Independence at Home (IAH):

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My own journey

1. Trained in VCUHS hospital and its clinics 1981-84
2. Started making house in 1984
3. Home-limited ill persons pose quality/safety challenges
   - Timely access to medical care
     - PROVIDER AND CAREGIVER SCHEDULES, TRANSPORT
   - Medical care uncoordinated + discontinuous
     - Lapses in care plans made at hospitals
     - Care plans not matched with patients’ actual needs
     - Insufficient interaction between home health agency + physicians
   - Lay caregivers desperate for help
   - Needless reliance on ambulance, ED, hospital, nursing homes

VCUHS: McKesson Safety/Quality Award 2014
Patient-centered care?

Hospital discharge instruction

“Office follow-up with PCP, within 3-5 days”
Social Supports ... and... Health Care

- Friends + family, in-kind
- Paid personal care
- Transportation, food, shelter, safety
- Communication
- Insurance
- Financial resources

- Accessible
  - Mobile team care
- Coordinated
  - Providers, time, settings
- Comprehensive
- Aligned with goals and needs
House call practice mechanics (care model)

Patients referred who are “too sick to go to clinic”, medically ill, function-limited, often with complex social issues

Initial comprehensive intake

Seen about once a month on average, 15 times a year; more or less often as needed

Seen same day for urgent problems
What happens during home visits

- Discover + accurately evaluate patient’s most important problems
  - “The only true ‘med rec’ is done at the kitchen table”
- Understand needs and capabilities of patient and caregivers
  - Functional and cognitive status
  - Environmental safety
  - Social support
- Develop trust
• Core House Calls team: ➤ “The right tool”

Physician
Nurse Practitioner or Physician Assistant
Nurse
Social Worker
Medical assistant/driver in some programs
Pharmacist consultant
Office support staff
IT support, mobile EHR is now vital
Data manager
Portable diagnostic technology
Administrator

Christine Yates-Patterson
Jay Holdren
Partners are essential

- SOCIAL SERVICE AGENCIES
- HOME HEALTH AGENCIES
- NURSING HOMES
- HOSPITALS AND SPECIALIST PHYSICIANS
- PHARMACIES
- Mobil x-ray and lab services
- CORE HOUSE CALLS TEAM, PATIENT + FAMILY
- DME PROVIDERS
Targeting: Population Needs + Resource Use

**NEEDS**
- Sick, frail, co-morbid, functionally impaired
- Mostly ambulatory, have chronic health conditions that require treatment
- Limited or no illness burden, episodic care, prevention

**COSTS (%)**
- Catastrophic illness: 70%
- Sick, frail, co-morbid, functionally impaired: 10%
- Mostly ambulatory, have chronic health conditions that require treatment: 30%
- Limited or no illness burden, episodic care, prevention: 60%

**POPULATION (%)**
Who needs home-centered team health care?

- Chronically home-limited, in community
  - About 3 - 4 million, with 3+ ADL deficits
  - Mostly elderly, some younger adults and kids
    - 1% of elderly in community are bedfast
  - Wide range of conditions, high co-morbidity, 5+ diagnoses
  - Reduced life expectancy
    - Most are not hospice-eligible at any time, acutely “sick” 2-3 times/year
    - Some are technology dependent (ventilators, etc.)

- Short-term home-limited subset
  - Another 2-3 million; acute illness/injury/surgery; hospice
Background to IAH design

- Evidence from 2 decades of work: clinical + financial success in the VA (130 programs) and in FFS Medicare
  - Estimated cost savings of 15%, relative to matched controls
- FFS mechanisms do not support full HBPC team model
  - Model is not prospering or growing in volume-focused FFS world
- Need alternate means of financing → shared savings
  - Value-based payment, align funding with desired outcomes
  - Payer partnerships
IAH design

- Medicare beneficiaries, voluntary participation
- Remain in Medicare, agree to have data analyzed
- Targeted: criteria required
  - Hospitalization in past 12 months
  - Use Medicare post-acute care (HHA, SNF, IRF)
  - Two or more serious health problems
  - 2 or more ADL deficits
- Care model: house calls team led by NP or Physician
- Use of EHR, 24/7 availability
- 200 or more patients managed per IAH site,
- QUALITY MEASURES – protect beneficiaries
- Guaranteed minimum savings, then shared savings
- Ineffective programs remediated or dropped
IAH Legislative timeline

- May 2009 House 2560, Markey, bipartisan support
- May 2009 Senate 1131, Wyden, bipartisan support, Senate Finance
- Became law March 2010, IAH demo created
- Demo initiated June 2012
- 16 individual sites and 3 consortia
IAH Demo Implementation

Disparate sites
> large
> small
> corporate
> academic
> health system affiliated
> varied geography

Formation of learning collaborative led by AAHCM, grant-funded helped true up model, support the sites: monthly phone calls and annual meeting

Model standardization and lessons learned
IAH Demonstration Year 1 Results (June 2015), per CMS website

Savings of over $25 million on 8400 high cost beneficiaries, over $3000 per beneficiary

12 of 17 programs (70%) participated in shared savings (saved 5% or more).
  - CMS awards incentive payments of $11.7 M

All programs improved on 3 out of 6 quality measures
  - Four programs (7 sites) met all 6 quality measures
Independence at Home
Independence at Home (IAH) Demonstration
Year 1 Practice Results
June 2015

<table>
<thead>
<tr>
<th>IAH Practice Name</th>
<th>Year 1 Spending Target*</th>
<th>Year 1 Expenditures*</th>
<th>Practice Incentive Payment</th>
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<tr>
<td>Boston Medical Center</td>
<td>$4,781</td>
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<td>Doctors Making Housecalls</td>
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<td>Mid-Atlantic Consortium</td>
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* The Year 1 Spending Target and Year 1 Expenditures are on a per beneficiary per month (PBPM) basis.

Monthly $ amounts

(VCU + 2 others)
IAH Extension Legislation

APRIL 21, 2015
IAH two-year extension (S 971) passes on Senate floor

MAY 31, 2015
Original IAH demonstration expires

JUNE 2, 2015
Ways and Means committee passes 2-year extension, by unanimous vote

JUNE 24, 2015
Energy and Commerce committee waives jurisdiction for IAH extension

JULY 15, 2015
IAH two-year extension H2196 (Burgess) passes on House floor

JULY 31, 2015
President signs two-year extension of IAH demonstration
Two Years of Success!

Demo Year 2

9 of 15 active IAH sites are reported with costs below “target”

Over $10 million in savings reported by CMS in Year 2, $35 million in 2 years

7 sites awarded shared savings in Year 2

IAH so far: 2 years of savings for Medicare, reduction in overall costs of care

*Work is ongoing to calibrate the shared savings model*
Questions?

peter.boling@vcuhealth.org
Please Fill Out Your Blue Evaluation Form
High-Need, High-Cost Patients: Challenges and Promising Models

#HNHC