Advanced Illness Management: The Missing Piece in Health Care Reform

NHPCO 2014 Management Leadership Conference

At Home SUPPORT

The Missing Piece

In Health Care Reform

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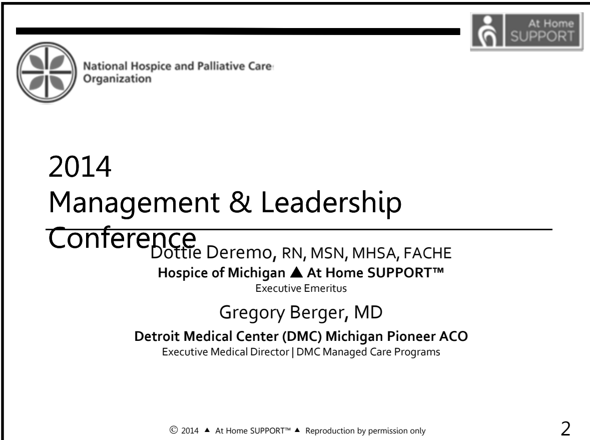

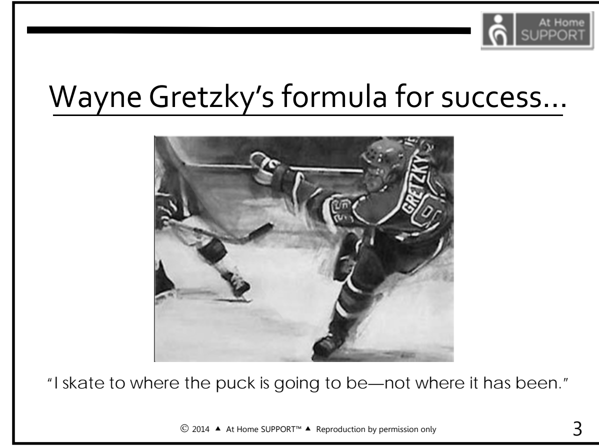

Dottie Deremo, RN, MSN, MHSA, FACHE
Executive Emeritus, Hospice of Michigan

Gregory Berger, MD
Executive Medical Director, Detroit Medical Center (DMC) Managed Care Programs, DMC Michigan Pioneer ACO

Presentation Overview

- ▲ The Future of 21st Century Health Care is ***Now***
  - →Where is the "puck" going to be?
  - →How fast is the puck moving?
  - →What role does "Disruptive Innovation" Play?
- ▲ Creating a Disruptive Innovation—a.k.a.
  - → How To Become An "Overnight Success" In 10 Years
- ▲ Results To Date
- ▲ Building a National Advanced Illness Management (AIM) Network
- ▲ Discussion

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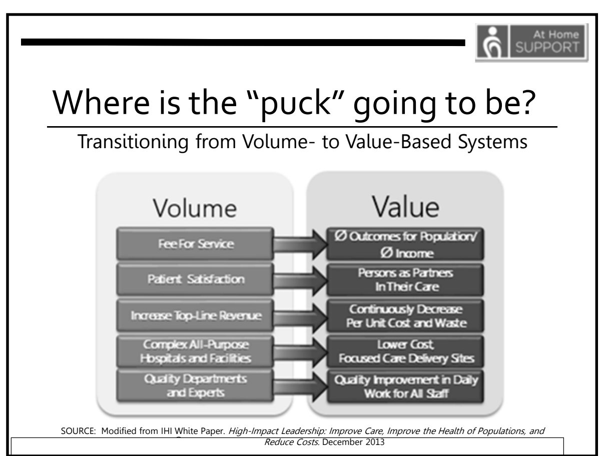

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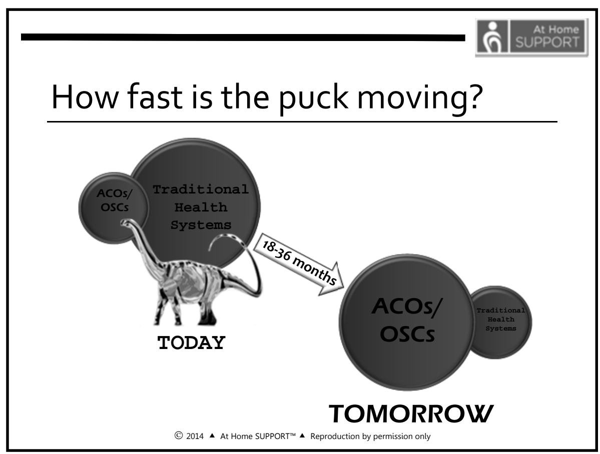

