integra
Community Care Network

Integra @ Home
Acute Care at Home – Partnering with paramedicine

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Disclosures

- Ana Tuya Fulton, MD
  - Member, Aetna national quality committee
  - Faculty, RI-GWEP HRSA funding to provide education in geriatrics for primary care teams and interprofessional trainees
  - No bias in presentation

Objectives

- Describe reasoning behind “acute care at home” and the evidence base
- Introduce our Integra @ Home model
- Review our partnership model
- Discuss lessons learned

Who Are We at Integra?

- Care New England - 3 hospitals: Kent, WIH, Butler
- Certified home health & hospice agency – VNA of CNE
- The Providence Center - ambulatory behavioral health provider
- Affiliated with RI Primary Care Physician Corporation
- Integra is responsible for ~ 120,000 covered lives
  - MA, MSSP, Commercial, Medicaid AE

Identified Operational Challenge

- High cost/high need beneficiaries
- Chronic disease
- Disabilities
- Social complexities

Why is this important?

- Hospitalization is not always ideal or even pleasant
- Patients, caregivers and families need options
- Expensive care doesn't always provide optimum health
- Older adults can have adverse events with hospitalization

Goal: Care that older adults *WANT*

- Increase “goals of care” conversations
- ***Anticipate*** emergencies & expected complications
- More care in the home, more options
- Partner with others to provide critical support services

Mrs. D

- 104 years old, medical history of CHF, hypertension, frequent UTIs and hospital stays typically complicated by delirium and confusion. Lives at home with her son who is her caregiver with private aid support, fiercely independent and does not want any aggressive care.

Mrs. D

- Typical course – UTI begins and she gets confused, disoriented and it's hard for her son to keep her safe
- She goes to the ER where she always gets admitted due to her age and medical history
- She gets more confused, ends up in bed with medications to keep her calm, and then needs a rehab stay prior to going home
- Cycle repeats....

Mrs. D

- She's frustrated and spends 2 -3 weeks at a time in this process
- Son feels guilty "but I had to take her in, right?"
- Our nurse care manager "there has to be a better way!"

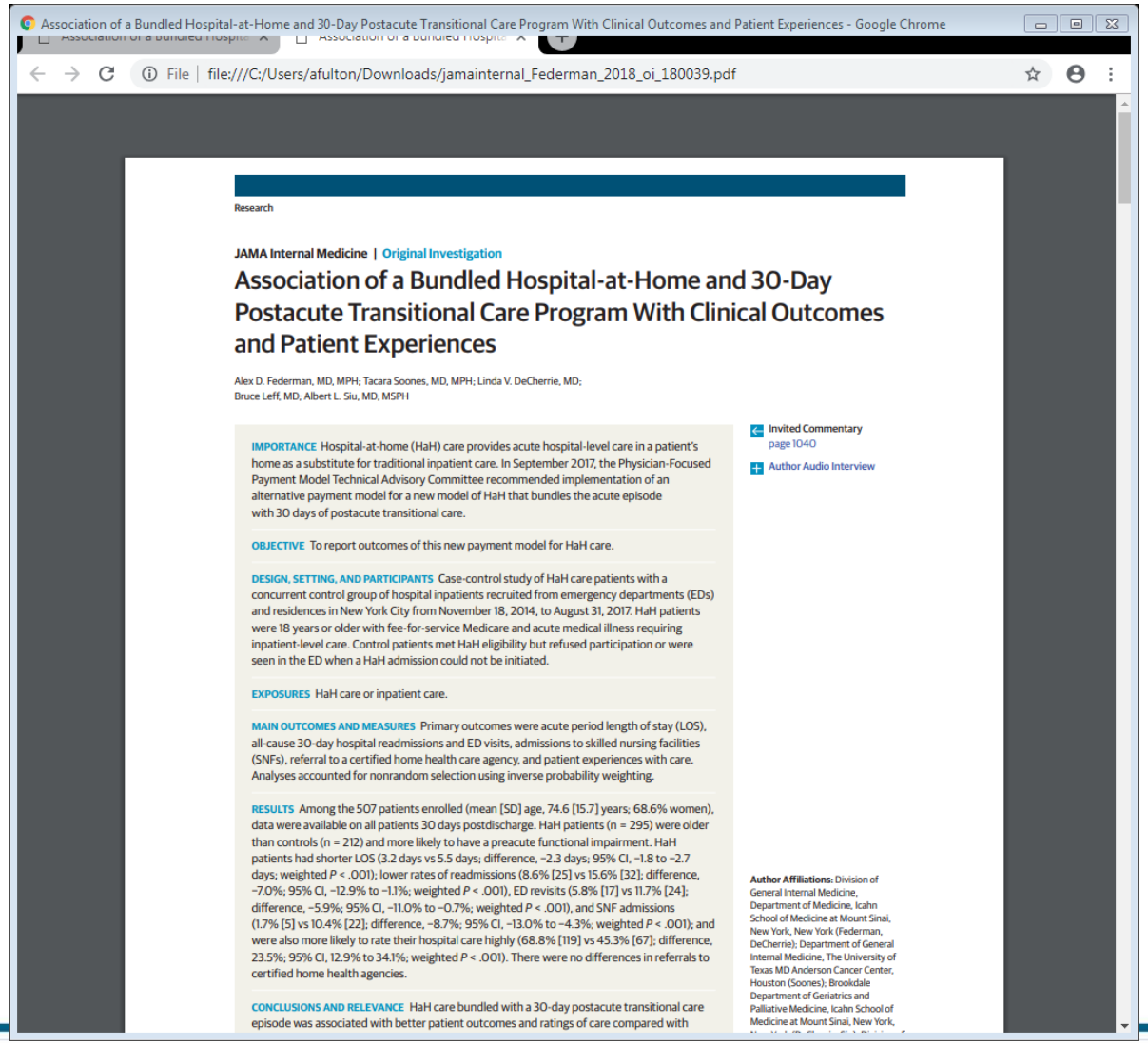
Why I@H?

