



Opportunity Knocks at Home: How Home-Based Primary Care Offers a Win-Win for U.S. Health Care

Jonathan Rauch

INTRODUCTION & SUMMARY



Jonathan Rauch is a senior fellow in Governance Studies at Brookings. He is a contributing editor of *National Journal* and *The Atlantic*, is the author of several books and many articles on public policy, culture, and economics. He is winner of the 2005 National Magazine Award for columns and commentary and the 2010 National Headliner Award for magazine columns.

For far too many Americans, growing old and frail today means confronting repeated cycles of crisis, hospitalization, and expensive but ineffective or even counterproductive treatment—leading to still more of the same. Instead of reliably providing high-value treatment aiming to maximize quality of life in our declining years, the health-care system often provides high-cost treatment that seemingly aims to maximize treatment itself. The result is bad for the federal budget and in many cases, alas, even worse for patients. “There’s a lot of spending, but also a lot of suffering,” as Dr. Steven Landers, the president and CEO of the Visiting Nurse Association Group of New Jersey, said in a recent discussion with the author.

At a time when so many of the country’s health-care and fiscal problems seem intractable, this paper surfaces some good news. A win-win alternative, one that can reduce both cost and suffering, is at hand. With some nudging, it could move fairly rapidly into the mainstream of health care. Home-based primary care, as this alternative approach is called, is “one of the big opportunities in health care,” Landers said. Specifically:

- Medicare beneficiaries who are in their declining years and have multiple chronic conditions can be provided with better care at lower cost, thanks to the use of multidisciplinary teams that treat them primarily at home.

- Because this population is the most expensive group of patients in the medical system, even fractional savings can make a significant dent in health-care costs. More important, the result is likely to be more humane and effective from the patient's point of view.
- The multidisciplinary, home-based approach is not “vaporware,” an untried concept. To the contrary, it has a distinguished pedigree and has shown during more than a decade of clinical use and development that it can work in a variety of contexts.
- To bring home-based care to a national market, much will need to happen. Demonstrations will need to show that home-based care can scale affordably; Medicare payment structures will need to change; medical culture will need to adjust. But many of those changes are under way already, and all are within reach.

In short, multidisciplinary, home-based primary care is low-hanging fruit in the search for a higher-value health-care system.

II. THE HIGH COST OF FRAILITY

Over the next twenty and more years, millions of Baby Boomers will enter old age and qualify for Medicare. According to the Coalition to Transform Advanced Care (C-TAC), a Washington advocacy group, the number of people over age 85 with multiple chronic conditions will rise to 9 million by 2030, from 4.2 million in 2000.¹ Moreover, beneficiaries with five or more chronic conditions represent the fastest-growing segment of the Medicare population.

Widespread survival into advanced old age with multiple chronic conditions is a new phenomenon, attributable to the health-care system's success at keeping people alive longer. Today, according to Joanne Lynn, the director of the Altarum Institute's Center for Elder Care and Advanced Illness, about half of elderly Americans will live for years with multiple chronic ailments, following what she calls the “frailty course” toward death. Of those living beyond age 65, she says, about a quarter will need eight years of chronic treatment. A single individual may be struggling with, for example, heart failure, vascular disease, stroke, diabetes, hypertension, renal disease, dementia, and more.

These are expensive cases. As Drs. K. Eric De Jonge, George Taler, and Peter A. Boling note,

1. “Advanced Illness Care: Key Statistics,” December 10, 2012. Accessed at www.advancedcarecoalition.org.

“A small subgroup of Medicare beneficiaries with multiple chronic illnesses, functional disability, and history of high prior use drive about half of the Medicare budget.”² In 2005, frail patients with multiple chronic conditions represented fewer than a fourth of Medicare beneficiaries but accounted for more than two-thirds of the program’s costs, according to C-TAC. Particularly costly is frequent hospitalization.

Most expensive of all is the intensive care unit, where, according to several studies, about a third of people wind up in the last months of life—despite the fact that most Americans strongly prefer to end their lives at home.

