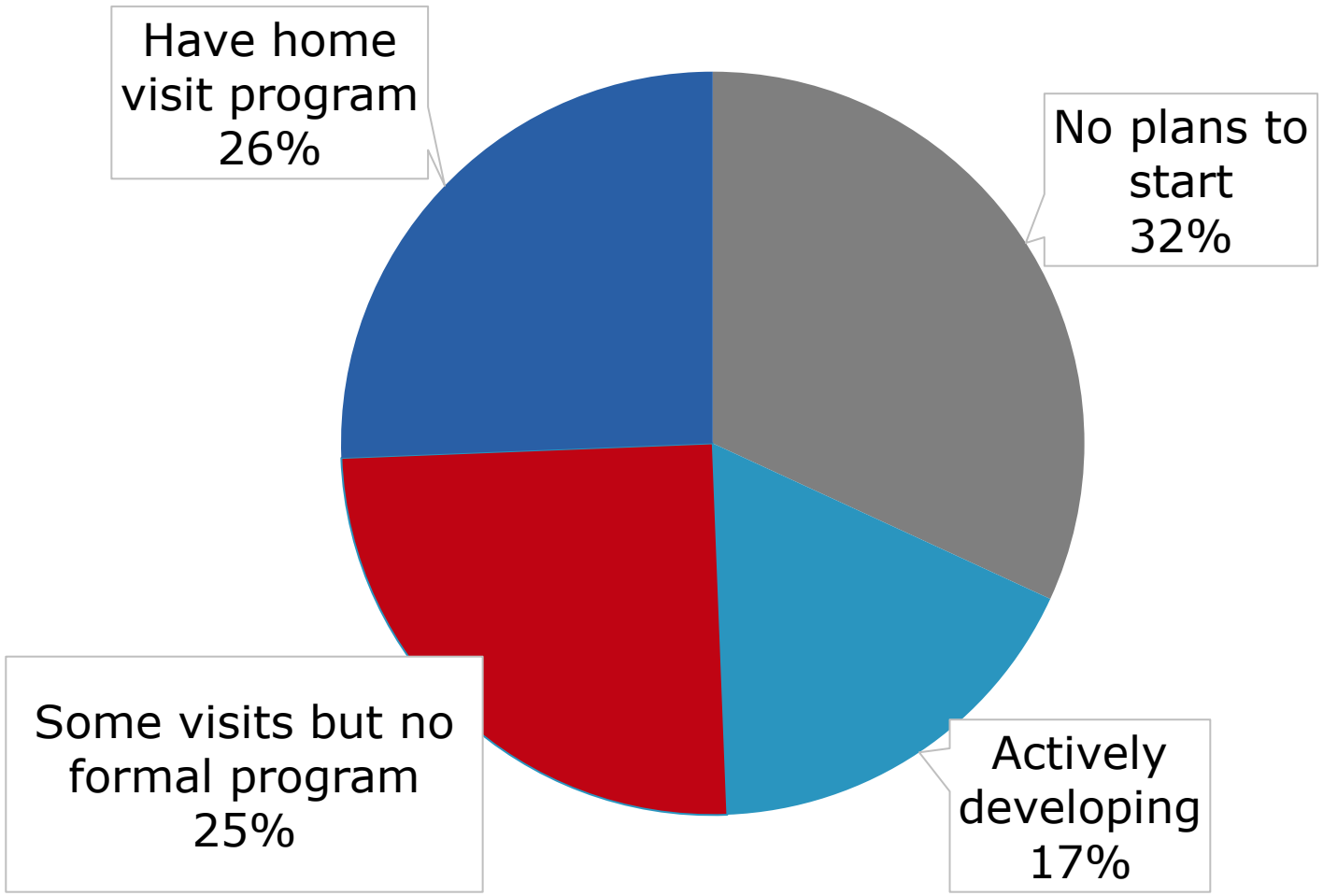
Care in the Home
Healthcare's Next Frontier

Robert Mechanic, MBA

National Association of ACOs
Spring Conference

June 17, 2022

Does Your ACO Have a Home-Based Care Program? (n=163)



Source: NAACOS/IAC Home Visit Survey

NAACOS/IAC Home Visit Learning Collaborative

abacus HEALTH
healthcare you can count on.