- Our patients needed a higher level of care at home, and often **expressed a desire to stay out of the hospital**
- We wanted to be proactive not reactive
- **Our staff were hungry for better options!**

Existing programs

- Mt. Sinai
- Hopkins
- Brigham

The evidence for hospital at home


Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences - Google Chrome

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Research

JAMA Internal Medicine | Original Investigation

Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences

Alex D. Federman, MD, MPH; Tacara Soones, MD, MPH; Linda V. DeCherrie, MD; Bruce Leff, MD; Albert L. Siu, MD, MSPH

Invited Commentary page 1040

Author Audio Interview

IMPORTANCE Hospital-at-home (HaH) care provides acute hospital-level care in a patient's home as a substitute for traditional inpatient care. In September 2017, the Physician-Focused Payment Model Technical Advisory Committee recommended implementation of an alternative payment model for a new model of HaH that bundles the acute episode with 30 days of postacute transitional care.

OBJECTIVE To report outcomes of this new payment model for HaH care.

DESIGN, SETTING, AND PARTICIPANTS Case-control study of HaH care patients with a concurrent control group of hospital inpatients recruited from emergency departments (EDs) and residences in New York City from November 18, 2014, to August 31, 2017. HaH patients were 18 years or older with fee-for-service Medicare and acute medical illness requiring inpatient-level care. Control patients met HaH eligibility but refused participation or were seen in the ED when a HaH admission could not be initiated.

EXPOSURES HaH care or inpatient care.

MAIN OUTCOMES AND MEASURES Primary outcomes were acute period length of stay (LOS), all-cause 30-day hospital readmissions and ED visits, admissions to skilled nursing facilities (SNFs), referral to a certified home health care agency, and patient experiences with care. Analyses accounted for nonrandom selection using inverse probability weighting.

RESULTS Among the 507 patients enrolled (mean [SD] age, 74.6 [15.7] years; 68.6% women), data were available on all patients 30 days postdischarge. HaH patients (n = 295) were older than controls (n = 212) and more likely to have a preacute functional impairment. HaH patients had shorter LOS (3.2 days vs 5.5 days; difference, −2.3 days; 95% CI, −1.8 to −2.7 days; weighted $P < .001$); lower rates of readmissions (8.6% [25] vs 15.6% [32]; difference, −7.0%; 95% CI, −12.9% to −1.1%; weighted $P < .001$), ED revisits (5.8% [17] vs 11.7% [24]; difference, −5.9%; 95% CI, −11.0% to −0.7%; weighted $P < .001$), and SNF admissions (1.7% [5] vs 10.4% [22]; difference, −8.7%; 95% CI, −13.0% to −4.3%; weighted $P < .001$); and were also more likely to rate their hospital care highly (68.8% [119] vs 45.3% [67]; difference, 23.5%; 95% CI, 12.9% to 34.1%; weighted $P < .001$). There were no differences in referrals to certified home health agencies.

