The Independence at Home Act

(H.R. 2560, S. 1131)

June 5, 2009

The Independence at Home Act

- Taking care of those who took care of us.
- Keeping America’s elderly as independent as possible for as long as possible.
- Reducing costs and improving quality while preserving patient choice.
- Making health care more affordable and available when it is needed, where it is needed.

Overview

- Background
- Independence at Home (IAH) Act
  - IAH Pilot Project
  - IAH Comparisons
  - Successful House Call Programs
  - Endorsements
- Bill History
- Support for IAH

Background

- Medicare beneficiaries with multiple chronic illnesses:
  - See about 13 doctors a year and fill about 50 prescriptions
  - Comprise the majority of hospital admissions, filled prescriptions, and physician visits
  - Often receive fragmented care, conflicting information, and multiple diagnoses for the same symptoms
  - Are 100 times more likely to have a preventable hospitalization
  - Account for a disproportionate share of Medicare spending
  - ***<u>Often don't get the care they need</u>***

- The optimal way to treat these patients is to bring coordinated, primary care services to their homes.

Independence at Home Act

Independence at Home Pilot Project

- Phase I: 13 highest-cost states, DC, and 13 additional states selected by HHS Secretary
- Phase II expands to entire country if Secretary approves

Key Elements

- **Coordinates** care for highest-cost Medicare beneficiaries
- Brings **primary care** services to the **patient's home**
- **Reduces costs** by coordinating care, reducing duplicative tests and preventing hospitalizations and emergency room visits
- Requires providers to demonstrate a **minimum 5% savings** to Medicare

IAH Beneficiaries

Eligible beneficiaries:

- Suffer from two or more chronic conditions
  - Including congestive heart failure, diabetes, Alzheimer's, Parkinson's, and others
- Need help with two or more ADLs
  - i.e. bathing, dressing, grooming, transferring, feeding, or toileting
- Have used certain Medicare Part A services in past year

IAH Participants:

- Receive an assessment to determine plan of care
- Have an IAH plan coordinator to coordinate their care
- May withdraw at any time

IAH Home Care Team

- Provides health services:
  - Primary care, home health care, and ancillary services including coordination across all treatment settings
  - Care coordination services, including coordination, medication monitoring, education, and caregiver counseling
- Directed by a qualified physician, physician assistant or nurse practitioner
- Includes an IAH Coordinator to oversee & coordinate care
- Must meet three performance standards:
  1. Improved patient outcomes
  2. Patient and caregiver satisfaction
  3. At least 5% annual savings to Medicare
- May keep 80% of savings achieved beyond initial 5% savings

Comparison to Medicare Benefits

	Independence at Home	**Home Health Benefit**	**Hospice**
Patient population	High cost, multiple chronic conditions, and 2 ADLs	Homebound	Less than 6 months to live
Care Provider	Team of physicians, NPs, PAs	Nurses, home health aides, therapists	Physicians, nurses, home health aides
Required savings	At least 5%	None	None
Location of Services	Home and other treatment setting	Home	Home, hospital, institution
Model	Home-based primary care with coordination	Home-based nurse and therapy	Home-based palliative care

Comparison to Demonstration Projects

	Independence at Home	**Medical Home**	**Physician Group Practice**
Patient population	High cost, multiple chronic conditions, and 2 ADLs	One chronic condition	All
Care Provider	Team of physician, NPs, PAs	Physicians only	Physicians only
Required savings	At least 5%	None	None
Location of Services	Home and other treatment setting	Medical office	Medical office
Model	Home-based primary care with coordination	Physician-centered coordination	Physician-centered coordination

Successful House Call Programs

- Home Based Primary Care, Department of Veterans Affairs
  - Operating for 30 years, now in 130 locations in 48 states with 17,000 patients
  - Demonstrated 62% reduction in hospital days, 88% reduction in nursing home days, and 24% reduction in total costs

- Washington Hospital Center Medical House Calls Program, Washington, DC
  - Operating for 10 years, now with 600 patients
  - Demonstrated 25% reduction in hospital stay length, 75% reduction in hospitalizations at the end of life
  - Achieved 7% re-hospitalization rate for CHF patients, compared to national average of 25%

