Success Stories: Improving Patient Care through Medical Home and Home Health Collaborations

Hosted by: Alliance for Home Health Quality and Innovation

October 14, 2013
About the Alliance

• 501(c)(3) non-profit foundation

• Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.

• www.ahhqi.org
Today’s Speakers: Dr. Rodney Hornbake

E. Rodney Hornbake, MD
National Medical Director, Gentiva Health Services
Internal Medicine and Geriatrics Fellow
American College of Physicians Diplomate
American Board of Internal Medicine

Dr. Hornbake, a board-certified physician in Internal Medicine and Geriatrics, is a leader in connecting the Patient Centered Medical Home to primary care services. As a co-founder of Essex Internal Medicine (now part of Pro Health Physicians), the National Committee for Quality Assurance (NCQA) recognized Dr. Hornbake’s practice in 2011 as achieving the highest level of care using the PCMH. In January 2013, Pro Health Physicians began operating as a federally designed Accountable Care Organization (ACO). Additionally, Dr. Hornbake’s career includes extensive medical leadership including his position as National Medical Director for Gentiva Health Services.
Today’s Speakers: Lisa Harvey-McPherson

Lisa Harvey-McPherson, RN, MBA, MPPM
Vice President Continuum of Care &
Chief Advocacy Officer
Eastern Maine Healthcare Systems

Lisa is the senior EMHS executive for home care, hospice, long term care, residential care, senior services and policy/advocacy serving all members of the EMHS health system. In her vice president role with EMHS Lisa also serves as the President and CEO for Eastern Maine HomeCare. She also serves as an EMHS senior executive supporting the Pioneer Accountable Care Organization Project. Through Lisa’s leadership EMHC developed the Community Care Team service model supporting patient centered medical homes throughout northern and eastern Maine. During her career, she has served as board chair of the Home Care & Hospice Alliance of Maine, board chair for the Maine Hospice Council, and representing the New England region as a board member for the National Association for Home Care & Hospice.
Home Care and the Medical Home

Rodney Hornbake MD, FACP
National Medical Director,
Gentiva Health Services

drhornbake@comcast.net
34-Year Career

- Management of hospitals, health systems, and for profit companies 1993-2002
- Return to clinical practice: 2002-present
- Career-long devotion to home-based care
Evolution Over the Past 5 Years

- Solo practice
- EMR implementation
- Group practice formation (3 physicians)
- Level 3 PCMH
- Merger with large primary care group practice (>300 physicians)
- Accountable Care Organization
Home Care Medicine

- Home-based primary care
- Patient centered home care
- Medicare home care benefit
  - Homebound requirement
  - Skilled services – RN, PT, OT, ST, SW
  - Case rate payment using HHRG methodology
  - Low Utilization Payment Adjustment (LUPA) for 4 or fewer visits
VA Home Based Primary Care

- Initiated in 1998
  - 25,000 enrollees by 2010
- Team based services in the home – Physician, Nurse, Social Worker, Rehab Therapist, Dietician, Pharmacist and Psychologist
- Focused on the most frail Veterans
  - 24% annual mortality rate
  - 48% dependent in 2 or more ADL’s
VA Home Based Primary Care

- By 2002, 24% reduction in total costs of care with:
  - -63% hospital costs
  - -87% nursing home costs
  - +460% home care costs

- By 2006 additional reduction in Medicare costs -10.2%
VAHBPC: Impact vs Frailty

- Observed Annual Cost
- Predicted Annual Cost
- Annualized Post-Enrollment Cost

Mean CMS HCC

$0 $20,000 $40,000 $60,000 $80,000 $100,000 $120,000

0.91 1.37 1.8 2.12 2.43 2.9 3.34 3.87 4.73 6.62
Kendal Communities Observational Study

- Not for profit, faith-based group of CCRC’s

**KENDAL Communities**

**Communities and Services for Older Adults in 8 states:**
- IL Chicago lakefront (under development)
- MA Northampton, Easthampton
- MD Metro Washington, D.C.
- NH Hanover
- NY Ithaca, Sleepy Hollow
- OH Oberlin, Granville, Cleveland
- PA Kennett Square, West Chester
- VA Lexington
Kendal Communities Observational Study

- Some communities provide on-site primary care services.
- In one community, a physician and 2 part-time nurse practitioners practice only on-site, caring for residents in all parts of the community.
- Patient outcomes in this community were compared to less intense, non-exclusive primary care at 3 other communities.
Kendal’s Results