CONCLUSIONS AND RELEVANCE HaH care bundled with a 30-day postacute transitional care episode was associated with better patient outcomes and ratings of care compared with

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H@H patients had:

- shorter LOS (3.2 d vs. 5.5 d)
- Fewer ED revisits (5.8% vs. 11.7%)
- Fewer SNF admissions 1.7% vs. 10.4%
- Higher ratings of care experience

Future developments

National efforts

- PTAC recommendation
- H@H user group – Sinai, Hopkins & Brigham with West Health and Hartford Foundation support
  - National + Canada
  - Goal – provide the regulatory guidance, quality metrics, and standards
- Integra at the table

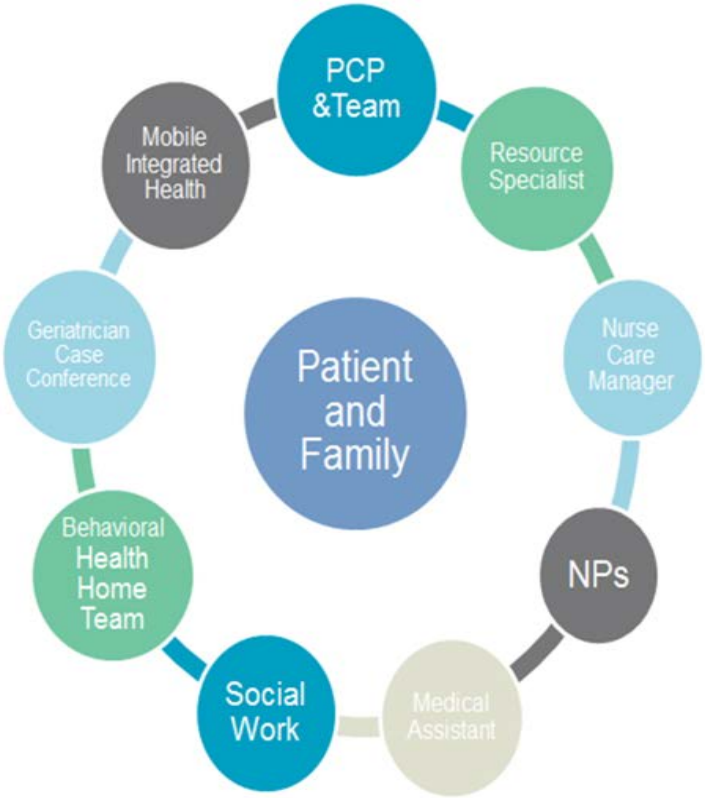
Our journey….

- New ACO
- Complex care management program
- Focus on “what matters”
- IHI conversation project sponsors
- IHI – West Health Institute - grant opportunity to “test alternatives to acute care”

Our Model:

- Step up from our existing complex care management program
- Careful patient selection
- Detailed criteria for enrollment

Complex Care Management Team



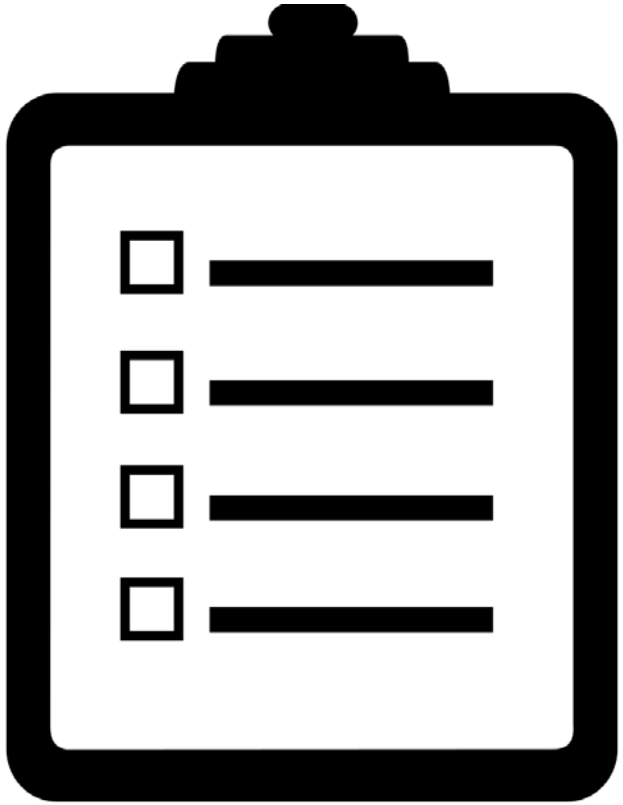
- Enrollment factors:
- Cost analysis
- Claims and utilization
- PCP referral
- Hospitalization outreach
- Risk assessment - payers
- Many are frail & older with multi-morbidity