BUENA VIDA Y SALUD (ACO)
GOOD LIFE & HEALTH

CONNECTED CARE
OF MIDDLE TENNESSEE

CCPM COMMUNITY CARE PARTNERSHIP OF MAINE

CHESS

MaineHealth

MISSION HEALTH PARTNERS

ORLANDO HEALTH®

Scripps

BJC Accountable Care Organization

SUMMIT MEDICAL GROUP

UnityPoint Health

Today's Panel

Bruce Leff, MD
Professor of Medicine
Johns Hopkins University
School of Public Health

Diane Schultz, DNP, MSN
Director of Operations
Care at Home & Hospital to Home
Unity Point Health System (IA)

Susan Erickson, RN
AVP of Care Management
Scripps Health Care System
San Diego, CA

Amina Ahmed, MD
CMO, CareOne
Former Chief of Hospital Medicine
Summit Medical Group (NJ)

Care in the Home: Health Care's Next Frontier

Home-Based Care Landscape

Bruce Leff, MD
Professor of Medicine
Johns Hopkins University Schools of Medicine

NAACOS Conference

Baltimore, MD
June 17, 2020

Home-Based Medical Care Will Be Mainstreamed into the US Healthcare Delivery System

ACP Observer
American College of Physicians News for Internists www.acponline.org

Seeing Patients as People: Why I'm a Home Care Physician

By Bruce Leff, ACP Associate

Mental Map of Home-Based Care

Informal Services	Formal Personal Care Services	Skilled Home Health Care	Home-Based Primary Care	Hospital at Home
10–15M	**2M**	**3.4M**	**500K**	**5K**