- In the most intensely served community:
  - No change in hospital admissions for surgical care
  - 50% reduction hospital admissions for medical care
  - 5% of deaths in the hospital vs. 15% in the comparison group of Kendal communities vs. 27% national average for age cohort >75.
Care Centered on Patient Goals

- Sutter Health – an integrated health system in Northern California (24 Hospitals, 5000 Physicians, plus Visiting Nurses, Hospice)
- Advanced Illness Management (AIM) Program at 2 Sutter Hospitals:
  - Assist patients with end-stage illness to clarify goals of treatment
  - Coordinate palliative care services
Sutter’s Results

- 63% reduction in hospital admissions
- Doubled the use of Hospice Care to 47% of patients enrolled in the program
- Net savings $2000/patient month
Post-Acute Costs Drive Total Costs

CMS data 2007-2009 from 306 Hospital Referral Regions from the IOM
Medicare Cost Per Beneficiary and 30-Day Readmissions by State

DATA: Medicare readmissions—2006–07 Medicare 5% SAF Data; Medicare reimbursement—2006 Dartmouth Atlas of Health Care
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009
Increasing the Value of Medicare Funded Home Health Care

**Triple Aim focus:**
- Better outcomes for individuals
- Better health for populations
- Better efficiency of care

**High Impact/High Value Home Care**
- Reduced readmissions
- Reduced admissions
- Substitute home for inpatient post-acute care
- Patient-centered care at the end of life
- Integrated with Home Based Primary Care
10 Things Your PCMH Can Do Today

1. Narrow your network of home care providers
2. Select home care teammates based on:
   a. [www.medicare.gov/homehealthcompare](http://www.medicare.gov/homehealthcompare)
   b. Agency willingness to reengineer the processes of care
3. Enhance communications between the medical home and the home care nurse
4. Implement Rapid Improvement Model applied to all patients referred for home care
10 Things Your PCMH Can Do Today (Continued)

5. Measure key outcomes of home care and use those metrics to drive improvements
6. Shift post-acute care from facilities to the home. Use the pre-operative visit to advance this agenda
7. Facilitate starting home care in the hospital
8. Question and stop the approval of inappropriate home care ordered by others
9. Focus on listening to, clarifying, and acting upon patients end-of-life preferences
10. Develop or grow physician home visit practices
Implications for Home Care

- PCMH/ACO physicians are in a strong position to influence how home care services are used.
  - Selection of preferred home care providers
  - Reengineering the processes of care
  - Shifting post-acute care away from facilities and into the home
  - New oversight of the care being delivered
- PCMH/ACO leaders could emerge as strong advocates for reforms to the home care and hospice benefits
Home Care Winners

• Will get themselves on the short list of preferred providers
• Will participate in collaborative efforts to improve the efficiency and effectiveness of home care services
• Will constantly focus on the customer’s needs and demands
• Will measure and report their performance to the customer
How PCMH & Eastern Maine HomeCare Collaboration is Improving Patient Care
PCPCC Annual Fall Conference
October 2013

Lisa Harvey-McPherson RN, MBA, MPPM
EMHS Vice President Continuum of Care
President & CEO Eastern Maine HomeCare
Overview

- EMHC Overview
- Bangor Beacon Community
- PCMH, EMHC & Community Care Teams
- EMHS Pioneer ACO
Eastern Maine HomeCare Today

• Medicare Certified & State Licensed Home Care and Hospice Provider
• Last year Eastern Maine HomeCare (EMHC) staff made 68,323 home care, hospice and telehealth visits to 3,280 patients. Clinicians drove over 1.35 million miles to serve their patients.
• Community Care Team program started in January 2012
EMHC Seven Sites

• Visiting Nurses of Aroostook
  – Caribou (home office for corporation)
  – Houlton
  – Fort Kent Drop Site
• Hancock County HomeCare
  – Ellsworth
  – Bar Harbor Drop Site
• Bangor Area Visiting Nurses
  – Bangor
  – Pittsfield & Waterville Drop Sites
Together We’re Stronger
EMHC Telehealth Basics

- Each patient had one telehealth encounter/day during their LOS
- The telehealth nurse calls patients with clinical “red flag” data and provides consultation over the phone or determines next level intervention i.e. home visit, physician notification, etc.
- Most clinical changes are handled by the telehealth nurse vs. an additional home care visit
- The cost difference between an in-home visit and telehealth encounter is $120
Telehealth Patient Participation