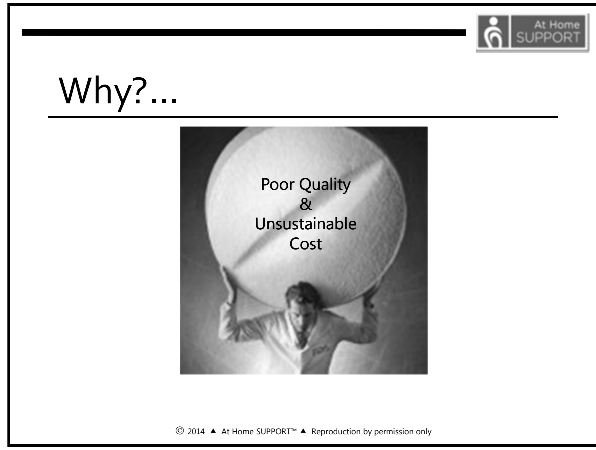

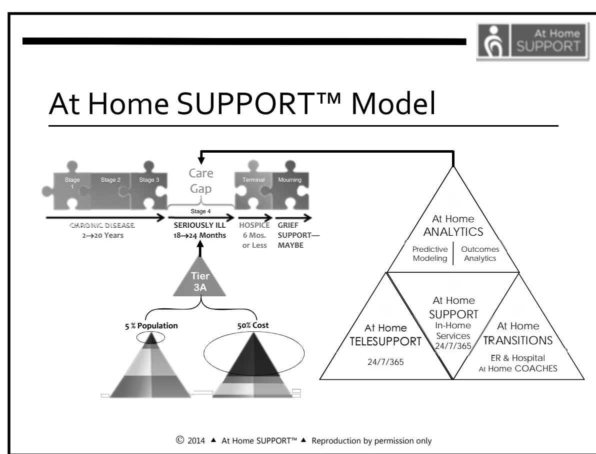

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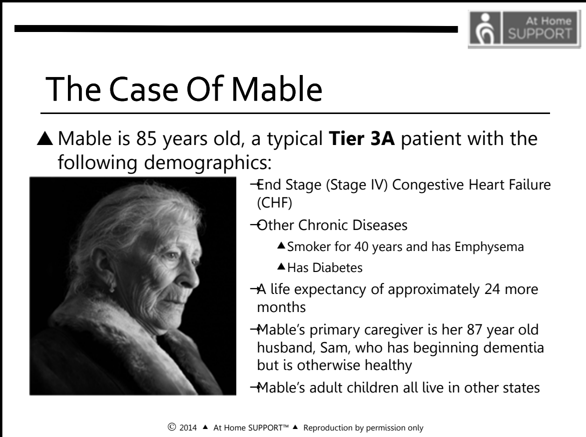

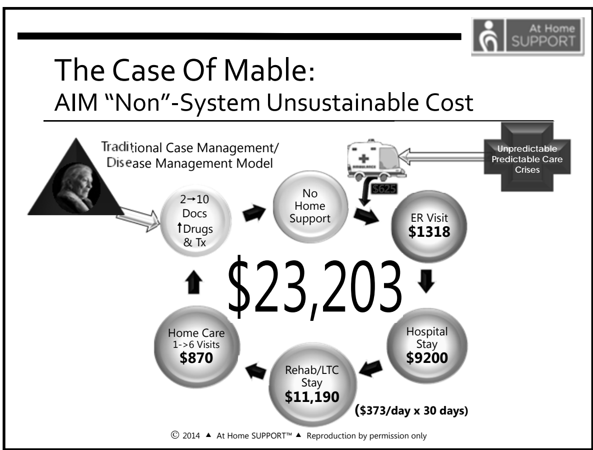

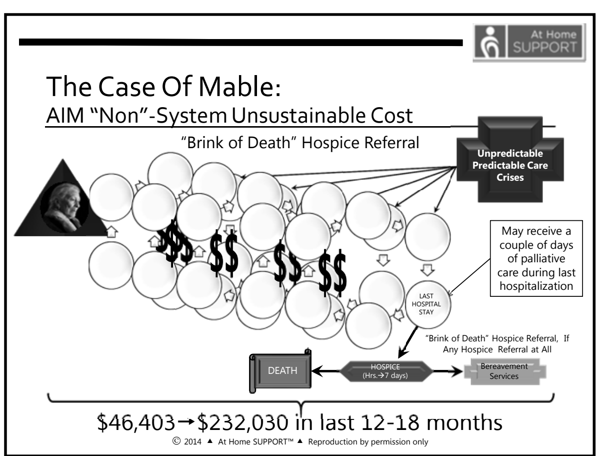

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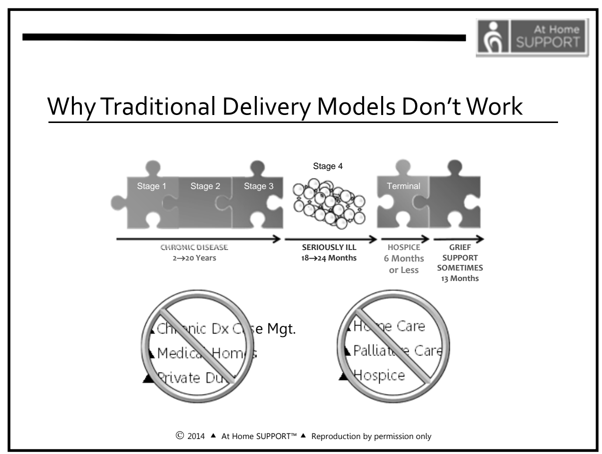

