Alliance for Home Health Quality and Innovation

CMMI Innovation Advisor Erin Denholm, Centura Health at Home:

Challenging Chronic Disease Through Telehealth

***Erin Denholm, of Centura Health at Home**, joins the Alliance for a discussion of her work with the Center for Medicare and Medicaid Innovation's Innovation Advisors Program. The goal of the Innovation Advisors Program is to improve healthcare delivery for Medicare, Medicaid and CHIP beneficiaries.*

Ms. Denholm, who serves as the Chief Executive Officer for Centura Health at Home, is a nationally recognized leader in the post-acute care space. Her work focuses on improving long-term chronic care management through the efficient use of health technologies. In addition to her work at Centura Health at Home, Ms. Denholm is a Robert Wood Johnson Nurse Executive Fellow. As a nurse, Ms. Denholm understands patient needs and brings a practitioner's passion to her field – passion that is illustrated through her additional work, such as her successful campaign for Colorado to be the first state to provide Medicaid funding for telehealth services.

We sat down with Erin to learn more about her project and to get her perspective on the role of home care in current health care delivery system reforms.

What is your role in health system reform as an Innovation Advisor and what contribution will your program make to the home care community?

First and foremost, I see my role as an opportunity to influence the Centers for Medicare & Medicaid Services' (CMS) view of home care's value proposition. As an advisor, I can really educate CMS about the total cost of care, rather than the traditional view of home care that looks at separate health care sectors and their utilizations. Home care is so cost-effective compared to others and the care provided is substitutive, instead of additive.

I believe that the Centers for Medicare & Medicaid Innovation (CMMI) understand the value proposition for home care. When you look at all the Innovation Advisors selected for the Innovation Advisors Program, at least 10 percent of the cohorts are in home care. I am very encouraged by that, not only this opportunity, but also the long-term opportunities this program creates for home care. It seems that CMS has every intention of keeping the advisor cohort as resources for advice. I think it's a phenomenal opportunity and I feel quite blessed.

In terms of contributions to the industry, I think my contribution will have a huge impact on how we deliver care. My project builds on Dr. Bruce Leff's work on the Hospital at Home. We propose to integrate our eight-year old, mature telehealth program with Dr. Leff's Hospital at Home model. Our telehealth program has been very successful, with a less than 2 percent recidivism rate for patients suffering with Chronic Heart Failure (CHF). This gives us a chance to prove to CMS that investing in home care is an added value. To date, CMS has been very reticent about a line item reimbursement for telehealth because of the fear that telehealth will increase the total cost of care. I think our project will show that home care can actually save dollars for CMS while improving patient care.

Tell me about your model of home-based healthcare delivery.

Our program begins with our existing telehealth program. We are proposing integrating the Centura telehealth program into home care and the Hospital at Home model. In a nutshell, the project itself brings together Hospital at Home with our telehealth program that uses data monitoring of patients. We work closely with our telehealth providers. Every patient that is admitted to our home care program is automatically in the telehealth program unless they meet disqualifying criteria.

It's important to remember, however, that a successful telehealth program is not about the technology alone. Our program works because it combines a workforce strategy and a clinical strategy. The tools do not make for the results. Results come from the meticulous case management process that we use, which goes hand-in-glove with the technology to get the outcomes we want. It's also critical that financial incentives align with the use of the technology. For example, we have, in Colorado, a physician community that has aggressively adopted the technology we use because they are able to cover its cost under different reimbursement models. Financial alignment allows providers to really do the right thing for patients. From a nursing perspective, it's refreshing to see financial incentives that allow providers to create care around patient needs, input, and empowerment.

You've talked about your work with Dr. Bruce Leff's model of Hospital at Home. What inspired you to combine his model with Centura's?

I met Bruce about 10 years ago, having spent 22 years of my career in public health and trans-cultural nursing and home care. I have always believed in home care. One source of inspiration for me has been the nursing theorist, Dorothea Orem, and her Self-Care Deficit Theory that addresses patient empowerment and autonomy. I think that the home care field is in alignment with empowering patients.

There is no one that feels empowered in a hospital. When you're in a patient's home, that patient is the king or queen of their castle – they own it, and you're a guest. That's the best laboratory for education because you don't have to deal with the barrier of

fear that people have when they're in the hospital.

Having followed Hospital at Home, I wanted to embrace the model and had to wait for the right timing. This is the right time. We are lucky because we are working with a capitated Medicare population in two of our 14 hospitals in the community that make our program financially possible. Our model may not work under conventional delivery systems paid by Fee-for-Service Medicare, but it would work as part of a bundled service or an Accountable Care Organization (ACO). As the population ages, we're fast approaching a demand that is unprecedented. I believe Hospital at Home is going to be the model that catches fire.

Tell me how about how your previous work with telehealth paved the way for this project.

If my organization were a research organization, I would have, long ago, selected the question of why providers get such profoundly different outcomes when we use telehealth with home care. Maybe because we catch people in the moment and are treating them in real time. People easily connect their health to their own behaviors and their chronic illnesses. When we started with the original program, which was only the size of a learning cohort, we followed our patients for three years. We identified the small, sample size population by the "frequent fliers" in the Medicare Advantage program. The program focused on patients with CHF who had a minimum of two visits to an Emergency Room (ER) or hospital in the last 12 months. One patient of note had been in the ER or hospital 12 times in the last 12 months.

