

No Place Like Home: Bringing Inpatient Care to the Patient

Case Study · August 15, 2019

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Contessa

KEY TAKEAWAYS

- 1 Establish clear processes and a well-defined team. These processes will yield superior outcomes and a lower cost of care.
- 2 Establish an expansive list of targeted conditions for the program. The Home Recovery Care (HRC) model is beneficial for numerous patients; if the number of treatable conditions is limited, the program will likely exclude many patients who could greatly benefit from this model of care, limiting the clinical team's opportunities to gain experience with this model. If a patient is inpatient-eligible and can be safely treated at home, Home Recovery Care should be considered as the primary treatment modality.
- 3 Technology plays a key role in developing a standardized HRC program. Today, electronic medical record systems do not have the ability to seamlessly document and disseminate critical information to a distributed care team outside of the inpatient setting. This ability is crucial in establishing a well-coordinated and seamless care delivery experience for the patient. Marshfield selected a technology-enabled partner that was able to integrate HRC-related information into Marshfield's native inpatient electronic medical record.

Security Health Plan of Wisconsin, Inc. (SHP), part of Marshfield Clinic Health System, was the first payer to implement Home Recovery Care (HRC), a care model that brings all the essential elements of inpatient care to a patient's home. Home Recovery Care covers over 150 diagnosis-related groups, treating patients with conditions like congestive heart failure, chronic obstructive pulmonary disease, pneumonia, cellulitis, asthma, and deep vein thrombosis.

SHP is a not-for-profit health maintenance organization providing coverage to more than 230,000 members across Wisconsin. Accredited by the National Committee for Quality Assurance, SHP offers health insurance coverage to employees of large and small businesses, individuals, and families, as well as Medicare and Medicaid beneficiaries. In addition, SHP provides full-service third-party administration for self-funded employers. By overall premium volume, SHP is the sixth-largest plan in Wisconsin, and by membership it is the fifth-largest health plan.

Avoiding hospitalizations results in fewer complications, reduces the cost of care, and reserves more inpatient capacity for higher-acuity patients who require continuous monitoring. In general, patients prefer the experience of being cared for in their own home environment due to increased comfort, lack of disruptions, and being closer to family and friends.

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After a patient in an emergency or urgent care setting is identified as needing hospital-level care (yet does not have an acuity that requires more strenuous monitoring such as ICU-level care), the admitting physician for the HRC program completes a thorough in-person visit before the patient is safely transitioned back to the home. Upon enrollment in the program, the patient is assigned a Recovery Care Coordinator who serves as the patient's primary point of contact, coordinates the physician-directed care plan, and is available 24-7.

The HRC program is an episode of care that lasts 30 days, broken into two phases: the acute phase and the monitoring phase. In the *acute phase*, the patient is treated with intensive services in the home for 3 to 5 days. Once the physician deems the patient stable and ready to be discharged from the acute phase, the patient transitions to the monitoring phase. During the *monitoring phase* (which lasts from the end of the acute phase until the 30th day from enrollment in the program)

the Recovery Care Coordinator assesses the patient's health via phone calls and virtual interactions, to ensure the patient is on the path to recovery.

Marshfield's first HRC patient was treated in September 2016. Since the program's inception, more than 300 patients have avoided a hospital admission through Home Recovery Care. The initial launch of Home Recovery Care started small by focusing on patients with six specific acute conditions: cellulitis, pneumonia, chronic obstructive pulmonary disease, congestive heart failure, urinary tract infection, and deep vein thrombosis/pulmonary embolism. Later, the program expanded to cover more than 150 diagnosis-related groups (DRGs). In its second year, Home Recovery Care experienced a 189% increase in the number of enrollees.

Home Recovery Care has a patient satisfaction in excess of 90%, calculated by frequency of responses in patient satisfaction surveys that have the highest possible response.

The Challenge

Similar programs, whereby providers delivered hospital-level care in the home, originated in the mid-1990s, however, this model has failed to gain traction largely due to the lack of reimbursement by health insurance plans. SHP recognized that creating a reimbursement mechanism for this model would enable its members to experience a high-quality care experience with better outcomes at a lower cost compared with traditional treatment plans.

To successfully launch a scalable version of this model throughout the area served by Marshfield and SHP, several challenges had to be resolved, including:

- Identifying and training an adequate number of nurses who would be comfortable rendering this level of care in a home setting;

- Implementing the appropriate technology for documenting, tracking, and monitoring this level of patient care in a home setting;

- Establishing a contracting structure with a health plan that would provide reimbursement; and

- Implementing the necessary administrative infrastructure, including policies, procedures, and workflows, to ensure patient safety and clinical quality for patients of a higher acuity being treated in the home environment by a geographically distributed workforce.

The Goal

Marshfield Clinic Health System's mission is to enrich lives through accessible, high-quality health care that is also cost effective and evidenced-based. Home Recovery Care is in strategic alignment with the system's goals.

The primary goals were threefold: add value to Marshfield patients' experience, lower the cost of care, and reduce readmissions.

The Execution

To successfully execute and scale this model, this effort required a trusted partner to help create the administrative and operational workflows to make it a successful long-term initiative.

Patients return home the same day and their home is equipped with the necessary items for the delivery of acute care, such as an IV, oxygen, and pulse oximeter.”

The Marshfield leadership team identified Contessa, a leading operator of HRC programs, to work with the internal provider team, develop the clinical models, manage the administrative tasks, and provide the necessary technology through its platform, [Care Convergence](#). The platform enables the ability to administer episodic claims payments from SHP and offers workflow management support for personalized care in the home.

Contessa worked directly with SHP to set up a 30-day episodic capitated risk arrangement based upon underlying DRG reimbursement that provides the health plan upfront savings while [limiting risk exposure](#) for each episode of care.

