Integrating primary, palliative & hospice care in the home

Terri Hobbs
Executive Director

Nurse practitioner with a hospice patient
Mission Statement

*Housecall Providers* is dedicated to
• providing quality home-centered medical care
• integrating primary, palliative and hospice services for
• homebound members of our community
• compassionate physical, emotional and spiritual support through life’s journey

Patient with Caregiving daughter
Successes & Value of Home Care Practice

- Proactive primary care
  - Mission-driven
  - Patient-centered
- Team approach for the most complex patients
- In the residence, clinicians can see functional status and understand context of care at a glance
- Medically manage patients with chronic conditions to maximize quality of life through symptom control
- Early and frank discussions of end-of-life treatment decisions
- Shared decision-making with family and caregivers
- Timely hospice referrals improve quality of life

It takes a team

- Clinicians – MD’s, DO’s, NP’s & PA’s
- Transition team – RN’s & LCSW
- Palliative care team – RN’s, LCSW & spiritual counselor
- Hospice interdisciplinary team
- Intake
- Care coordinators
- Reception
- Administration
- Human resources
- Credentialing
- Billing
- Community relations/marketing
- Quality management
- Development (grants and fundraising)
- IT
- Board of directors
Successes & Value of Home Care Practice

• Satisfaction of patients/families/providers (2014)
  • 95% would recommend Housecall Providers to others
  • 99% said our service improves their quality of life
• Reduction of hospital admissions and readmissions
• Care coordination across multiple settings especially during transitions of care
• Care coordination insures patients have what they need when they need it
• Overall health care cost savings

Administrative Buckets

• **HR/Training** – Hiring, compensation, benefits, credentialing, orientation/mentoring, continuing education.
• **Accounting/Billing** – AP, AR, coding, contracting, ICD-10, payroll
• **Quality management** – Compliance, data tracking, hipaa, security, MU, PQRS, answering service (24x7 coverage)
• **IT** – servers, desktops, laptops, printers, landlines, cell phones, hotspot, copiers, fax. Support, maintenance, interfaces, EHR
• **Marketing/Community relations** – Advertising, newsletters, e-news, media, community outreach
• **Fund development/Board** – philanthropy, donor software, events, board/committee meetings
Independence at Home

- Designed by the American Academy of Home Care Medicine
- Introduced into Congress by Senator Ron Wyden (D-Oregon)
- Included in the Affordable Care Act of 2010 - Obamacare
- Housecall Providers is one of 17 IAH demonstration sites
- Criteria for patient enrollment into IAH – all 5 must be met
  - Medicare fee-for-service
  - Two or more chronic conditions
  - Dependent in two or more ADL’s
  - Received home health or rehab in previous 12 months
  - Hospitalized in previous 12 months

IAH Shared Savings Methodology

- Shared savings payment model rewards clinicians for saving Medicare dollars while improving care for the 5% of beneficiaries who use nearly half of the Medicare budget
- Model compares practice with control group selected by Medicare for similar demographics
- IAH practice must show minimum of 5% cost savings in comparison to control group. If less, practice does not receive shared savings.
- If cost savings >5%, split excess 80% to practice, 20% to Medicare
- To receive cost savings, practice must also achieve minimum quality measures and patient satisfaction
Trends since IAH started in 2012

- Shifting reimbursement models
  - Movement toward quality indicators driving reimbursement, away from FFS
- What pays off
  - Increased interdisciplinary support for patient primary and palliative care
  - Tighter control of care transitions in and out of hospital
- Introduction of transition team coincided with marked reduction in HCP all-cause 30-day readmission rates:
  - Our average all-cause readmission rate prior to TT introduction – 16%
  - Average all-cause readmission rate since TT introduction – 10%
Readmission Rate Data

Independence at Home Year One Results

• Medicare savings on 8,400 pts = $25,000,000
• 9 out of 17 practices showed savings
• 2 year extension began October 1 2015
• Goal is to convert IAH to a permanent Medicare benefit

• HCP Total Patients enrolled = 219
• Savings percentage revised methodology actual = 31.8%
• Total Dollars saved = $1,859,141
Financial Data

- Overall budget $10 million
- *Fee-for-service* currently doesn’t cover the cost of in-home primary care
  - not a financially viable practice model
- How we manage the shortfall
  - Hospice program – mutual offset
  - Fundraising
  - IAH - The future of shared savings
  - Enhanced insurance contracts
  - Meaningful use, PQRS, PCPCH

### EXPENSES & REVENUE

- **Expenses**: $4,340,959.00
  - MU Bonus: $197,000.00
  - IAH: $1,228,000.00
  - Stipend: $700,000.00
  - Fee for service: $2,270,000.00
Contract Negotiation

- Payer 1 – Medicare/Medicaid Contractor - FFS plus $100 stipend PMPM plus NP salary for 1 year
- Payer 2 – Medicare Advantage plan - FFS plus $150 stipend PMPM plus FFS payment for palliative care nurse and social worker
- Payer 3 – Medicare Advantage plan - PMPM stipend
- Payer 4 – Medicare Advantage plan – currently negotiating, meeting April 21st

Amy Long, NP with hospice patient
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