# Medical Care for the Elderly Living at Home: Home-based Primary Care and Hospital at Home

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National Health Policy Forum, Washington, DC, July 22, 2011

# Agenda

- Provide context of home-based care with focus on Hospital at Home and Home-based Primary Care – Independence at Home (section 3024 ACA)

- VA experience in home-based primary care (HBPC)

- Home-based primary care for dually-eligible

# The Spectrum of Home-based Care

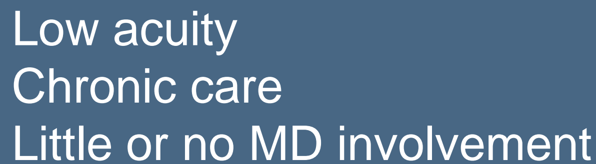
Informal Services

Formal Personal Care Services

Skilled Home Care

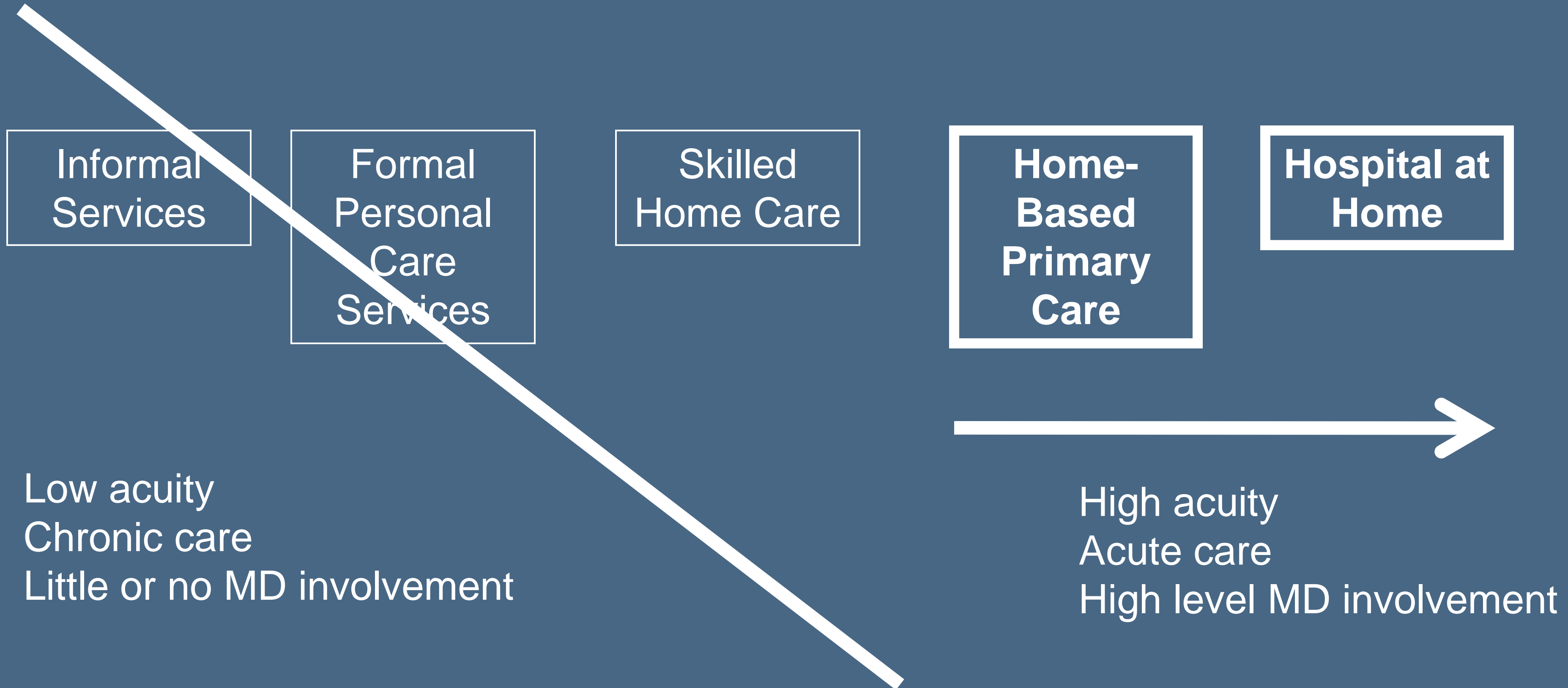
Home-Based Primary Care

Hospital at Home

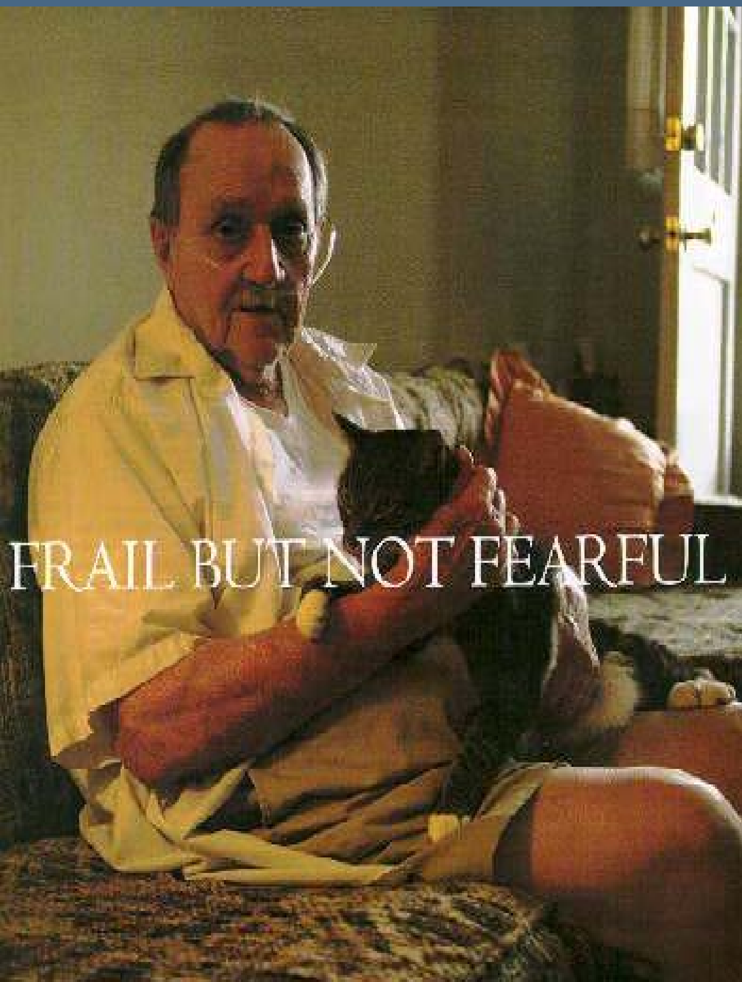



High acuity
Acute care
High level MD involvement

# Our Focus Today

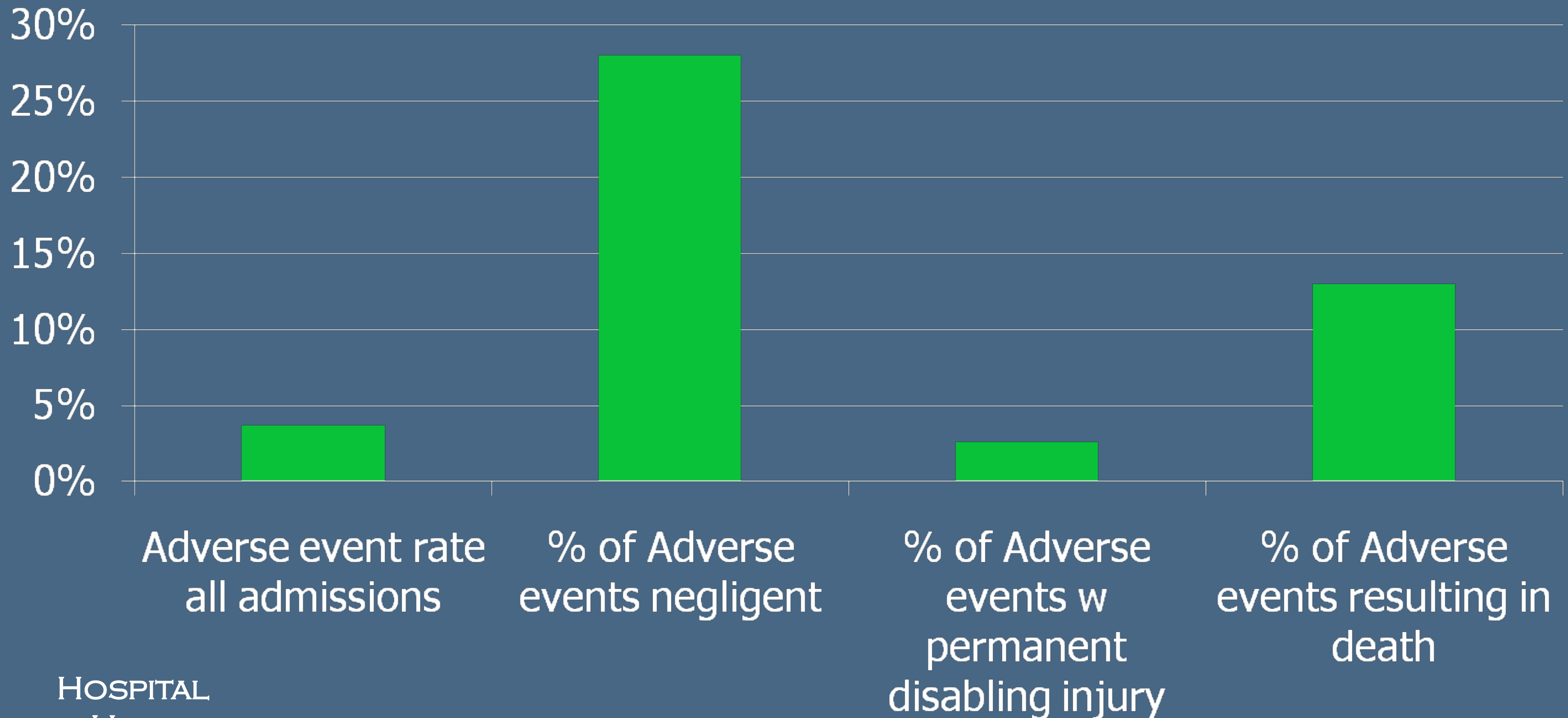


# Why We Need Hospital at Home




- Walter, 82, lives with his cat
- Multiple chronic conditions, meds, and admissions
- Walter's Gripes
  - "I can't get nebs on time so I end up on the tube"
