Improving Care for High-Need, High Cost Patients

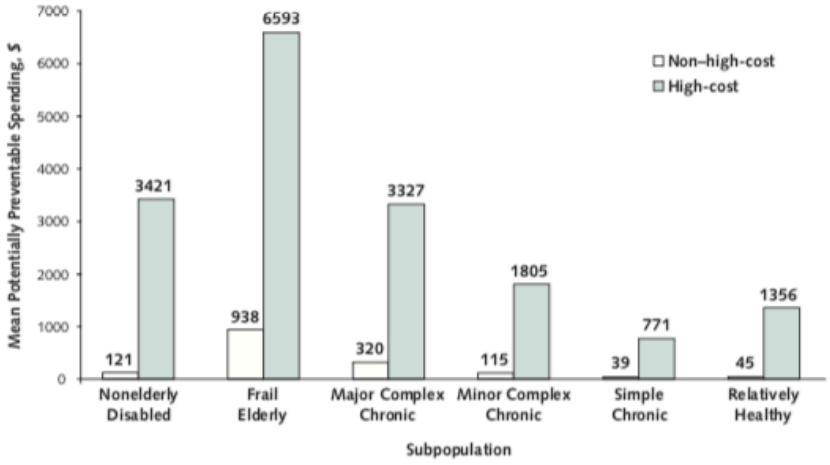
Home Visit Demonstration Project

Background. Healthcare systems are reaching beyond their traditional boundaries to engage patients in their homes and communities. One objective of these initiatives is to create a closer link between patients with complex needs 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 visit staff can do this by identifying initial signs and symptoms of an exacerbation, making medical appointments to address emerging problems, and arranging transportation.

ACOs are also focusing on social determinants of health, which if not addressed can lead to substantial preventable spending. Thus, a second objective of these initiatives is to identify social risk factors like inadequate access to healthy food, unstable housing, lack of physical activity and social isolation, and to actively patients in social services available in their communities.

Finally, some patients have difficulty getting to medical appointments. Home visit programs can offer primary care services to patients in their homes. This can provide substantial benefit to frail elders, patients with complex co-morbidities, behavioral health conditions and cognitive impairment, and reduce preventable health care use that result from 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. Three foundations have partnered with the Institute to design a demonstration project in which ACOs deploy evidence-based programs to improve care for high-need, high-cost individuals. The demonstration will offer technical support and shared learning opportunities to participating ACOs and the Institute will evaluate the impact of the program for each ACO.

Project objective: The purpose of this project is to support ACOs with implementation of programs to improve care for high-need, high-cost individuals through a combination of technical assistance, training and systematic learning activities. Our goal is to develop tools that will help ACOs target patients and use resources most effectively in order to reduce healthcare spending. The Institute will capture learnings on implementation and key success factors as resources for the ACO community.

Home visit program objectives. This project will work with ACOs to implement proven home visit models that more effectively address patient needs and reduce avoidable medical spending. Home visit personnel will facilitate timely communication with the patients' primary care team and help enroll patients in community based social service programs. The program objectives are improving individuals' quality of life, reducing use of unnecessary or avoidable health spending, and closing quality gaps. The overall project goal is to develop models that can be replicated and scaled across ACOs nationwide.

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 difficult social and physician environments. Each ACO will 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. ACOs can select a variety of personnel for home visits: 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. Participants must clearly articulate their program's supervisory structure and how home visit staff will interact with the primary care team.

Home visit structure. Each ACO must articulate the objectives, frequency, and standard elements of home visits. We will provide project resources to help ACOs make these decisions. 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 collect some limited amount of information during visits to inform program evaluation, but this will be limited to information that most ACOs would routinely collect anyway.

Assessing return on investment. We will evaluate the impact of these models using the NAACOS Medicare claims data warehouse. This allows us to limit required data collection for participating ACOs. Each ACO will be asked to identify the beneficiaries served by the program, date of enrollment, number of home visits provided and services delivered during the visits. We will work with ACOs to minimize the work required for data submission.

Technical assistance. Participants will receive technical assistance from the Institute to launch their home visit programs. Support will include help 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 have the opportunity to 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 are forthcoming.

Learning collaborative structure. The learning collaborative will run for approximately 12 months with two in-person meetings and monthly virtual meetings. We will develop the initial agendas for the virtual meetings but the content will ultimately be driven by the interests and needs of participants. Virtual meetings will include presentations by expert faculty, ACO presentations about their own model development and group problem solving. By sharing the experience of planning and launching home visit programs, ACOs have the opportunity to learn from their peers which will facilitate more efficient problem resolution and adoption of best practices.