Early steps

- Existing program with NPs in the field to augment PCP practice care
- “Call first” campaign -- we were using this to engage with patients and families to call our team before seeking acute care/ED care
- Patients were engaged in needs assessment by our nurse care managers & they were excited about the option for more care at home

Enrollment criteria

- Adults over 70
- Higher risk population
- Target diagnoses
- Exclusion criteria



Pre-enrollment:

- Nurse case manager electronic referral form
- PCP referral
- I@H team case discussion and review
- I@H clinician and Community Paramedicine pre-enrollment home assessments
- Patient/family consent
- Social work screening – caregiver support
- Proactive visits begin

Early lessons learned:

- Finding the right partners is important
- Response time is key
- Test, test and test some more!!
- Adequate coverage and collaboration is crucial
- Communication and team building

Team building

- Weekly “huddles” I@H team and community paramedicine team
- Team checklists with processes and communication guidelines for I@H episode
- Layers of coverage to have backup available

Key decisions

Most successful team for our go-live involved:

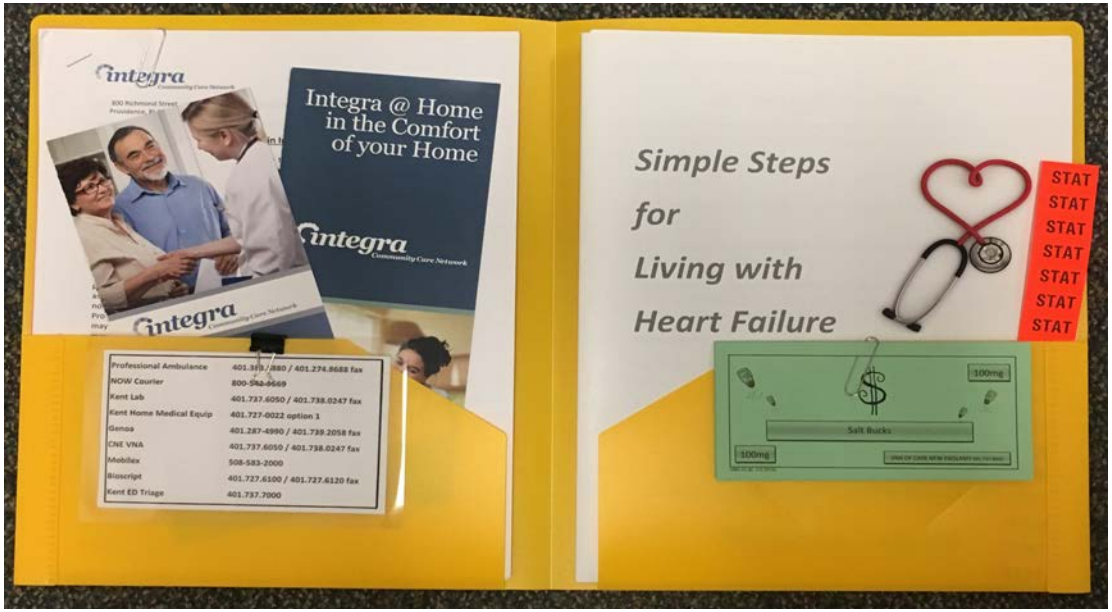
- Physician, physician assistant/NP clinician team
- Nurse care manager as the communication lead/hub of care
- Community paramedicine as core partner and team member