  - "Food stinks"
  - "Wake up in middle of night and can't get to bathroom"
  - "No one talks to me"
  - "I get confused –get tied down"
  - "I always come home with a completely new set of medicines"
  -
- "I won't go to the hospital"

# Hospital Safety Pre IOM



# How Hospital at Home Can Help

**Homeward bound**

*Snapshot of the Hospital at Home process*

**Assessment**

Patient presents to ED. Clinicians determine patient has acute illness that could be treated at home. Patient chooses home-care option.

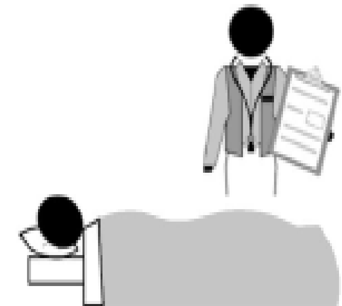
**Transport**

Patient transported home accompanied by nurse or physician with appropriate medications and equipment, including oxygen, if necessary.

**Home care**

Nurse remains with patient

**Discharge**



Nurse provides instruction about medications, follow-up care, sends letter to primary care physician.

Source: *Watch* interview, 5/8/06; Naik, *Wall Street Journal*, 4/19/06; Leff et al., *Annals of Internal Medicine*, December 2005.

Annals of Internal Medicine | Improving Patient Care

# Hospital at Home: Feasibility and Outcomes of a Program To Provide Hospital-Level Care at Home for Acutely Ill Older Patients

Bruce Leff, MD; Lynda Burton, ScD; Scott L. Mader, MD; Bruce Naughton, MD; Jeffrey Burl, MD; Sharon K. Inouye, MD, MPH; William B. Greenough III, MD; Susan Guido, RN; Christopher Langston, PhD; Kevin D. Frick, PhD; Donald Steinwachs, PhD; and John R. Burton, MD

- 61% chose HAH care
- HaH is feasible and efficacious
- High-quality care
- Fewer complications
- Higher satisfaction
- Lower costs of care
- Less CG stress
- Better function
- High provider satisfaction

*Ann Intern Med. 143:798-808, 2005. J Am Geriatr Soc. 54:1355-1363, 2006. J Am Geriatr Soc. 2008;56(1):117-23. Am J Manag Care. 15:49-56, 2009. J Am Geriatr Soc. 2009;57(2):273-8. Medical Care, 47(9):979-85, 2009.*

# What Did Walter Think?

"I definitely would have ended up on a breathing machine if I had been in the hospital."

