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Serious Illness Approaches by ACOs: Presbyterian Healthcare Services (PHS)

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Summary

Background

Presbyterian Healthcare Services (PHS) was established in 1908 as a tuberculosis sanitarium and has developed into a system of nine hospitals, a multi-specialty medical group with more than 950 physicians and advanced practice clinicians, and a statewide health plan. While PHS still participates in accountable care organization (ACO) arrangements, it has transitioned to a more general accountable approach with coordinated care and financial risk through its integration as a payer and provider. By aligning incentives between the delivery system and the health plan, PHS can focus on care delivery changes to reduce the total cost of care for its patient population.

Approach

PHS' Healthcare at Home division takes care of people with serious illness through Home Healthcare, Palliative Care, Hospice, Hospital at Home, Advance Care Planning, and Complete Care. The Complete Care program serves high-need patients in the Albuquerque area with serious illnesses and functional decline who are at risk for long-term institutional care. Complete Care home patients receive primary, urgent, palliative, and even hospital-level care in the home. Patients receive nurse case management, social work support, advance care planning, and have one number to call 24/7 for help. An outpatient Complete Care clinic launched in 2018 offering the same high-touch, easily accessible services, but it focuses on patients who prefer care in a clinic setting, rather than in the home. The Complete Care clinic also integrates with Hospital at Home when necessary for patient care.

PHS has taken an incremental approach to its Healthcare at Home program, with each successive intervention building upon the infrastructure and capabilities developed from previous programs. Physicians and administrators within PHS have achieved buy-in from leadership for Healthcare at Home programs by first testing through small pilot efforts. Through specific and measurable goals, pilot programs demonstrated their success in increasing patient satisfaction and lowering the total cost of care before expanding into broader programs.

Key Learnings

An incremental approach makes growth easier. The step-by-step approach PHS has taken to build its Healthcare at Home division allows the system to develop new programs that leverage the information technology and staffing infrastructure of previously established home-based interventions.

Champions can drive positive change within health care organizations. Both clinician and administrator champions made successful business cases for each of PHS' Healthcare at Home programs.

Finding the right clinicians is key. Physicians and nurse practitioners who are comfortable with, and excel at, providing care in the home environment are critical to the program's success.

Aligned financial incentives enable better care delivery. The payer/provider integrated system and full risk that PHS accepts for Medicare Advantage and managed Medicaid beneficiaries enabled the development of the Complete Care program.

A culture of continuous learning and improvement is vital. This culture permeates the system and allows for the innovation necessary for meaningful care delivery changes.

This approach allowed PHS to develop and implement new programs by building on the health information technology and personnel infrastructure and capabilities that the system had developed in previous interventions.

Results to Date

From January 2015 through December 2018, 1,416 patients joined the Complete Care program. In addition to primary care, social work, and case management services, 16% of all visits with patients were urgent, which helped patients avoid an emergency department (ED) visit or hospitalization. Of the 650 people in the program who died during those three years, 87% died at home, per their wishes. Due to the intensive in-home care approach, guided by patient wishes for their care, patients experienced fewer ED visits and hospitalizations, less need for long-term care, and improved medication management. Furthermore, PHS decreased the cost of care for Complete Care patients by 38% on a per member per month basis, compared with predicted costs for similar patients. In repeated patient surveys, 98% of patients said they would recommend the program.

Tools & Vendor Partners

PHS uses several tools to customize and leverage data, drawing from the Epic electronic health record (EHR) used across the system. The integrated system allows access to claims data, such as drug spending and durable medical equipment utilization. In 2016, the health system began to use the Johns Hopkins' ACG® system, using both its EHR and claims data, to identify patients with rising risk.[1]

Challenges with Implementation

Outside of traditional home health, Medicare does not reimburse adequately for team-based serious illness care in the home, so PHS cannot offer the Complete Care program to fee-for-service Medicare beneficiaries. Complete Care has significantly reduced the cost of care for patients served by the program, but its impact on cost could be more significant with a larger patient population. New Mexico's rural nature also presents challenges, particularly because of low population density and a shortage of health care providers. Complete Care currently operates predominantly in the Albuquerque region, in the center of New Mexico.

PHS Details

Presbyterian Healthcare Services, a not-for-profit integrated health care system founded in 1908, serves one in three New Mexicans with a health plan, statewide delivery system, and medical group. Presbyterian Health Plan serves more than 600,000 commercial, Medicare Advantage, and Medicaid members and has more than 19,200 providers in its network. The integrated system includes nine hospitals, 950 employed providers, and more than 100 clinics in New Mexico. They have multiple ACO contracts and a general accountable care approach.

Location: Headquartered in Albuquerque, New Mexico; serves patients statewide.

