives largest spend in care



# Geisinger at Home Vision



To improve quality and decrease total cost of care by delivering team-based comprehensive and acute care in the home for Geisinger Health Plan's most complex members

# Creating a Care Model in our Communities

*Supporting those with serious & significant health conditions*



## Geisinger at Home

### *Coordinated Medical Care*

- Comprehensive assessment of disease burden
- Condition optimization & management
- Close coordination

### *Integrated Social & BH*

- Social determinants of health
- Behavioral health

### *Acute Care*

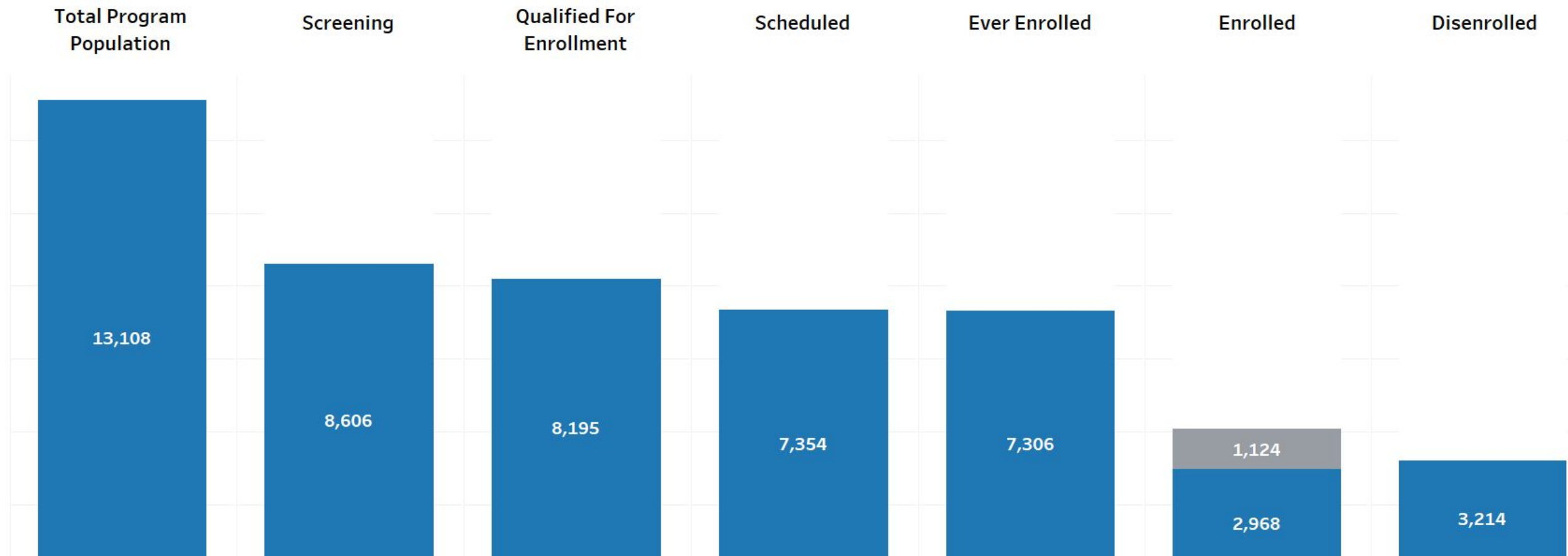
- Mobile paramedics
- Case Management
- Home Health

### *Advanced Illness*

- Plan of care
- Symptom management
- Palliative care
- Timely transition to hospice

## Geisinger at Home Progression

Data as of: August 3, 2020



# 2020 Areas of Focus



## Improve Quality

Ensure the delivery of high-quality care and continue to decrease unnecessary utilization. Particular emphasis on acute exacerbation and advancing illness



## Manage the Population

Increase the enrollments into Geisinger at Home to ensure we are managing enough of the population to see an impact



## Operational Excellence

Continue to innovate and adapt model of care to drive efficiency and economic sustainability

# Leveraging telehealth tools

- CHA does home visit in place of licensed staff
- Connects to our “Remote Medical Collaborator”
- High patient and provider satisfaction
- Some connectivity issues in rural areas
- Early use for acute care as well
- Use of peripherals to enhance visit impact