Successful House Call Programs

- Housecall Providers, Inc., Portland, OR
  - Operating for 15 years, now with 1,300 patients
  - Over 10,000 home visits in 2008
  - Demonstrated prevented ER visits and hospitalizations
- Call Doctor Medical Group, San Diego, CA
  - ER visits reduced by 59% and achieved per capita savings of $1,075
- Urban Medical House Calls program, Boston, MA
  - Operating for 10 years, now with 550 patients
  - Reduced hospital admissions by 29% and hospital days by 34%

Successful House Call Programs

American House Calls	Texas
Geriatric Care of Nevada	North Central Nevada
Group Call Doctor Medical	San Diego, CA
GRACE House Calls Program	Indianapolis, IN
House Call Doctors	Nevada
House Call Program – Boston Medical Center	Boston, MA
HomeCare Physicians	Wheaton, IL
Home Physicians Program	Chicago, IL
Montefiore House Call Program	Bronx, NY
Mount Sinai Visiting Doctors program	New York, NY
Personalized Physician Care, Inc.	Bonita Springs, FL
Physician House Call Program – Johns Hopkins	Baltimore, MD
Senior Care of Colorado	Denver, CO
Visiting Physicians, Inc.	Michigan/Midwest
VCU Medical Center	Richmond, VA

IAH Endorsements

- AARP
- Wyeth Pharmaceuticals
- Intel Corporation
- Alzheimer's Association
- Alzheimer's Foundation of America
- American Academy of Home Care Physicians
- American Academy of Neurology
- American Academy of Physician Assistants
- American Academy of Nurse Practitioners
- American Association of Homes and Services for the Aging
- American College of Nurse Practitioners
- American Society of Consultant Pharmacists
- Family Caregiver Alliance/National Center on Caregiving
- Housecalls Doctors of Texas
- Housecall Providers, Inc. (Portland, OR)
- National Family Caregivers Association
- Maryland-National Capital Home Care Association
- Massachusetts Neurologic Society
- MD2U Doctors Who Make Housecalls (Louisville, KY)
- Naples Health Care Associates
- National Council on Aging
- Urban Medical House Calls (Boston, MA)
- US PIRG
- Visiting Nurse Associations of America

Bill History

- Developed in consultation with patients, caregivers, physicians, nurse practitioners, physician assistants, and representatives of CMS and the Office of the Inspector General at HHS.
- **H.R. 2560**
  - Introduced by Rep. Ed Markey (D-MA) on 5/21/2009 with original cosponsor Reps. Chris Smith (R-NJ)
  - Referred to Ways and Means and Energy and Commerce Committees
- **S. 1131**
  - Introduced by Sen. Ron Wyden (D-OR) on 5/21/2009 with original co-sponsors Sens. Richard Burr (R-NC), Ben Cardin (D-MD), and Sheldon Whitehouse (D-RI).
  - Referred to Finance Committee
- Introduced in 110th Congress as H.R. 7114/S. 3613

Support for IAH

Congressional Budget Office

CBO Budget Options, Volume 1, December 2008, p.77

- "An intervention that focused on coordinating care for [beneficiaries with multiple chronic conditions] could both improve their health and reduce Medicare spending."
- "…improving care could reduce spending by eliminating duplicated services, making more appropriate use of specialists, and averting serious complications from chronic conditions through better medical management."

White House Stakeholders Discussion

May 27, 2009

Health Stakeholders	The Independence at Home Act
Health care reform must address cost, quality and choice.	IAH will lower costs, improving quality of care, and maintain patient choice.
Reimbursements should be realigned with savings and health outcomes.	IAH organizations receive incentives for achieving savings.
Medicare should pay for managing care for high cost, chronically ill beneficiaries.	IAH provides teams to coordinate care for this population.
Reimbursements should reward physicians for preventing high-cost, catastrophic events.	IAH incents providers to demonstrate savings by preventing hospitalizations and emergency room visits.
Health care programs should fit the needs and age of patients.	The IAH care plan is tailored towards each patient's specific needs.
We need more opportunities for primary care physicians.	IAH creates attractive and rewarding career paths for PCPs.