“The dramatic increase in costs in the last month of life is largely driven by inpatient hospital stays,” reports *Medicare NewsGroup*, citing Center for Medicare Services data.³ Most expensive of all is the intensive care unit, where, according to several studies, about a third of people wind up in the last months of life—despite the fact that most Americans strongly prefer to end their lives at home.

Given the large amounts spent on frail patients with multiple chronic conditions, even fractional reductions in unnecessary hospitalization could generate notable savings. According to one estimate, a five percent reduction in end-of-life costs would amount to Medicare savings on the order of \$90 billion over ten years.⁴

III. A HIGHER COST THAN MONEY: LOST QUALITY OF LIFE

The U.S. health-care system was designed primarily for isolated episodes of intensive, acute care, and it shines at that function. But chronic care is another matter, especially for the frail elderly, who need ongoing, low-intensity support, much of it not strictly medical in nature. They tend to be left to their own devices until a medical crisis occurs, at which point they are likely to call 911 and be swept into the acute-care system. But an 83-year-old with multiple chronic conditions is often not someone whose situation will be improved by acute intervention. Instead, many of these patients are only briefly stabilized or, indeed, leave the hospital in worse shape than when they entered, only to repeat the cycle of crisis, hospitalization, and decline.⁵

2. “Independence at Home: Community-Based Care for Older Adults with Severe Chronic Illness.” *Clinics in Geriatric Medicine* 25:1 (February 2009), pp. 155-156.

3. Helen Adamopoulos, “The Cost and Quality Conundrum of American End-of-Life Care,” June 3, 2013.

4. Robert A. Berenson, John Holahan, Linda J. Blumberg, Randall R. Bovbjerg, Timothy Waldmann, Allison Cook, and Aimee Williams, *How We Can Pay for Health Care Reform: Summary*. Urban Institute and Robert Wood Johnson Foundation, July 2009.

5. The author’s views are influenced by his own father’s unnecessary and catastrophic hospitalization.

“More than 80 percent of patients say that they wish to avoid hospitalization and intensive care during the terminal phase of illness,” reports the *Dartmouth Atlas of Health Care*.⁶ Their preference is well founded. The consensus among geriatric doctors is that the hospital is generally no friend of the frail elderly. “Hospitals are a very, very bad place” for the medically frail elderly, as one geriatrician put it. Research finds that most people (78 percent) would give up months or even a couple of years at the end of life in exchange for better quality of life (better management of pain and discomfort, more family support, firm personal control over medical decisions, and familiar, pleasant surroundings).⁷ Often, however, avoiding traumatic or disruptive hospitalization makes life not only better but longer, too. Hospice care provides an invaluable alternative; but, although it is well established and growing, most people are reluctant to use it until they are on death’s doorstep, partially because, once in hospice, they generally must forgo Medicare-reimbursed therapeutic treatment.

Inappropriate hospitalization is not the only problem with today’s standard care model for advanced illness. Others include poor continuity, poor coordination, and poor communication. As the chronically ill elderly progress through stages of frailty, the levels and kinds of support they need change, as do their priorities and those of their families. The acute model copes with transitions poorly, often adjusting in sudden lurches during critical episodes. Shuttling between facilities and seeing multitudes of medical providers make handoffs and transitions jolting. People with multiple chronic conditions may be seeing not only a primary care doctor but several specialists, a psychiatrist, and one or more physical therapists. That reduces continuity. And coordinating multiple appointments and regimens is a challenge even for professionals; for the frail elderly and their family members, it can be unendurably confusing and stressful.⁸

Poor continuity and coordination contribute to a third problem: As patients trudge from specialist to specialist, and lurch from one crisis to the next, their goals and preferences

6. Topic page, “End of Life Care.” Accessed at www.dartmouthatlas.org/data/topic/topic.aspx?cat=18.

7. Cindy L. Bryce, George Loewenstein, Robert M. Arnold, Jonathan Schooler, Randy S. Wax, and Derek C. Angus, “Quality of Death: Assessing the Importance Placed on End-of-Life Treatment in the Intensive-Care Unit.” *Medical Care* 42:5 (May 2004).

