Alliance for Home Health Quality and Innovation

CMMI Innovation Advisor Julie Lewis, Amedisys:
Challenging Conventional Chronic Care Management

Julie Lewis, of Amedisys, joins the Alliance for a discussion of her work with the Center for Medicare and Medicaid Innovation's Innovation Advisors Program. The goal of the Innovation Advisors Program is to improve healthcare delivery for Medicare, Medicaid and CHIP beneficiaries.

Ms. Lewis serves as Vice President of Health Policy and Government Relations at Amedisys, one of the founding organizations of the Alliance. A former Director of Health Policy at The Dartmouth Institute (TDI) for Health Policy and Clinical Practice, Ms. Lewis has also previously led the Surgical Quality Alliance at the American College of Surgeons and worked for the former Speaker of the House, Congresswoman Nancy Pelosi.

We sat down with Julie to learn more about her project and to get her perspective on the role of home care in current healthcare delivery system reforms.

What is your role in health system reform as an Innovation Advisor and what contribution will your project make to the home care community?

When I applied to the Innovation Advisors Program, I had no idea what to expect. This is a new role for CMS – that is, working as a partner with innovators. So far, my experience has been really positive. I view my role as an advisor in three parts: a personal learning experience, an opportunity to establish relationships with like-minded CMS staff and other advisors, and an opportunity for Amedisys to focus on an innovative project with CMS as a partner.

When I look around at the other 72 advisors, more projects are related to home care than I expected. There are projects that look at home-based primary care delivery, care transitions to the home, and a hospital-at-home model. To me, this indicates that CMS is interested in learning more about care delivered in the home. Through these innovative projects, we are going to increase our knowledge about how to make the patient – and the patient's home - the center of care, rather than a physician office or hospital.

Tell me about your model of home-based healthcare delivery.

Our research question is, "Can you make the home, where the patient wants to be, the hub of the patient's care?" To do this, our delivery model uses a physician-led team with care coordination nurses embedded in primary care practices. The care coordinator leads a mobile healthcare team, which includes a community care nurse, a social worker and a health coach. For the pilot program, we have selected high-risk patients who are not homebound but are trying to manage multiple chronic conditions while maintaining their independence. Patients are identified in one of two ways: by physician referral in the clinic or through data analysis of patients who have multiple hospital admissions or emergency department visits in the last year. Louisiana State University's Health Sciences Center – including two physician clinics in New Orleans – are partnering with us on the project.

As we stepped back from our current clinical delivery and reimbursement models, three areas of focus were identified for the project: 1) access to needed resources, including primary care, transportation, mental health services, prescription drugs, and healthy food; 2) patient education and engagement, including education materials, as well as clinicians and health coaches with time to dedicate to education; and 3) care coordination, including a healthcare advocate to help the patient navigate healthcare, social, and community resources. Our model is built to address these three areas.

We've made a point to really separate the care teams from our traditional home care operations. The clinical teams will not be housed in our current care centers and many members of the care team will not have a home healthcare background. The project is about innovation, so we need to think "outside of the box," while expanding on the great lessons we've learned providing traditional home care. For example, if we only use clinicians with home care experience, we run the risk of our team

being artificially constrained by "how we do things" today, a model which is greatly impacted by the current reimbursement structure. In contrast, we are looking for a well-rounded team with experience in care coordination, health coaching and education, and community social work. For example, one of our embedded care coordinators worked as an emergency department nurse for 15 years in a New Orleans safety net hospital with a Level 1 Trauma Center, but has never worked in home care.

We know that it will take experience from multiple disciplines to be successful. In addition to our clinical team on the ground, we have the support and resources of Amedisys behind us. In addition, Jeff Brenner and his team from Camden, New Jersey are serving as advisors to the project and we have a non-clinical care coordination advisor to lend expertise.

How will you know when your model has succeeded?

To be consistent with the larger CMMI mission, success will be measured on the Three-Part Aim – improved health, improved healthcare, and reduced costs. The project will track hospitalizations and emergency department visits as a proxy for improved healthcare and reduced costs. We will also use patient-reported health status measures to track improvement in health. Using a validated survey, patients will answer five questions periodically to help us gauge improvement in their health status. It's not clear what process measures will be available, but we may include disease-specific measures (such as Hemoglobin A1c levels for patients with diabetes) depending on the characteristics of the patient population.

What about the development of clinical protocols? Does your project use existing clinical protocols?

Our care team is looking at existing clinical protocols to determine what needs to be tweaked and what protocols and processes are missing. In many ways, we are blazing a new trail in care delivery and coordination, and we're not

expecting that we have it all right at the outset.

This project is really about "rapid cycle learning." The team is expected to learn every day and modify their approach. The goal is that at the end of the project we have a structured care delivery model we can use to improve the Three-Part Aim for our patients while keeping patients in their homes.

What about other measures of success, such as an impact on the Medicare home health benefit?

I'm not sure that this project will impact the current Medicare home health benefit, but I also don't know that it should. I think the home health benefit was designed for a good purpose – post-acute care – and I think it serves that patient population well. However, with the growing prevalence of patients with multiple chronic conditions, we are asking the current home health benefit to serve a purpose it wasn't designed to address. The real question is how do we successfully care for (and pay for) patients with chronic disease?

I hope this project gives us more information about how to successfully participate in new payment models, such as ACOs and bundled payments. If this project is successful, the results could impact how we think about chronic care bundling or even partial capitation models designed to care for patients with chronic disease.

Ultimately, the project is less about creating a new benefit and more about understanding how to provide longitudinal, coordinated care. Our program includes a broad spectrum of services not currently covered in our healthcare system, including transportation to clinic visits, temporarily paying co-pays for prescription drugs, in-home tele-monitoring and health education. These types of benefits aren't included in the current Medicare fee-for-service structure, but as we understand more about their impact, we may begin to incorporate these elements under risk-based models like a bundled model.

Tell me what outcomes you hope to achieve by the end of the project.

We eventually want to answer two questions: Can providers actually affect the health status – and consequently, healthcare costs - of the chronically ill through a program focused on keeping the patient at home with improved access, education, and coordination? Of course, we think the answer is "Yes!" Secondly, is our model of care replicable and sustainable? I think so – I think our model could potentially affect how traditional home care providers operate in the future healthcare system.

What is the most exciting part about your work on this project, as an Innovation Advisor?

First, I think we're going to make a real difference for a small group of high-risk patients, about 500 individuals in New Orleans who are participating. The need in that area is so great. We won't fix the system, but we will make a small dent in a big problem. More broadly, this program is an opportunity to test a new model of care delivery based in the home. Frankly, we will likely fail many times as we try to learn how to move to a new model of care delivery. At the last Innovation Advisor's meeting I heard a phrase that is very appropriate – "fail often to succeed more quickly." The prospect of failing is hard for any of us, and hard for large organizations, but I think projects like this one give home health providers the opportunity to be viewed as an innovative force.

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The Alliance would like to thank Ms. Lewis for her time and insight. If you would like to learn more about the Innovation Advisors Program, please visit CMMI's site by clicking here. To suggest an Innovation Advisor for our interview series, please email your suggestion to Special Assistant C. Grace Whiting, at gwhiting@ahhqi.org.