# Tele-Health Models



About 20% of all provider visits are done via telehealth

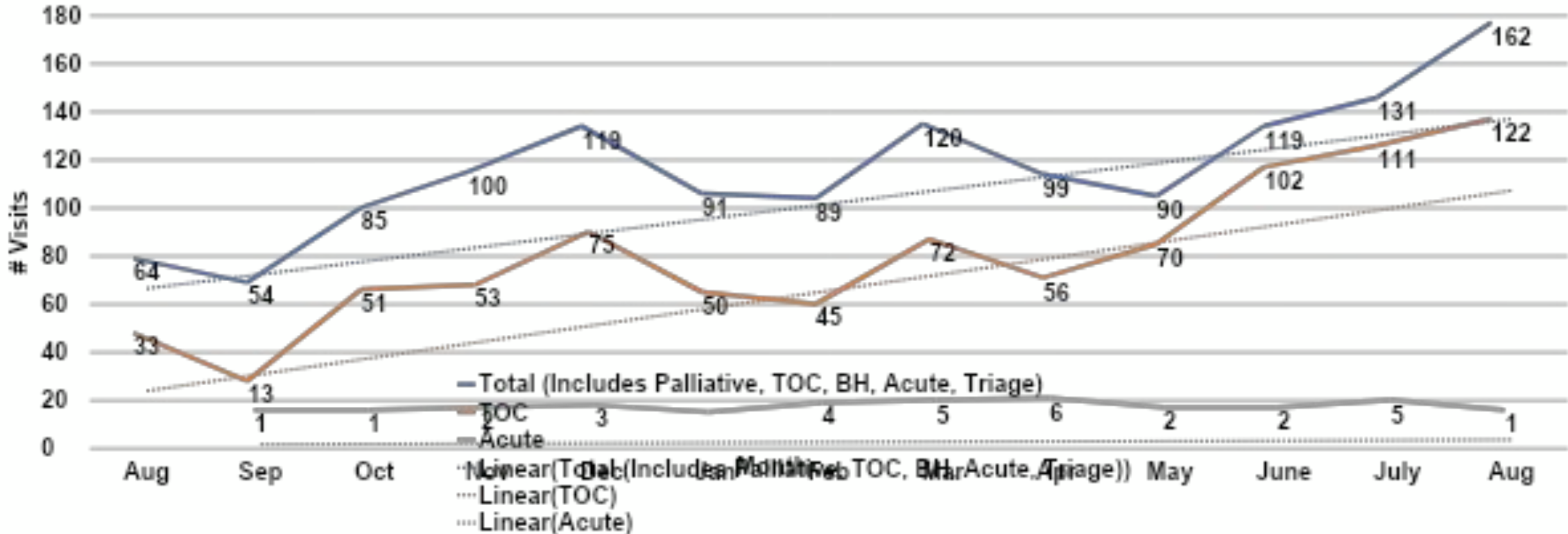
45% of all Physician visits are done via telehealth

- Transition of Care
- Palliative Tele-Health
- Behavioral Health
- Tele-Triage
- Tele-Nutrition ( September 2020)

# Geisinger at Home Telehealth Volumes

Geisinger at Home Telehealth Program Overview (Monthly)	2019					2020							
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Total (Includes Palliative, TOC, BH, Acute, Triage)	64	54	85	100	119	91	89	120	99	90	119	131	162
TOC	33	13	51	53	75	50	45	72	56	70	102	111	122
Acute		1	1	2	3	0	4	5	6	2	2	5	1

