Large regional health plan successfully implements Home-Based Primary Care model to reduce MLR and increase member satisfaction.

Providing in-home care for the most vulnerable and medically-complex members results in a 2.29 program ROI and 87 Net Promoter Score.

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case study

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case study

the situation

A large regional health plan provides coverage to nearly 1.5 million members, including enrollees of Medicare Advantage. Many in this population live with underlying medical conditions and are homebound, making it a challenge to meet with their Primary Care Physicians as they should. This results in higher hospital and emergency care utilization.

the dilemma

With multiple chronic conditions, polypharmacy issues, and most importantly, significant barriers to care (e.g. social determinants of health), these members represented a significant portion of the health plan's costs. Yet there was very little the plan—or its providers—could do to influence these. This translated to increased costs and reduced quality of life for the plan's most vulnerable members. The health plan sought an experienced and proven partner with a comprehensive solution to meet the following objectives for this population:

- Reduce unneeded utilization
- Lower total cost of care
- Enhance health and quality of life
- Improve member satisfaction

the solution

In 2016, the plan partnered with PopHealthCare to rollout a robust, home-based primary care solution. This physician-led, in-home medical care solution increases access to timely and longitudinal treatment for the health plan's most at-risk members through:

- Coordination with community care teams and more
- In-home visits
- Telehealth check-in calls
- Medication refills

The collaborative care solution includes:

1. Predictive models that accurately pinpoint members who are consistently high cost and can be positively impacted through additional home-based care and treatment.

The solution focuses on members who:

- Drive 50% of acute hospital admissions
- Account for 40% of total cost
- Cost a minimum of $38k/year
- Have 4+ chronic conditions
- Are on 6+ medications

2. Integrated, multi-disciplinary in-home care teams that apply appropriate interventions and referrals based on a patient's social, behavioral, and physical needs.

Emcara Health, PopHealthCare's home-based primary care provider group, services include:

- Coordination with the primary care team
- Identification and mitigation of social determinants of health (SDoH)
- Caregiver and community resource coordination
- Disease education and self-management
- 24/7 availability
- Post-acute transition of care
- Palliative care referrals
- Behavioral health referrals
- Quality gap closure
- Medication reconciliation and adherence

"House calls dramatically improve patient outcomes, lower health care costs, and help family caregivers correctly provide homebound, and often immunocompromised, older adults with complex care without having to leave their homes. This can also save older adults from needless and expensive visits to the hospital, which is especially critical in the midst of a pandemic."

– Thomas Corwell

MD, Executive Chairman for the Home Centered Care Institute

the results

To measure the program's return on investment (ROI), Emcara Health applied its peer reviewed, science-based Coarsened Exact Matching (CEM) methodology. This new method uses actual claims data to show how members in the program perform compared to those not enrolled in Emcara Health's home-based primary care program.

Other, less reliable methods rely on a best guess of what might happen in the future (expected performance) based on past, often absent data. Not only is Emcara's measurement methodology more accurate, it's more conservative and avoids overstating the impact.

The success of the partnership between the health plan and Emcara is reflected by the multiyear relationship that began in 2016 and was extended through 2022.

During this collaboration, the health plan has achieved the following results:

Consistently positive ROI
The program has consistently delivered a positive ROI—essentially saving the health plan more dollars than what it spent on implementation

Program ROI for 2020 was 2.29.
When comparing claims data from members enrolled in the Emcara Health program to those targeted for the program but not enrolled, the health plan realized the following outcomes:

▼27.5%	▼10.7%	▼14.6%
Net change in total cost of care	Net change in hospital utilization	Net change in emergency department visits

Enhanced care and relationship with patients
Emcara Health delivered a positive Net Promoter Score (NPS) of 87 in 2020 and a 51% response rate, which has the potential to improve the plan's Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey score. A steady increase in identifying eligible members and expansion of geographic areas covered further demonstrate member satisfaction and overall success of the program.

Potential for developing future value-added programs
Falls are a major driver of cost in the elderly. To address this issue, the health plan launched a Fall Prevention program pilot with PopHealthCare and the Department of Rehabilitation Medicine at a major university. The goal of the pilot is to explore opportunities for reducing falls and related costs. New learnings will be integrated into the Emcara Health program.

Preliminary results are promising and indicate a potential 20% reduction in hospitalizations for fall related injuries. The pilot was easy to implement with the existing Emcara Health solution since the at-home framework was already in place.

key drivers of success

These results demonstrate the effectiveness of a collaborative care model that works with community primary care providers (PCPs) to maintain continuity of care, decrease unwarranted utilization, and control costs. Ultimately, members who receive in-home care are able to sustain a higher quality of life.

Success of this program is attributed to four essential best practices:

1. Establishing a trusting, collaborative relationship between plan members and medical providers
2. Improving continuity of care and communication between members and their health care team
3. Identifying and mitigating SDoH that contribute to physical and mental health
4. Leveraging Emcara Health's proprietary analytic model to identify those members most likely to drive healthcare costs

Through this unique partnership, the health plan is able to provide better support and access to timely, in-home care for the high risk members in its population.

summary

Home-based care, once a luxury, became a necessity due to the pandemic, and is now the new normal. In addition, its effectiveness is accelerating the shift from volume to value-based care. By providing home-based services, the health plan is better able to address high-utilization cost drivers, such as falls, while diminishing social isolation for its most vulnerable members.

In-home care will continue to play a vital role in the future, with the potential to deliver greater cost efficiency, better health outcomes, and higher member satisfaction. Having a proven, experienced care partner can offer critical support to health plans as the industry evolves toward a more collaborative care model with the consumer at the heart.

References:

Home Centered Care Institute. "No Place Like Home: House Calls Enable Homebound Older Adults to Receive Care During COVID-19." Dec. 3, 2020.

No Place Like Home: House Calls Enable Homebound Older Adults To Receive Care During COVID-19 | Home Centered Care Institute (hccinstitute.org)

Since 2014, PopHealthCare has been successfully delivering care in the home, conducting more than 500,000 member months of clinical management, 100,000 in-home assessments (IHAs) and 250,000+ patient home visits. In 2021 we expanded upon this experience and launched Emcara Health; a value-based national medical group that does house calls for vulnerable populations.

it's time to change the way healthcare is delivered

Email or contact your representative today to discuss how Emcara is a better model of care for patients, providers and partners.

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