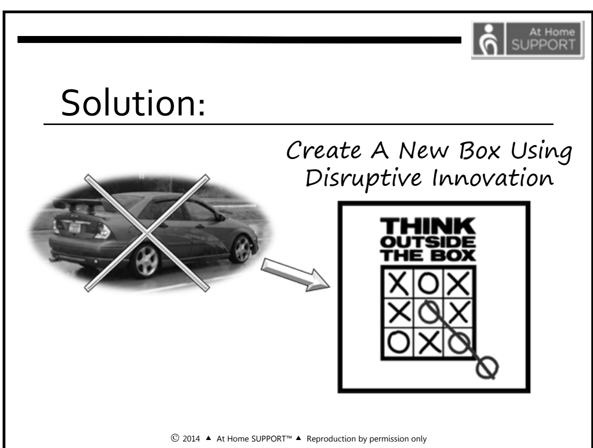

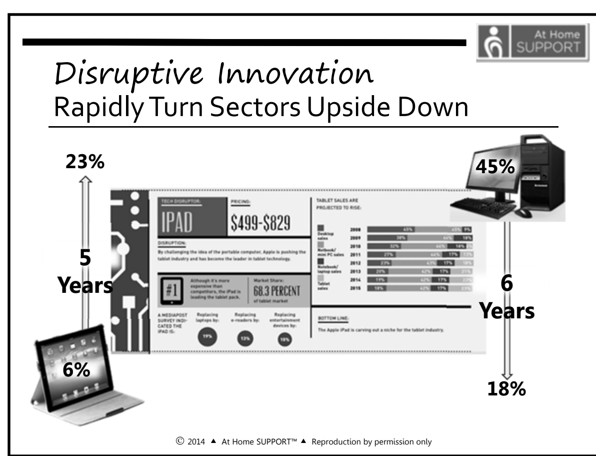

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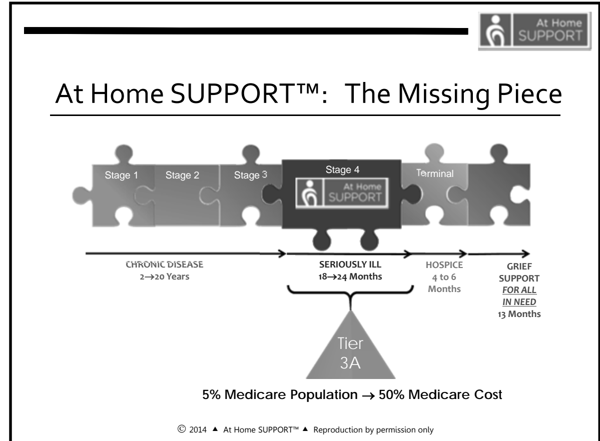
At Home SUPPORT™: The Missing Piece
Stage 1
Stage 2
Stage 3
Stage 4
Terminal
CHRONIC DISEASE 2→20 Years
SERIOUSLY ILL 18→24 Months
HOSPICE 4 to 6 Months
GRIEF SUPPORT FOR ALL IN NEED 13 Months
Tier 3A
5% Medicare Population → 50% Medicare Cost
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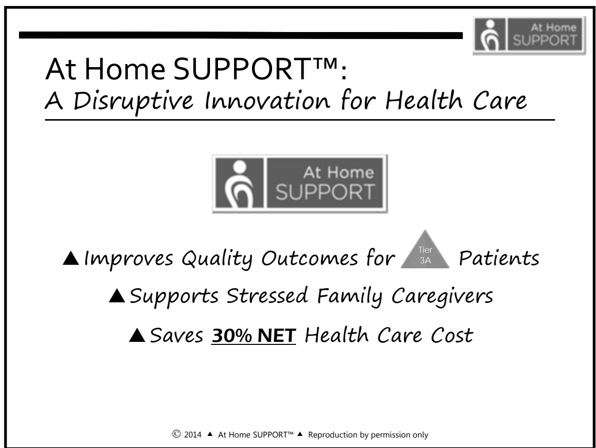
At Home SUPPORT™:
A Disruptive Innovation for Health Care
▲Improves Quality Outcomes for Tier 3A Patients
▲Supports Stressed Family Caregivers
▲Saves 30% NET Health Care Cost
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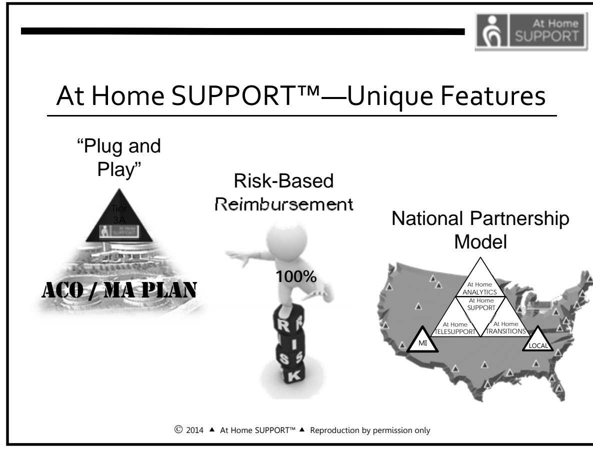
At Home SUPPORT™—Unique Features
"Plug and Play"
ACO / MA PLAN
Risk-Based Reimbursement
100%
National Partnership Model
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Becoming An "Overnight Success"

...In 10 Years!

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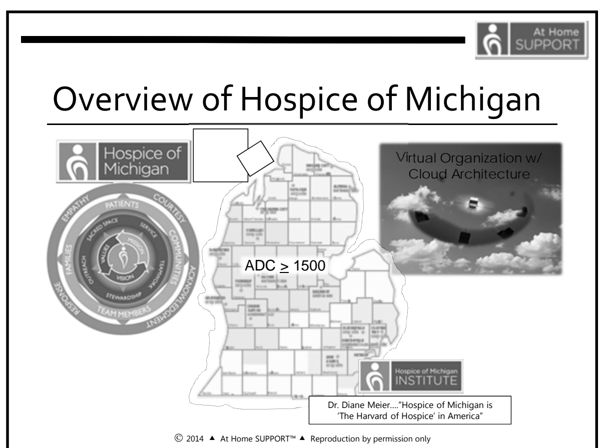
Overview of Hospice of Michigan



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Living Our Mission—Circa 2000

To ensure quality of life, comfort, and peace for our patients and provide support for their loved ones during their *end-of-life experience.*
We will *serve everyone* in our communities *who needs and seeks our care* and strive to *improve the state of comfort care.*

Yet, ...

