CT Primary Care Payment Reform
Draft Capabilities Skeleton: Home Visits
This Draft: July 12

Understanding the Need

Please go to the survey to rate this capability's impact as high, medium or low on the following criteria:

Aim
Health promotion/prevention
Improved quality and outcomes
Patient experience
Provider satisfaction
Lower Cost

The Problem:
In 2013, 15.4 percent of people in the US over 65 years (more than 6.6 million people) had independent living difficulties, defined as difficulty with activities such as visiting a doctor's office or shopping without help because of a physical, mental, or emotional problem; 9.2 percent (over 3.9 million) had a cognitive difficulty; and 8.5 percent (over 3.6 million) had difficulty with self-care such as dressing, bathing, and eating. While the percentages are smaller, a similar number of adults 18 to 64 years old have functional difficulties (3.6%, equaling 7.1 million, have independent living difficulties; 1.9%, equaling 3.6 million, have a self-care difficulty) (AHRQ, 2014).

These patients may struggle to get to the provider's office due to functional impairments, costs, or other limitations that make transportation to doctors' offices or clinics challenging, or caregivers may not be available to accompany them during normal office or clinic hours. In some situations, going to an office may be contraindicated, such as for patients with cognitive deficits who may become confused or agitated in unfamiliar surroundings. Patients with complex needs may require frequent monitoring, intense management, or rapid follow-up that cannot be easily accommodated by an office-based provider. The current care delivery system often does not address these needs, leading to ED visits and hospitalizations that may have been prevented by more timely and accessible primary care.

Proven Strategy:
Name: Home Based Primary Care (HBPC) /Home or Community Face to Face (F to F) Visits

Definition:
Home based Primary Care (HBPC) combines home-based primary care for medical needs with intense management, care coordination, and long-term services and supports (LTSS) when needed. HBPC interventions aim to better address the needs, values, and preferences of chronically ill, frail, and disabled patients who have difficulty accessing traditional office-based care primary care or newer models of care that also require office visits. This definition includes:

1. Visits by a primary care provider (including physician, nurse practitioner [NP], or physician's assistant [PA]). Additional visits by extended care team members.
2. Visits to a patient's home which is defined as any non-institutional setting where the patient resides. It can include adult homes or senior housing. The patient is followed across settings (e.g., hospital management and short term post-acute rehabilitation)
3. Longitudinal management (until admission to an institution, change in status, or death).
4. Comprehensive primary care including medical care for and the management of chronic conditions and disabilities, preventive care, and environmental assessments. (AHRQ, 2014)

The CMS Independence at Home Demonstration (IAH) tests a service delivery and payment incentive model that uses HBPC teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. Practices that meet quality measures while generating Medicare savings may share in savings.

There is no single model adopted across practices, with many variations in size, technology used, and team composition. However, generally the three core components of HBPC (as well as the complex care management model) are:

1. Use of multidisciplinary care teams
2. Regular care-team meetings
3. After-hours support

Complex Care Management: Many managed care organizations/ACOs work closely with office-based PCPs to have complex care managers make home visits for the purposes of assessment, transition to home (after hospitalization), and patient education. Providers may be better able to obtain insight into the patient's needs with a home visit, often finding environmental factors that are related to patient problems (e.g. asthma triggers). Working closely with extended care teams (CHWs, social workers, BH care managers), these complex care managers will 'meet the member where they are', often in the home but also in the community or at a homeless shelter.

Home or Community Face to Face Visits: There are some patients who will not allow providers into their homes on a regular basis nor will they keep scheduled appointments. For this subset of patients, a combination of office visits, home visits and 'meeting the patient where they are' may be the correct combination. If patients have unstable housing or are homeless, they may require having a care team member meet them at the location of their choice to assess, build alliances and begin to develop treatment plans and/or crisis plans. This may be accomplished by a care coordinator/care manager, community health worker or social worker as key members of the extended care team.

Intended Outcomes:

- Reduce avoidable Emergency Department visits
- Reduce hospitalizations, length of stay and readmissions
- Identify new and/or worsening conditions sooner
- Ease care transitions to the home following hospitalizations

Consumer Needs:

- Wait times are too long, especially in rural and underserved areas
- Transportation, childcare and needing time off from work make it difficult to access primary care in office-based settings. Alternatives are needed.
- Needs of caregivers are often not recognized or addressed. Caregivers need more information so they know how they can support the care plan, ask the right questions.
- Patients need a variety of support services beyond traditional medical care

Health Equity Lens:

- Alternative mode of care for vulnerable populations, including disabled and elderly.
- Reduces access barriers such as transportation and ability for caretaker to manage getting patient to appointments as frequently as necessary.
- Need to adjust model for patients that are homeless or experiencing unstable housing.

Implementing the Strategy

Example Scenario: A HBPC (NP) visits her 25-year-old patient who has had a cervical spinal cord injury for 4 years. She talks with him and his mother with whom he lives and provides his care. He is still in bed when she arrives at 2 PM and he says that he hasn't felt like getting out of bed every day for the past month or so. She examines him and notices a very slight redness on his heel which could be the very beginning of a pressure sore. She talks to him about his moods, administers a screening for depression and conducts a physical exam. They discuss wearing protective booties and changing bed positions to avoid pressure sores and antidepressant medications. The NP documents the visit and problems identified in the EHR to alert the care team, and notes that the social worker might want to follow up. She returns in 5 days for a follow up visit.

