VCU Health

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

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Patient-centered care?

bedroom

Staircase

Hospital discharge instruction

"Office follow-up with PCP, within 3-5 days"

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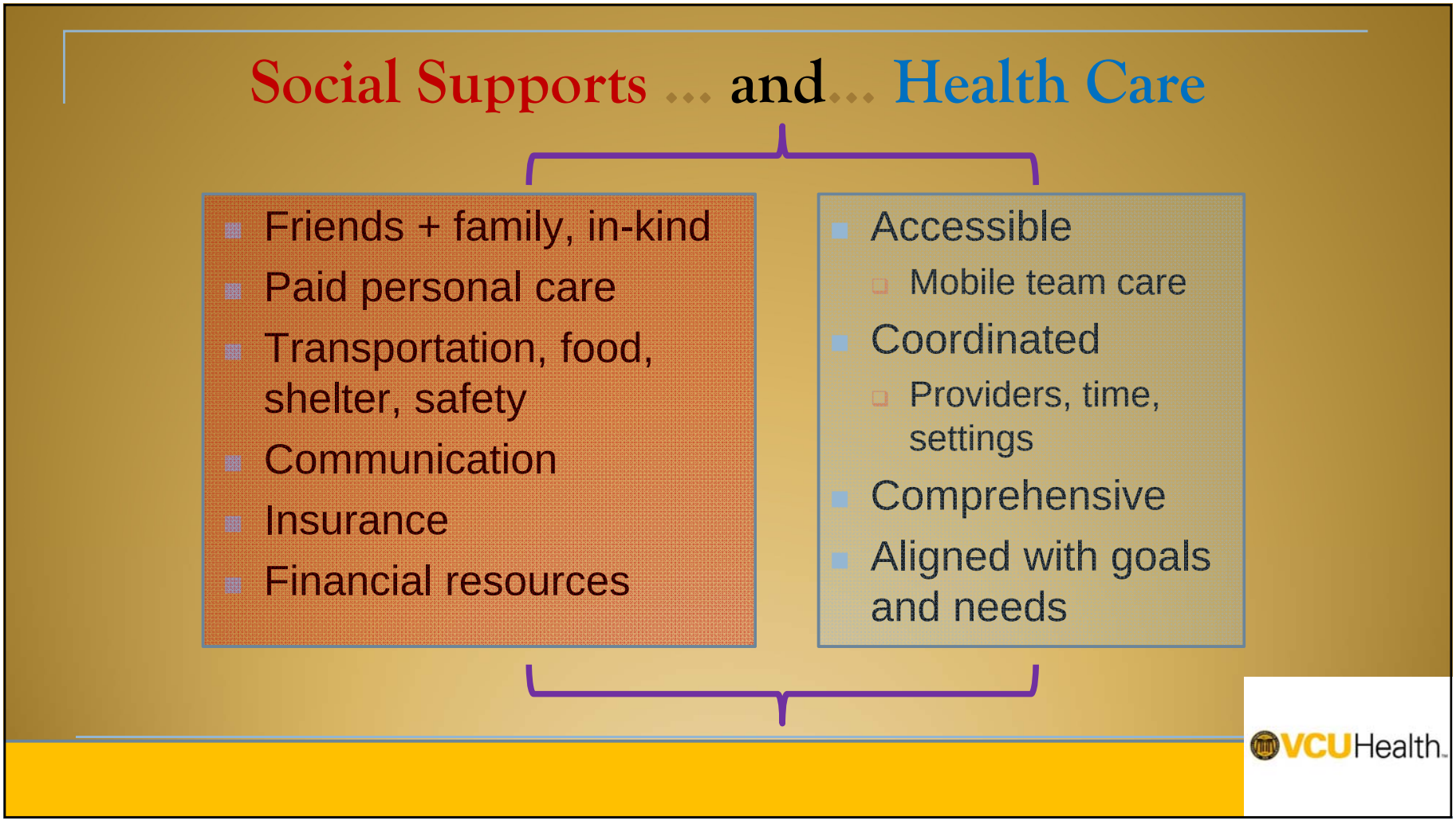
Social Supports … and… Health Care
Friends + family, in-kind
Paid personal care
Transportation, food, shelter, safety
Communication
Insurance
Financial resources
Accessible
Mobile team care
Coordinated
Providers, time, settings
Comprehensive
Aligned with goals and needs
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House 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

