Answering the Call

Finding the Right Solution for Home-Based Advanced Primary Care

emcara

COVID-19 pandemic drove us all into our homes and forced us to rethink how we met many of our most basic needs. As we adjusted, we discovered that with the help of technology, the world can be brought to our doorsteps. Work. Education. Groceries. Supplies. Entertainment. Even healthcare. When it comes to healthcare the pandemic advanced the adoption of virtual care technologies. It advanced the shift from volume to value-based care. And it solidified the efficacy and necessity of home-based care solutions, particularly for frail and vulnerable individuals.

It's been well-documented that the US population is rapidly aging. The number of Americans older than 65 increased by 34 percent between 2010 and 2020, with an additional 32 percent increase predicted by 2030. A growing share of these individuals are covered by health plans that take risk on their total cost of care. For example, currently about 36 percent of American seniors are covered by Medicare Advantage (MA), but the share will grow to 51 percent by 2030.

As Managed Care Organizations assume more financial risk for a rapidly growing population of geriatric and vulnerable members, they face a significant challenge of reducing the cost of providing care, particularly for the sickest members they serve.

An entire industry has emerged to address this need in the form of Home-based advanced primary care (HBAPC) solutions which aim to reduce expensive facilities-based utilization with high-touch care in the home. The right HBAPC partner can deliver powerful outcomes, reducing the total cost of care for geriatric and vulnerable populations by between 10 to 20 percent.

Unfortunately for health plans, this promising new market has been filled with many different types of solutions, ranging from shiny startups with no track record for delivering in-home care to legacy bricks and mortar providers who are extending their capabilities to the home. These various competitive solutions vary greatly in their efficacy and effectiveness. Choosing the right partner for HBAPC-related services has become a challenge in, and of, itself.

In this whitepaper, we will further examine the HBAPC landscape, discuss key considerations and help health plans objectively compare the various solutions available to them.

Understanding the Landscape

Managed Care Organizations are increasingly aware of how challenging it is for traditional primary care providers to address their most vulnerable members holistically. A clinic-only care model requires high member density to rationalize the cost, and also requires struggling members to make the trip to a clinic for their care.

HBAPC delivers high-touch care to geriatric and vulnerable members using the member's home as the primary point of care (home can be traditional homes, group homes, retirement communities, assisted living).

House calls are nothing new, but, until recently, they have been a niche for mission-driven providers focusing on strictly homebound members. This has been partly driven by the reality that it was more expensive to deliver care in this manner. Drive time and other demands of in-home care equals smaller member panels.

Innovations in care models, and evolving member preferences, have shifted the conversation and created interesting new possibilities. HBAPCs typically offer sophisticated analytics, multi-disciplinary care team strategies and logistics management capabilities. Analytics identify appropriate members and track changes in status to match resource intensity with acuity. The multi-disciplinary team maintains a frequent, coordinated rhythm of member contact and efficiently addresses broader member issues. Multi-disciplinary teams also provide physicians with clinical leverage. Finally, logistics management ensures the deployment of technology (e.g. telehealth, remote member monitoring or RPM, durable medical equipment or DME) in the home, and redirection of clinical resources in response to emerging acute issues.

Digital data capture and integration to support analytics has been a critical enabler for HBAPC. Emerging models are also putting in place portable diagnostics and treatments to expand the range of members that can be effectively and safely managed in the home.

Meanwhile, it is becoming clear that members prefer to stay at home. The COVID-19 pandemic dramatically added clinical relevance to this stated preference. Patients who are most appropriate for HBAPC are struggling to avoid risky and overburdened facilities while finding a way to access proper care for their chronic conditions. It is becoming more obvious that the best way to provide care to this population is to bring the care to them.

Who Can HBAPC Help?