HIT Requirements:

- Ideally requires an electronic health record (EHR) or web-based platform and patient/ designated representative portal.
- Connection to a Health Information Exchange (HIE) helpful to communicate with long term support service providers and other ancillary providers who may not be on primary care EHR.
- Scheduling module that can accommodate and automate routing would be optimal.

Implementation Concerns[1]:

- Frequency of needed visits and travel times decreases panel sizes that PCPs/NPs can handle. Need to rely on extended care teams for associated functions.
- Provider-to-provider contact can be clumsy
- Frequent need for face-to-face visits.
- Need for specialist visits still present barriers for very complex patients.
- Need algorithms for visit for team. Who does assessments, at what frequency, when does PCP need to see patient vs nurse CM
- In other models, where PCP does not make home visit, need to identify and document communication channels

Impact

A brief summary of the available evidence on impacts of this capability, according to the criteria below.

Aim	Summary of Evidence
Health promotion/prevention	Health promotion and primary and secondary prevention are inherent in the home care model. For the HBPC model, the PCP arranges all appropriate preventive care as noted in Case Study #1. In the Complex Care model, secondary prevention and health promotion is key and is role of the care manager (RWJ, 2009). In the team-based model, it is the collective role of the team to improve patient self-management. However, data does not specifically address its effectiveness in this.
Improved quality and outcomes	The strongest evidence (moderate) is that HBPC reduces hospitalizations and hospital days. Reductions in emergency and specialty visits are supported by less strong evidence, while no or

[1] Payment methods to support new capabilities will be considered as part of the payment model options

	unclear effects are identified on hospital readmissions and nursing home days. Evidence about clinical outcomes are limited to studies that reported no significant differences in function or mortality (AHRQ 2016).
Patient experience	Three studies included measures of satisfaction or quality of life. In the two RCTs of HBPC model only, most caregiver outcomes were better for the HBPC group, and the patients experienced a statistically significant improvement in health-related quality of life. In a study that focused on caregiver burden and needs, caregivers of patients in a HBPC program reported a decrease in unmet needs 9 months after enrollment and a decrease in caregiver burden (AHRQ 2016). Satisfaction increases when palliative care and hospice care can be incorporated (Commonwealth Fund 2017).
Provider satisfaction	Maintained provider satisfaction similar to office based (but no hard data). Issue regarding reimbursable time spent on weekends, late evenings, and on-call, sometimes up to 4-8 hours/week (Norman 2018)
Lower Cost	The CMS IAH analysis found that, for the second performance year, Independence at Home participants saved Medicare $7,821,374 in aggregate, or an average of $746 per beneficiary. Year 1 savings were approximately $25 million in savings. Most of these savings can be attributed to decreased inpatient and emergency department admissions. Of the seven practices receiving incentive payments, the lowest amount was $116,555, while the highest was more than $1.3 million.

Please complete the survey on this capability.

APPENDIX

Learning from Others

State and National Scan:

Case Study #1:

Doctors Making Housecalls is a Medicare IAH demonstration project participant and covers 150 communities across North Carolina. They are a HBPC practice that provides comprehensive primary care to patients ages 3 to 103, and specialize in caring for complex, high-risk and high-needs patients.

Best Practices:

- Will treat young children age 3 and over
- Will meet patients in alternative locations (work offices, homes, etc.)
- Does a wide range of preventive tests at home (e.g., pap tests, mammograms)

- Primary care clinicians make up to 15/visits/day (more than the average of 9/day) when making visits in assisted living facilities

Lessons Learned:

- Scheduling is crucial to be efficient
- Contracting with vendors who can perform a wide range of preventive testing is helpful and a good marketing tool.

Results:

- **Quality:** Claims to have succeeded in "all 6 IAH Quality Measures"
- **Cost Savings:** Received $1.44 million in practice incentive payment for year 2 of Medicare IAH Demonstration Performance.
- **Member and Provider Experience:** Anecdotal testimonials on website from members, providers, and other staff. No hard data available.

Case Study #2: Neighborhood HP (NHP) of RI insures RI Medicaid (all categories as well as dually eligible) and participates in the RI Exchange. Health@Home is one of their innovative programs for members with chronic conditions that collaborates with the primary care provider but does not substitute for the PCP of record. It is team based, with NPs, pharmacists, CHWs, RNs, and licensed social workers who visit the patient's home to meet the individualized needs of the patient. Patients are identified monthly based on high cost, high risk, chronic conditions. The NP does the clinical assessment, diagnosis and treatment planning. There is ongoing communication with PCP.

Best Practices:

- Collaboration and documentation is crucial to the program.
- Joint visits with member and various care team members initiated as needed to foster continuity.
- Monthly dashboard shared with staff has been helpful

Lessons Learned:

- Patient enrollment techniques vary by population
- Staffing models have changed over time
- Practice management and operational tracking is crucial
- Employee burnout is a realistic concern
- Measuring outcomes for the dual populations is a challenge

Results:

- Decrease in ER visits/thousand (2013-15), and some decrease in inpatient days/thousand 2014-15 (statistical significance is unavailable)
- Member Story: https://www.youtube.com/watch?v=YrxlI3ufmIY&t=21s

Additional Reading and Bibliography

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