• Patients upload data daily to telehealth nurse in Caribou Maine
• Data can include:
  - Blood Pressure
  - Weight
  - Blood Sugar
  - Pulse
  - O2 Saturation
  - Responses to individualized questions, ex. shortness of breath, dietary compliance, endurance, etc.
## Telehealth Patient Outcomes
### 2012 Results by Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th># of Patients</th>
<th>Percent of Hospitalizations 6 Months Prior to Teledem*</th>
<th>Percent of Hospitalizations while on Teledem**</th>
<th>Percent of ED Visits 6 Months Prior to Teledem*</th>
<th>Percent of ED Visits while on Teledem*</th>
<th>Healthcare Cost Savings***</th>
</tr>
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<tbody>
<tr>
<td>CHF</td>
<td>81</td>
<td>70%</td>
<td>2%</td>
<td>80%</td>
<td>2%</td>
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<tr>
<td>COPD</td>
<td>63</td>
<td>70%</td>
<td>6%</td>
<td>73%</td>
<td>8%</td>
<td>$612,093</td>
</tr>
<tr>
<td>Diabetes</td>
<td>51</td>
<td>31%</td>
<td>2%</td>
<td>53%</td>
<td>6%</td>
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<tr>
<td>Cardiac</td>
<td>61</td>
<td>72%</td>
<td>0%</td>
<td>77%</td>
<td>3%</td>
<td>$643,589</td>
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<tr>
<td>Other</td>
<td>6</td>
<td>83%</td>
<td>17%</td>
<td>83%</td>
<td>17%</td>
<td>$45,764</td>
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</table>

* Data obtained from patient interviews at time of admission to telehealth program. Patient admitted to hospital were admitted for their chronic diagnosis (CHF, COPD, etc.). ** Data represents actual hospitalizations/ED visits occurring during patient’s length of stay on home health program for their telehealth diagnosis. ***Savings based on EMHS affiliate hospital and its average costs for listed diagnoses.
Beacon is a National Program Started in the Spring of 2010

• Beacon is a federally funded grant program, overseen by the Office of the National Coordinator in communication with the White House, which provides communities with funding to build and strengthen their health information technology (health IT) infrastructure and exchange capabilities.

• These communities will demonstrate the vision of a future where hospitals, clinicians, and patients are meaningful users of health IT, and together the community achieves measurable improvements in health care quality, safety, efficiency and population health.
Beacon is a National Program (continued)

• Beacon communities will disseminate evidence and insights that are applicable to the rest of the nation regarding the use of HIT to improve care delivery and support reforming health care.

• The Bangor Beacon Community is one of 17 nationwide sites. The Bangor Beacon Community Grant is a 3 year project funded by $12.7 million.
Bangor Beacon Community Participants (*home care)

- Acadia Hospital
- *Community Health and Counseling Services
- Eastern Maine Community College (EMCC)
- Eastern Maine Healthcare Systems (EMHS)
- *Eastern Maine HomeCare
- Eastern Maine Medical Center (EMMC)
- EMMC Clinical Research Center
- HealthInfoNet
- Maine Primary Care Association
- Penobscot Community Health Care
- Ross Manor
- *St. Joseph Healthcare
- Stillwater Health Care
Why Home Care is a Critical Component of the Bangor Beacon Community

- Within EMHS home care is identified as an essential component of our strategy to deliver high quality health care in the most cost effective setting
Bangor Beacon Grant Goals

• Patients will improve self management of their identified chronic disease through primary care, care coordination and increased adoption of health information exchange among inpatient & outpatient sites.
  • COPD
  • Heart Disease
  • Diabetes
  • Asthma

• In general, HealthInfoNet will establish health care information exchange for all participants. For EMHC, information exchange with EMHS providers will be developed through the purchase of a new EMR system EMHC will:
  • Increase MD ability to view home care EMR & Telehealth Data
  • Connectivity with physician and hospital EMR
  • Establish the home care and hospice data infrastructure with HealthInfoNet ultimately allowing all providers in the state to participate with the HealthInfoNet information exchange.
Beacon Telehealth & Patient Centered Medical Homes

• Homebound and NON HOMEBOUND patients will be admitted to the home care telehealth program

• Telehealth & home care nurses will partner with the care managers in the PCMH to manage chronic diseases

• Homebound patients will receive telehealth & home care nursing visits, non homebound patients will receive telehealth nursing partnered with the nursing care managers. Nursing care managers will coordinate primary care physician follow up visits.
Beacon Telehealth & Patient Centered Medical Homes

Outcome Measures:

- Decrease ED visits of patients in the project
- Decrease hospital readmissions
- Improve patient self management of medications & decrease adverse drug reactions
- Increase the use of home care & home telehealth
Beacon Telehealth Story

• Congestive heart failure and diabetes had Gerald in and out of the emergency room and hospital over the years. In the summer of 2011 he seemed to be getting worse. “I was in the hospital a few days every month.”