"It was great to get the attention I had from the nurses and to have the doctor see me at home."

"I didn't have to worry about my cat."

# Moving from Research to Practice

# Ms. Irene

- 91 year-old 2 weeks of mental and physical decline. Hx of severe dementia, diabetes, diffuse joint pains, ? Seizure vs. fainting spells
- **House call:** "Sleeping 99% of the time", lethargic and talking less. Poor oral intake. "She was playing cards 2 weeks ago"
- **Medicines:** seizure med, tylenol w/ codeine, diuretic, aricept, namenda, antidepressant
- Drowsy, dry mouth, heel sore

# Usual Care for Ms Irene

- 911 to ER, admit to hospital
- Care by strangers, multiple FFS specialists
- Functional decline - long hospital stay
- ? SNF or inpatient rehab care
- ? Return home

# Chronic Conditions and Expenditures to the Medicare Program

| Number of Chronic Conditions | Percent of Beneficiaries 65+ | | Percent Medicare Expenditures | |
|---|---|---|---|---|
| 0 | 18 | | 1 | |
| 1 | 19 | | 4 | |
| 2 | 21 | | 11 | |
| 3 | 18 | | 18 | |
| 4 | 12 | 24% | 21 | 66% |
| 5 | 7 | | 18 | |
| 6 | 3 | | 13 | |
| 7+ | 2 | | 14 | |

# House Call Medicine Clinical Model: Focuses on Cement, Not Just Bricks

- Continuous, comprehensive, longitudinal medical care in a patient's residence,
- Interdisciplinary team care - coordinate ALL medical AND social services
- Geriatrics and palliative care skill sets
- Strong medical component, MD, NP - extraordinary means to prevent crises
- Careful selection of specialists
- Portable diagnostics
- Support and empowerment of caregivers / family
- 24/7 ready access to care
- **<u>Not in the body part business! A model that builds trust!</u>**

# Outcomes of House Call Medicine

- VA - 24% ↓VA costs and 11% in Medicare costs. Highest patient satisfaction of any VA program
- U Penn ↓ health care costs by 50% and hospitalizations by 64%. Also ↓ Medicaid costs 24%
- Medicare managed care
- VCU Medical Center- ↓ hospital costs 60%
- Urban Medical House Calls, Boston- ↓ hospital admissions by 29% and hospital days by 34%

# Why it Works: Targeted Population, Right Tool, Right Outcome

Outcomes

- Safer, higher quality, more satisfactory care
- Lower costs

# Independence at Home (IAH)

- ACA, Section 3024
- H.R. 2560 (Rep. Markey), S. 1131 (Sen. Wyden)
  - Developed by AAHCP and IAH Coalition
  - Bipartisan – Co-Sponsors: 13 Senators, 27 Reps
- Demonstration to begin 1/1/12 – 10K patients

# IAH- Attacks Root of Current System on Payment and Quality

- Targets high cost MC benes with mult chronic conditions ($\geq$ 2), hosp prior year, use of post-acute care w functional impairment
- Team care: MD and/or NP as part of "team that includes MDs, RNs, PAs, pharmacists, and other health and social services staff as appropriate…"
- Requires practitioners and providers as a condition of participation to
  - Achieve annual minimum savings of 5%,
  - Improve outcomes, and achieve patient/caregiver satisfaction
- Share Savings- First 5% to Medicare, then share further savings with successful providers
- Metrics: relevant clinical outcomes, satisfaction, cost-reductions

# How Did Ms. Irene Do?

- Offending medications stopped, oxygen and blood tests show only dehydration
- NP visit in 24-48 hrs., RN for heel sore
- Aide and family push fluids/food
- Calls from MD to son about goals
- Day 3- Alert, eating and drinking
- Not admitted - got safer care at home

# Summary - HBPC, IAH, and Hospital at Home

- Bring care to ill elders, when and where they need it
- Disruptive, mobile innovation that prevents high-cost events -- more convenience, higher satisfaction
- Tackles FFS incentives that drive high costs and poor care and will save serious Medicare $$
- Also solutions for managed care and Medicaid