65 % of patients in Michigan eligible for hospice care, their families, and their physicians ***did not want*** hospice care in order to pursue aggressive treatment for their disease.

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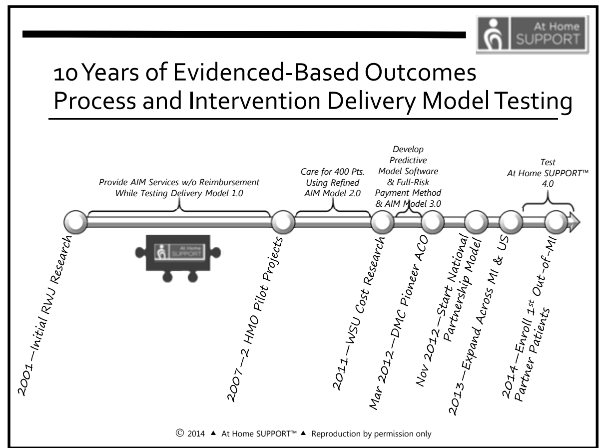
10 Years of Evidenced-Based Outcomes
Process and Intervention Delivery Model Testing
Provide AIM Services w/o Reimbursement While Testing Delivery Model 1.0
Care for 400 Pts. Using Refined AIM Model 2.0
Develop Predictive Model Software & Full-Risk Payment Method & AIM Model 3.0
Test At Home SUPPORT™ 4.0
2001—Initial RWJ Research
2007—2 HMO Pilot Projects
2011—WSU Cost Research
Mar 2012—DMC Pioneer ACO
Nov 2012—Start National Partnership Model
2013—Expand Across MI & US
2014—Enroll 1st Out-of-MI Partner Patients
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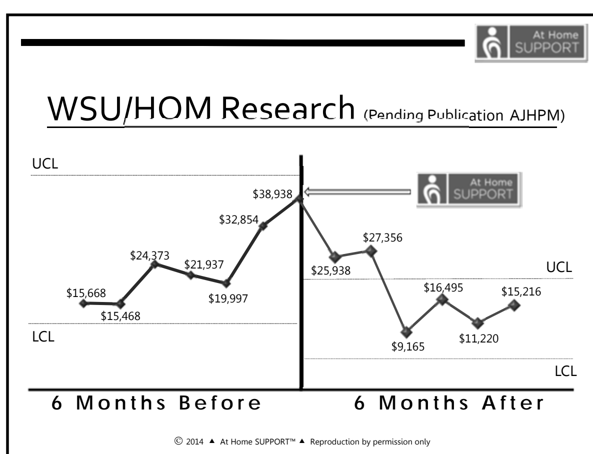
WSU/HOM Research (Pending Publication AJHPM)
UCL
LCL
$15,668
$15,468
$24,373
$21,937
$19,997
$32,854
$38,938
$25,938
$27,356
$9,165
$16,495
$11,220
$15,216
6 Months Before
6 Months After
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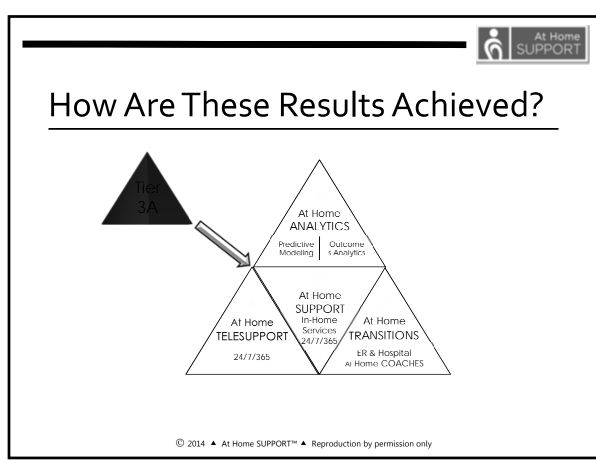
How Are These Results Achieved?
Tier 3A
At Home ANALYTICS
Predictive Modeling
Outcomes Analytics
At Home SUPPORT
In-Home Services 24/7/365
At Home TELESUPPORT
24/7/365
At Home TRANSITIONS
ER & Hospital At Home COACHES
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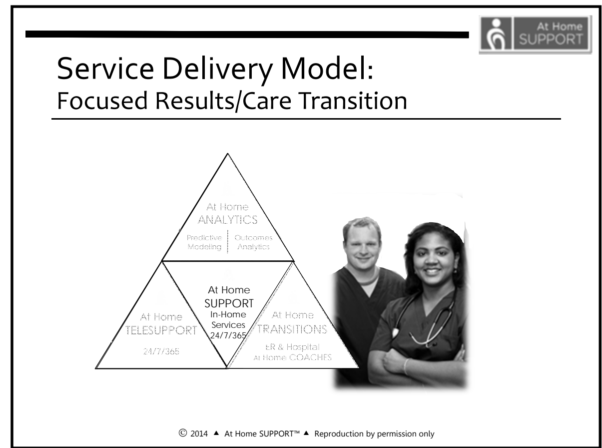

