CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Case STUDY

Learning Systems
for Accountable Care Organizations

Providing Primary Care To Homebound Patients: UCSF Health's Care At Home Program

This case study describes how University of California San Francisco (UCSF) Health delivers primary care to homebound patients through its Care at Home program. Care at Home providers use a multifaceted approach when conducting home visits to address clinical needs, environmental factors, and social determinants of health. The Care at Home team has a three-step process: (1) identify patients eligible and well-suited for the program, (2) complete an initial home visit to assess patient needs and fit for the program, and (3) deliver on-going primary care through home visits. Preliminary internal analyses show decreased inpatient and emergency department utilization for patients enrolled in Care at Home, and nearly 95 percent of patients surveyed expressed satisfaction with the program. UCSF Health's experience may be useful for ACOs or health care organizations interested in offering home-based primary care to their beneficiaries.

BACKGROUND

UCSF Health joined the Medicare Shared Savings Program as a Track 1+ ACO in 2018. As of 2020, the UCSF Health ACO includes about 2,700 providers and serves nearly 10,000 beneficiaries, primarily throughout the greater metropolitan area of San Francisco.

UCSF Health operates multiple programs that deliver specialized care to ACO beneficiaries, including the Care at Home program that provides primary and palliative care to homebound patients. The program began in 1999, when the UCSF Medical School's Division of Geriatrics received a philanthropic gift to establish a home-based primary care program. The program was originally conceived to teach medical students how to care for frail, homebound adults. Over time, providers in the program gained expertise in managing chronic illness in the community, a skillset that became increasingly useful as value-based payment models, such as Medicare ACOs, emerged.

In 2016, UCSF Health incorporated the Care at Home program within its Office of Population Health and Accountable Care, recognizing the program's potential to expand access to value-based care for medically complex and homebound patients. The Care at Home Medical Director, Dr. Carla Perissinotto, now leads a team of approximately 20 employees, which sums to approximately 12 full time equivalent staff as many of these staff divide their time between the Care at Home program and other responsibilities within UCSF. The program serves approximately 400 patients, with roughly 40 percent of those patients in the ACO. UCSF Health supports the operations of Care at Home, including the salaries of the operations manager, practice coordinators, social workers, and nurse coordinators. Physicians, nurse practitioners (NPs), and geriatric fellows,

funded through the UCSF Medical School and School of Nursing, provide care for patients in the program. In addition to the UCSF Health and the Medical and Nursing School funding streams, the program continues to seek support from philanthropy to fund education, leadership, and research.

OPERATIONALIZING THE CARE AT HOME PROGRAM

Care at Home provides primary care to homebound older adults who have great difficulty traveling to a provider office. The program's goals are to manage complex conditions, provide individualized care that addresses patients' preferences, and improve overall health outcomes. The program includes three major workflow components (see Figure 1), beginning with identifying patients eligible and well-suited for the program from multiple settings of care. A physician or NP then conducts an initial primary care visit in the patient's home to assess the patient's needs and fit for the program. Once a patient enrolls in the program, a Care at Home physician will become the patient's designated primary care provider (PCP) and they or an NP will deliver on-going care through home visits. All UCSF Health patients are potentially eligible for Care at Home; however, UCSF Health prioritizes identification and enrollment of Medicare ACO beneficiaries. Medicare beneficiaries served by the program continue to be eligible for and may also receive home health benefits, in addition to the program's primary care home visits.

Figure 1

Care at Home program workflow

Identify patients

Providers in inpatient and ambulatory settings may refer patients to the program and patients may self-refer. UCSF also proactively identifies patients who may be well-suited for the program based on their clinical and social needs.

Complete an initial home visit

A Care at Home physician or nurse practitioner completes an initial visit to assess the patient's needs, home environment, and suitability for the program.

Deliver on-going primary care through home visits

If the Care at Home team and the patient agree to move forward, the patient enrolls in the program and is assigned a primary care provider who continues to deliver care in the patient's home, usually through monthly visits.