Website: **www.phs.org**

Detailed Case Study: Presbyterian Healthcare Services (PHS)

Overview

Presbyterian Healthcare Services (PHS) is a not-for-profit integrated payer and provider health system based in Albuquerque, New Mexico that operates throughout the state and serves one in three New Mexicans. Established in 1908 as a tuberculosis sanitarium, PHS includes a health plan, statewide delivery system, and medical group. Presbyterian Health Plan serves more than 600,000 commercial, Medicare Advantage, and Medicaid members and has more than 19,200 providers in its network. The integrated system includes nine hospitals, 950 employed providers, and more than 100 clinics in New Mexico. While PHS still participates in accountable care organization (ACO) arrangements, it has transitioned to a more general accountable approach with coordinated care and financial risk through its integration as a payer and provider. These aligned incentives between the delivery system and the health plan allow PHS to focus on improving care delivery and managing the total cost of care for their patient population.

PHS cares for patients with serious illness through its Healthcare at Home division. The division offers five home health programs and five hospice programs across New Mexico. PHS has provided home health care services since 1973 and began offering inpatient palliative care 12 years ago, followed by clinic and community palliative care in 2012. In 2008, PHS began offering the Hospital at Home program based on the Johns Hopkins model,[2] which was followed by a House Calls program to allow for provider care of home health patients with urgent needs who did not qualify for Hospital at Home admission. Designed specifically for patients with serious illness in the system's Medicare Advantage population, PHS launched the Complete Care home program in 2015 and, in April 2018, began the Complete Care clinic pilot. The variety of available programs not only provides critical care for frail and elderly patients, but has also contributed to PHS' ability to offer new interventions for this population.

New Mexico offers a challenging context for PHS since this state depends heavily on government payers (both Medicare and Medicaid) and, compared to other states, fewer New Mexicans receive coverage through their employers. New Mexico has the highest percentage of the population covered by Medicaid[3] and has the third highest percentage of the population below the federal poverty line.[4] Because Medicaid reimburses at a lower rate than private insurance and even Medicare, the high percentage of the population on Medicaid means PHS operates in a lean environment. Similar to the rest of the country, the state has a growing aging population, but, unlike surrounding states such as California and Arizona, it has not experienced the same population growth. Significant portions of the state are rural and without reliable electricity, roads, cell service, or even clean water.

Despite the state's economic and social challenges, PHS has succeeded in delivering high quality care for patients with serious illness. In the first four years, from January 2015–December 2018, 1,416 patients joined the Complete Care program. Of the 650 people in the program who have died, 87% died at home, per their wishes. Due to the intensive in-home care approach, guided by patient wishes for their care, PHS decreased the cost of care for Complete Care patients by 38% on a per member per month basis, compared with predicted costs for similar patients. As a result of this approach, patients experienced fewer emergency department (ED) visits and hospitalizations, less need for long-term care, and improved medication management. In repeated patient surveys, 98% of patients said they would recommend the program.

The success of PHS can be attributed to several key themes. First, its integrated system provides aligned financial incentives that enable the type of care delivery interventions necessary to provide care for this patient population. Second, the step-by-step approach PHS has taken to developing its Healthcare at Home division allows for a new approach to be piloted and then expanded into a new program. Third, champions among clinicians and administrators have made successful business cases for new programs. Finally, a culture of continuous learning and improvement permeates the system and allows for the kind of experimentation necessary for meaningful care delivery changes.

Short overview of PHS.