GaH Telehealth Program Overview: August 2019 - August 2020



# Provider Visits

GaH provider visits conducted using Telehealth September 2019 to July 2020

Including RMDs, PA-C, and Pharmacists

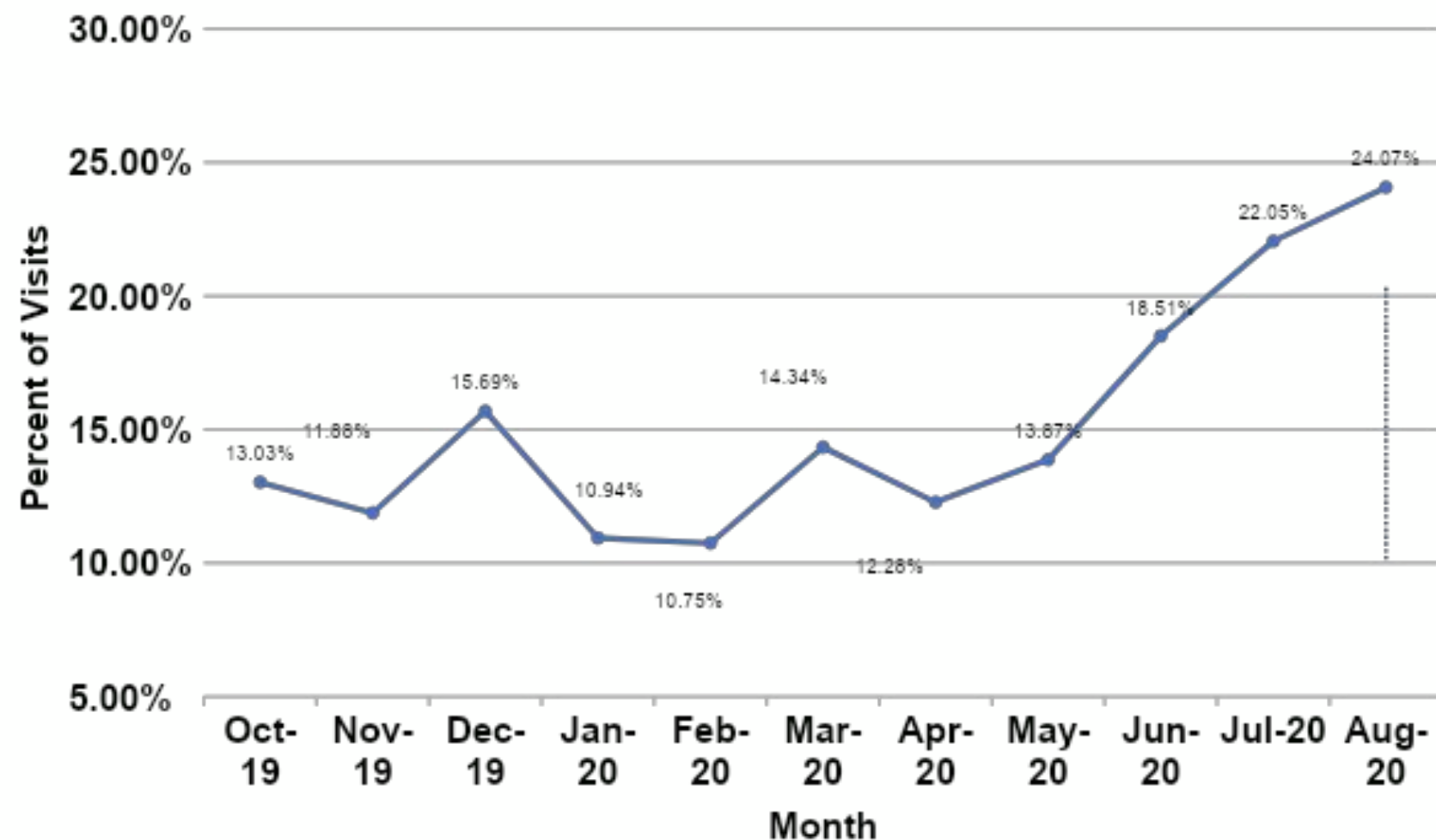
This data set does not include Behavioral Health Visits

Month	GaH Home Visits	GaH Telemedicine Visits	Percent
Sep-19	369	22	5.96%
Oct-19	399	52	13.03%
Nov-19	463	55	11.88%
Dec-19	497	78	15.69%
Jan-20	457	50	10.94%
Feb-20	456	49	10.75%
Mar-20	537	77	14.34%
Apr-20	505	62	12.28%
May-20	519	72	13.87%
Jun-20	562	104	18.51%
Jul-20	526	116	22.05%
Aug-20	511	123	24.07%