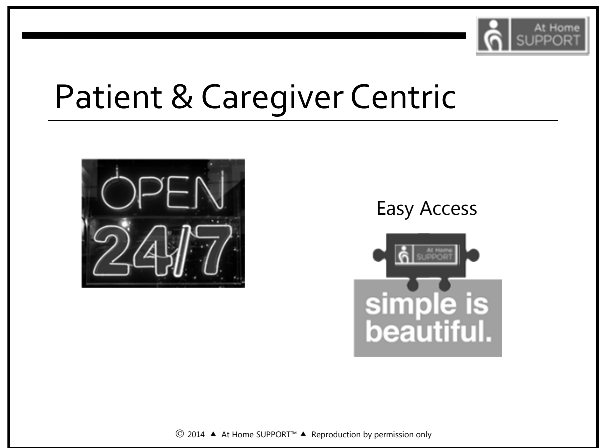

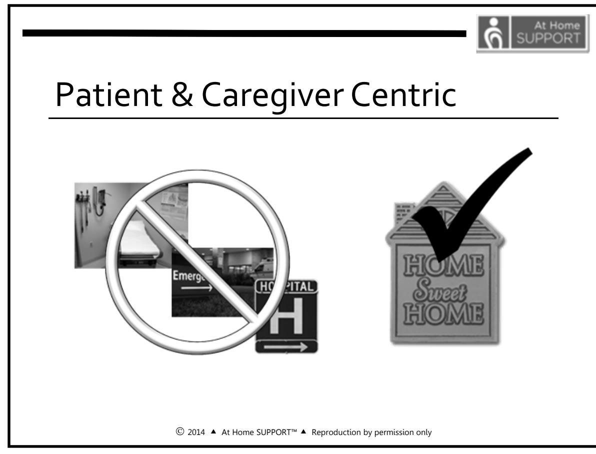

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Supports Optimum Quality of Life
INDEPENDENT ORDER OF
Odd Fellows
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Comfort and Companionship
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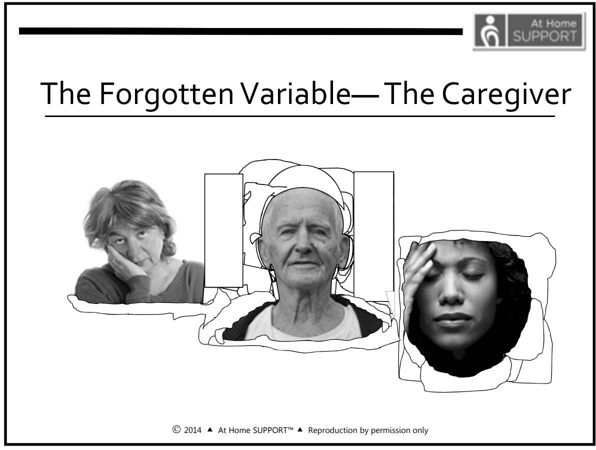
The Forgotten Variable— The Caregiver
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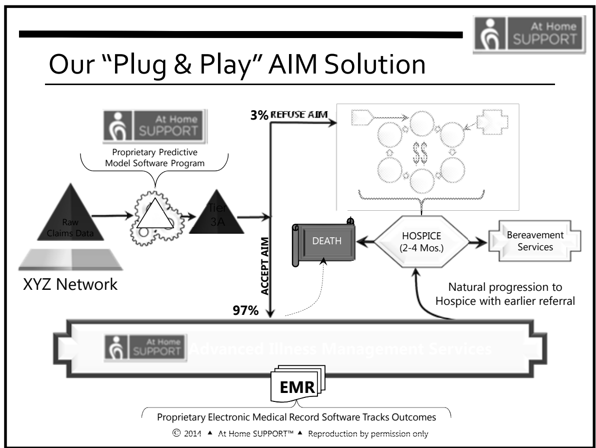

Our "Plug & Play" AIM Solution
Proprietary Predictive Model Software Program
3% REFUSE AIM
Raw Claims Data
Tier 3A
XYZ Network
ACCEPT AIM
97%
DEATH
HOSPICE (2-4 Mos.)
Bereavement Services
Natural progression to Hospice with earlier referral
EMR
Proprietary Electronic Medical Record Software Tracks Outcomes
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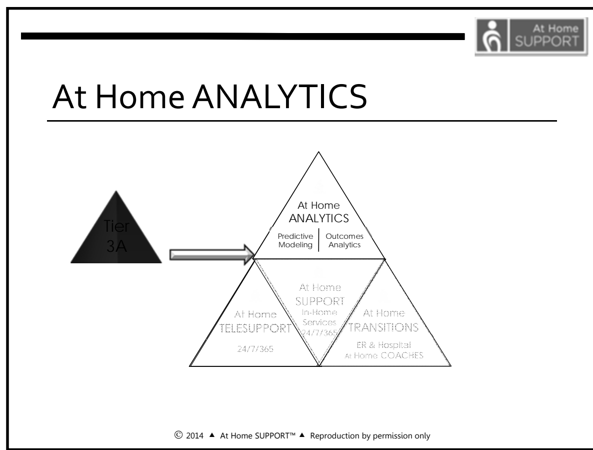

At Home ANALYTICS
Tier 3A
At Home ANALYTICS
Predictive Modeling
Outcomes Analytics
At Home SUPPORT
At Home TELESUPPORT
24/7/365
At Home TRANSITIONS
ER & Hospital
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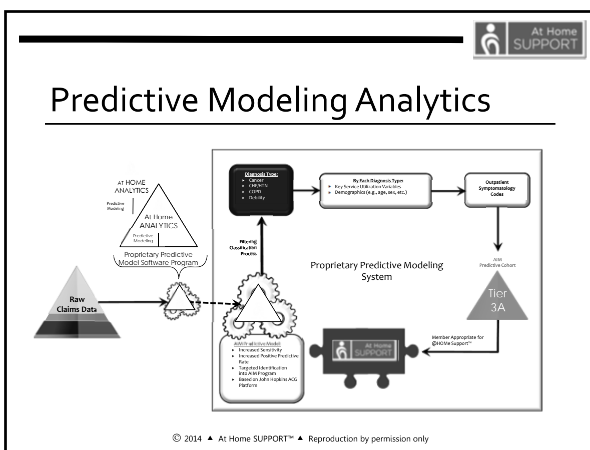