• Gerald was admitted to the Beacon Telehealth Program resulting in successful management of his chronic diseases.

• Gerald is more confident than ever how to spot warning signs and get help before a trip to the emergency department becomes necessary. “I am thankful for this program; I know it’s kept me out of the hospital. I hope to very soon get my energy back so that I can get on stage again!”
Patient Centered Medical Home Demonstration Project & Community Care Teams

- In 2009 Maine established 22 PCMH pilot projects across the state including EMHS primary care sites
- In 2010 CMS Center for Innovation creates “Multi-Payer Advanced Primary Care” (MAPCP) demonstration Project
- Maine selected as one of 8 states to have Medicare participate as payer
- Quality Counts is the Project Manager
- Summer 2012 50 Additional PCMH’s and 57 MaineCare Health Homes Added to Project Starting Jan 2013
- Every PCMH and MaineCare Health Home has a designated Community Care Team
PCMH & Health Home Project – Community Care Teams

- EMHC Participates with Development of CCT Project with Quality Counts
- CCTs based on Camden Coalition & Dr. Jeffrey Brenner work “hot spotting”
- Community Care Teams must be:
  - Multi-disciplinary, community-based, practice-integrated care teams
  - Support patients & practices in Pilot sites, help patients overcome barriers to care, improve outcomes
  - Key element of cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (ED use, admits)
Community Care Teams

- The primary goal of the CCT is to provide support for the most complex, high risk, high need and/or high cost patients served by the PCMH Pilot Sites
- Current Maine CCT Programs
  - Eastern Maine HomeCare
  - PCHC
  - MaineHealth
  - MaineGeneral
  - Androscoggin Home Care & Hospice
  - DFD Russell
  - Hancock County Regional Team – Coastal Care
  - Community Partners (Newport FM & Reddy Ctr)
- 2013 New Teams: AMHC, CHANS & Additional So. Maine Team
EMHC Community Care Team

• Team serves designated Patient Centered Medical Homes – Functions as an extension of the primary care practice.
• Goal to provide high cost high utilization patients in the PCMH with community support and services to reduce the cost of care and improve outcomes.
• Primary focus - Patients with 5 or more ER visits in a 6 month period, frequent hospitalizations, high risk, high cost patients.
• CCT staff include LCSW leaders, home care RN, MSW, SW interns from UMO and pharmacy students from Husson Univ.
• Community Partners include Area Agency on Aging, Local Healthy Maine Partnerships, Bangor Public Health.
• HIT infrastructure developed to add CCT information to the PCMH medical record in addition to home care information HIT developed through the Beacon project.
EMHC CCT Risk Stratification

• Original Proposal - Patients with >5 ED visits w/in 6 months NOW 2 or more ED visits for chief complaint that is readily ID’d as non-emergent
• Transitions of Care
• History of medication non-compliance
• 2 or more chronic illnesses
• 1 chronic illness with comorbid mental/behavioral health diagnosis
• Barriers to care
• Additional criteria for pediatrics: multiple children with needs, new diagnosis, change in family structure
Referral Demographics

• Ended 2012 (Year One) with 107 referrals from 3 practices
• Ended 2013 Q3 with 999 total referrals from 28 practices…
• 42 % Medicare, 35% MaineCare, 8% Self Pay, 15% Commercial, (17% Dual Eligible)
Referral Reasons

Top 5 Reasons
• Frequent ED use
• Behavioral health
• Community Resources
• Home safety
• Medication adherence/reconciliation

Other reasons
• Transportation
• Nutrition
• Diabetes management
• Other chronic disease management
• New diagnosis
• Financial
• Dementia
• Multiple medical co-morbidities
Priority Patients for CCT

• Frequent ED Utilization
  (>3 vs. in 6 mos., > 5 vs. in 12 mos.)

• Multiple Hospital Admissions
  (>3 in 6 mos. or > 5 in 12 mos.)