Organizational Description	Not-for-profit integrated health care system founded in 1908. The integrated payer-provider system includes nine hospitals, 950 employed providers, and more than 100 clinics in New Mexico.
People in the Model	The Complete Care program uses a multidisciplinary approach with a broad care team, including physicians, nurse practitioners, registered nurses, podiatry nurses, social workers, nurse care managers, and nurse assistants. The program serves Medicare Advantage and managed Medicaid beneficiaries, many of whom are among the most frail and vulnerable patients who have multiple chronic conditions and who take many different medications. Patient care goals and preferences guide the treatment they receive, including hospital-level and palliative care in the home.
Key Programs and Care Innovations	PHS's Healthcare at Home division includes Home Healthcare, Palliative Care, Hospice, Hospital at Home, Advance Care Planning, and Complete Care.
Local Market and Context	Serves one in three New Mexicans, and offers a health plan, statewide delivery system, and medical group. Presbyterian Health Plan serves more than 600,000 commercial, Medicare Advantage, and Medicaid members and has more than 19,200 providers in its network. The home health, hospice, and Complete Care programs operate predominately in the Albuquerque metropolitan area.
Evolution and Buy-In	Developed first program for seriously ill patients 12 years ago as an inpatient palliative program, followed by the development in 2008 of the Hospital at Home program. Has gradually developed more programs specifically designed for patients with serious illness. Buy-in from leadership achieved through starting with pilot programs with specific, measurable goals, evaluating the pilots, demonstrating their success of increasing patient satisfaction and lowering the total cost of care, and expanding the pilot into a broader program.
Financing & Infrastructure	The integrated structure allows PHS to focus on programs that seek to lower the total cost of care throughout the system. Some programs, such as the Complete Care program, are only available to patients with Medicare Advantage or Medicaid managed care because the system is fully at risk for those patients and receives a capitated per member per month payment for their care.
Implementation Challenges	New Mexico has a challenging socioeconomic environment that includes less economic growth than surrounding states and a larger percentage of patients on government rather than commercial insurance. The rural environment also creates challenges for the health system, particularly in recruiting providers and offering programs in areas with low population density.
Results and Key Outcomes	During the initial three years (January 2015 through December 2018), 1,416 patients joined the Complete Care home program. From 2015–2018: • 87% of patients had a completed Advance Healthcare Directive in their medical record. • More than 16% of all Complete Care home visits with patients were urgent, which helped patients avoid an ED visit or hospitalization. • Of the 650 people in the program who have died, 87% died at home, per their wishes, using hospice and palliative care services. • In patient satisfaction surveys, 98% of patients said they would recommend Complete Care. • Due to the intensive in-home care approach, guided by patient wishes for their care, PHS decreased the cost of care for Complete Care patients by 38% on a per member per month basis, compared with predicted costs for similar patients. As a result of this approach, patients experienced fewer ED visits and hospitalizations, less need for long-term care, and improved medication management.

Key Components of the Care Model

The Complete Care program

PHS provides both home-based and clinic-based services for individuals with serious illness through Complete Care (in addition to their community-based palliative care programs). The Complete Care programs are only available for Presbyterian Health Plan beneficiaries (including Medicare Advantage and Managed Medicaid members) for whom the health system is at risk. The Complete Care home program is designed for the frailest patients, often those in the top 5% of health care spending, who have difficulty leaving the home. The newly launched Complete Care clinic cares for a similar patient population, but is available for those who instead wish to be seen in the outpatient setting. Complete Care aims to understand and honor patients' wishes, help the patient and their family members understand the patients' conditions and medications, and reduce the total cost of care by preventing unnecessary ED visits and hospitalizations.

PHS was able to begin the Complete Care home program with only a modest investment—approximately $600,000—because they had existing infrastructure for providing in-home and palliative care services from previous interventions. The home-based and clinic programs integrate together to ensure the right care for each patient.

Complete Care home

The Complete Care home program is integrated with the house calls and palliative care programs, offering patients primary care, urgent care, and even hospital-level care in the home. The program provides 24/7 access through a nurse-staffed call center, which provides an alternative to 911. Seven days a week, a nurse or physician can see patients with urgent needs during the day. At night, an on-call nurse can also visit patients in the home. In many cases, phone support is all that is needed.

The Complete Care home program begins with a nurse case manager's assessment of the patient's clinical needs, including medication reconciliation, understanding medication adherence, an evaluation of fall risk and depression, and the social factors affecting the patient's health. The next visit can range from the next day to the next month, depending on acuity and needs of the patient.

Additionally, social workers conduct an initial home visit to help improve communication with the family, assess whether the patient needs additional help in their home, and offer psychosocial support for patients (and family members) who may be suffering from the implications of their advanced illness, chronic pain, or depression. When needed, social workers also help to address patients' social determinants of health, in some cases calling adult protective services; helping the patient obtain Section 8 housing; or connecting the patient to Presbyterian's Food Farmacy, which provides free healthy food to patients in need.

The Complete Care program uses a multidisciplinary approach with a broad care team, including physicians, nurse practitioners, registered nurses, podiatry nurses, social workers, nurse care managers, and nurse assistants. Communication between the care team is key. The entire care team meets weekly to discuss their patients, with extra attention given to complex cases. The patients in this program, as well as the clinic program, are assigned an "acuity level" based on their needs, which determines the frequency of interventions and monitoring. The team also has a daily phone "huddle" to review any patients requiring a Hospital at Home level of care. Every two weeks, providers and nurses hold a clinical meeting to discuss complex cases and present relevant findings from the literature. To assist with frequent communication, PHS issues all Complete Care team members a cell phone with a data plan and apps for clinical care, as well as a cell-enabled laptop.

The patient's acuity determines how frequently they receive a visit from a member of the care team. Some patients are visited every week, others every four to six weeks, and others every 10–12 weeks. If a patient is hospitalized or visits the ED, a member of the care team sees them within 48 hours after discharge to help prevent readmission. PHS' goal for 2019 is to see every patient within 24 hours of discharge. The Complete Care program is a no-discharge model, which helps to avoid the gaps in care that are common when patients transition between hospital, post-acute, and home health care settings.