Predictive Modeling Analytics
At Home ANALYTICS
Proprietary Predictive Model Software Program
Raw Claims Data
Proprietary Predictive Modeling System
Tier 3A
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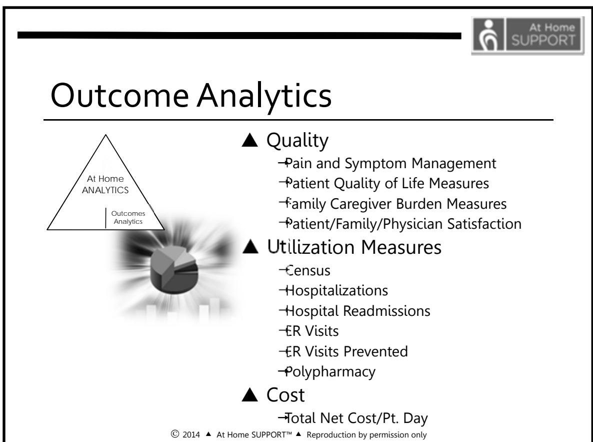
At Home SUPPORT
Outcome Analytics
At Home ANALYTICS
Outcomes Analytics
Quality
Pain and Symptom Management
Patient Quality of Life Measures
Family Caregiver Burden Measures
Patient/Family/Physician Satisfaction
Utilization Measures
Census
Hospitalizations
Hospital Readmissions
ER Visits
ER Visits Prevented
Polypharmacy
Cost
Total Net Cost/Pt. Day
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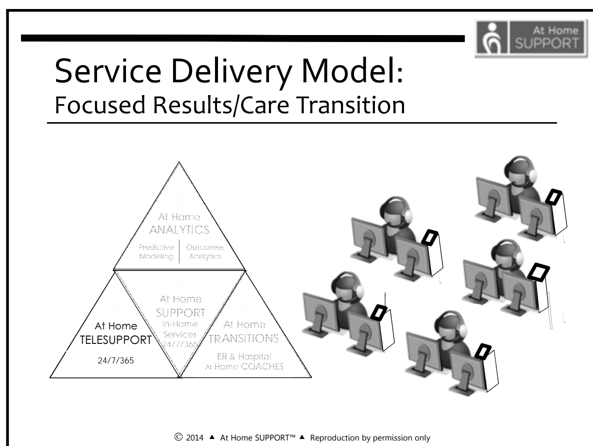
At Home SUPPORT
Service Delivery Model:
Focused Results/Care Transition
At Home ANALYTICS
Predictive Modeling
Outcomes Analytics
At Home SUPPORT
In-Home Services
At Home TELESUPPORT
24/7/365
At Home TRANSITIONS
ER & Hospital At Home COACHES
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At Home SUPPORT
One-Stop Shopping
At Home TELESUPPORT
24/7/365
24-7 HOMES.
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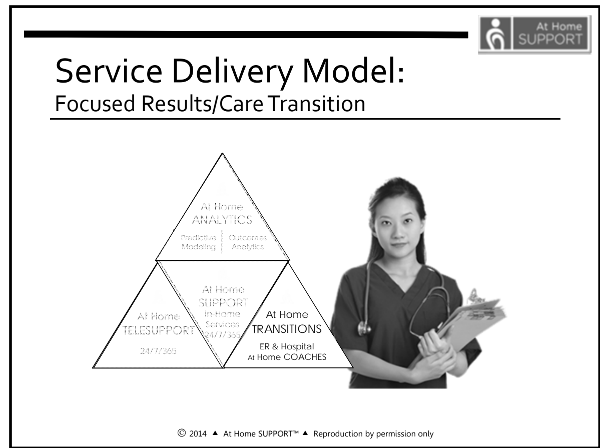
Service Delivery Model:
Focused Results/Care Transition
At Home
ANALYTICS
Predictive Modeling
Outcomes Analytics
At Home
SUPPORT
In-Home Services
At Home
TELESUPPORT
24/7/365
At Home
TRANSITIONS