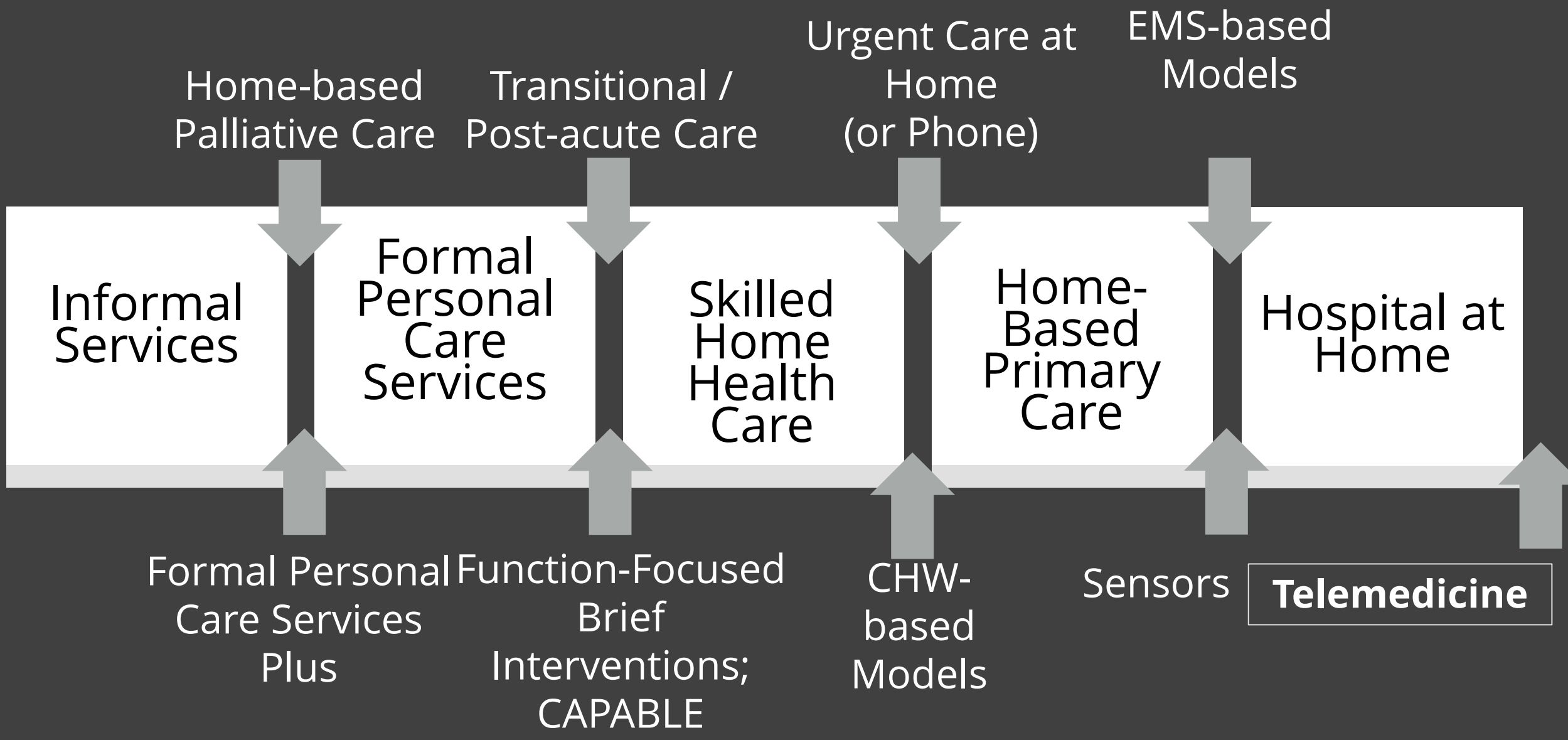
Low Acuity → High Acuity

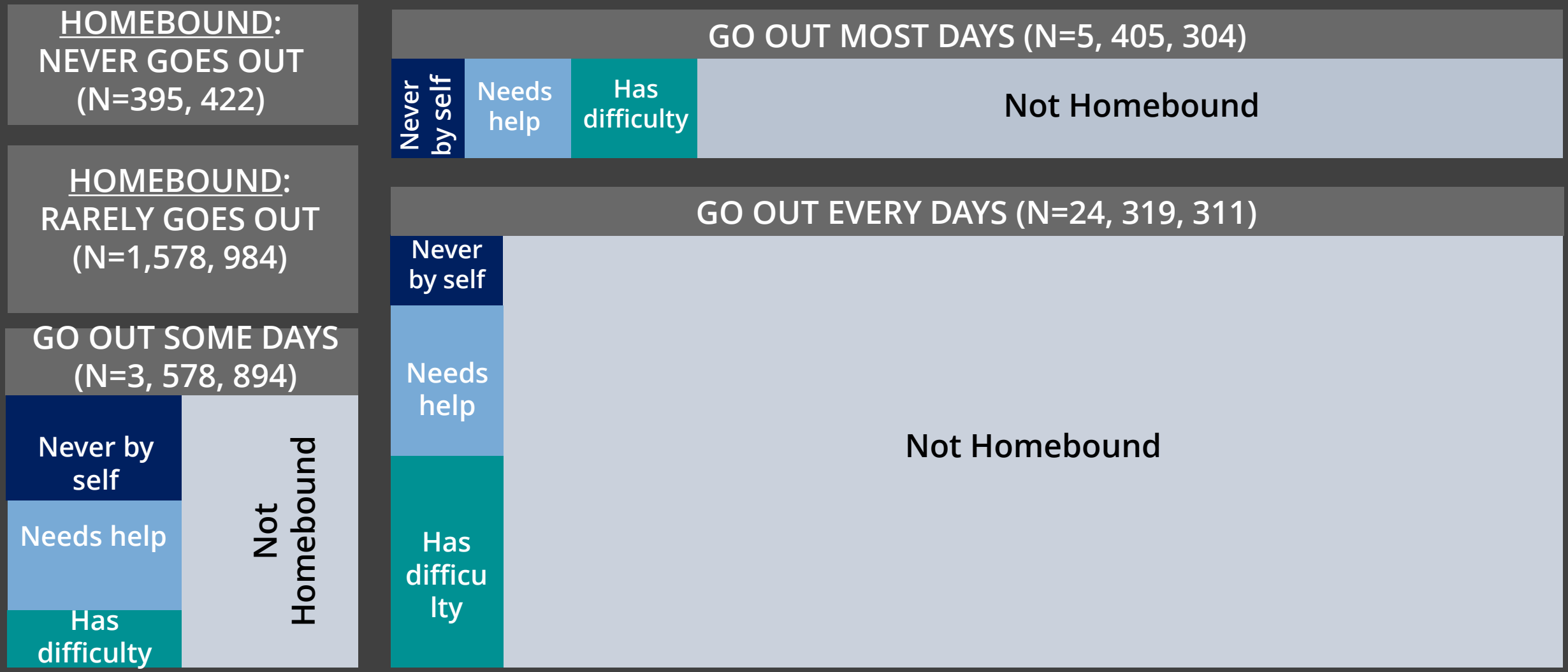
Chronic Care → Acute Care

Little or No MD Involvement → High Level MD Involvement

IOM Workshop: The Future of Home Health Care, 2015

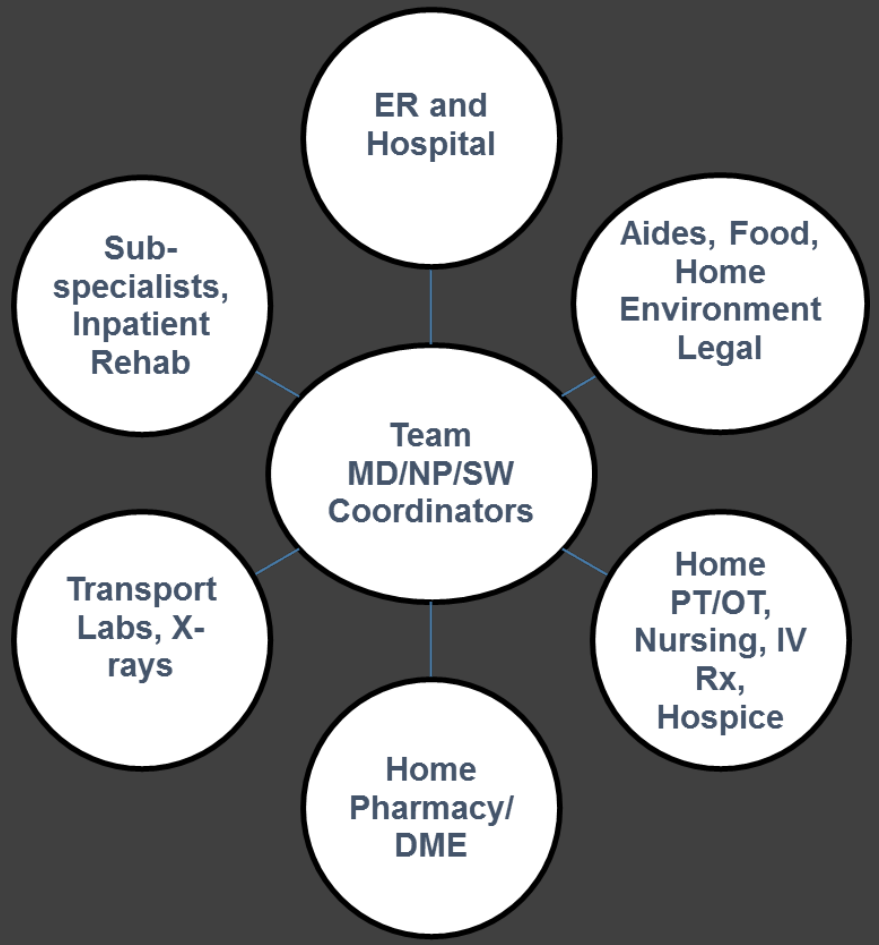
The Field is Expanding + Being Disrupted