8. “Coordination of care is especially important for patients with multiple chronic conditions, because it is not uncommon for them to receive duplicate testing, conflicting treatment advice, and prescriptions that are contraindicated. In a 2000 survey, 14 percent of people with chronic conditions reported receiving different diagnoses from different providers; 17 percent reported receiving conflicting information from providers; and 18 percent reported having duplicate tests or procedures. Some combination of these factors may play a role in the fact that there is a correlation between the number of chronic conditions and the number of inappropriate hospitalizations of Medicare patients.” Social Security Advisory Board, *The Unsustainable Cost of Health Care*, September 2009, p. 23.

...the system intervenes to treat whatever condition is presented, often without stepping back to get a clear fix on the patient's desires and goals—goals that change over time as patients age and their medical circumstances change.

are often lost in the shuffle. Instead, the system intervenes to treat whatever condition is presented, often without stepping back to get a clear fix on the patient's desires and goals—goals that change over time as patients age and their medical circumstances change.⁹

In short, the U.S. health system has many strengths, but late-life chronic care is not among them. That is the bad news. The good news is that the U.S. health system is bedeviled by problems for which solutions are elusive—but late-life care is not among them.

IV. MULTIDISCIPLINARY HOME-BASED PRIMARY CARE

Home-based primary care is arguably the oldest form of care of all, known long before there were modern hospitals. Even in its contemporary form, it is not a new idea. The Veterans Administration, as it was then called (now the Department of Veterans Affairs), began a home-based primary care program in the early 1970s. In 1980, Dr. George Taler, a geriatrician, created a home-based primary care program in Baltimore. Today, such programs are established in places around the country. Though no two programs are identical, they have in common a number of elements.

First, *they attempt to prevent hospitalization* by doing as much as possible at home, thus bringing care to the patient rather than the other way around. Many routine and some non-routine procedures can be performed in the home, and regular home visits can help identify and remediate problems before they become critical. Seeing a person in his or her daily environment can give a far richer view of the person's capabilities, needs, and vulnerabilities, often allowing for a higher degree of proactivity. Moreover, for the frail population, in many cases the home is a safer environment than the hospital. Finally, of course, home-based care avoids the trauma of stumbling from one institutional setting to the next.

9. "Research suggests that the care they get is not necessarily the care they want. Evidence comes from a large-scale study funded by the Robert Wood Johnson Foundation. Most patients with serious illness said they would prefer to die at home. Yet most patients died in the hospital, and care was rarely aligned with their reported preferences, even though extensive efforts were made by trained nurses to align their care with their wishes. For example, among the patients who indicated that they preferred to die at home, the majority—55 percent— actually died in the hospital. The evidence therefore suggests that patients often prefer a more conservative pattern of end-of-life care than they actually receive—and that a patient's wishes can be less influential than the practice patterns at the hospital where care is delivered." *Dartmouth Atlas of Health Care*, "End of Life Care" topic page, accessed at <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2944>.

Second, the programs *use multidisciplinary teams*. Formulas vary, but a typical team might consist of a nurse or nurse practitioner, a care coordinator (who might also be a nurse), a social worker, and a physical or occupational therapist. All work with and under a primary care physician. The team-based approach improves continuity on two dimensions. First, with each patient typically assigned to one or two teams, many of the same health professionals stay involved over time. Second, as the patient's medical situation evolves over time, the team can adjust the medical regimen continuously by changing the mix and intensity of skills it deploys. Early on, the patient may need only, say, one monthly visit from a nurse or a social worker. Later, the same patient may need much more intensive attention—followed, eventually, by hospice care, also at home. Adjustment shocks are fewer.

