Leadership Question #2

How Is Your Organization Prepared To Participate In New Non-Traditional Care At Home Models?

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New choices to receive care at home centers on patients receiving acute level care in the home. COVID-19 was the accelerator, but many of these models were already launched pre-COVID. What do these new models mean to the future of your organization?

Non-traditional care at home models is expanding into a new era. The focus of non-traditional models offers choice to consumers and their preferences and the ability to expand connected health programs to the home.

The twist to non-traditional programs is to keep care at home leadership's eyes wide open about the impact to their organizations. Waivers are changing rules, policies have changed, and the role of who can care for patients in the home is transforming models.

In this article, are two examples of non-traditional care at home models creating new choices for consumers/patients.

1.

The Acute Hospital Care at Home Program

The Acute Hospital Care at Home program builds off of CMS's Hospitals Without Walls program launched in March 2020. The program provides regulatory flexibility for hospitals to treat patients in locations outside the hospital, including their homes.

Patients in the program can only be admitted for at home acute care from an emergency room or inpatient bed. They will receive at least two in-person visits a day from a registered nurse or paramedic. To qualify for CMS waivers, participating hospitals would have to screen patients and their homes to assess compatibility.

The program expands beyond COVID-19 patients. The broad range of acute conditions includes asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease (COPD).

THE TWIST TO CARE AT HOME PROVIDERS

The new program is separate from more traditional home health services. It will be only for patients who would otherwise be admitted as hospital inpatients and require daily monitoring by a physician and a medical team for their care needs on an ongoing basis.

"The program clearly differentiates the delivery of acute hospital care at home from more traditional home health services," CMS said in the press release. "While home health care provides important skilled nursing and other skilled care services, Acute Hospital Care at Home is for beneficiaries who require acute inpatient admission to a hospital and who require at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis."

KEY FACTS ABOUT THE PROGRAM

- The program would waive requirements that nursing services be provided 24 hours a day and that a registered nurse be immediately available if needed for any patient receiving care on hospital premises.
- The program is designed for patients who meet acute inpatient or overnight observation admission criteria for hospital-level care. The patient's home is considered part of the hospital during the admission.
- A program does not have to be physically administrated within a hospital, but a hospital must accept responsibility for the program to satisfy the Conditions of Participation for this level of patient care. Additionally, the program must be integrated within a hospital to a sufficient degree to ensure that rapid escalation of care is seamless.
- Nothing in this waiver prevents Medicare Advantage beneficiaries from being treated with this level of care if the local MA plan is in agreement.

CMS has approved waivers for six health systems that have extensive experience providing acute hospital care at home that will now begin immediately participating in the new program. These include Brigham and Women's Hospital and Massachusetts General Hospital in Massachusetts; Huntsman Cancer Institute in Utah; Mount Sinai Health System in New York; Presbyterian Healthcare Services in New Mexico; and UnityPoint Health in Iowa. More participants are expected to join.

For more frequently asked questions visit:
https://www.cms.gov/files/document/covid-acute-hospital-care-home-faqs.pdf

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2.

Home-Based Primary Care (HBPC)

Home-based medical care models are shaking-up the $260 billion primary care market. Primary care practices are getting hit hard by the loss of revenue during the COVID-19 pandemic and the impact of the health crisis is forcing organizations to rethink how they operate.

HBPC programs provide appropriate care (primary, urgent, or palliative) to high-risk, medically vulnerable patients, often suffering multiple chronic conditions, when and where they need it. This patient-centric, continuous care model delivers clinical, economic, and human benefits such as:

- facilitating timely interventions when chronic conditions worsen and preempting avoidable emergency department visits and hospitalizations
- alleviating social stressors that contribute to poor health
- comforting patients by giving them loving care and letting them know they're not alone.

The aging population and the shift to value-based payment models are arguably the two most disruptive forces in healthcare. Yet, payers and providers too often fail to see, monitor, and manage those individuals who will disproportionally affect the impact of this gathering storm.

They are the "invisible homebound," an estimated 2 million frail, functionally impaired, and vulnerable adults who

- are unable to visit their primary physician's office
- have severe functional impairments, disabilities, and/or multiple chronic conditions
- may require palliative or end-of-life care
- often are not cared for by disease-specific management programs
- account for approximately half of the costliest 5% of patients.

Examples:

Landmark Health: The model focuses on managing multiple chronic care patients in the home. Partnering with health plans in shared savings arrangements, Landmark's 24/7 in-home medical care brings medical, behavioral health, and palliative care, along with social services to patients in 46 communities across the U.S.

Iora Health: Iora Health is a clinic-based, interdisciplinary team model that offers medical care to a broader population of clinically complex patients.

MedStar: MedStar's medical house call program in Washington, D.C., offers team-based primary care to patients in their homes.

ChenMed: A physician-led primary care company, ChenMed is focused on providing services to moderate-to-low-income seniors with complex chronic conditions.

Oak Street Health: Operates 54 primary care centers in 9 states targeting seniors who are Medicare Advantage members.

VillageMD: VillageMD, through its subsidiary Village Medical, is a leading, national provider of value-based primary care services.

Home-based care delivery or home-based primary care will become even more important going forward for Medicare Advantage (MA) health plans and risk-bearing providers to close care gaps.

For Additional Resources: It's Time to Think Beyond the Clinic Walls. September/October 2020 – pages 4-8.