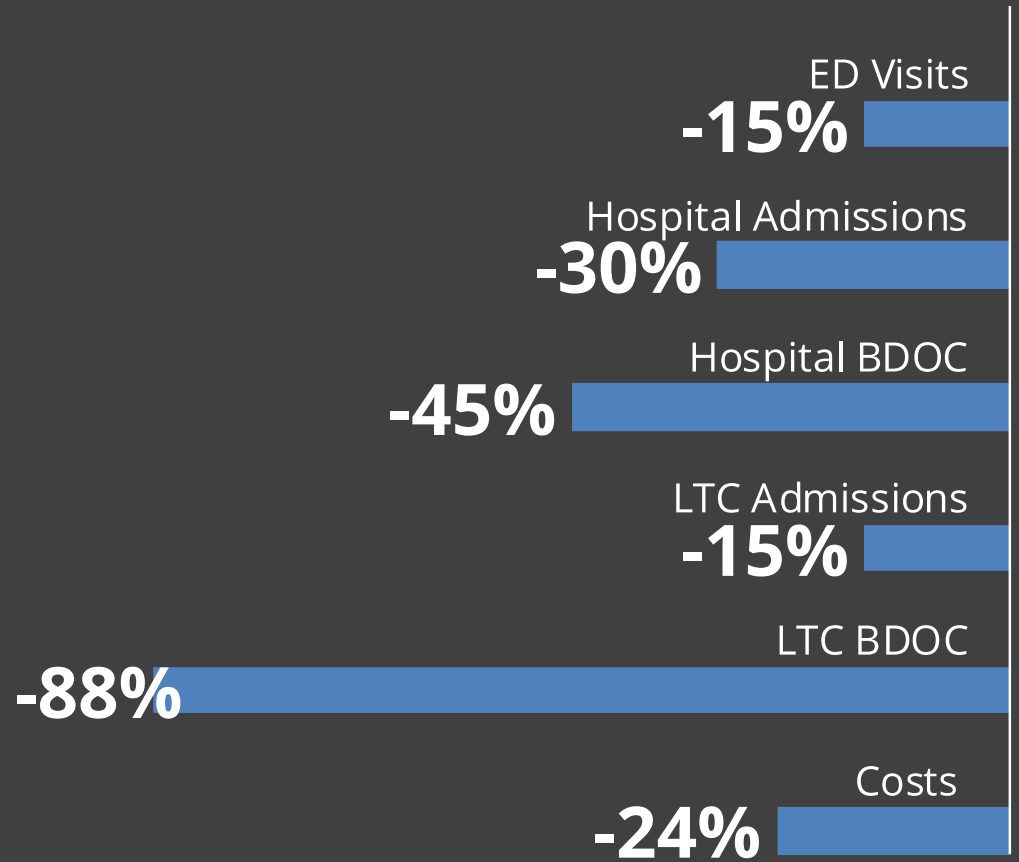


JAMA Intern Med. 2015;175(7):1180-6.

Home-Based Primary Care



Outcomes from Home-Based Primary Care for Homebound Older Adults

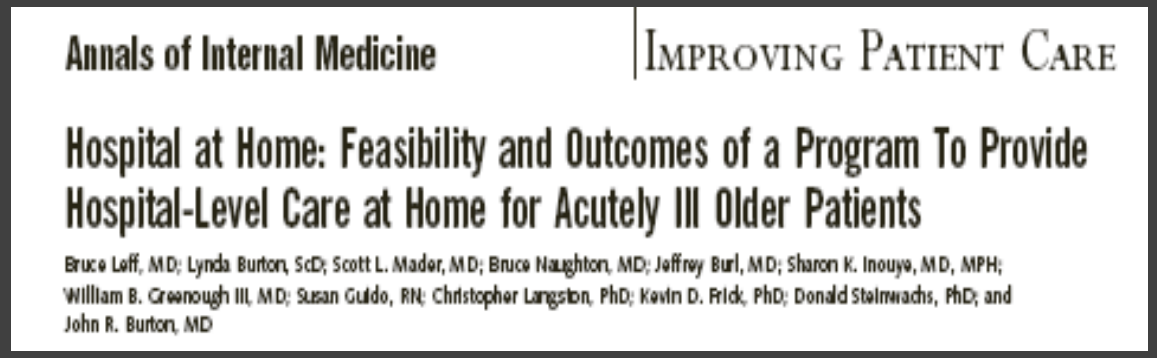


Core components:

- IDTs that meet regularly
- After-hours support

Satisfaction and caregiver QOL better

JAGS 2014;62:2243



Annals of Internal Medicine | Improving Patient Care

Hospital at Home: Feasibility and Outcomes of a Program To Provide Hospital-Level Care at Home for Acutely Ill Older Patients

Bruce Leff, MD; Lynda Burton, ScD; Scott L. Mader, MD; Bruce Naughton, MD; Jeffrey Burl, MD; Sharon K. Inouye, MD, MPH; William B. Greenough III, MD; Susan Guido, RN; Christopher Langston, PhD; Kevin D. Frick, PhD; Donald Steinwachs, PhD; and John R. Burton, MD

- 61% chose HAH care
- High-quality care
- Fewer complications
- Better patient /family experience
- Lower costs of care
- Less CG stress
- Better function
- High provider satisfaction

HaH Meta-Analysis

- **21% Reduction in Mortality NNT=50**
- **24% Reduction in Readmissions**

HaH CMMI Demonstration

Multiple HaH Service Lines

Issues to Consider in Adopting Home-Based Care Model

- What is the problem you are trying to solve?
  - Hospital capacity issues / avoidance of capital construction
  - High costs of care for at-risk populations
  - Want to provide better care
  - Staying in business in a pandemic
  - Other?

- Other major considerations
  - Organizational culture
  - A way to make it financially viable
  - Do you have or can you buy or collaborate with the providers you need to do this?

When Care Delivery Models Are Effective They Line Up 3 Things…

Targeted Population

Care Model

Outcome

- USMM - #4 ACO 2018

Leadership, Backwards Bicycles, and Culture Change

With Leadership and Culture Change…

Can Mount Sinai be serious? The answer is a resounding yes. In fact, we couldn't be more serious.

Mount Sinai's number one mission is to keep people out of the hospital. We're focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside of the traditional hospital setting.

Thus the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners, registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as problems with medication management and provide continuing support after discharge.

It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

1-800-MD-SINAI
mountsinai.org/myhealth

Mount Sinai

IF OUR BEDS

ARE FILLED,

IT MEANS WE'VE FAILED.

New York Times, 2015-present

Scripps Home Based Care Program

June 17, 2020

Susan Erickson RN, MPH
AVP Care Management
Scripps Health Care System
San Diego, CA 92121

Scripps Health Care System

Integrated health system in San Diego, CA

- Not-for-Profit
- 5 Hospitals / 2 Trauma Centers / 4 EDs
- 26+ Clinics/UCC/Health Express Centers
- Knox Keene License / Health Plan
- 15,000 Employees
- 3,000 Affiliated Physicians

~ 250,000 Value Based Lives

- 42,000 MSSP ACO
- 150,000 Health Plan (MA Senior, Commercial, IPA)
- 14,000 Qualcomm Premier ACO
- 40,000 Commercial ACO

Hospital System  **Population Mgmt**

Scripps Home Based Care

Objective: Provide home based care services to vulnerable, high cost/utilization patients who are not well established with their PCP or who need short term in home primary care

Goal: Improve care, lower costs, enhance patient experience, transition from HBC to most appropriate care environment

Services: Primary care, palliative care, care coordination, psycho-social support, home care (aid) support and referral to community services

Patient Participation: ~ 6 months (longer as needed) then transition back to their PCP, to hospice or other disposition as appropriate

Patient Identification: Analytics + provider referral

Target Population: Significant medical conditions; history of ED/UCC utilizations or IP admissions; Not well established with their PCP or difficulty getting to Scripps facilities for care; care gap / risk score opportunities

Scripps Home Based Care Program

Phase1 Pilot:

- 30 Medicare Advantage Members
- September 2019 - February 2020
- Model: MD + RN Care Managers
- Provider costs paid by health plan per contract
- Current enrollment = 79 patients / 120 since program start
- Disposition: 26 Hospice;18 back to PCP; 6 deceased