# Telehealth Utilization

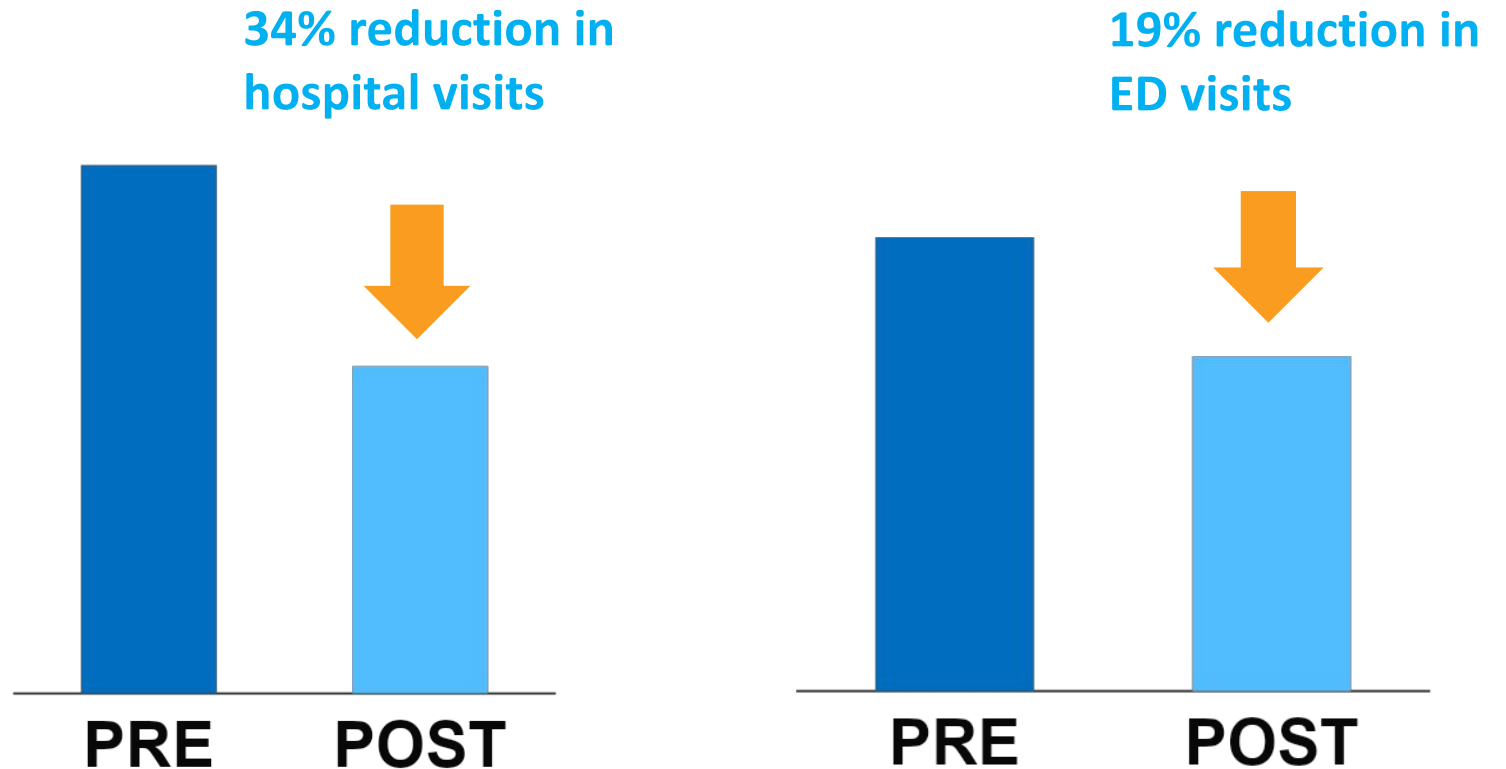
*Geisinger at Home*

Percent of GaH Provider Visits Completed Using Telehealth



# We have enrolled more than 7000 total patients in our model

- More satisfied patients
- More coordinated care
- Lower utilization



# Future Focus

- Propensity matched analysis
- Drive efficiency in the model
  - Enrollment, optimizing the travel, etc.
- “Dosing” the intervention
  - Who, how much and when
- Hospital at Home
  - Very focused on 3 – 5 day admissions
  - Often not the top 5 – 8%