We took these patients and admitted them to the telehealth program, following them for six months and setting a goal of decreasing ER and hospitalizations by 60 percent. After six months, we had decreased hospitalizations by 90 percent and ER visits by 100 percent.

We then followed the cohort for an additional three years. Not a single patient ever went back to ER. We did have some hospitalizations, but upon closer examination we suspect the hospitalization rate for chronic illnesses was very low, as most patients returned to the hospital due to non-chronic illness issues, such as a broken hip or femur.

What's the advantage of pairing technology with patients suffering from chronic illnesses?

From a research perspective, there is something very different about an integrated model of chronic care management for a high-risk population. From an emotional perspective, patients have a safety net. Patients that have Chronic Obstructive Pulmonary Disease (COPD) with anxiety as an ongoing issue can end up in a pathological situation because they're so concerned about their health. Integrating telehealth for these types of patients has a very positive modality.

Sometimes I hear clinicians say, "We have telehealth and don't have the outcomes you have." You can't just throw technology in the mix. It's about the overall program that you pair with the technology. It is the case management model and how we support the home care population that is making the difference, although we couldn't do it without the technology.

The other question is whether there will be increased savings when using telehealth with Hospital at Home. I think this program will show that the use of telehealth in the home, when paired with a strong chronic care management model, can yield significant savings.

Tell me about the typical beneficiary in your program.

When we originally started working with this model, we targeted CHF patients because that diagnosis had the most expense and the highest utilization of the ER and hospitalizations. That was 8 years ago. Now we are using our model of care with all chronic care patients, typically seniors with an average of three - five diseases. The one exception is that we don't use the telehealth tools with patients who have rotary phones or who are cognitively unable to perform the functions required to work with the technology in the home and might not have a caretaker in their home to assist them. Eventually, we plan to grow this program to other disciplines.

In terms of patients, Centura has an average daily census of 200 patients on telehealth in the state of Colorado. Overall, we have an average daily census of 3,000 patients statewide, so we have less than 10 percent of patients in the program. That said, the program has tripled in the last 12 months and we anticipate huge growth. Since we use the telehealth tool within a home care episode, we anticipate the total number of patients who will benefit from the program will be about 3,000.

Do you think this program will have an impact on the Medicare home health benefit?

Absolutely – I think this work could inform changes to the home health benefit and all education principles about the role of home health care in chronic care management. I am relentless about the regulations for a qualifying home care benefit that requires patients to be homebound. Quite frankly, we have people who are eligible for home care but not homebound and it's these patients who end up in the hospital over and over again. I think our program has helped our hospitals to defy the typical admissions for CHF patients, and helped to keep their readmission rates way below 20 percent. Our system encourages hospitals to see the advantages in providing financial support for these programs, especially when caring for patients that have CHF, pneumonia and myocardial infarction (MI).

Even where hospitals can fund these services, CMS should still look at total cost of care, rather than at silos of care. We need to be able to waive the homebound requirement when someone has the kind of health issues and skilled care needs that would qualify them for an episode of care and keep them out of the hospital. This is a view that I think we can spread through innovations like this one.

When I think about Hospital at Home, CMS has always been supportive, but has also been afraid that the model will increase cost of care. Even so, CMS is interested in migrating to a different reimbursement model than fee-for-service. Innovation Advisors have to be available, accessible, and ready for whatever our successful projects are so that we can share these programs with CMS. I am very excited about the possibilities that have evolved from home care, the possibility of an evolving home care benefit and really changing the primary site of care.

What challenges have you seen in the home health care community as providers try to take on disease management programs?

There's a whole plethora of services needed to help a patient maintain the optimal level of wellness. The first is that patients need a medical neighborhood where the physician is key. I have seen, in Colorado, a higher value proposition coming from physicians for home care because those physicians are getting paid for the wellness of the patient. We, as providers, get to do the right thing because the financial incentives

have changed. Physicians want our help, where historically they felt we were competitive.

The number one barrier to better disease management is the current financial model. This incredible program doesn't have legs in other parts of the health care system because of the current financial model. With the increase of Medicare Advantage enrollees, the increase of primary care physicians getting rewards for keeping patients out of the ER and the hospital, and the increase of hospitals looking to avoid disincentives– there is a perfect forum to address financial barriers and allow for true collaboration. I think, too, that it's much easier for an integrated system to address these barriers.

Another barrier is that home care is a "cottage industry." For example, Centura's market share is 11 percent. We're the giants here in Colorado, with other providers taking 8 percent and 4 percent of the market. The majority of the market share is divided among providers that have only 1 – 2 percent each. The challenge is trying to develop standards and consistent measures across these various small organizations. Many doctors and physicians hesitate to work with several small organizations and would rather work with a larger organization with consistency and standards that allow for true change. If there's any degree of hope for our industry to have the respect and prestige, we need evidence-based practice.

Any final advice you would offer home health care providers and others interested in pursuing better management of chronic diseases?

For a program to succeed, providers must have an iron-clad focus on creating evidence-based practice. We are at the best point in the history of home care for our value proposition. When I was younger, I did not think that in my lifetime we would see what we're seeing today. We have a window of opportunity that we need to seize because if we don't, others will. It will take courage and remarkable leadership and it cannot be divided leadership. We need to move forward in a very collaborative way.

The Alliance would like to thank Ms. Denholm for her time and insight. If you would like to learn more about the Innovation Advisors Program, please visit CMMI's site here. To suggest an Innovation Advisor for our interview series, please email your suggestion to C. Grace Whiting, Special Assistant, at gwhiting@ahhqi.org.