Transforming the Health Care Delivery System:
Proposals to Improve Patient Care and Reduce Health Care Costs

Senate Finance Committee - April 29, 2009

Elements of Senate Finance Proposal	The Independence at Home Act
Patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries.	Creates a care coordination benefit for the highest cost beneficiaries with two or more chronic conditions.
Multi-disciplinary, in-person, team-based care with a close relationship between care coordinators and primary care physicians.	Includes an IAH care team designed to bring primary care services to patients through house calls; requires close coordination within team.
Integrated, transitional care management.	Incorporates transitional care to avoid unnecessary hospitalizations, ER visits, and nursing home placements at any time, not just within 60 days.
Enables providers to share in cost-savings they achieve for Medicare.	Organizations are required to demonstrate at least 5% savings, and may keep 80% of additional savings achieved.

CNNHealth.com

May 25, 2009

Black bag and Blackberry in hand, this doc makes house calls

- Profile of Dr. Eric DeJonge, who runs the Medical House Call Program at Washington Hospital Center
- “DeJonge says the one-on-one care is invaluable. ‘We know the patients, their families,’ he says. ‘We know when they change medically, what has to happen to prevent them from making an ER visit.’”
- “Now, with DeJonge making regular visits, Carter's father doesn't have to be moved from his home and his health has improved. ‘He's only been in the hospital twice in the last three years,’ says Carter. ‘Before that he was in the hospital every other month.’"

http://www.cnn.com/2009/HEALTH/05/25/hm.doctor.house.call/index.html#cnnSTCText

Akron Beacon Journal

June 1, 2009

Hospital resurrects practice of making house calls

- Profile of several house calls programs in Ohio
- “The thing that motivates me is being able to increase access to care…I hopefully am providing higher value health care.” – Dr. Bill Zafirau, SummaCare Physician House Calls program.
- “The idea is to provide more routine and preventive care to a select group of frail patients who struggle to get to their doctor's.” – Annette Ruby, SummaCare
- “She used to get her care through the emergency room on a frequent basis…Now, instead of going to the emergency room, she calls me. We're doing the coordination. – Dr. George Kikano, University Hospitals house calls program

Dr. Bill Zafirau examines patient Marian Graham in her home in Akron, Ohio.

http://www.ohio.com/news/46600982.html

New England Journal of Medicine

December 4, 2008

Home Delivery — Bringing Primary Care to the Housebound Elderly

- Profile of Urban Medical’s “House Calls” program, which employs multidisciplinary health care teams to treat patients at home in Boston, MA.
- “An internal evaluation found that among 70 House Calls patients studied, hospital admission rates were reduced by 29% and hospital days by 34% during patients' first year in the program, as compared with the previous year.”
- “We pay for things that people don't necessarily benefit from. If we were able to divert those expenditures to programs like this, it would be affordable, and I think it would save the entire system money while improving the quality of care." JudyAnn Bigby, Massachusetts Secretary of Health and Human Services

http://content.nejm.org/cgi/content/full/359/23/2409

Support for IAH

- Call to Action: Health Reform 2009 – Chairman Max Baucus
  - “In addition to the medical home, Medicare should test other primary care models that promote comprehensive care management and coordination, particularly for the chronically ill. Recent proposals to focus on caring for the sickest patients in their home, or those that rely on a geriatric assessment to qualify patients for comprehensive care coordination programs, show promise and should be examined in more detail.”
- President-elect Barack Obama in The Washington Post, 11/4/2008
  - "My grandmother was able to stay in a home all the way until recently," Obama told the caller, turning his back to the cameras. "Because she just had someone who could come in once in a while and that ends up saving a whole lot more money." He added, "It's a lot better for yourself and my grandmother."

Support for IAH

- Senator Edward M. Kennedy, Boston Globe, May 28, 2009
  - "As experience has shown, it's better - and cheaper - to get it right the first time rather than have patients go in and out of the hospital. So we'll start paying for the overall quality of care, not the quantity of procedures."
  - "…we'll make it possible for the elderly and disabled to live at home and function independently. Our bill will help them…pay someone to check in on them regularly, or any of an array of supports that will enable them to stay in their communities instead of in nursing homes."