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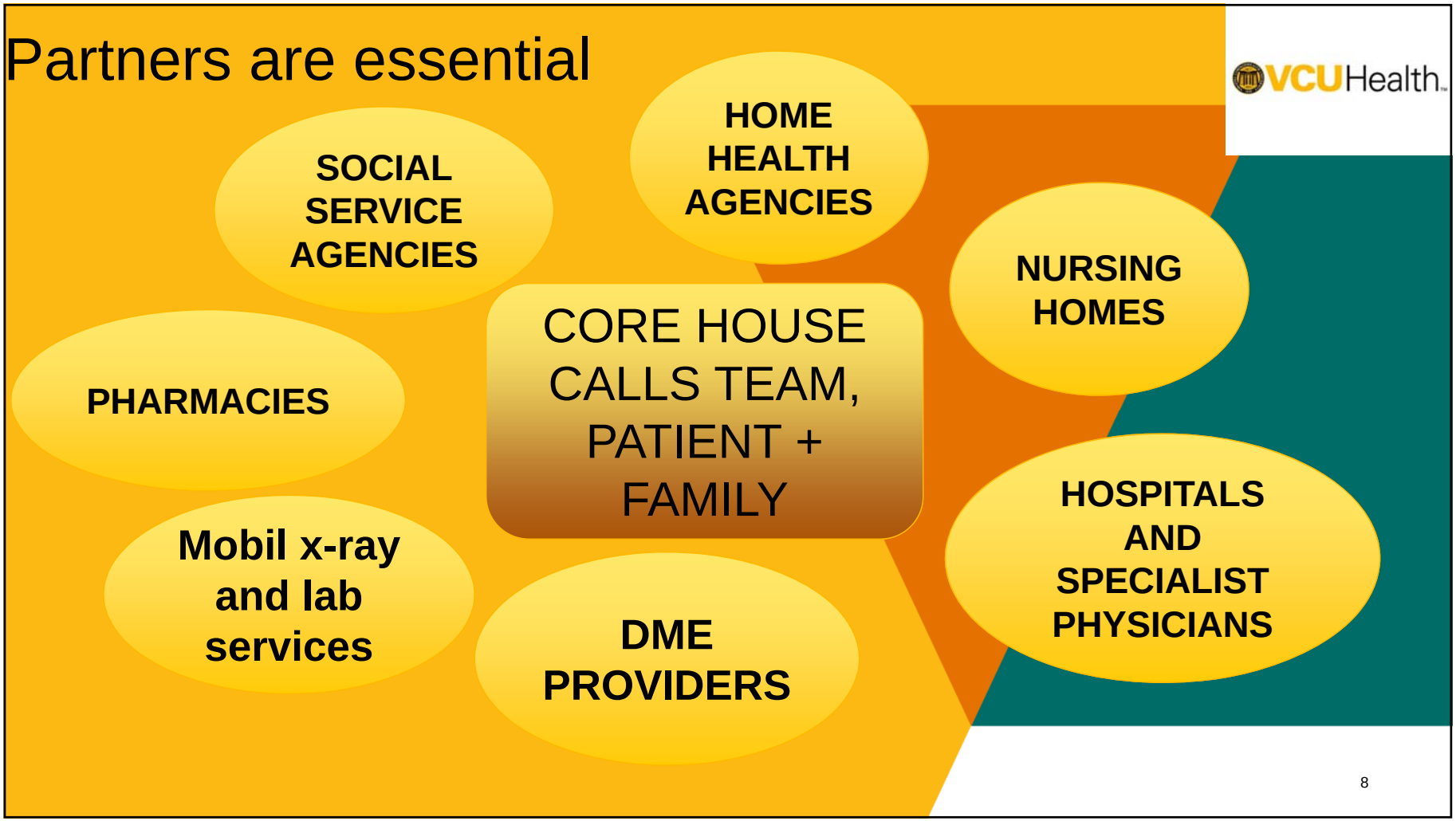
Partners are essential
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SOCIAL SERVICE AGENCIES
HOME HEALTH AGENCIES
NURSING HOMES
PHARMACIES
CORE HOUSE CALLS TEAM, PATIENT + FAMILY
HOSPITALS AND SPECIALIST PHYSICIANS
Mobil x-ray and lab services
DME PROVIDERS
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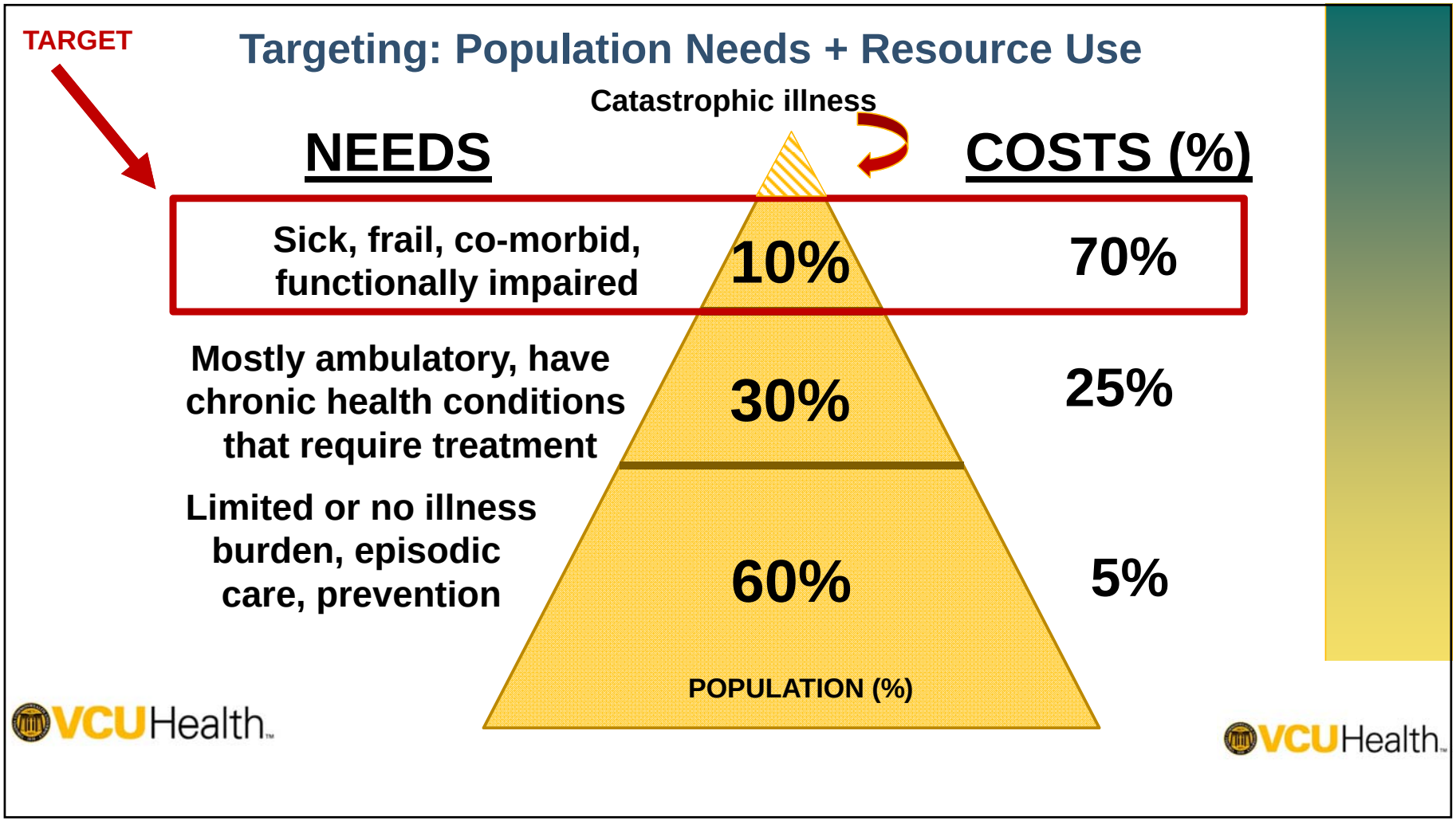
TARGET
Targeting: Population Needs + Resource Use
Catastrophic illness
NEEDS
COSTS (%)
Sick, frail, co-morbid, functionally impaired
10%
70%
Mostly ambulatory, have chronic health conditions that require treatment
30%
25%
Limited or no illness burden, episodic care, prevention
60%
5%
POPULATION (%)
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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 <u>not</u> 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