This innovative new care model expands the reach of in-home care beyond the strictly homebound to include many geriatric and vulnerable members. Appropriate members typically make up from 3 to 12% of an MCO population depending on the Line of Business (LOB). While high-risk members exist in all LOBs, the largest clusters will be found in MA plans (including dual eligibles). These members typically have 3 or more chronic conditions, and many have functional limitations. On average, they account for 40-50 percent of all claims.

Foundational Elements to Consider

HBAPC solutions are multifaceted and complex, but a few fundamental building blocks are showcased below. These include strategic program design, smart targeting, the right team and holistic care delivery.

STRATEGIC PROGRAM DESIGN

At the end of the day, delivering better care to complex members is the right thing to do for your plan. However, the economics of an HBAPC have to work to facilitate that level of care. A quality partner will work with you, both on program design as well as measurement to ensure a positive return.

There are several ways to approach the payment structure for an HBAPC solution. These include:

- MLR-based risk model
- PEMPM/Case rate with upside and/or downside opportunity
- FFS with quality bonus opportunity

In our experience, the greatest value creation occurs with an MLR-based risk model, but each plan has its own unique circumstances to consider.

The other lever in ensuring strategic program design and economic viability involves the chosen measurement methodology. Many legacy methodologies in the healthcare space come up lacking, especially when you consider a value-based care model typically used within the context of HBAPC. As you evaluate the measurement approach of various partners, make sure they address the deficiencies present in long-standing methods. Your measurement approach should accomplish the following;

Flexibility – Intrinsically adjusts to external changes in the marketplace that affect outcomes, a prime example being the COVID-19 pandemic.

Accuracy – Addresses specific challenges, such as selection bias, that can create inaccuracies in reporting. It should be a proven model with evidence documented by peer-reviewed research.

Transparency – Enables specific program attribution, providing direct insight into provider practices and care programs actually creating value, while reducing double counting of value across groups.

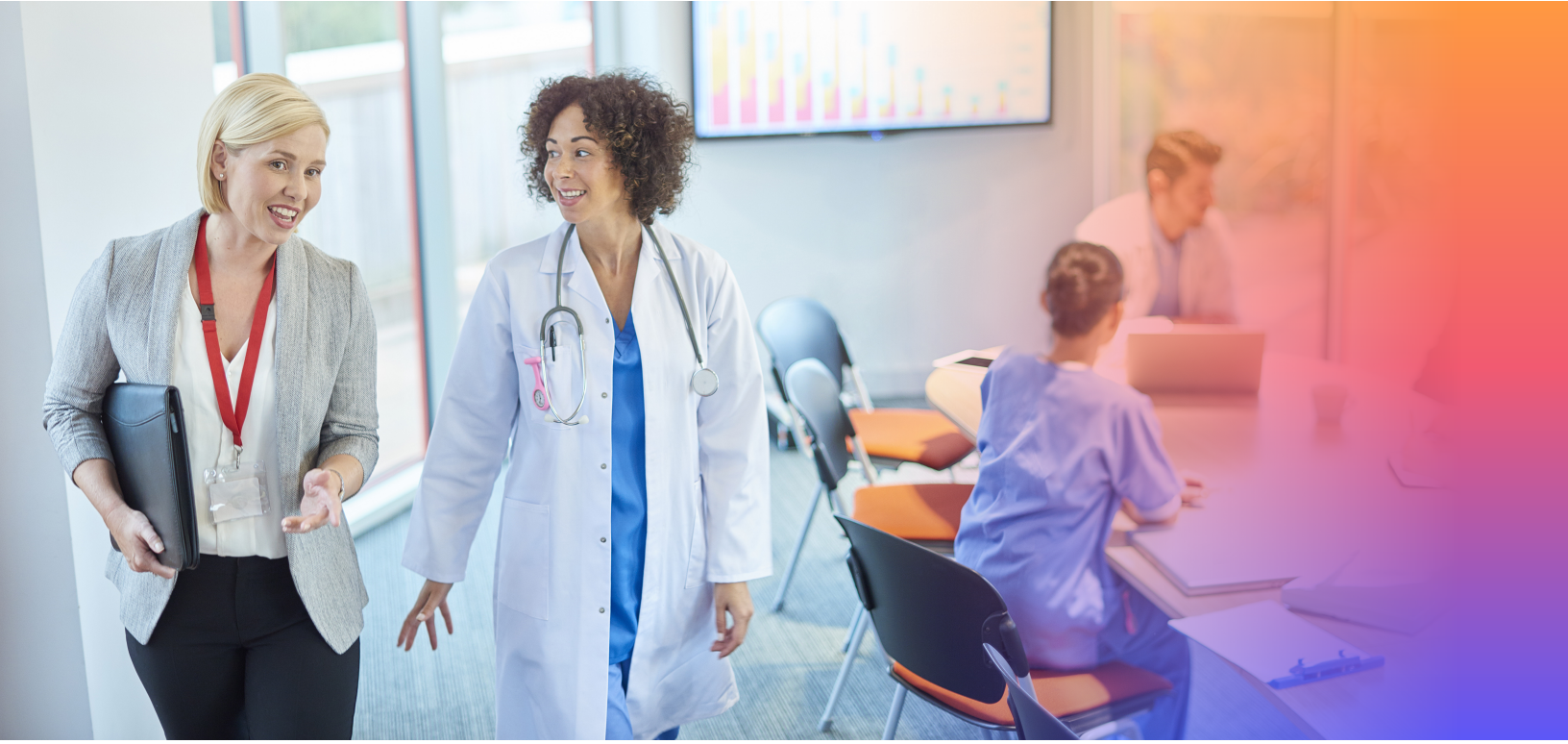
Simplicity – Requires only a limited set of key decisions by the parties involved in a value-based contract, and can be simply explained at all levels within an organization.

