



Case STUDY

 **Learning Systems**
for Accountable Care Organizations

UnityPoint ACO's Home Visit Program

This case study describes UnityPoint Accountable Care's approach to implementing a home visit program to improve the care experience and health outcomes of beneficiaries. The accountable care organization's (ACO's) strategy has three components: (1) identifying beneficiaries who would benefit from a home visit as a follow-up to an inpatient discharge; (2) using the home visit to review post-discharge instructions, assess health and social service needs, and provide follow-up care; and (3) documenting and billing for reimbursement using a waiver available through the Next Generation ACO Model. UnityPoint's preliminary analyses suggest that the home visit program led to a drop in emergency department utilization and inpatient hospital admissions. The ACO's experience is informative for other ACOs interested in or currently implementing a home visit program.

BACKGROUND ON THE ACO'S HOME VISIT PROGRAM

UnityPoint Accountable Care is an ACO within the UnityPoint Health delivery system. The ACO comprises nearly 8,000 providers across Iowa, Illinois, and Wisconsin and is organized into 10 regional care networks that include hospitals, primary care and specialist provider groups, and post-acute care providers. ACO providers use approximately 40 different EHRs, but UnityPoint's implementation of the home visit program focused on regions that use its most common EHR platform. UnityPoint participated in both the Pioneer ACO Model and the Medicare Shared Savings Program, and it joined the Next Generation ACO Model in 2016. As of January 2019, the UnityPoint ACO served approximately 88,000 aligned beneficiaries.

UnityPoint's strategy for reducing readmissions and emergency room utilization focused on providing specialized support to beneficiaries

in their home during the weeks and months following discharge from an inpatient stay. As a Pioneer ACO, UnityPoint implemented Care at Home, a program in which nurses visited patients' homes to conduct medication reconciliation and home safety assessments. In addition, one UnityPoint region, Quincy, established a care management program in 2015 in which case managers visited patients in their homes if they were identified as high risk for readmission. Through these early experiences with home visits, UnityPoint ACO achieved the buy-in of clinicians and leaders for expanding the post-discharge home visit program.

In late 2016, Pam Halvorson, the lead executive of UnityPoint ACO, identified the Next Generation ACO waiver as an opportunity to solidify the home visit strategy by refining operational processes and seeking reimbursement for completed visits. The home visit waiver allows the ACO to take a flexible approach to delivering care for Medicare beneficiaries who are not eligible for home health care during the critical transition from

acute or emergent care to their home. Through the waiver, ACOs may bill for evaluation and management services for up to nine home visits during the 90 days after a triggering event (such as discharge from an inpatient or skilled nursing facility, or after an emergency department visit). Clinicians provide these services under general supervision of the ACO provider.

“We implemented the home visit program because we anticipated improvements in transitions from the acute and post-acute care setting for those patients going home. We wanted to reduce ED utilization and rehospitalizations which would in turn lower cost and improve the patient experience.”

—Chris Butters, Manager of network development for post-acute care services, UnityPoint ACO

LAUNCHING THE HOME VISIT PROGRAM

UnityPoint ACO first implemented the home visit program in select regions in order to clarify the optimal operational strategy before considering whether to spread the work across the ACO. Pam Halvorson worked with Chris Butters, the ACO’s manager of network development for post-acute care services, to launch the program. They began with a focus on the Quincy region, which had momentum from a previous home visit program. With time, the ACO expanded the home visit program to two other regions on the same EHR platform: Central Iowa (the largest region in the ACO) and Waterloo.

UnityPoint designed a decentralized implementation strategy in which the ACO provides foundational and generalizable guidance documents to participating regions as a starting point for planning program operations. The two documents, a readiness checklist and a process map, enable regional staff to identify customizations and refinements that reflect the local landscape in terms of provider composition, the availability of home care clinicians, and beneficiary needs. The ACO lead, Mr. Butters, uses these tools to forge a partnership with regional staff as they define processes for identifying

and referring eligible beneficiaries, conduct home visits, and document any outcomes and relevant information following the visit.

Readiness checklist

Mr. Butters, the ACO representative who works with regional leaders, uses the readiness checklist as a framework to guide conversations about the program’s processes and the implementation approach. The checklist outlines strategic decisions that must be addressed before launching operations, such as:

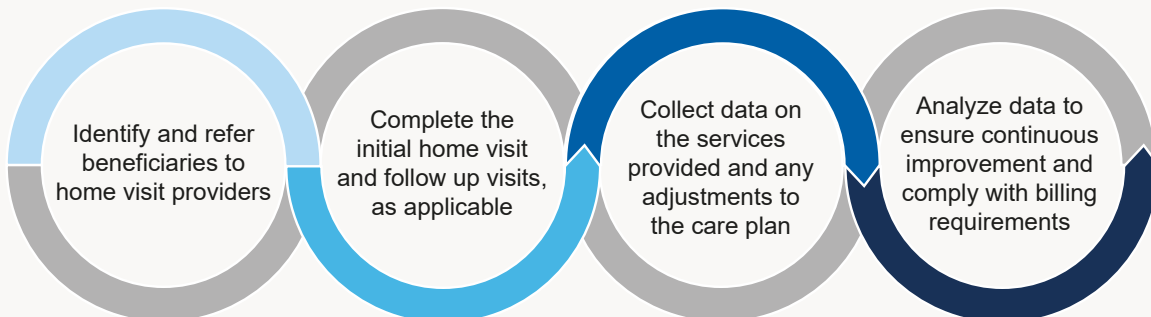
- Identify subject matter experts to be consulted during the implementation process
- Establish a process for identifying and referring eligible beneficiaries
- Create plans to document relevant patient characteristics and details of the visit
- Ensure effective communication between providers
- Educate and train clinicians about the home visit benefit and the process for referring beneficiaries

Process map

After defining the strategic decisions based on the readiness checklist, Mr. Butters works with regional leaders to construct a detailed process map that defines the operations of the home visit program. UnityPoint created a generic version, called the macro-level process map, that is intended to be applicable in any region. Figure 1 is a simplified version of this map.

Regions customize this macro-level map in order to address the infrastructure, staffing needs, and other factors that are unique to the local area. This version is called the micro-level process map. For example, the Central Iowa region determined that discharge planners or care coordinators should engage beneficiaries about the home visit opportunity before they are discharged from an inpatient setting. In contrast, care coordinators in the Quincy region engage beneficiaries by telephone to discuss the visit opportunity after they return to their home.

Figure 1
Home visit macro-level process map



OPERATING THE HOME VISIT PROGRAM

UnityPoint developed a set of processes and tools to keep program operations consistent and efficient across regions. The resources focus on defining the criteria through which beneficiaries are identified, specifying the care and services provided during the home visits, leveraging information technology (IT) to support home visit program operations, and securing reimbursement by submitting Medicare claims. Regional staff use these resources in conjunction with the adaptable readiness checklist and process map.

Criteria for identifying eligible beneficiaries

The ACO developed a home visit referral checklist that helps to identify beneficiaries who would both benefit from a post-discharge home visit and be eligible for reimbursement under the Next Generation ACO waiver. Examples of criteria in the checklist include: a high risk of re-hospitalization or an emergency department visit, a recent discharge that would trigger the home visits, and confirmation that the beneficiary is not eligible for the Medicaid home health benefit. Once the referring provider determines that a beneficiary is appropriate for the home visit program, she or he submits an order within the EHR, which is then routed to the beneficiary's primary care physician (PCP). The PCP reviews and approves the order, which is then routed to the providers who will conduct the home visit. Once the providers receive the order, the scheduling process begins.

Services provided during the home visits

UnityPoint partners with ambulatory care providers who are part of the UnityPoint Health delivery system. Initially, the ACO looked to a home health agency that is part of the UnityPoint Health system but found that the limited availability of the home health nurses, in certain regions, impeded the progress of the program. The ACO therefore worked with their ambulatory care partners within the health system to transition responsibility for the home visits. UnityPoint provides these nurses specialized training on the care and services to be provided during the first and subsequent visits. The emphasis of this training is on promoting care coordination and recognizing any need for more intensive home health care or other services. During the first home visit after an inpatient discharge, the nurse reviews the discharge instructions with the beneficiary and his or her caregivers, conducts a comprehensive assessment of the beneficiary's functional and behavioral health, screens for social service needs, and assesses the safety of the home environment. The nurse also completes a medication reconciliation and may provide wound care or respiratory therapy, as needed. Following the initial visit, the nurse may recommend additional home visits to meet the beneficiary's needs. These visits may be conducted by social workers, physical therapists, or occupational therapists.

The home care provider documents the services provided and the results of the assessments in a visit note within the EHR, which the PCP reviews to determine whether a follow-up office visit would be beneficial.

IT tools to support the program

Recognizing that the regions involved in the launch of the home visit program used the same EHR platform, UnityPoint built multiple IT tools within the EHR to facilitate the implementation and operations of the home visit program. To develop these tools, the ACO partnered with subject matter experts in compliance, quality improvement, and care delivery (such as nurses, social workers, and physical and occupational therapists). Through meetings and work sessions with the experts, UnityPoint designed the tools and also gathered feedback on proposed processes related to beneficiary identification, referral, and visit tracking. The final EHR-based tools include the following:

- **A beneficiary flag** to indicate the beneficiaries' alignment to the Next Generation ACO, which allows the home visits to be reimbursed under the waiver.
- **A referral checklist** to support the referring providers when confirming the beneficiaries' appropriateness for the home visit program.
- **A visit note** in which the providers who conducted the visits describe the services they delivered and the results of the assessments and the screening. The visit note is made available to the beneficiaries' PCPs and includes the documentation required for billing.

