



housecall providers

bringing health care home

Integrating primary, palliative
& hospice care in the home

Terri Hobbs
Executive Director



Nurse practitioner with a hospice patient





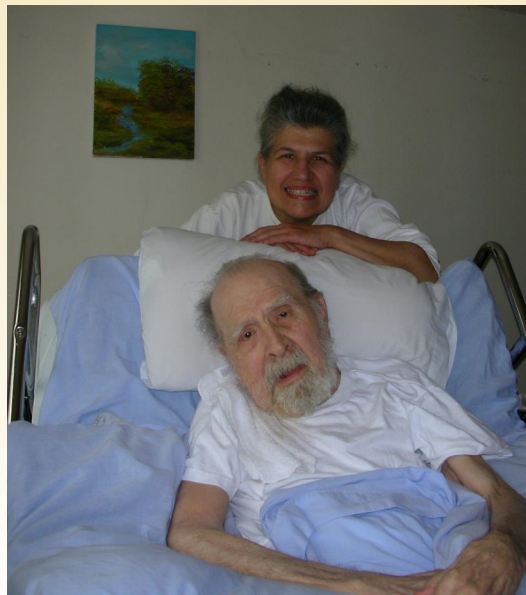
Mission Statement

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 | • Administration |
| • Transition team – RN's & LCSW | • Human resources |
| • Palliative care team – RN's, LCSW & spiritual counselor | • Credentialing |
| • Hospice interdisciplinary team | • Billing |
| • Intake | • Community relations/marketing |
| • Care coordinators | • Quality management |
| • Reception | • 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

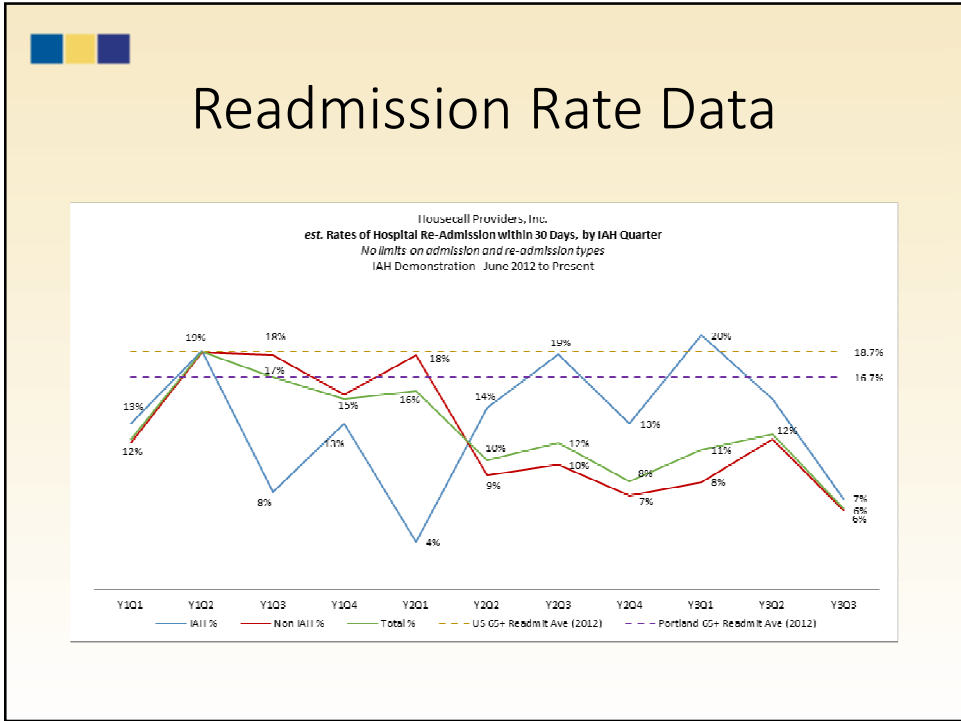


HCP Founder Dr. Benneth Husted with Senator Wyden and IAH patient, June 2012




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%

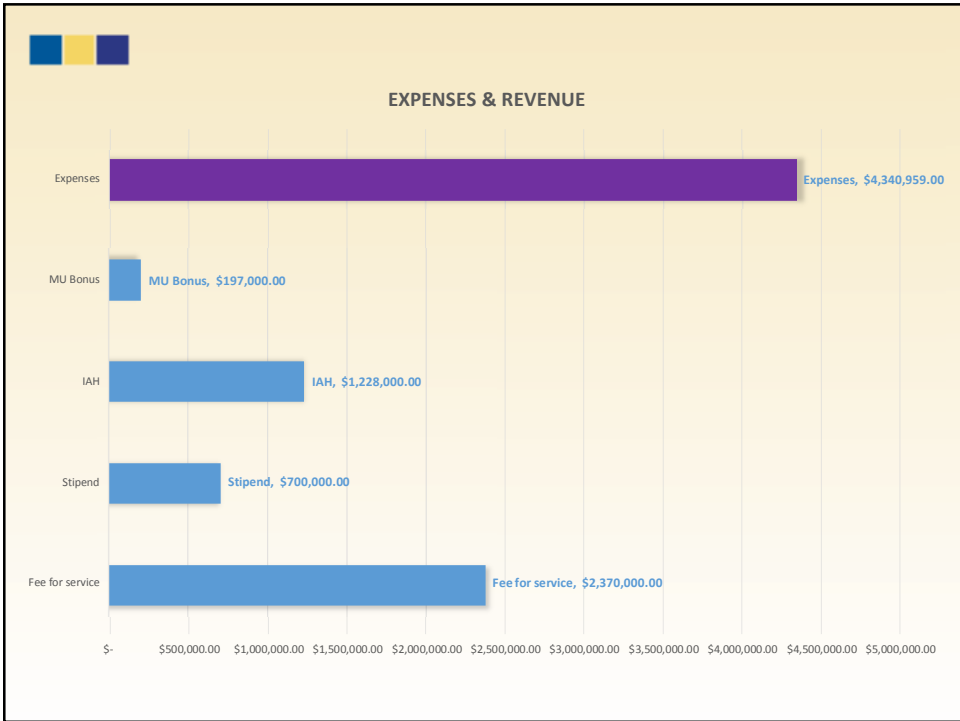


- ### Independence at Home Year One Results
- Medicare savings on 8,400 pts = \$25,000,000
 - 9 out of 17 practices showed savings
 - 2 year extension began October 1 2015
 - Goal is to convert IAH to a permanent Medicare benefit
 - HCP Total Patients enrolled = 219
 - Savings percentage revised methodology 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





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





Contact Information

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