SMART IDENTIFICATION

Patients supported by an HBAPC solution can be identified using proprietary algorithms applied on claims and clinical criteria flagging sustained high risk (high cost) members who won't be returning to lower costs on their own in the future. Criteria used in the analysis could include:

- Physical diagnoses
- Behavioral conditions
- Frailty and other physical limitations
- Social vulnerability
- Engagement with care
- Utilization

Using analytics, the solution should stratify members and schedule them for the most appropriate level of support. The analysis is typically repeated monthly to add member targets. While it is a decision for the MCO, the default position of an HBAPC should be that members do not graduate from such a program, but instead are transitioned to a maintenance status to prevent them from returning to high-risk status in the future.



The Right Team

HBAPC requires a multi-disciplinary team led by a complex care physician. In addition to traditional medical expertise, a well-rounded team will also include practitioners skilled at supporting behavioral and social challenges. Specifically social determinants of health (SDoH) account for a vast majority of ongoing care needs.

In total this team should represent a wide range of specialties. These roles include:

- Complex Care Physician
- APP (NP/PA)
- Community Health Worker (CHW)
- RN & Social Worker
- VP of Operations
- Medical Director
- Shared Specialized Resources (e.g. Palliative Care)
- Care Coordinators
- Integrated Functions (e.g. Coding)
- Behavioral Health Specialist
- Dietitian

This team should be technology-enabled in order to efficiently and effectively care for all members. Team structure should be designed in a way that helps all clinical resources work at the top of their license, while ensuring the right support is offered to the right member at the right time.

Roles and Responsibilities for HBAPC Team
Providers: (Physician, Advanced Practice Provider): Diagnose, treat, and lead the development and delivery of a longitudinal care plan, including advance directives.

Registered Nurses: Help to coordinate member's care plan as well as deliver direct care through standing orders for major complex chronic conditions such as diabetes, as well as wound care.

Community Health Workers: Support member and caregivers in-home and telephonically for adherence to the care plan and resolving barriers to care.

Shared Resources: Team has access to outreach and care coordination support as well as shared local and/or centralized resources, including social work, geriatric, palliative care, pharmacy, and psychiatric support.