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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

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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

Ed Markey

Ron Wyden

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Date

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

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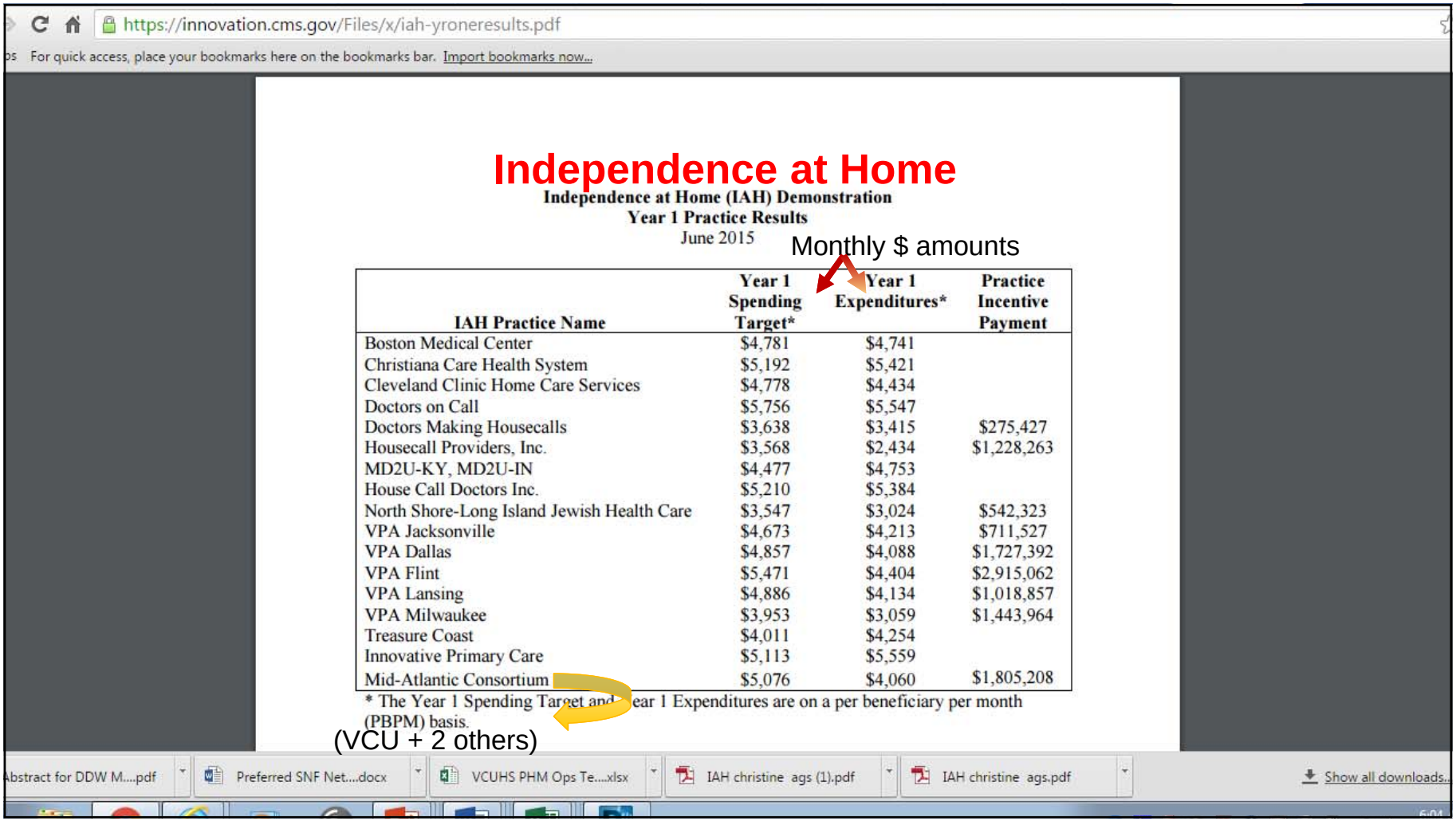