Third, teams *provide coordination*. Partly because the team is a team, it can work as a cohesive unit rather than as a collection of subcontractors. Some programs staff their teams with full-time employees, while others combine staff providers with community services. All, however, place primary responsibility on the team, rather than the patient or care giver, to orchestrate care. A typical model assigns each patient to a case manager charged with keeping team members on the same page, interacting with physicians and hospitals, and keeping care givers and family informed. Generally team members will meet regularly (say, weekly) to discuss patients, identify problems or gaps, and deploy personnel and resources to fill them. By comparison with the standard model, what the patient experiences is relatively seamless.

If a patient's goal is to travel to Thanksgiving dinner with grandchildren, the team may focus on that, rather than on an abstract treatment plan. The goal, of course, is not to skimp on care but to let the patient, rather than the medical system, be in charge, and to see patients as people rather than as bundles of diseases.

Fourth, programs attempt to *serve patients' goals* instead of merely treating diseases. They attempt to elicit and understand what clients want to get out of their treatments and their lives, and they ask—indeed, usually require—that patients and their families discuss and decide questions about goals of care. If a patient's goal is to travel to Thanksgiving dinner with grandchildren, the team may focus on that, rather than on an abstract treatment plan. The goal, of course, is not to skimp on care but to let the patient, rather than the medical system, be in charge, and to see patients as people rather than as bundles of diseases.

Critical to understanding home-based primary care is recognizing that it is not for everyone. Rather, it seeks to identify and enroll patients with multiple chronic conditions and poor prospects for full recovery. A patient might be referred by her primary-care doctor after an initial hospitalization, for example. Although expensive, home-based primary care can work because it specifically targets the people who cost the most and are least well served by conventional acute-care and institution-based arrangements. Selectivity is the key to both the program's medical coherence and its financial viability. By appropriately targeting its services, home-based care, expensive though it is, can and often does cost less than the alternatives—while offering a much better experience for the patient. Viewing it in action helps to illustrate how.

V. HOME-BASED CARE IN ACTION

I observed two programs at first hand and conducted interviews about two others. Brief descriptions follow.

Sutter Health's Advanced Illness Management (AIM)

Sutter is one of the country's largest health systems, including 24 hospitals and 5,000 physicians, as well as home care, hospice, and other services, all in northern California. Beginning in the late 1990s, Sutter began experimenting with team-based approaches. Those efforts evolved into Advanced Illness Management about five years ago.

AIM attempts to catch high-cost, multiple-ailment patients after an initial hospitalization or through referrals by Sutter physicians. Once enrolled, each patient is assigned to a team that includes nurses, social workers, physical therapists, and case managers. A typical team of 16 might include eight registered nurses, two licensed practical nurses, three social workers, a hospital liaison, and two care coordinators. Each team would handle a caseload of 150 or more patients. Team members receive four initial days of specialized AIM training, and AIM's philosophy and ethos—which emphasize collaborating to prevent medical crises and meet patients' goals—receive reinforcement in weekly team meetings where patients and problems are discussed. At a team meeting in San Mateo, California, for example, the group discussed a dozen or so patients, such as an 86-year-old woman—“well known to us” and “a lovely person,” as one team member put it—who resisted taking her medications; a physician questioned whether she really needed to be on Norvasc; and a social worker explained that a fall had finally persuaded the patient to get a medical-alert button. As each case was discussed, slides on a screen summarized patients' medical records but also included their goals, such as, for the 86-year-old woman, to “go out and have hair done.”

In San Mateo, I tagged along with a nurse and social worker who visited a new AIM patient, a 76-year-old man with edema, obesity, congestive heart failure, diverticulitis, gout, seizure disorder, depression, and sleep apnea. Sitting at the living room table, the three discussed his mobility, organized his medications, and asked a lot of questions in an effort to get a 360-degree view of the patient's circumstances. They also agreed to talk to the pharmacist at Walgreens about prescription packaging and they unobtrusively inspected his house. The nurse made an appointment to come back in a week.