Team Member Spotlight: Community Health Workers (CHW)

Not all HBAPC solutions offer comprehensive resources within their interdisciplinary team model. A common, but critical, missing link for many teams is the role of a community health worker. These individuals are selected and deployed based on their familiarity and relevance with the local community. They make visits to motivate members to meet their action plan goals and to address psychosocial barriers and socio-economic factors of health (i.e., home safety, affordable healthy eating). They also can collect vitals and other data and assist with virtual visit technologies.

Holistic Care Delivery

The right HBAPC partner can integrate and coordinate care to address medical costs, quality, and revenue challenges associated with high-risk populations. This support will include medical, behavioral, and social care needs, delivered 24 hours a day, 7 days a week. Telehealth capabilities should be available as an alternative mode of engagement.

Primary care

Irrespective of member benefit design (HMO or PPO) and its status as PCP-of-record or attributed provider, an HBAPC solution should manage members as a coordinated, accountable medical group.

The level of routine care delivered through an HBAPC will depend on member status, with higher risk members receiving more intense intervention and support. Patients with changes in status or in need of ad hoc support should be able to draw on additional fast responding acute clinical and supportive resources on a 24/7 basis. Care teams should also participate in regular rounding for each member to coordinate care and ensure optimal clinical management.

Each member should be seen for a clinical risk assessment at the start of care, at least once each year thereafter and within 72 hours of facilities discharge. This assessment will identify opportunities to address decompensated conditions, behavioral health conditions, and any SDoH barriers. The RN, in collaboration with the APP and physician, would develop a clinical treatment plan for evidence-based interventions to close gaps in care.

Specialized resources

The Care Team can draw on shared consultative and supporting resources (available centrally or remotely through partnered groups or attached to the HBAPC via part-time arrangements) as needed including:

- **Palliative care** (clinical treatment plan development, advance care planning, early referral to hospice when appropriate)
- **Kidney care** (member education, CKD-specific algorithms, early referral to nephrologist for in-home dialysis when appropriate)
- **Psychiatry** (diagnosis, medication management, bridging care for members with SPMI until they can be plugged in to local resources)
- **Pharmacy** (medication management including polypharmacy and high-risk medications, medication reconciliation and adherence, preferred formulary, specialty alternatives)
- **Nutrition** (consultative support and planning for members with complex nutrition needs)
- **Surge resources** (RN team with provider back-up to address urgent care needs of members and provide temporary respite for caregivers on a 24/7 basis)

Capabilities to Consider When Building a Holistic Approach to HBAPC

Comparing the Competition – The Major Options for HBAPC

Potential solutions in the HBAPC market come in the following broad segments:

National Medical Group Model
Organizations that fit this model offer both a provider-led treatment option (attributed), as well as a care coordination model (collaborative), where an interdisciplinary team supports the previously established PCP for each member. This model provides holistic care in the home and is flexible enough to work with various plans and other at-risk entities and across LOBs (MA, managed Medicaid, ACA).

Point Solutions
From urgent care to end stage renal disease, there are many point solutions available to address specific care episodes. These models don't offer a holistic approach for home-based care and fall short of what plans need to comprehensively support at-risk members.

Traditional HBAPC
These practices are usually non-profit or professional corporations and are focused on the strictly homebound where they can earn incremental Medicare FFS fees. They have generally been more physician heavy and rely on the independent and assisted living facilities where the member is residing for support and monitoring.

Clinic-based Advanced Primary Care (CBAPC)
These companies have mature operating platforms. Several are adding in-home capabilities or developing telehealth offerings. But they are constrained to their bricks and mortar, requiring a high density of members, and favoring clinic-and telehealth-based contact vs. in-home encounters.

Startup Solutions
New market entrants are joining the landscape at a rapid pace. While many of these solutions will position themselves as offering a comparable solution, they largely lack deep experience in delivering care in the home. They also present a potential business risk, since some will be positioning themselves for acquisition by a national plan or other third party.

