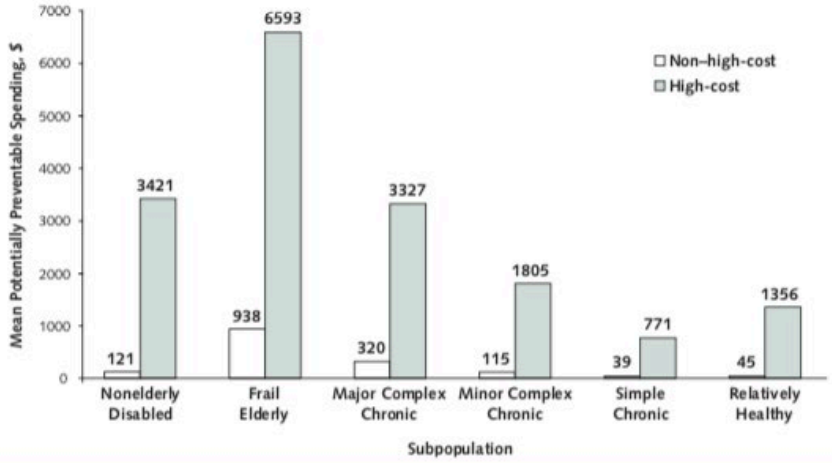
Home Visit Model

Background. To improve population health and ensure that their most vulnerable beneficiaries receive timely effective care, healthcare systems are increasingly reaching beyond their traditional boundaries to engage patients in their homes and communities. One important goal of these initiatives is to create a closer link between patients and their primary care teams so that patients receive proactive timely care in order to reduce exacerbations of chronic conditions that might otherwise result in emergency department visits or hospitalizations. Home visiting staff might accomplish this by identifying initial signs and symptoms of an exacerbations, making medical appointments and arranging transportation to the appointment or for services to be brought to the patient's home.

Healthcare systems and ACOs are also focusing to a much greater degree on the impact of social determinants of health on their covered populations and the impact of these social factors on health care utilization. Thus, a second important goal is to identify social risk factors like inadequate access to healthy food, unstable housing, lack of physical activity and social isolation, and to actively enroll patients in social services available in their communities. Finally, some patients have great difficulty getting to medical appointments. Some home visit programs also deliver primary care services to patients in their homes. These efforts are likely to benefit frail elders, patients with complex co-morbidities and those with psycho-social risk factors who are at risk of declines in heath and potentially preventable health care utilization (which is substantial based on the chart below) due to gaps in care.

Figure 2. Mean potentially preventable spending, by high-cost status, in Medicare subpopulations.



Costs were calculated from Medicare administrative claims data from 2012.

Source: Jose Figueroa et al. Concentration of Potentially Preventable spending Among Medicare Subpopulations. Annals of Internal Medicine.

Six national health foundations have joined in a major initiative to improve care for high-need, high-cost individuals. The foundations have identified accountable care organizations (ACOs) as an important venue to implement evidenced-based programs that better address the needs of this population. The ACO financial model creates incentives to actively manage this population while the ACO structure provides a platform to do so effectively. Three of the foundations have partnered with the Institute to support a planning process to design a demonstration project in which ACOs deploy evidence-based

programs to improve care for high-need, high-cost individuals, with technical support and an evaluation of clinical and economic outcomes provided through the Institute.

Project objective: The purpose of this project is to support ACOs with implementation of new programs to improve care for high-need, high-cost individuals through a combination of technical assistance, training and systematic learning activities.

Home visit program objectives. Participants in the demonstration project are expected to establish a systematic process to identify high-risk patients who would benefit from a home visit initiative, recruit and train individuals who can develop trusting relationships with patients, systematically assessing patients' unmet medical and social needs and developing plans for closing these gaps. Home visit personnel are expected to facilitate timely, effective interactions with the patients' primary care team and help them enroll in community based social service programs. The ultimate objectives of the program are improving individuals' quality of life, reducing use of unnecessary or avoidable health services, closing quality gaps and taking steps to address social isolation.

Identifying patients with complex needs. Many types of patients could benefit from home visit programs. As shown above, frail elderly, the disabled, and patients with major complex chronic conditions are more likely to incur preventable healthcare spending. Within these groups, ACOs may focus on subsets of patients such as those with functional limitations, socially isolation, behavioral health diagnoses, or social and physician environments that adversely affect their health. Each ACO will be select its target group of patients and its preferred method for identifying eligible beneficiaries, which may include clinician referral, risk stratification algorithms or some combination of the two.

Staffing. This demonstration program offers participants flexibility in the personnel they select for home visits. This could include trained lay persons functioning as community health workers, paramedics, nurses or nurse practitioners. Each site may choose a staffing model that fits their objectives for the target population. However, participants will need to clearly articulate their program's supervisory structure and how home visit staff will interact with the primary care team.

Home visits structure. Each participating ACO must articulate the objectives, frequency, and standard elements of home visits. New patient visits should include an assessment of patient goals, care gaps, relevant social factors and service needs, which could be conducted with standardized tools or check lists. Participants will be expected to collect some standard information during each visit to support future program evaluations. To the degree possible, these requirements will focus on information that most ACOs would routinely collect anyway.

Assessing return on investment. To determine the effectiveness of these models, each site will be asked to provide some information about beneficiaries served, non-billable services provided and operating costs. We will work with participating organizations to devise a feasible approach.

Technical assistance. Participants will receive technical assistance with: identifying high-risk patients; program design (job descriptions, training modules, patient assessment tools, home-visit protocols; data analytic support; and staff training. All ACOs will participate in a learning collaborative that includes expert faculty (ACO leaders with home-visit program experience), and peer-to-peer workshops. The learning collaborative includes two in-person meetings with travel support. More details forthcoming.