As of today, AIM enrolls nearly a thousand patients. and its cumulative patient census is more than 2000. With support from a Medicare innovation grant, Sutter is currently extending its AIM program, previously limited to several districts, throughout its entire health network. Internal studies find that AIM achieves substantial reductions in hospitalizations (over 60 percent), intensive-care days (80 percent), and physician visits (50 percent), with high patient and physician satisfaction and no diminution of life expectancy. They also find savings to Medicare of more than \$2000 per patient per month.¹⁰ However, since Medicare does not reimburse for care coordination and travel, among other AIM elements, Sutter manages only to break even on the program financially.

MedStar Washington Hospital Center's "House Call" Program

Initiated in 1999 by two geriatricians, Drs. Eric De Jonge and George Taler, MedStar Washington Hospital Center's program targets frail elders in Washington, D.C., who have trouble getting to doctors' offices—the sickest 5 percent of Medicare patients. It currently supports two teams, each with a staff of eight to nine and serving about 300 patients in nine ZIP codes near Washington Hospital Center. Each team includes two physicians, nurse practitioners, social workers, and office coordinators. Unlike AIM, which seeks to coordinate with patients' original primary-care doctor, House Call requires that its own primary-care doctors take over from the patient's original physician, a "one captain of the ship" philosophy. Physician and team stay with the patient whether she is at home or in the hospital, avoiding handoffs. The core team also coordinates other services, such as urgent care, specialist visits, rehabilitation, pharmacy services, home equipment and health aides, and financial and legal assistance.

As at Sutter (and elsewhere), weekly team meetings discuss patients and keep team members on the same page. An average patient receives in-home physician visits several times a year, as well as monthly nurse-practitioner visits. An advantage of the system,

10. Estimates provided to the author by Sutter. See also, e.g., Guy Kovner, "At Home and at Ease," *Santa Rosa Press Democrat*, August 4, 2013.

Taler said, is that “you’re there as the situation unfolds.”

I accompanied Taler on two house calls. One patient was a 92-year-old man who was blind and had diabetes, hypertension, and gout. He had cycled through repeated hospitalizations until he joined the House Call program in 2006, and had not been hospitalized since. “I can’t ask for no better,” he said. “I hate the hospital.” A second patient was a 75-year-old woman who had been in the program for about nine months after suffering a disabling stroke.

Taler, after examining her, told her daughter, “Let me get a physical therapist in to help with her shoulder.” The daughter said that home visits had averted at least two ambulance calls—once, for example, by adjusting medications when the patient experienced head pain and abnormal vision.

The daughter said that home visits had averted at least two ambulance calls—once, for example, by adjusting medications when the patient experienced head pain and abnormal vision.

According to De Jonge, internal data comparing patients with their own previous history show significant reductions in frequency and length of hospitalization, with average hospital stays reduced from eight days to six. On standardized surveys, the program achieves 98 percent patient and family satisfaction. Forthcoming evidence will show cost savings, he said. Each team costs about \$1 million a year to operate. Because travel time, care coordination, family meetings, and various other services are not covered by Medicare, the program operates at a 30 percent loss. The program has been sustained by philanthropic support and internal subsidies from MedStar. “For 14 years we have been mission-driven,” De Jonge said. “George [Taler] and I decided we wanted to create the right model for this patient population and then we’d figure out how to pay for it.” Lack of a Medicare reimbursement model, however, remains a major obstacle. “The financial incentives, as of today, are still a huge problem.”

Hospice of the Valley’s Arizona Palliative Care Program

Hospice of the Valley, in Phoenix, is one of the country’s biggest nonprofit hospice providers. Noticing that seniors who were not ready for hospice were often suffering from multiple chronic conditions and cycling through repeat hospitalizations, in the early 2000s Hospice of the Valley used a foundation grant to launch a program for the medically fragile. Today, according to Dr. David Butler (the system’s executive medical director), Arizona Palliative Care treats about 900 patients. Patients are referred by physicians, family members, health plans, and themselves.