IAH Practice Name	Year 1 Spending Target*	Year 1 Expenditures*	Practice Incentive Payment
Boston Medical Center	$4,781	$4,741	
Christiana Care Health System	$5,192	$5,421	
Cleveland Clinic Home Care Services	$4,778	$4,434	
Doctors on Call	$5,756	$5,547	
Doctors Making Housecalls	$3,638	$3,415	$275,427
Housecall Providers, Inc.	$3,568	$2,434	$1,228,263
MD2U-KY, MD2U-IN	$4,477	$4,753	
House Call Doctors Inc.	$5,210	$5,384	
North Shore-Long Island Jewish Health Care	$3,547	$3,024	$542,323
VPA Jacksonville	$4,673	$4,213	$711,527
VPA Dallas	$4,857	$4,088	$1,727,392
VPA Flint	$5,471	$4,404	$2,915,062
VPA Lansing	$4,886	$4,134	$1,018,857
VPA Milwaukee	$3,953	$3,059	$1,443,964
Treasure Coast	$4,011	$4,254	
Innovative Primary Care	$5,113	$5,559	
Mid-Atlantic Consortium	$5,076	$4,060	$1,805,208

* The Year 1 Spending Target and Year 1 Expenditures are on a per beneficiary per month (PBPM) basis.

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

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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

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Questions?

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The COMMONWEALTH FUND

Affordable, quality health care. For everyone.

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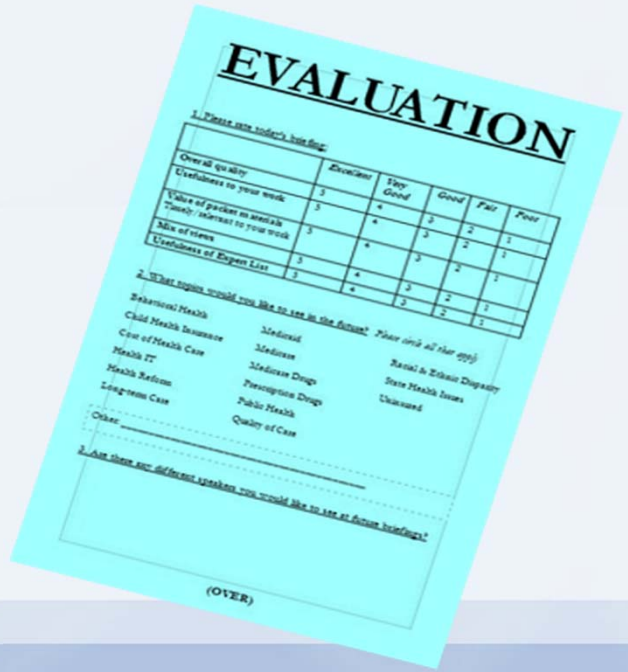


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The
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Affordable, quality health care. For everyone.
High-Need, High-Cost Patients:
Challenges and Promising Models
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