Lessons Learned

- RN care not reimbursable
- Too many cooks in model
- EPIC access critical
- Need to scale to get efficiencies

Phase 2 Expansion:

- 200 MSSP ACO + 200 Medicare Advantage
- April 2020 to present
- Model: MD + Nurse Practitioner
- PMPM paid by ACO/Health Plan
- Revenue offset for ACO
- RAF/HCC score pick up for Health Plan
- Current enrollment 60 ACO / 75 since program start
- MA enrollment in new model pending completion of contract

Lesson Learned

- Critical to engage physicians upfront
- Physicians need to trust HBC physicians
- Need flexible model in COVID times

All Payer Patient Enrollment HBC = 194 Current / 367 since start 9/19

Scripps Home Based Care Program Flow

Identify + Engage	Prep	Enrollment Initial Visit	Ongoing Care
Identify patient per analytics / provider referral Chart review to determine fit with program Outreach to explain program, engage, schedule initial visit Notify PCP via EPIC in basket + Good Med MD outreach to PCP	Advance Practice Pharmacist med review and recommendations Med Rec Tech updates med list Clinical Documentation team chart review and suggestions re: closing gaps in care MD / NP review	MD + *Med Tech* initial visit Determine patient issues/concerns Assess Med Reconciliation Goals of care discussion, POLST Review plan Med tech coordinates f/u services	Follow up visits by NP – biweekly till patient stabilized then 1+ / month SW referral for home or telephonic visit 24/7 patient call line Daily 30 minute team huddle – problems/issues; new patients Weekly IDT conference

Scripps Home Based Care Metrics

HOME BASED CARE	Source
Patient Identification (Analytics / Referral)	Analytics – Med Insight Referral - PRN
Enrollment (Initial home visit completed)	Program Tracker
Engagement Rate / Decline Reasons	Program Tracker
Duration in Program	Program Tracker
Utilization and Cost : (6 months pre/post program) • **ED** • **Hospital** • **Total Spend**	Pre/Post - Data Scientists Matched Controls - Data Scientists / TBD
Advance Care Planning • **Goals of Care / POLST Completed**	Documentation in EHR
Quality Gap Closure / HCC Score	MA/ACO Quality Data RAF Scores (MA)
Disposition (Discharge Date) • **Back to PCP – Hospice – Death - Other**	Program Tracker
Satisfaction (Tools TBD) • **Patient** • **Provider**	**TBD**

UnityPoint at Home UnityPoint Clinic UnityPoint Health

UnityPoint - One Team Care at Home Services

2020 Overview

Amid a COVID New Normal

6.17.20 NAACOS National Conference

2020 Care at Home Services Aim

- Develop proactive ambulatory-based, alternative care options to reduce our patients' need for ED & hospital utilization

- Deliver improved quality (safety), experience, & economic outcomes through innovative home-based care services.

Care at Home Suite of Services

Hospital to Home (2-hour response time): Home-based hospital acuity care model for qualified patients to avert need for hospital facility care

Primary Care at Home (4-hour response time): Home-based urgent care model for qualified patients to avert their need for ED facility care

30-60 Day Ambulatory Care Bundles: Integrated, interdisciplinary home-based model to provide proactive, urgent and interventional response to manage acute events for qualified patients.

Waiver Services:

- Care Management Home Visits (CMHV) – NGACO Benefit Enhancement
- Post Discharge Home Visits (PDHVs) – NGACO Benefit Enhancement
- Care at Home / Hospital to Home Waiver (UnityPoint ACO-Specific Waiver)

Care at Home (CaH) Outcomes:

QI Intervention: Introduced 30-Day Ambulatory Care Bundle on October 1st 2019			
	Outcome Target	HTH Baseline Pre-intervention	HTH with 30-Day Bundle (Post-Intervention)
Months of Service		9/18 – 9/19	10/19 – 04/20
Number of patients served		59	36
7-Day ED Escalation Rate	≤ 10%	8.5%	0.0%
7-Day Hospital Admit Escalation Rate	≤ 10%	6.8%	0.0%
30-Day ED Escalation Rate	≤ 15%	27.1%	3.0%
30-Day Hospital Admit Escalation Rate	≤ 13%	22.0%	3.0%