The program's medical staff is made up of three physicians, three nurse practitioners, and a dozen or so nurses who also act as case managers. Each nurse visits about four patients a day. Many patients, especially at first, require only phone contact and occasional visits, but for those in worse shape the program can provide weekly visits (for which an hour is allotted) from a nurse, biweekly visits by a social worker, and monthly visits by a physician or nurse practitioner. Rather than taking over patients' care, the team coordinates with their doctors and with available community providers.

According to Butler, Hospice of the Valley estimates that the in-home program has decreased patients' hospitalization rate by about 40 percent and has decreased emergency room visits by 25 percent to 30 percent. Hospice of the Valley has been self-financing the program, at a loss, for almost four years. "It's basically a research and development project for Hospice of the Valley, thinking this must be the way health care is going to go," Dr. Gillian Hamilton, the company's vice president for education and innovation, said. "The challenge for everybody is how do we get reimbursed." Significantly, however, the company believes that a business model is emerging, as will be discussed below.

The Department of Veterans Affairs Home Based Primary Care Program

The Veterans Administration, as it was then called, was among the first adopters of home-based care, with a program dating back to the early 1970s. Partly this was because the VA, being a large, vertically integrated health system, was in a good position to provide coordinated, multidisciplinary care and to capture savings that resulted. Today, according to Dr. Thomas Edes, the VA's director of geriatrics and extended-care clinical operations, the program operates in almost all VA medical centers and serves more than 31,000 patients a day.

A patient might be referred by a relative who notices, for example, that her father is not managing well at home; more often, a clinician or social worker might notice multiple hospitalizations in the past year. Patients suffer from an average of 19 clinical diagnoses.¹¹ About a third of patients enter the program after a hospital discharge. Each patient has a nurse case manager who visits the home, and patients can also receive visits from physicians, dietitians, rehabilitation therapists, mental health providers, and social

11. Emily Egan, *VA Home Based Primary Care Program: A Primer and Lessons for Medicare*. American Action Forum, November 1, 2012. Accessed at <http://americanactionforum.org/sites/default/files/VA%20HBPC%20Primer%20FINAL.pdf>.

workers. Often patients remain in the program for the rest of their lives. Where possible, patients see the same providers over time, and programs are “very individualized” based on patients’ goals, according to Edes.

The VA has conducted several analyses of the program’s relative utilization intensity and cost. In 2002, comparing patients before and after admission to the program, it found a 62 percent reduction in hospital days and a 24 percent reduction in cost to the VA. A subsequent analysis, taking into account spending by Medicare as well as the VA, found a 25 percent reduction in hospital admissions, a 36 percent reduction in hospital days, and a 13 percent reduction in combined costs.

VI. TURNING OBSTACLES...

Why, if it is so promising, does home-based primary care remain on the fringes? Largely because it has confronted a series of financial and cultural barriers.

The most important is the prevalent fee-for-service system. “There are a lot of these programs springing up,” one geriatrician told me of home-based primary care. “The challenge for everybody is how we get reimbursed for that.” Medicare pays for most inpatient services, but only for post-acute, rather than chronic, home care. It does not generally cover travel time, travel expenses, conferences and coordination with family and caregivers, or, for the most part, coordination between medical providers, all of which are vital to successful in-home primary care. Moreover, the traditional fee-for-service Medicare model neither measures nor credits savings that are attributable to ailments prevented and treatments averted.

Medicare...does not generally cover travel time, travel expenses, conferences and coordination with family and caregivers, or, for the most part, coordination between medical providers, all of which are vital to successful in-home primary care.

The result has been an obstructive misalignment of incentives. Arguably, indeed, nowhere in U.S. health care have the perverse effects of fee-for-service been as damaging as in late-life care. “There’s never been, frankly, a business model where you could get paid for providing this much-needed care,” Butler, of Hospice of the Valley, said. “That’s the challenge.”

The lack of a payment model, in turn, created a chicken-and-egg problem. Widespread adoption of a new model requires evidence of its effectiveness

and value—but demonstrating effectiveness and value requires adoption. “You have to build these programs and prove their value before anyone will pay for them, and you have to fund that,” Landers said. “It’s just slow and tedious.” As a result, most evidence for the success of home-based care is generated by the institutions running the programs, and results are indicative but not authoritative. “We need to get good data,” said Hamilton, of Hospice of the Valley in Phoenix.