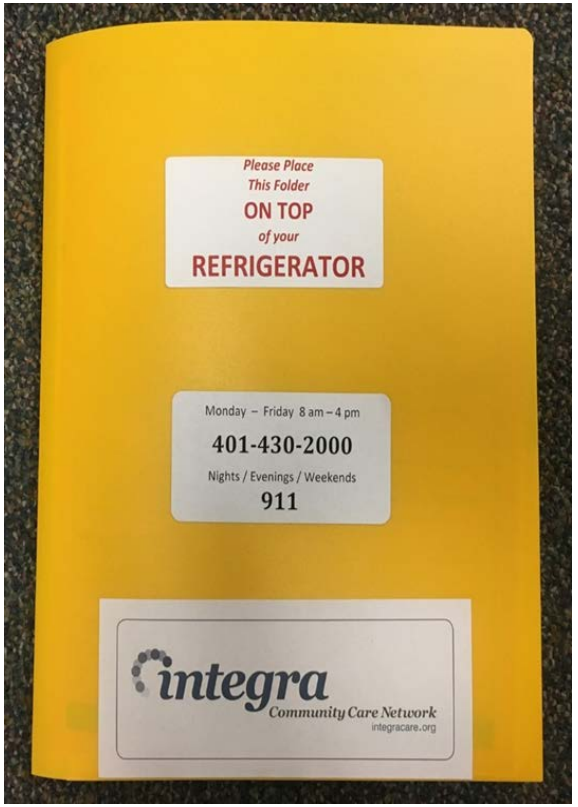
Model at Go Live!

- Patient identified and pre-enrolled
- Pre-enrollment visits by I@H clinician (PA or MD), MSW and community paramedicine team
  - Safety assessment, medication reconciliation, goals of care discussion, plan of care, care giver stressors
- VNA, Pharmacy, IV infusion, lab services lined up
- “Activation” call to Integra on call triggers I@H episode.
- Followed x 30 days after discharge from acute episode of care

Family and Caregiver Education

- When, Why and How to call us
- Integra @Home folder





Mr. F.

- 82 years old with COPD, CHF, CAD, former smoker, frail, frequent hospitalizations for CHF and COPD exacerbations. Lives with a family member who is a full time caregiver and his only support. He has been frustrated by ongoing hospitalizations and gets confused by all the medication changes that happen each time.

Mr. F.

- His NCM introduces I@H for CHF and he is thrilled, he signs right up. First hospitalization at home goes well and 48 hours in he is thrilled.
- 24 hours later his shortness of breath is worse and he is seen acutely by the community paramedicine team and the PA.