How Home Recovery Care Works

A patient is typically identified in the emergency department or urgent care clinic, where Recovery Care Coordinators screen them to see if they qualify for Home Recovery Care. Criteria include: SHP coverage, inpatient acuity care needs, clinical eligibility, and passing the health and home assessment to ensure patient safety. The treating physician performs a history and physical evaluation to make the ultimate determination as to whether Home Recovery Care is appropriate. Once a positive determination has been made, the Recovery Care Coordinator and the treating physician work with the patient to review the HRC option, perform evaluations, and provide additional informational materials.

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Acute Care Phase

During the first 3 to 5 days of Home Recovery Care, an acute-care registered nurse provides care in the patient's home at least twice daily. In addition, the patient has at least one virtual visit per day with the hospitalist. To conduct the visit, physicians use a telehealth platform to virtually round on patients and perform assessments as they would during traditional hospital rounds. This virtual visit is conducted while an acute-care registered nurse is at the patient's bedside.

The patient's care team has greater insight into their progress, due to the capturing of vital biometric data via the telehealth platform (blood pressure cuff, pulse ox, weight, etc.), and can thus ensure that the patient is adhering to their physician-directed care plan for the entire episode. Depending on the patient's treatment plan, as determined by the treating hospitalist, the Recovery Care Coordinator may arrange for IV medications, additional in-home nursing, and other clinical services such as lab draws or mobile imaging.

Monitoring Phase

Once the treating hospitalist has deemed the patient safe for discharge from the acute phase, patients are moved into the monitoring phase for the remainder of the 30-day episode. The patient's primary care provider resumes physician oversight via clinic visits where additional diagnostic tests and treatment may be ordered. The Recovery Care Coordinator schedules follow-up appointments with the patient's primary care or specialists, as needed, and arranges for any other traditional post-acute services such as home health, social services, and physical, speech, or occupational therapy.

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The Recovery Care Coordinator remains engaged throughout the 30-day episode, monitoring vital signs virtually (using the same telehealth platform used by the physician for virtual rounding during the acute phase) and communicating with the patient regularly to coordinate any care or required follow-ups. At the end of the 30-day episode, the Recovery Care Coordinator refers the case to a SHP transition-of-care nurse to continue post-acute care follow-up as needed.

The Team

The Home Recovery Care team consists of:

Hospitalists who oversee the patient's care and round on the patients virtually through telemedicine;

Acute-care RNs who care for patients in their home; and

Recovery Care Coordinators who guide patients through the physician's care plan.

The care team is on call 24-7 and the Recovery Care Coordinators serve as patients' primary contact throughout the 30-day episode.

Metrics

Outcomes

Home Recovery Care has resulted in the following quality outcomes:

HRC patients had 44% fewer 30-day readmissions than SHP members within the same group of DRGs who were treated in the hospital.

HRC patients had 37% shorter length of stay, compared with historical data from SHP members within our diagnosis-related groups. (Length of stay for HRC patients was measured as number of days in the "acute" phase.)

Patient satisfaction is greater than 90%, based on the number of top-box responses for all questions administered via the HRC program patient satisfaction survey.

Cost Savings

Contessa worked directly with SHP to identify opportunities for cost savings through a risk-based arrangement, where a 30-day episodic rate is established for all costs of care related to the hospitalization. SHP saves approximately 15–30% per episode, when compared with their historical baseline costs, depending upon the health plan product (Medicare Advantage, commercial, etc.) Home Recovery Care is able to meaningfully reduce costs due to the elimination of fixed-cost allocations associated with traditional hospital-level care, as well as the reduction in post-acute utilization and readmissions.

Service Expansion

Home Recovery Care has truly been embraced by Marshfield's patients, as proven by the 93% acceptance rate.

Home Recovery Care has expanded to serve patients in the Eau Claire community, as part of a newly built Marshfield Clinic Health System hospital facility. Additionally, Home Recovery Care

has expanded its clinical applicability to allow post-acute patients to be treated at home in lieu of a stay at a skilled nursing facility. This model targets patients of a higher acuity who have required stabilization in a hospital and are eligible for intensive post-acute services. If deemed clinically appropriate by the attending physician, the patient can opt to receive intensive therapy services in the home, as opposed to a skilled nursing facility.

Where to Start

First, clinical leadership must serve as the champions for this model of care. This modern-day approach for delivering acute care requires changes in practice patterns. A critical element for successful adoption is the visible and vocal support of the leaders who recognize and empathize with the challenges an organization will face through adoption and implementation.

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Second, engage operational and financial leadership early, as this model will directly impact the entire enterprise. Appropriate financial incentives for the provider organization can be maintained by incorporating the model into an existing risk-based arrangement, such as an ACO, or developing a stand-alone risk arrangement. Ultimately, the implementation team must obtain the support of multiple subject matter experts (clinical, financial, and operational).

Finally, it is critical to establish a limited group of clinicians who will serve as the admitting providers. These clinicians do not need to be exclusive to the program but should be small enough in number to give each of them a significant number of HRC patients, so that they can quickly develop experience and comfort with the model. This same group of clinicians should work together to establish the policies, protocols, and procedures they will use as a common framework for practice. Later, these clinicians should train other providers, to create an integrated team of clinicians steeped in the nuances of this care model.

Next Steps

Assess leadership engagement across all disciplines, including clinical, finance, operations, and managed care, to explore your readiness and commitment to pursue this truly differentiated care model.

Identify a targeted population to which the model could be applied. Examples include:

ACO lives

Associates of your organization

Lives for which you are at risk

Patients covered by local payers that are engaging with your team to establish new models

Quantify the potential volume for the targeted population, identified in the bullet above, using historical admissions data related to general medical conditions.

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