Another difficulty with home-based care is that no single program can simply be adopted and cloned everywhere. To work efficiently outside the context of large, integrated health systems like Sutter and the VA, home-based care needs to plug into available community resources. Rural areas, where patients live far apart and provider and social-service networks are thin, pose particular challenges. Nor is there a one-size-fits-all business model. Every market is has its own mix of insurers, doctors, hospitals, and health groups. “There’s no easy answer to how to create a business model,” Butler said. “It depends on who’s at risk in your market and how to get their ear.”

Not least among barriers is cultural resistance. For medical professionals trained in the American tradition of acute care for which patients travel to providers, home-based care often seems suspect. For many physicians, having non-M.D.s, such as nurses and nurse practitioners, lead multidisciplinary teams and coordinate care raises yellow flags. Patients themselves, and their family members, not uncommonly regard home-based care as a compromise—even though it can provide a superior patient experience.

VII. ...INTO OPPORTUNITIES

With so many obstacles to overcome, home-based care might seem doomed to remain marginal. Even five years ago that would have seemed a fair conclusion. But today, among people consulted for this paper, the tone is very different. “Compared to if you look back five years ago, there’s been progress,” Landers said.

Perhaps the most significant development is erosion in the dominance of the fee-for-service payment model. Among the less publicized, and less politicized, changes made under the Affordable Care Act (“Obamacare”) is the establishment of new structures called Accountable Care Organizations. These are networks of doctors and hospitals that provide coordinated care to patients and, importantly, share in cost savings if they succeed in keeping people well. They now provide coverage to about a seventh of the population.

“You may even be in one and not know it.”¹² Another program, Medicare Advantage, pays health plans (many of them health-maintenance organizations) to care for entire people, rather than paying for procedures. Both of those payment structures incentivize providers to consider value rather than just to maximize treatment. Meanwhile, in the private sector, a growing number of health systems are entering the market as insurers; since they are, in effect, billing themselves, they, too, have value-oriented incentive structures. Also influential is an Affordable Care Act policy levying financial penalties on hospitals that rapidly readmit patients, making frequent hospitalization of the chronically ill much less attractive as a business proposition.

Though fee-for-service remains the predominant model, and will for some time yet, the new models are making marketplace inroads, often sufficiently to give home-based care a financial foothold. Hospice of the Valley, in Phoenix, has begun contracting with health plans to take on caseloads of high-cost chronic-care patients. Early in 2013, only one in seven patients in the Arizona Palliative Home Care program was paid-for; by August the share was about a third, and rising. According to Butler, when a few hundred more paid-for patients come in, probably in a year to 18 months, compensation levels will be high enough to shift the program into the black. “It will be a stand-alone product independent of hospice services,” he said.

Not every in-home care program is in sight of financial independence, but the fact that some are is significant. Although home-based primary care cannot become the standard model without direct Medicare reimbursement, it can become a viable alternative model in particular markets. That, in turn, will help establish its bona fides. So will a series of experiments funded by Obamacare. Under the so-called Independence at Home demonstration, 15 health systems and three consortia are running three-year tests of interdisciplinary home-based care for the chronically ill, with evaluation of outcomes and savings to be performed by an independent research group.¹³ Separately, Sutter received a \$13 million research grant from Medicare to expand AIM throughout the entire Sutter health network of 24 hospitals and 5,000 physicians, an opportunity to show how the idea scales.¹⁴ As a result of those and other experiments, the uncertainty surrounding home-based primary care is likely to diminish.

12. Jenny Gold, “FAQ on ACOs: Accountable Care Organizations, Explained.” *Kaiser Health News*, August 23, 2013. Accessed at www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx.