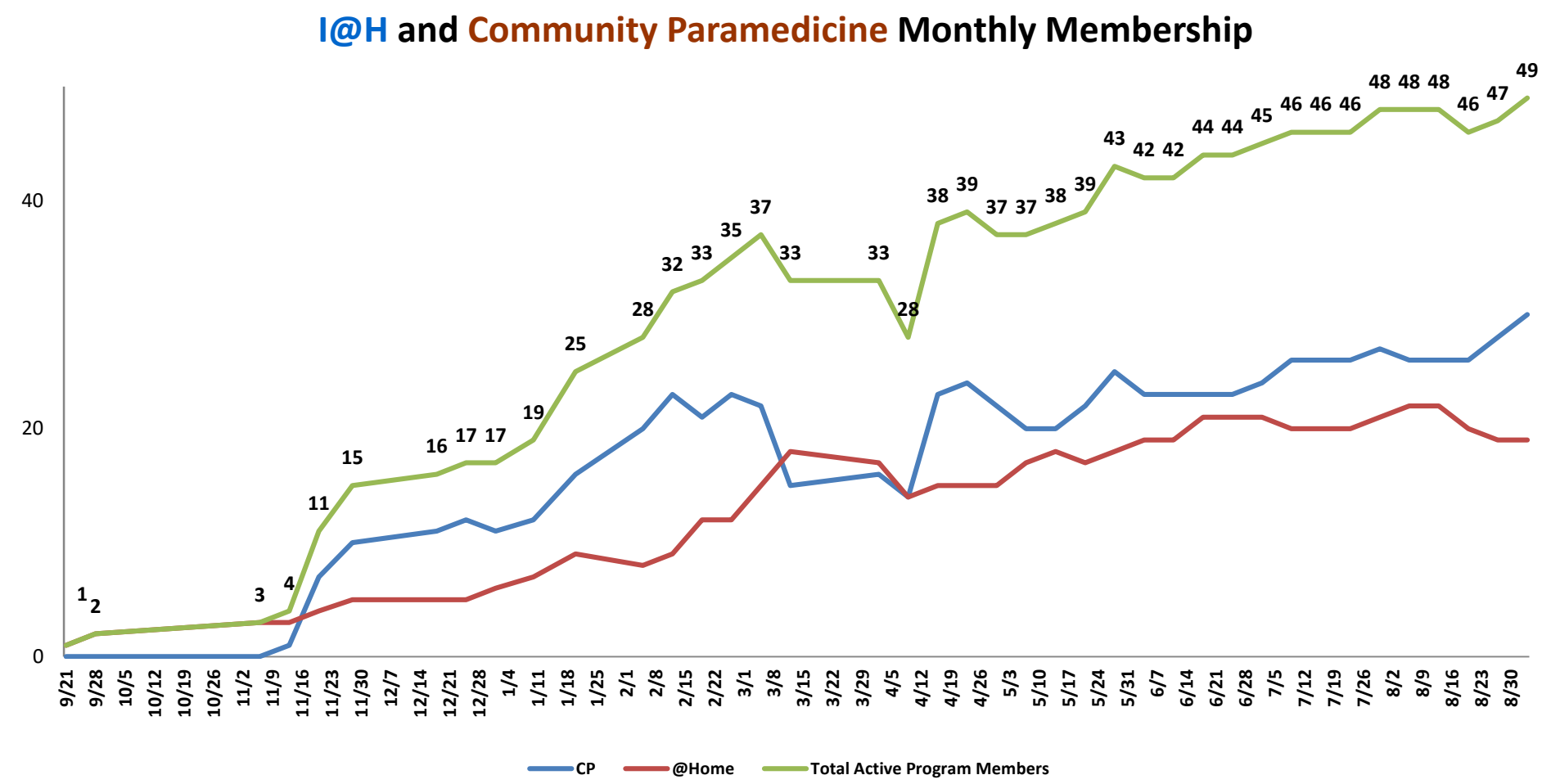
Mr. F.

- What happened?
- “The comforts of home…”
  - Delivery and processed foods
  - Cigarette breaks

Identifying safety risks

- Response to change in condition – can we be timely enough?
- Adverse events – medications, disease escalation
- Family/caregiver buy in and adherence
- Injury due to physical hazards in the home
- Non-arrival of equipment – O2 for example
- Adverse effects on family caregivers - How can we watch for that? Social work support?

Monthly Membership



Clinical results to date

Program	Possible ED diversions	Possible IP diversions	I@H activations	Totals
Community Paramedicine	54	32	n/a	86
Integra @ Home	53	31	47	84

Referrals	Number	Percent
Hospice	7	20

Patient survey results

17 Surveys	48 Mailed since inception*	35% Response rate
Were we able to provide coverage during the D		53% Always
Evening, Nights,Wkend?		47% Always
Did we provide explanations?		73% Always
Were we all respectful?		75% Always
Did our team members discuss specific goals?		88% Always
How do our programs rate?		94% Good or Above
Have our providers improved your knowledge?		59% Just Some
Was the ER Avoided?		47% of the time
Do you Recommend our Programs?		94% Yes
Patient completed the survey:		50%

* some patients have dis-enrolled &/or expired. A few have recieved duplicate mailings.

Mrs. B

- Mrs. B. 72 year old with anxiety, COPD/CHF, lives alone. Functional impairment, frequent episodes of shortness of breath, ER and hospitalizations. CP visits once a week proactively helped her with anxiety and reduced ED/inpatient stays. Developed a closer relationship with NCM and more supports provided in the home.

Future Plans

- Provider survey
- Increase eligibility criteria
- Hiring additional clinicians
- Dedicated CCM team (nurse care manager and scheduler/coder/biller)

Summary:

- Hospital at home programs improve quality of care and to better meet “what matters” to our patients
- Individualizing the program to the setting & the patient population is important
- Partnerships, the right ones, are key
- Patient/caregiver education & support is important
- Test, and re-test & adapt as you go

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Questions?

Thank you

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