• Patients identified as high-risk or high-cost using payer or health plan data

• CCT Risk Stratification Criteria
Population Challenges

- Domestic Violence
- Substance use/abuse & dependence w/o resources for inpatient or outpatient detox
- Behavioral health (SPMI/SED excluded from MeCare currently)
- Lack of affordable out of home placement & in home supports
- Medication access & rationing of medications
- Transportation
Population Challenges Con’t

• Lack of communication between all providers of care
• Food insufficiency
• Isolation
• Systems Challenges
  – Discharges from practices
  – Same day schedule full
Patient “EKG”

50 yr old, Substance Abuse w/o detox

255 active days – 8 home visits, 4 visits w/ patient @ PCP office & Hospital, 2 visits in Community setting, & 34 phone calls/collateral contacts **Cost Est < $1850**

1- 6 = Hospital ED visits each month for the 6 months during CCT intervention (total 18)

7-12 = hospital ED visits each month for the 6 months following CCT intervention (total 2)
Patient “EKG”

Same patient

1-6 = # of hospital days spent inpatient during 6 months of CCT intervention (total 27)

7-12 = # of hospital days spent 6 months following CCT intervention
EMHC CCT Savings

• Analysis of ED and Readmission Super Users

• January 2012 – June 2013
  – For CCT Referrals Targeting
    Emergency Room Utilization = 64%
    Reduction in ED use and 74%
    Reduction in Hospital Readmissions
A New Journey Begins
CMS Pioneer ACO

• In January 2012 EMHS became one of 32 CMS Pioneer Accountable Care Organizations

• An ACO is a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.”

– NEJM and EMHS ACO Executive Steering Committee
Pioneer ACO Locations
The ABCs of ACO
Accountable Care Organization

• ACO is part of the Affordable Care Act (ACA) – national health reform.
• ACOs use partnerships between hospitals and physicians to improve the coordination, efficiency, cost, and quality of patient care.
• Patients don’t lose choices, rather the ACO assumes responsibility for better coordination of patient care.
• The structure of care delivery shifts from how much a provider does to how well the patient does – and will determine how hospitals/doctors are paid for the care they provide.
Pioneer ACO Highlights

- 5 Year Pilot Project
- Medicare attributes patients to the ACO (Today 14,000 patients assigned to EMHS ACO)
- The ACO accepts financial risk to reduce the overall cost of care for the Medicare population assigned and meet quality performance standards
- Patients retain ability to choose providers of care
- Participants must also engage in risk based contracting models with other payers during the pilot project period
### Yearly Preliminary Baseline/Benchmark Report for Pioneer ACOs

**Pioneer ACO P040 - Beacon Health LLC**

**Worksheet 1: Preliminary Prospective Baseline/Benchmark**

**Performance Year 1: Jan 1, 2012 to Dec 31, 2 **

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<td><strong>Capped baseline / benchmark calculations</strong></td>
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<td><strong>Aligned population</strong></td>
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<td>52. Benchmark</td>
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*How do we impact this number?*
EMHS ACO Financial Risk Model

- Annual expenditures for 9,000 beneficiaries: \( \sim \$ 90 \) million
- *Increase accountability for costs over 5 year period*
  - **YEAR 1**
    - 50% share of savings (*varies with quality score*) up to a cap of 5% of total part A and part B expenditures
    - Must achieve a Minimum Savings Rate of approximately 2.5%
  - **YEAR 2**
    - 70% share of savings or losses (*varies with quality score*) up to a cap of 15% of total part A and part B expenditures
    - 1% Minimum Savings Rate
  - **YEAR 3**
    - Migrate to capitation models, *and*
    - Have > 50% of revenue from risk share contracts
  - **YEAR 4&5** Same model as year three with updated baselines
ACO - 33 Clinical Measures

- 7 dedicated to **Patient Experience** of Care, timeliness of care, doctor communication, access to specialists, health promotion and education, shared decision making, health/functional status.
33 Clinical Measures (continued)

- **6 Care Coordination** and Pt Safety: Ambulatory Sensitive Conditions, EMR use, medication reconciliation, falls screening
- **8 preventive health**: Immunizations, Screenings, Weight, and Tobacco
- **12 at risk population**: Diabetics, HTN, IVD, CAD
EMHC & Pioneer ACO Savings

• Year One of the ACO (2012) demonstrated for every $1 spent on EMHC services, home care, telehealth, community care team, hospice, EMHS Pioneer ACO saved $3 in Medicare spending.
EMHS Pioneer ACO Year One

10 Pioneers have savings of at least 1.5 percent

12 Pioneers have small changes between -1.5 to 1.5 percent

10 Pioneers have losses of at least 1.5 percent
THANK YOU

lmcpherson@emhs.org
Questions and Discussion

Thank You!

Alliance for Home Health: Quality and Innovation