Identifying patients for the program

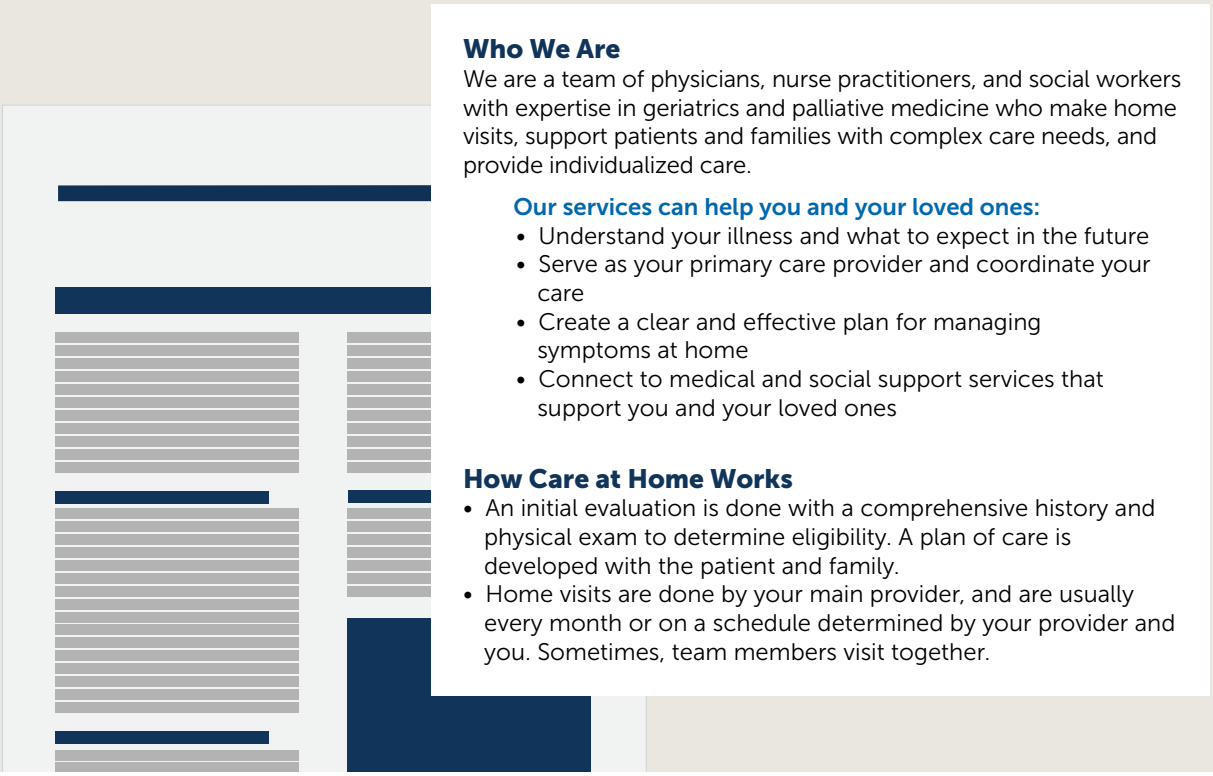
UCSF Health identifies most patients for Care at Home based on provider referral. Providers in hospital and ambulatory care settings identify and refer patients who are 65 and over and meet the Medicare criteria for being homebound. These providers may use brochures to introduce potential patients to the program (see Figure 2 for excerpts from the brochure). In addition, a Care at Home nurse coordinator participates in a UCSF Health clinical team daily call to discuss currently-hospitalized ACO beneficiaries and identify those who may be well-suited for the program. During this call, the clinical team considers appropriate care options for ACO beneficiaries, including Care at Home. The call is an opportunity to proactively identify ACO beneficiaries who would be good candidates for the program. These are usually beneficiaries who are high-risk, not getting to clinic appointments, and have had a recent emergency department (ED) visit or hospital readmission.

Patients may also self-refer by expressing interest to their provider or by calling the program telephone hotline. Patients learn about the opportunity from their PCPs, who describe Care at Home and address common questions that patients might have about transitioning to primary care visits in their home.