ER & Hospital
At Home COACHES
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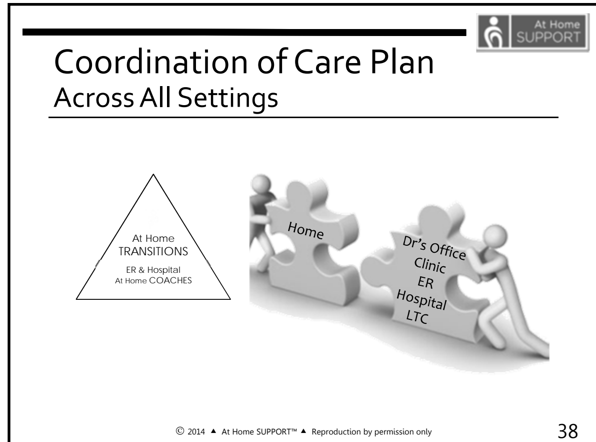
Coordination of Care Plan
Across All Settings
At Home
TRANSITIONS
ER & Hospital
At Home COACHES
Home
Dr's Office
Clinic
ER
Hospital
LTC
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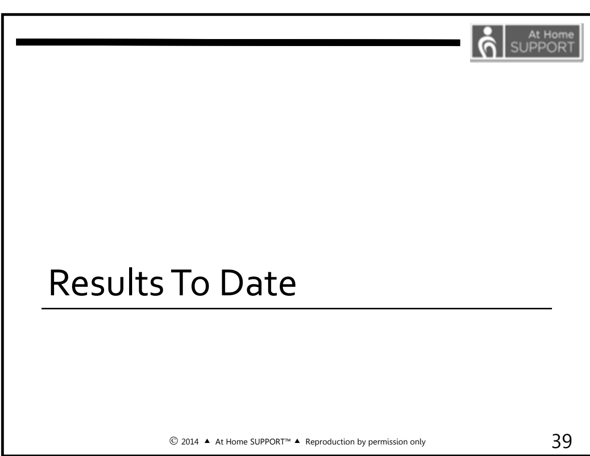
Results To Date
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At Home SUPPORT
Our "Plug & Play" AIM Solution
Tier 3A
ACO / MA PLAN
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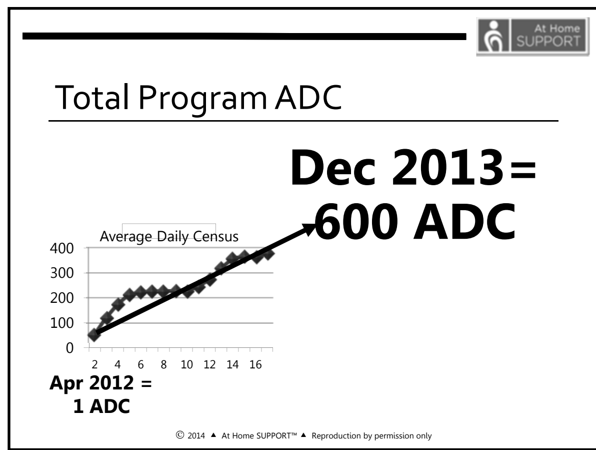
At Home SUPPORT
Total Program ADC
Dec 2013=
600 ADC
Average Daily Census
400
300
200
100
0
2 4 6 8 10 12 14 16
Apr 2012 =
1 ADC
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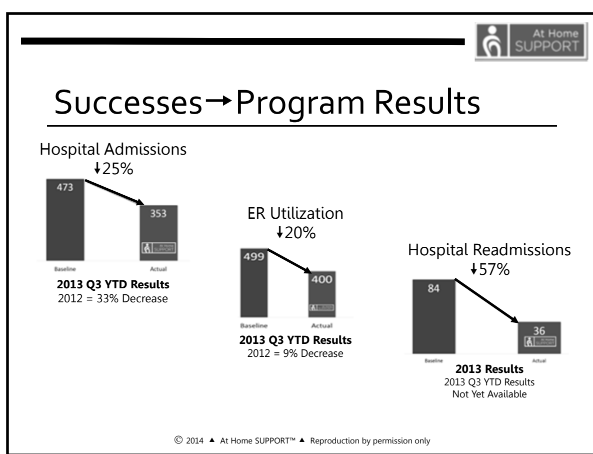
At Home SUPPORT
Successes→Program Results
Hospital Admissions
↓25%
473
353
Baseline
Actual
2013 Q3 YTD Results
2012 = 33% Decrease
ER Utilization
↓20%
499
400
Baseline
Actual
2013 Q3 YTD Results
2012 = 9% Decrease
Hospital Readmissions
↓57%
84
36
2013 Results
2013 Q3 YTD Results
Not Yet Available
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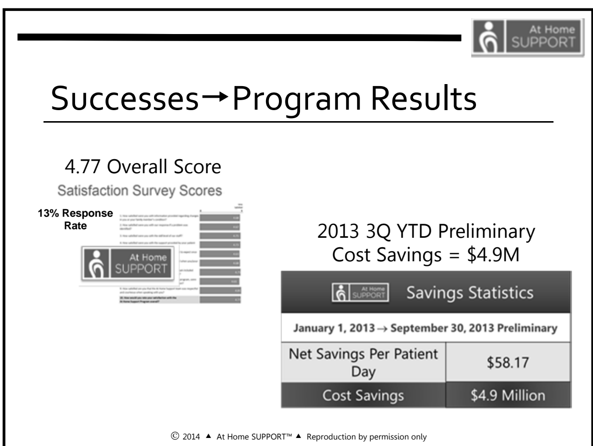
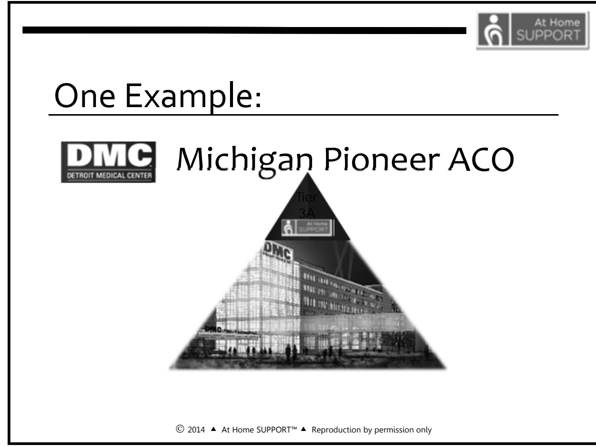
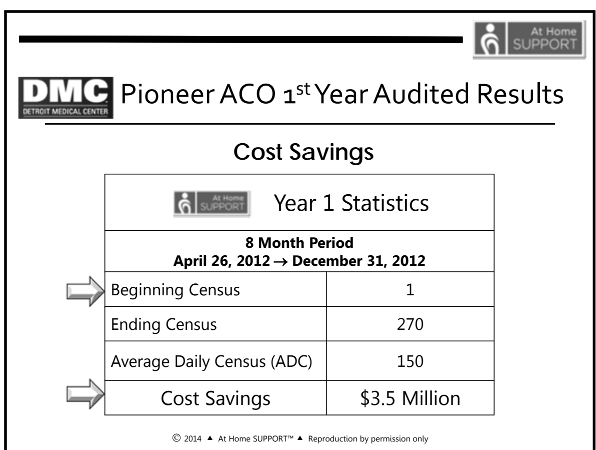
Advanced Illness Management:
The Missing Piece in Health Care Reform