What's most important is that your plan has a clear understanding of its objectives. Several factors drive MCO decision-making regarding member targeting and provider selection. Some plans favor stricter focus on homebound members. Others are more willing to assume any complex and undermanaged members will benefit from a high-touch model. Additional key drivers of MCO strategies are:

1. Strength of relationship between plan and provider; plans with "skinnier" networks of VBC providers will be sensitive to abrasion. Others are willing to administratively reassign members away from poor performing providers.
2. The plan's ability to field supportive resources. Plans with their own nurses and social workers able to go in the home will have higher thresholds of selecting members for HBAPC.
3. Local variation in provider quality. Some markets have a more geriatric-savvy network skilled at coding and management while others have more generalist/family practice models. The return on an HBAPC for an MCO with less savvy networks is obviously higher.

At the end of the day, many plans find the National Medical Group model addresses their most pressing needs, based on its flexibility and comprehensive set of clinical resources.

Checklist: Evaluating Your Perfect Fit

Regardless of your specific needs, there are standard criteria that are important. When assessing a potential partner for HBAPC, the following checklist is a good reference tool. It can help you quickly filter candidates to find a solution that will achieve your goals. The right HBAPC partner should:

- ☐ Deliver medical, behavioral, social care and treatment to members where they live 24x7x365 and across major at-risk coverage lines of business
- ☐ Provide a compelling risk arrangement, and be willing to place fees fully at risk
- ☐ Have a care model that delivers high frequency contact with assigned/attributed members ensuring tightly attuned treatment plans, closure of gaps in care, as well as higher member quality of life and delight
- ☐ Possess specific expertise in member acquisition, engagement and satisfaction
- ☐ Build a strong presence in each market to ensure highly collaborative relationships with providers (hospitals, physicians, home health) and sustained relationships with members
- ☐ Offer a flexible approach – including variety of approaches for member selection, care delivery (attributed versus collaborative) and measurement of performance
- ☐ Demonstrate a proven track record and evidence of success in delivering home-based medical care
- ☐ Ensure strategic neutrality toward your plan with no conflicts of interest

In Summary

HBAPC solutions have proven their potential to improve the care, and lower the cost, of geriatric and vulnerable populations. Selecting the right partner is key to achieving the full value of these solutions. We hope this whitepaper has offered additional considerations for your plan as you search for the right fit. In the meantime, we will leave you with the following key takeaways.

Proven Results
The healthcare landscape is currently overrun by shiny new objects. Many newcomers are "saying the right things" but don't have proven solutions that have delivered value over time.

Flexible and Scalable Solutions
Your approach to home-based care has to be responsive to your specific needs, including different program designs for subsets of your population and across lines of business.

Member Trust
Ultimately, the key driver to effective health care delivery is a trusted relationship – so satisfaction rates, such as Net Promoter Score (NPS) are leading indicators for success.

SDoH Success
SDoH is just a buzzword, unless you have concrete strategies to impact it, such as including dedicated community health workers as a critical part of the interdisciplinary care team.

Transparent and Accurate Measurement
You need a partner who aligns with your goals by taking on full risk and/or uses a measurement methodology that accurately reports on value by accounting for issues such as selection bias and regression to the mean.

About Emcara Health

Emcara Health is at the forefront of delivering a proven model for in-home care solutions. With a passionate team of dedicated healthcare experts, we improve the quality of life for vulnerable populations with health challenges across urban and rural communities in 14 states and counting. Our integrated suite of in-home care solutions spans advanced-primary care, complex care management and treatment, transition of care, and annual in-home assessments. Our physician-led multidisciplinary care teams deliver industry-leading outcomes across the quadruple aim in health care delivery- patient experience, quality, lower cost of care, and joy in work. Part of PopHealthCare (a GuideWell Company), Emcara Health is one of the nation's leading value-based medical groups, focused on the mission of reimagining how healthcare is delivered. For more information, visit

EmcaraHealth.com