Care at Home staff review the list of patients identified, either through referral or self-referral, to confirm eligibility and interest in the program. Practice coordinators complete a preauthorization process to ensure the patient meets the program's requirements, such as having a health plan accepted by UCSF Health and meeting Medicare homebound criteria. Care at Home staff also alert the patient's current PCP, if they have one, that the patient is being evaluated for the program and to ensure he or she agrees with the patient shifting receipt of primary care services to Care at Home. UCSF noted that PCPs rarely have concerns about their patients shifting to the Care at Home program, but may not have been aware that they were referred. Finally, the practice coordinator confirms that the patient is willing to transition from their current PCP to a Care at Home provider. To avoid any gaps in care, the patient remains assigned to their original PCP until they complete their initial visit and formally enroll in the program.

Figure 2

Excerpts from UCSF Health brochure on the Care at Home program



Who We Are

We are a team of physicians, nurse practitioners, and social workers with expertise in geriatrics and palliative medicine who make home visits, support patients and families with complex care needs, and provide individualized care.

Our services can help you and your loved ones:

- Understand your illness and what to expect in the future
- Serve as your primary care provider and coordinate your care
- Create a clear and effective plan for managing symptoms at home
- Connect to medical and social support services that support you and your loved ones

How Care at Home Works

- An initial evaluation is done with a comprehensive history and physical exam to determine eligibility. A plan of care is developed with the patient and family.
- Home visits are done by your main provider, and are usually every month or on a schedule determined by your provider and you. Sometimes, team members visit together.

Completing an initial home visit

After determining that the patient is eligible for Care at Home, a practice coordinator places an introductory telephone call to briefly explain the program, conduct an initial safety check, and schedule an initial home visit. Approximately 80 percent of these patients agree to an initial visit with a program provider, which the ACO attributes to the accuracy of their identification processes and the methods used to describe the program.

The goal of the initial home visit is to address any immediate primary care needs, assess the home environment, and confirm the patient's need for continued home-based care. During this visit, the provider considers the patient's full range of health care needs and priorities, including the role for palliative care. Also, the provider assesses environmental risk factors that might impact the patient's health, including transportation limitations, mobility impairment, home safety, cleanliness and operability of durable medical equipment, availability of social support, and functional impairments. The visit may also include evaluation and management of patient health concerns, in-home diagnostic testing (such as phlebotomy for blood tests), and provision of treatments in the home like ear lavages, toenail care, and wound care. The initial visits typically require 45 to 60 minutes and the provider captures information about the patients' care needs and barriers in UCSF Health's EHR.

Care at Home practice coordinators determine the logistics of the initial visit. USCF Health aims to complete the visit within one month of the patient expressing interest in the program, with shorter timeframes for patients with intense care needs or no recent primary care visits. The practice coordinator assigns a physician or NP to conduct the initial visit based on proximity to the patient's residence. The practice coordinator also considers the providers' certification (such as palliative medicine) to best meet the patients' care needs, as documented in the EHR from previous encounters. If an NP conducts the initial home visit, patients will also be assigned a PCP who is familiar with the patient's care needs and available to consult with the NP after the visit.

> *"That is what is so critical about home-based care—it's truly looking at a holistic view of the person. So often the bulk of work we do addresses social determinants of health and all the additional resources needed to keep someone healthy."*
>
> —Dr. Carla Perissinotto, Medical Director for Care at Home

Delivering on-going primary care through home visits

The vast majority of patients that receive an initial home visit will enroll in Care at Home and continue to receive regular home visits. For patients enrolled in the program, the practice coordinators collaborate with the provider who completed the initial home visit to determine the frequency of the ongoing visits. Care at Home providers typically see patients monthly at first, noting the importance of meeting frequently to build patient trust with the provider and to assure the patient that he or she now has regular access to care. Visit frequency changes over time based on the patient's clinical needs. For example, patients recently discharged from the hospital may receive biweekly visits to stabilize their condition, while other patients may transition to a quarterly schedule for home visits once they are established in the program.

When possible, the PCP or NP assigned to the initial visit will conduct all subsequent home visits to provide interpersonal continuity when addressing the identified medical, environmental, and social health needs. Additional program staff—such as a social worker or interpreter—may join the home visits in-person or via video conference, as needed. If the assigned provider is an NP, a PCP may join the home visits to treat a patient's particularly complex medical care needs. UCSF Health also partners with local radiology services to provide X-rays and EKGs using portable devices administered by technicians from the service partners. After each home visit, a nurse from the Care at Home team reviews the EHR notes to determine the necessary follow-up care, perhaps calling the patient to discuss care instructions or engaging a social worker to connect the patient to local community resources for support with social service needs.

