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PROFILES IN INNOVATION

At Home SUPPORT™

Hospice of Michigan is expanding access to palliative care services

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In 2000, Hospice of Michigan (HOM) began piloting a home-based care service for Medicare's sickest, costliest patients, bridging the gap between traditional medical care and case management for chronic disease and hospice. In just over a decade, that initial pilot service has matured and grown into *At Home SUPPORT™*, the driving force behind the largest body of savings at one of the most successful Medicare Pioneer Accountable Care Organizations (ACOs) in the country. Today, *At Home SUPPORT* annually serves 700 patients with serious illness, covering an area that includes 15 Michigan counties. Targeting patients who are not yet hospice eligible but are in the last two years of life, the program provides patients with medical care, social work services and spiritual support. The program particularly emphasizes caregiver support, including through 24/7 access to a nurse advisor who can dispatch a clinician to the home when needed.

This data-driven program has seen remarkable results in reducing expenditures and utilization of services for some of its customers' highest cost patients, which *At Home SUPPORT* proactively identifies by applying a proprietary predictive model to claims data. AAHPM spoke with HOM's President and CEO, Dottie Deremo, RN MSN MHSA FACHE, and Vice President for Medical Affairs, Michael Paletta, MD FAAHPM, to learn more.

Your program has evolved over a fairly long period of time. What was its inception?

DD: Yes – it took us 10 years to become an overnight success! In the beginning, we saw the silver tsunami as an impending crisis which we did not have the financial or caregiver resources to manage. I thought we would really have to reinvent delivery models. At the same time, looking at hospice care, I asked why there was only 35 percent penetration among eligible patients in Michigan. Patients, families and physicians knew that hospice existed and thought it was wonderful. But in the very next breath it was, "I hope I never need you."

Michael Paletta
MD FAAHPM

MP: All of us who grew up in hospice believed that utilization would increase if we could just get the word out about how great hospice is. With all of our massive education and public awareness efforts, we moved the needle one little tick. People still didn't want any part, prior to delivery, of a product that has a 99 percent customer satisfaction rating after delivery. It was the linkage to dying. So, we started looking at how we could get in the game and build relationships earlier in an advanced illness.

What led to At Home SUPPORT*'s focus on a population with significant illness burden, but not necessarily hospice eligibility?*

DD: It's a product uniquely designed for this population — we're not just providing "hospice care upstream." If you look at the last 24-36 months of an advanced illness, there are cycles of clinical care crises/hospitalization/stabilization, but never a return to previous function. So, from our perspective, advanced illness management is divided into two parts: there's the advanced illness component, which is palliative care, and there's the intensive end-of-life care component, which is hospice.

MP: The model borrows the best aspects of hospice care but isn't hospice. It grew out of HOM's participation in the late 1990s in a Robert Wood Johnson (RWJ) Foundation study of providing palliative-like services in addition to disease-directed services to cancer patients.[1] Although a small study, this was the first randomized clinical trial in end-of-life-care that had ever been done. Some significant findings came out of the study. We found that additional services in the home actually reduced cost and emergency department (ED) usage and, most notably, that caregivers reported a significant decrease in perceived burden.

We saw a potential game changer in this. The caregiver is the one who decides at 10:30 on a Friday night that they can't cope, who calls 911, who takes mom to the ED because they're exhausted. We saw that if we could alleviate caregiver exhaustion, then we could keep people at home and, ultimately, build the trust necessary to facilitate a transition to a formal hospice situation when appropriate.

So how have you translated that game-changing knowledge into innovative applications?

DD: In many places, palliative care has morphed into a hospital and clinic delivery model rather than one that brings services where folks need them, which is in their home. With *At Home SUPPORT*, we contract to provide additional in-home services to the highest need, highest utilization, highest cost patients — the 5 percent of Medicare patients with Stage IV chronic disease that account for 50 percent of the entire Medicare expenditure annually.

MP: One important application of the knowledge is in the development of our predictive model and how we use it to find patients and families who can really benefit from the program. It's based largely on the Johns Hopkins model, but we tweaked it using customized variables that we learned were important data points in the RWJ study, particularly related to what we learned with respect to the caregiver. We started using the model immediately after the RWJ study for several years and then developed pilot programs in two health maintenance organizations in 2007. Accessing and filtering claims data through the model was something we started doing at a time almost no one else was (the early 2000s).

How was support for the program generated and maintained?