NHPCO 2014 Management Leadership Conference







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Putting the Year 1 Cost Savings Into Perspective

Pioneer ACO 1st Year 2012 Results	
32 Pioneer ACOS	At Home SUPPORT
669,000 Beneficiaries	150 ADC for 8 Months
Total Savings = $87.6 M	Total Savings = $3.5 M

AT HOME SUPPORT™ SAVINGS=
4% OF THE ENTIRE NATIONAL SAVINGS

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Satisfaction Survey Comments

…in their own words

"A wonderful program."

"Absolutely wonderful service!"

"Everyone is fantastic!!!"

"Every visit has been great, informative, and caring."

"I am happy with your staff. I look forward to seeing them. They listen to my problems. They make me happy just to have someone helping me."

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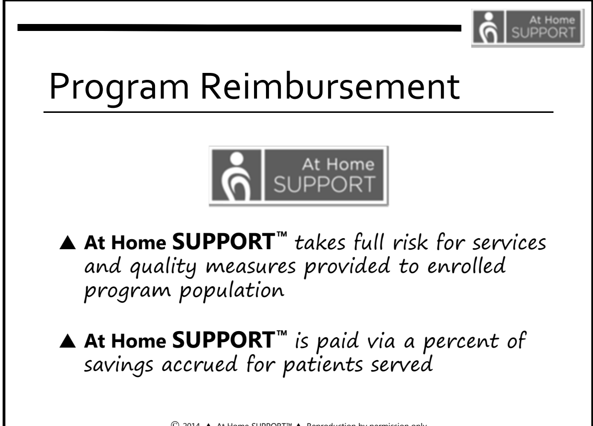

Program Reimbursement

- ▲ **At Home SUPPORT™** *takes full risk for services and quality measures provided to enrolled program population*
- ▲ **At Home SUPPORT™** *is paid via a percent of savings accrued for patients served*

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Building A National Network

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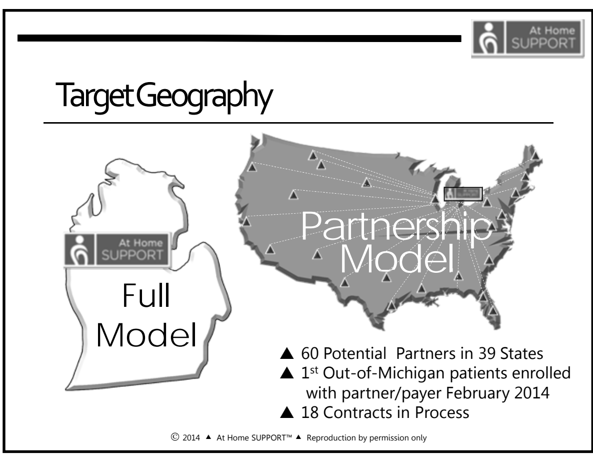

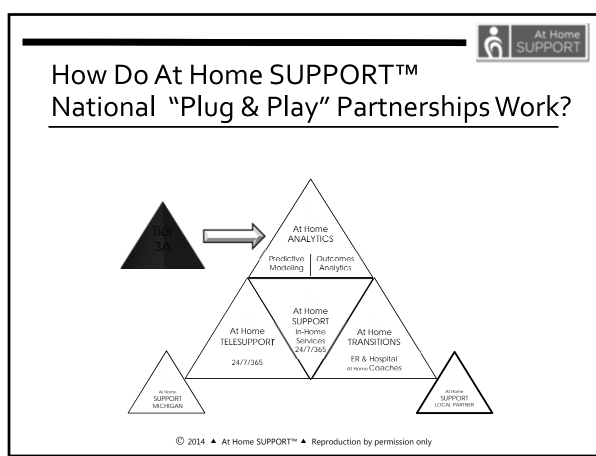

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Building National Network AIM Outcomes Measures

Partnership Model

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Could You Do This Yourself?

- ▲ Yes, if—
  - →Your organization has 3-5 years to create the:
    - ▲Predictive modeling and outcomes analytics,
    - ▲Algorithms,
    - ▲Training modules,
    - ▲Infrastructure, including a proprietary EMR that tracks outcomes, and
    - ▲Specialized delivery system

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Could You Do This Yourself?

- ▲ Yes, if—
  - →Your organization has 3-5 years to produce significant quality and cost-savings outcomes

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Could You Do This Yourself?

- Yes, if—
  - Your organization has sophisticated expertise in advanced illness and end-of-life care case management

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In Summary

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Words From A Great Philosopher…

"Somebody has to do something, and it's just incredibly pathetic that it has to be us!"

Jerry Garcia

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Discussion

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