OUTCOMES

UCSF Health monitors utilization data to assess Care at Home's potential impact on cost, an important component of value-based care. In 2018, program leaders examined UCSF Health data to consider differences in health care utilization between patients in the Care at Home program and patients not enrolled in the program. This early analysis found that patients in the Care at Home program experienced approximately 70 percent fewer inpatient admissions, 65 percent fewer ED visits, and nearly 70 percent fewer observation stays than those patients not in the program.

The Care at Home team also monitors quality to inform ongoing process improvement. They selected measures that align with national guidelines on measures of high-quality, home-based care. Each month, the team reviews data on the use of advanced care planning, completion of functional assessments, and immunizations rates for patients in the program. As of early 2020, just over 80 percent of older adults in the Care at Home program had an advanced care plan, compared to approximately 30 percent of older adults treated by all UCSF Health practices.

The Care at Home team also recently fielded a satisfaction survey to all program patients to understand the patient experience with the program. An analysis of 140 responses from July through December 2019 showed a nearly 95 percent overall satisfaction rate. The patient or caregiver respondents' comments emphasized the compassion of the providers and staff, and the excellent quality of care. UCSF Health uses the survey responses to improve the program. For example, answers to the survey revealed that patients appreciated having a specific time estimate of a provider's arrival, so the Care at Home team now provides patients with additional communications about the expected visit timing and also defines narrower time windows.

> *"Care at Home providers and support are top notch. Doctors and NPs are very compassionate, caring, and all ears to patients' concerns and well-being."*
>
> —Patient satisfaction survey respondent, July 2019

LESSONS LEARNED

The Care at Home program has refined the patient identification strategy to consider how to proactively engage patients based on utilization data. In addition to provider referrals and self-referrals, UCSF Health had tried engaging beneficiaries with a history of frequent inpatient admissions or ED visits. However, program leadership found that some beneficiaries were not interested in, or comfortable with, home-based primary care services. The program also reached out to beneficiaries with a recent hospitalization. This proactive approach was more effective, likely because UCSF Health had access to recent and accurate data on the beneficiary's diagnosis and suitability for the Care at Home program. Learning from these experiences, the program's current strategy incorporates recent hospitalization data to help prioritize patients identified through the historically effective referral and self-referral methods.

Care at Home modified its patient communications after observing the number of patients who initially expressed

interest in the program and then ultimately declined to enroll. The program staff concluded that patients are more likely to participate if they understand the program's logistics and offerings earlier in the enrollment process. In addition, they found that patients trusted the program description when first learning about the option from their referring provider in the hospital or clinic, as opposed to the brochure. Care at Home modified their communications processes to ensure that providers throughout the health system had a full understanding of the program so that they could provide patients with a complete and accurate description of the benefits of home-based primary care.

Finally, UCSF Health learned that effective home-based care requires providers who are comfortable providing care in a non-traditional environment. When recruiting new providers and training existing staff, they emphasize the importance of skills such as ability to work in the low-resource setting of the patient's home or flexibility to respond to competing priorities. The Care at Home team must continuously update care delivery strategies to address health needs and safety concerns identified during the home visits. While this can be challenging from an operational perspective, they noted that a willingness to adapt is a critically important characteristic of staff supporting a home-based care program.

> *"All of the workflows that exist in medicine are inpatient- or ambulatory-based, so we are constantly reinventing the wheel and adapting, which takes a special team to envision how to do this. Home-based care is incredibly rewarding, but it's not for the faint of heart."*
>
> —Dr. Carla Perissinotto, Medical Director for Care at Home

NEXT STEPS

UCSF Health continues to identify ways to expand access to the Care at Home program by recruiting new providers to complete home visits. Currently, most Care at Home providers are trained in geriatrics or palliative care, two fields with provider shortages. UCSF Health is considering how to engage general internists in the program and how to educate and support them in effectively delivering home-based care. In addition, to further expand access to the program, UCSF Health is exploring ways to use telemedicine to enable providers to efficiently deliver more services in the home.

About the ACO Learning Systems project
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For more information, contact the Medicare Shared Savings Program Learning System at ACOLearningActivities@mathematica-mpr.com