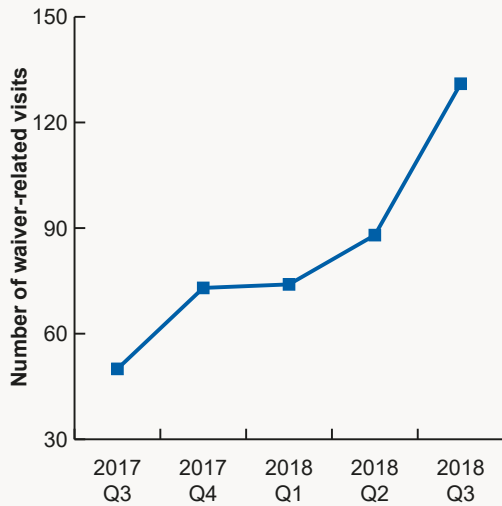
Reimbursement for completed home visits

UnityPoint established a centralized billing process to be reimbursed for the home visits under the Next Generation ACO waiver. In order to meet the documentation and coding requirements, the billing process leverages the detail captured in the providers' visit note. The PCP who oversaw general supervision of the home visit provider also reviews the visit note and routes it to the ACO's quality assurance department. The quality assurance department ensures that the documentation complies with Medicare's evaluation and management coding guidelines and then initiates the billing process.

RESULTS

UnityPoint's home visit program began small, and it grew over time as the initial Quincy region matured and as the program expanded to two additional regions. As shown in Figure 2, the number of home visits steadily increased from 50 in the third quarter of 2017 to 131 visits in third quarter of 2018.

Figure 2
UnityPoint Home Visits, 2017-2018



^aIn January 2018, the Next Generation ACO home visit waiver expanded from covering two home visits in the 30 days post discharge to covering nine home visits in the 90 days post discharge. To accommodate the change, the ACO Learning System extended the first quarterly data collection in 2018 from January through April. As a result, the final quarter in 2018 included only November and December.

UnityPoint collects monitoring data from the EHR-based visit note in order to examine the characteristics of the completed home visits. In addition, the ACO uses these data, combined with health care claims, to consider the potential impact of the home visit program on health outcomes. In 2018, the ACO analyzed care provided to the small sample of beneficiaries who received home visits and found that their emergency department use was lower, and they had fewer inpatient hospitalizations than a control group that did not access the home visit program. This preliminary analysis suggests that home visits may influence emergency department use and the need for inpatient care. UnityPoint continues to explore strategies to assess the impact of the program.

LESSONS LEARNED

UnityPoint found that beneficiaries are more likely to participate in the home visit program if they understand the connection between its services and the care they receive in a PCP’s office. The ACO used plain language to describe the home visits to beneficiaries who are not familiar with the program, emphasizing how the home visit gives them support that is recommended by PCPs to enable a safe transition home.

The ACO gave this language to providers who identify potential participants in the home visit program to aid in their conversations with beneficiaries.

Reflecting on its implementation approach, UnityPoint emphasized the importance of educating and training providers on how to deploy the home visit program. For instance, the ACO developed PowerPoint templates to convey tailored information to the referring clinicians (e.g., care coordinators, care navigators, discharge planners) and created a one-page summary for physicians that describes the importance of the post-discharge visit. These educational materials articulated why the home visit is important, how it differs from home health, how it relates to other care management processes, and relevant documentation guidelines. Regional staff used both tools in individual or group meetings to educate providers on the availability of the home visit and the process for scheduling one.

“Start to collect and share stories. If you talk to physicians about numbers or cost, sometimes they glaze over. Seeing the benefit we’ve had and sharing actual stories that they can relate back to their own patients has been really beneficial.”

—Chris Butters, Manager of network development for post-acute care services, UnityPoint ACO

NEXT STEPS

As UnityPoint’s home visit program grows, the ACO has begun to explore strategies for engaging independent participating providers who do not use the same EHR as the regions involved in the launch. This expansion strategy involves a more centralized approach in which additional operational support is provided by ACO staff rather than regional staff. For example, the ACO plans to create a team to monitor encounter data in order to identify aligned beneficiaries who have recently been discharged from a hospital and would benefit from a home visit. The team will then call the beneficiaries to introduce the program and schedule a home visit, and UnityPoint will use clinicians affiliated with local UnityPoint outpatient clinics to conduct these home visits. By expanding the program through this modified process, UnityPoint will be able to offer home visits to more beneficiaries in the critical period following discharge from an inpatient facility.

About the ACO Learning Systems project

This case study was prepared on behalf of CMS’s Innovation Center by Natalie Graves and Sonya Streeter of Mathematica under the Learning Systems for ACOs contract (HHSM-500-2014-000341/ HHSM-500-T0006). CMS released this case study in May 2019, and we are tremendously grateful to the many staff from UnityPoint who contributed to it.

For more information, contact the ACO Learning System at ACOLearningActivities@mathematica-mpr.com.