DD: If you study companies with sustained, long-term success, you see a philosophical commitment to innovation and an R&D arm focused on new products. I felt that, if we were going to be successful long term, we needed to have a research, education and innovation center. So, I went out and got a donor to provide start-up funding for the Maggie Allesee Center for Innovation in 2000. This Center for Innovation is now housed in the Hospice of Michigan Institute with other key centers of study and focus. We also made a strategic decision to not invest in bricks and mortar — which means we have no hospice residences or inpatient units. This strategic decision freed up capital to invest in IT infrastructure. Throughout our organization, we have a "high-touch, high-tech" strategy. We look at best practices and information in our records and use that to improve our model of care in both hospice and *At Home SUPPORT*.

MP: The rise of integrated health systems was also huge. Without ACOs, we'd still be stuck with a few patients here and there and payers saying, "We already do case management. We don't need this program." With the advent of shared risk, organizations were precipitously spending their own money, in a sense, and had interest in efficiency without denying care. Suddenly, we could approach an ACO and say, "If you partner with us on managing the 5 percent of patients who represent 50 percent of your spending, and we reduce their cost by even, say, 25 percent, you save millions."

Is the case for partnering with a palliative care program like At Home SUPPORT *clear to an ACO?*

MP: Physicians understand the incentive to diminish the indiscriminate use of diagnostics, the ED, and repeat hospitalizations. They also 'get it' that a small portion of their population generates disproportionate costs. Still, understandably, they want to maintain control and preserve their relationship with the patient. So even though our HPM-certified consultants are available to visit patients too sick to travel easily, many primary care physicians waive this service. We suspect that when the improved clinical and cost outcomes are demonstrated to them, these physicians will embrace the idea of HPM consultants and nurse practitioners complementing their management by visiting folks in their homes.

What other challenges have you faced?

MP: We've faced situations where partners already had care and case management departments where nurses were monitoring these patients. It was a threat to them, so it took time to get traction.

DD: What happens with a startup is like foreign bodies — the rest of the organization attacks: "Why are we doing this? This isn't part of our mission. Why are they getting resources?" That's normal and, for home care and hospice staff that we hire for *At Home SUPPORT*, we have to un-train them.

From a payer perspective, traditional payers have no interest in this model. They are still riding the fee-for-service "horse" for as long as it stays viable. Payers under the new Affordable Care Act incentive payment structures are much more receptive. ACOs and Medicare Advantage plans – which are at risk for the quality and cost outcomes of a defined population – embrace this program as a solution to their toughest population cohort to manage.

MP: Some prospective partners believe that the program is 'hospice-lite,' or intended as a direct bridge to hospice. They want to add this service as an additional duty for their hospice teams, but we discourage that. In fact we use a separate workforce in our own program, nurses, social workers and aides who are specifically trained to follow the *At Home SUPPORT* care model, not the hospice, home care, or traditional palliative care models. We expect our national partners to also keep their staff separate from their traditional organizational staff.

Another challenge was preference for a physician referral model, as opposed to identifying eligible persons by claims data analysis. Our predictive model proved much more effective at identifying cases than waiting for doctors to recognize and refer. Another barrier results from the limits of tracking cases inherent in our partners' data sets. With one early partner, diminished spending was initially encouraging, but our partner couldn't tell us if this meant that the patient died, that they transitioned to hospice, or that they left the service area. That was a major challenge, and it hampered our early efforts to understand our own model.

What metrics are you using to evaluate the program? What has the data shown?

DD: Some of the program's most promising data comes from its partnership with the Detroit Medical Center's (DMC) Michigan Pioneer ACO. Nationwide, the entire group of 32 Pioneer ACOs saved $87.5 million in the first year of the program. The Michigan Pioneer ACO was 10 percent of that savings, and we were almost $4 million of that $8 million in savings. Other ACOs are trying a variety of things, and the DMC is trying a variety of interventions, but our program was the single largest component of savings they had. In essence, *At Home SUPPORT* accounted for 4 percent of the entire national savings for the Pioneer ACO Initiative in Year 1, with an average daily census of 150 patients for 8 months.

MP: And, more broadly, in those cases we've followed over time, we've not only demonstrated a significant reduction in cost, use of the ED, hospitalizations, and readmissions, we've shown some very nice customer satisfaction surveys for patients and caregivers.

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[1] Finn JW, Pienta KJ, et.al. *Palliative care project: bridging active treatment and hospice for terminal cancer.* Proceedings of the American Society of Clinical Oncology 2002;21.