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Future of home and community-based care: Opportunities and obstacles

Now that non-traditional care models have demonstrated their effectiveness, CEOs discuss the potential for personalizing care to improve outcomes and reduce expenses by serving more people in new settings.

The stage has been set for health systems, health plans and policymakers to continue moving more — and increasingly advanced — care into home and community settings.

"It's no longer about proving the model," said Patrick Conway, MD, CEO of Care Solutions at Optum. "It's about how we scale a model that cares for people's physical, mental, and social needs for everyone across America from the low acuity to highest complexity. And how we manage health equity, better health outcomes, and a lower cost of care system that centers on individuals and families in their homes and communities."

Conway hosted a Health Evolution Virtual Executive Briefing, ***Future of Home and Community Based Care,*** sponsored by Optum, that featured Chris Palmieri, President and CEO, Commonwealth Care Alliance; Mark Prather, MD, CEO and Co-Founder, DispatchHealth; and Nick Loporcaro, CEO, Landmark Health.

"We are fast approaching a time when the idea of an efficient decentralized care delivery model is becoming a reality," Prather said.

The CEOs discussed opportunities and challenges each has encountered in developing successful care and payment models for transitioning more care services into the home.

Opportunities

The federal government made sweeping policy changes during the early days of the pandemic that opened the door to more care being delivered outside hospitals and clinics. Notably, relaxations to HIPAA, changes to telehealth reimbursement, cross-state licensure as well as emergency waivers and flexibilities enabled Commonwealth Care Alliance, DispatchHealth and Landmark Health, among others, to leverage the enabling components, concepts and tools for interdisciplinary teams that have traditionally been inhibited regulatory barriers.

While it remains to be seen whether the changes become a more permanent part of the regulatory framework or are simply extended for a finite period of time, Conway noted that the pandemic response

"created a real opportunity where making significant regulatory changes unleashes creativity and innovation."

For DispatchHealth, the opportunity arose to innovate on what Prather described as "the last-mile ancillary service," by creating its Clinic Without Walls program to bring lower-cost providers into the home equipped with technology that facilitates a high-quality visit for Medicare and sometimes Medicaid patients.

"It allowed us to see patients in a more cost-efficient manner, for cases that weren't quite acute enough to warrant an ER visit," Prather added.

DispatchHealth, for its part, is building on its comprehensive, high-acuity medical care in the home. The company's system includes a set of services that enable it to be what Prather described as "an ER substitute," delivering on-demand treatment instead of in emergency departments or skilled-nursing facilities, for example.

"We put the patient back in the center, and we built a clinical technology platform that delivers highly trained providers, the necessary equipment for ancillary services like radiography, in order to provide care for the highest acuity patients in their home," Prather said.

Loporcaro noted that for Landmark Health, the relaxations helped it advance practices already underway. Landmark Health is essentially a mobile practice working with primary care providers to deliver longitudinal and comprehensive care in the home by leveraging its platform, known as Ubiquity, which consists of a proprietary EHR, telehealth capabilities, home monitoring and therapeutic applications. "One of our mantras is 'giving the people the care that they want, when they want it, where they want it.' That is usually at home or within the community or a different setting so they're not traveling," he said.

Commonwealth Care Alliance is an integrated care system that equips all beneficiaries with Uncommon Care, its innovative care management model to address unmet social determinants of health and medical needs.

"That starts with fully integrated interdisciplinary care," Palmieri said. "It also includes ensuring access to healthy foods, making sure people have housing security, making sure they have transportation, so that's not a barrier to either medical visits or socialization."

Commonwealth Care Alliance also sends outreach workers into the community to help people navigate the complexities of the health care system, which can involve work other than delivering care services, such as enabling people to obtain broadband access.

"Because we're doing more telehealth, people who are poor need access to the technology and devices for a video visit," Palmieri said. "And very similar to DispatchHealth, we have a program that provides ED-level care in someone's living room so that they're not needing, for a variety of reasons, to visit the emergency department for something they probably didn't need in the first place."

Prather added that advanced care home hospitalization programs present an opportunity to impact people longitudinally. Often, that work can begin with an acute event, Prather said, because it presents the opportunity to help people make significant changes in their approach to health since many people are scared and more receptive to conversations about lifestyle changes and other ways to improve their health during these events.

"Our high-quality advanced care programs typically include a transitional phase. The entire episode lasts 30 days, which is a lot of time to build trust. And when you build trust in that window, there's an opportunity to address a number of social issues, adjust chronic medications, have meaningful goals of care discussions that positively impact the patient, longitudinally and with regard to future health care utilization," Prather said.

While each is embracing opportunities to leverage community and home models of care, Commonwealth Care Alliance, DispatchHealth and Landmark have taken distinct paths to embracing new payment models.

"More often than not, the incentives and the reimbursement models are barriers," Loporcaro said. "I credit CMMI (Center for Medicare and Medicaid Innovation) in the early days for creating demonstrations so we can prove new models out.
In this case, it's 'necessity is the mother of invention.'"

DispatchHealth's model was initially a challenge to get off the ground because there were not readily available off-the-shelf codes to bill with other than the old home-based primary care codes and those did not reflect what the organization was doing, Prather said. The enterprise used the opportunity to work with health plans to develop reimbursement models that could commence in a semi-fee-for-service construct and ultimately move toward value-based care.