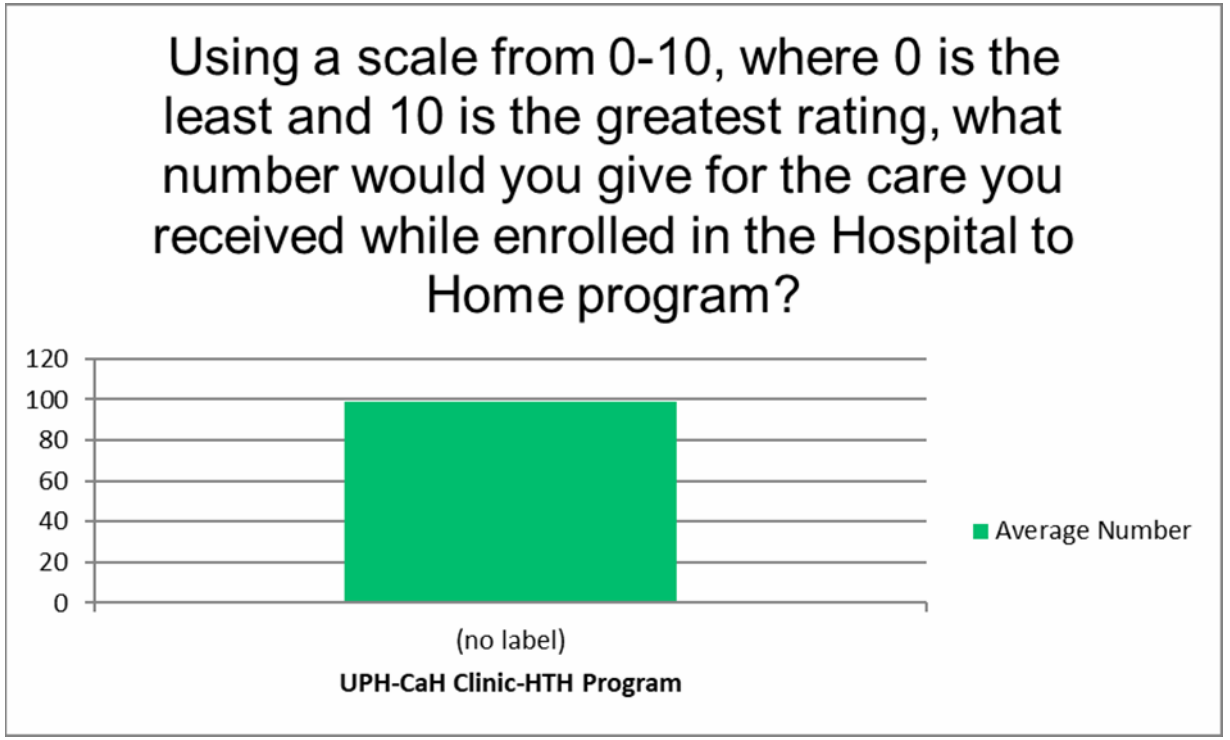
Data Source: UPH Analytics Report-April 2020 / Todd Richard VP Pt Access

Hospital to Home Patient Experience
99.05% Top Rating

- Patients Served (N=95)
- Survey Response Rate: 44%; Target ≥ 30%

PX Survey Design & Process developed by UPH PX Team

Data as of 05.31.20



Care at Home: 2020 Priorities Amidst a COVID-Driven New Normal

- Continue to support the safety & well being of patients & team
- Return to normal operations – our new normal
- Rebuild Care at Home / Hospital to Home Patient Volume
- Resume Care at Home Systemwide Rollout:
  - CMHV/PDHV Services in Peoria & Fort Dodge Regions
  - PCaH & 30-Day Bundle Services in CR, QC, & WL
  - SNFaH Pilot implementation in CI Region

Discussion and Questions