13. See <http://innovation.cms.gov/initiatives/independence-at-home/#collapse-tableDetails>.

14. Sutter is supplementing the Medicare grant with more than \$21.6 million of its own.

The problem of local diversity—how to bring home-based care to scale when no one model works everywhere—is inherent and implies that the model will spread gradually. But advocates say that gradualism may be for the best, because prematurely locking in one preferred model as Medicare’s reimbursable standard could do more harm than good. Meanwhile, impetus for seeding in-home care is likely to come, increasingly, from the market itself, partly because of the payment-structure changes already mentioned, and partly because of changes now becoming apparent in the medical and business cultures of health care.

In the world of medicine, according to a variety of people interviewed for this report, something of an awakening is taking place. “There’s more and more recognition that a small group of high risk patients drives a lot of costs, and that, on top of that, their care experience isn’t always that great,” Landers said. “There’s more and more of a discussion of how to help them from both a cost and quality and compassion standpoint.” Even as physicians become more sensitive to the special requirements of frail, late-life patients, patients themselves, and their children and care givers, are becoming more accepting of alternatives such as hospice, whose utilization almost doubled between 2000 and 2010. The sheer proliferation of old people with multiple chronic conditions all but ensures that the hands-on education of patients and their care givers will continue apace. Most Americans want to die at home, but only about a quarter do so.¹⁵ Other things being equal, patient preference is likely to drive change as awareness spreads of home-based models.

Most Americans want to die at home, but only about a quarter do so.

Not least important, the business culture of health care is also changing. By funding alternatives and seeding demonstrations, Medicare and the Affordable Care Act are signaling to providers that change is in the offing—and providers are receiving the message. According to people consulted for this report, whereas health-system executives once focused on maximizing revenues by adding capacity, buying equipment, and charging for ever more procedures, today many or most understand that the old cash cows are drying up. Medicare cost growth and health-care inflation are unsustainable, the fee-for-service model is under siege, new payment structures are taking shape, and private insurers are imposing more discipline and transparency. As a result, advocates and practitioners of

15. Penelope Wang (citing 2009 federal data), “Cutting the High Cost of End-of-Life Care.” *CNNMoney*, December 12, 2012. Accessed at <http://money.cnn.com/2012/12/11/pf/end-of-life-care-duplicate-2.money/index.html>.

home-based care report a new level of interest from chief financial officers. Increasingly, the promise of caring for expensive, challenging patients more effectively and efficiently is becoming attractive as a business proposition.

VIII. CONCLUSION: A WAY AHEAD

None of this implies that the path toward home-based care is swift or certain. “It is changing,” Landers said. “It’s just not changing fast enough. We’re taking too long to implement the things that we know work. We’re on pace to change this stuff over a couple of decades, when if we had more dramatic policy changes or payment reforms it could change more quickly.” He and other advocates of home-based care would like to see, among other things, faster movement by Medicare to create and build upon home-care demonstration projects; more and better education of patients and their families about home-based options; more creative and assertive use by states of Medicaid and other state programs to propel change; stronger backing from insurers; more federal support for research on home-based care from agencies such as the National Institutes of Health and the Centers for Disease Control, which, according to Landers, spend “almost nothing” on home- and community-based care.

Some or all of those proposals may be good ideas, and certainly, at a minimum, Medicare’s payment structure will need to change if home-based primary care is to become available to most chronically ailing seniors. Nonetheless, the current moment is pregnant with opportunity. Home-based primary care is not assured of success, but it is poised to move into the mainstream and prove its mettle. It deserves attention from policy makers, the opportunity to prove itself, and, if results are promising, rapid integration into Medicare.

Governance Studies

The Brookings Institution
1775 Massachusetts Ave., NW
Washington, DC 20036
Tel: 202.797.6090
Fax: 202.797.6144
[www.brookings.edu/
governance.aspx](http://www.brookings.edu/governance.aspx)

Editing, Production & Layout

Beth Stone

Email your comments to
gscomments@brookings.edu

This paper is distributed in the expectation that it may elicit useful comments and is subject to subsequent revision. The views expressed in this piece are those of the authors and should not be attributed to the staff, officers or trustees of the Brookings Institution.