"The payers really helped us think all the way up about how to structure this so it's best for the plan and the consumer," Prather added.

Landmark, for its part, was born from relationships with Medicare Advantage plans. Loporcaro said the company has since diversified and is now working with health systems, provider-backed plans and large provider groups taking risks.

"That has allowed us to go into markets and continue to build density. As we built that density, we lowered unit costs, and we now can start considering taking on the duals and the Medicaid populations and, dare I say, the commercial populations at some point," Loporcaro said.

Commonwealth Care Alliance started with the dual eligibles covered by both Medicare and Medicaid and has since built what Palmieri described as enough critical scale in Massachusetts to branch out into other states and impact new types of patients. This opportunity includes people who are aging or near-poor, irrespective to whether they are on Medicaid.

"The next ring in our sphere is what we consider the near-duals, and these are folks that are living with Medicare eligibility or in a Medicare Advantage plan, but they also have complex behavioral needs so they have to pay for a lot of care out of pocket, and it's still fragmented. At some point, unfortunately, they may not be able to afford to do so and will find themselves as a dual-eligible, so we want to get upstream on that," Palmieri added. "That's the pathway."

Challenges

Despite the causes for optimism in the current regulatory environment, persistent challenges remain to widely transitioning more care delivery into home and community settings, notably: information interoperability, communication and workflow as well the workforce required to support new models.

"Those are the realities of what we live. And I'm the first one to admit that I'm guilty of saying 'this should be pretty easy, look at the technology that's available,'" Loporcaro said. "But it's one of the more daunting tasks."

The current widespread lack of data interoperability inherently makes communication and workflow more challenging across all relevant caregivers, patients and their families, particularly for providers working to deliver a coordinated experience.

"Most of us think in a clinic-based way or a facility-based way and software is not designed for this decentralized care delivery," Prather added. "But what we really need is something that is decentralized."

Loporcaro added that even though it appears that data sharing and workflow should be straightforward given the power of smartphones, it is actually much more complex. Technology designers need to take into account that asking clinicians to check three more boxes or toggle between two screens to complete a chart adds even more to their existing tech-burdened workflow.

"One of the things I've become very sensitive to through the years working with clinicians and practitioners is that we have to make it easy to access the necessary information and reduce the complexity of connecting everybody," Loporcaro said.

In addition to technological issues with clinicians, the broader health care workforce presents its own set of challenges.

"All three of us are built on the backbone of individuals who want to take these heroic jobs and go into someone's home and deliver really great care and treat the consumer with the highest level of humanity and integrity," Palmieri said "We have to get really smart, quickly, about how to create a compensation model that rewards this type of work to build the workforce we need two or three decades into the future."

Workforce considerations also include physicians and how they operate. As Prather noted, even for a primary care physician in a capitated or value-based arrangement, for example, keeping options other than sending patients to the ER top of mind can be difficult.

"Physicians encounter a complex case and the knee jerk is to send them to the ER," Prather said. "It's yeoman's work to re-engineer that."

But when the opportunities are embraced, the incentives aligned, effective policies put in place, challenges addressed, technologies applied in new ways and the workforce supported accordingly, that is how new models emerge and become sustainable.

"When we're able to put those sets of care delivery models together to address the whole person, that's when the magic really happens in terms of the impact on the person, the family, and caregivers we're serving," Conway said.

Future potential of home and community-based care

Beyond fee for service, what shape will care models take moving forward?

Given existing high-acuity skilled models that operate via phone or video today, and with effective last-mile ancillary services, Prather is bullish about more care being delivered in the home.

“We believe that you can address somewhere between 60 percent and 70 percent of ER visits in the home or community with the right tools,” Prather said.

He also expects it to be appropriate to use hospital at home models for 20 percent to 30 percent of patients currently admitted to the physical care facility and envisions what is currently “a very narrow funnel” into ambulatory surgery centers growing as well. And the number of patients in skilled-nursing facilities who could be cared for more effectively in the home is between 25 percent and 50 percent, Prather added. “All of that feels directionally correct.”

Conclusion

The opportunity for community and home care is significantly larger than current patient populations because the models hold the potential to include people who are not yet receiving care.

“When I think about the Medicaid population, the pie is going to grow. There’s more than enough work for all of us,” Loporcaro said. “Let’s just focus on making sure we’re taking care of people in the most ideal setting. If we do, then the good news is that more people get access to good care. That’s the real win here.”

Palmieri envisions today’s facility-based health care ecosystem evolving into a care continuum across multiple settings.

“The entrepreneurs have proven that this can be done in a very different setting that is not a sterile hospital or nursing home environment,” Palmieri said. “Instead of duking it out with those that are in a traditional health care model, let’s focus on the populations that are not being served by anybody right now.”

In a previous role at Cincinnati Children’s Hospital Medical Center, Conway said that even when the system decreased admissions by caring for people in the community and focusing on prevention, the organization still provided specialty care, operations, ICU and other services in the hospital.

“There will be an opportunity for high-end hospital care in America, and home and community care that meets the needs of the various populations,” Conway added.

Home and community care models, in fact, have demonstrated their ability to improve outcomes and reduce expenses by enabling personalized care that focuses on the individual.

“The results are there,” Palmieri said. “We’re at the time these evolutionary care models can propel us forward as a better society that can deliver better care in a setting that people want.”