The program offers comprehensive services to its enrolled members. Home visits are much longer than traditional physician office visits, lasting at least 45 minutes and sometimes extending to two hours. Members of the care team order x-rays, collect labs and urine samples, give vaccines, and more in the home. Beyond the home visits, patients who need therapy services or additional skilled nursing care may be referred for home health. Palliative services, which help patients maintain their quality of life and explore their own health care goals, are offered by both Complete Care primary care providers and PHS' palliative care specialists. If patients decide to begin hospice care, the Complete Care team transitions most care to the hospice team, but tracks patients to ensure they do not have additional needs that the program could address.

Patients are identified for Complete Care in a number of ways, including EHR data analyses, hospital referrals, and referrals from PHS' home health and palliative teams. Outpatient care managers in PHS' primary care clinics also refer patients. Members of the Complete Care program also educate PHS physicians about the program. Most recently, the team analyzed all hospitalized patients to determine who might benefit from Complete Care admission after discharge.

Approximately 700 patients are currently enrolled in Complete Care home.

Complete Care clinic

In 2018, PHS added a Complete Care clinic to its Healthcare at Home division. In most primary care environments, the patient receives a short visit from the primary care provider and then has a series of visits with subspecialists to address clinical needs. In the Complete Care clinic, the care team spends a significant amount of time evaluating the patient's needs when they first come to the clinic. Evaluation includes a fall risk assessment, depression screening, and cognitive evaluation, as needed. The clinic performs more services than traditional primary care clinics, including administering intravenous fluids and antibiotics. Urgent visits are readily available, which allow patients to receive care in the clinic, rather than going to Urgent Care or the ED. A Complete Care pharmacist clinician at the clinic reviews medications and helps to manage ongoing medications and chronic conditions, such as diabetes or anti-coagulation needs. A social worker in the clinic provides similar services to those available in the home. Both the social worker and clinic nurse case manager may do in-home visits, if needed. If in-home medical care is required, Complete Care home providers may assist, including with Hospital at Home admission. The clinic has a weekly interdisciplinary team meeting to review patients, determine acuity levels, and identify needed interventions.

Many patients who are identified for the Complete Care clinic have already begun the cycle of toggling between hospital and skilled nursing facility stays. A primary goal of the clinic is to disrupt this back and forth pattern, help stabilize the patient by developing a thorough care plan, and take ownership of the patient's care. The Complete Care clinic aims to eliminate or reduce gaps in care. PHS' goal is to address 80% of its patients' care needs in the clinic, as opposed to the hospital or another setting.

The clinic currently has around 200 patients. PHS' goal is to serve 400 patients.

Implementing a New Care Model in an Integrated System

An enabling factor allowing PHS to provide innovative and high-quality care for patients with serious illness is its integrated provider and payer system with capitated per member per month payment. This integration aligns provider and payer incentives and enables the kind of care delivery interventions that are required for patients with serious illness. Presbyterian Health Plan gives the PHS delivery system a per member per month capitated rate for all physician, hospital, and pharmaceutical costs. The delivery system is 100% financially at risk for health plan patients, which means that the delivery system may lose revenue if costs exceed what the health plan has provided. This capitated payment approach allows the delivery system to focus on implementing outpatient clinic and in-home services that manage patients' conditions and coordinate care, which in turn helps keep patients out of the hospital. If patients do not have costly hospital visits, then PHS can spend more on home- and clinic-based services to keep patients as healthy and stable as possible. The Complete Care program would not be possible under the traditional fee-for-service model because fee-for-service incentivizes more, rather than less, care and would not support Complete Care's higher provider-to-patient ratio and the additional time that providers spend with their Complete Care patients.

One Complete Care physician explained that the integrated system and accountable care approach allows PHS to provide "the actual intervention that we want, not just the intervention that is allowed by the payment model."

Ultimately, the integrated system does not only align payer and provider incentives, but changes the mindset of PHS' clinicians, executives, and administrators. This mindset focuses on how to keep patients as healthy as possible in order to bring down the total cost of care. Integration helps the organization think differently about what kind of care patients with serious illness actually need and want versus what is most financially viable. A common EHR across the integrated system also enables identification and tracking of patients across the different care sites.

Making the Business Case

Although an integrated system aligns the incentives and provides the infrastructure for care delivery changes, the actual implementation of programs like Complete Care is reliant upon successfully making the business case for why it is worth investing in serious illness care to organizational leadership. For PHS, the successful business case came from subject matter experts making persuasive and data-driven arguments to leadership. These champions made the cases for the kind of care delivery interventions they wanted, then steadily built upon past successes to continuously expand programs for patients with serious illness.

Although the business case for each program has required unique elements, PHS has developed a reliable approach for pitching new programs to leadership. The first step for a successful business case is developing a vision for the program and pulling together data to support it. For example, when making the case for the Hospital at Home program, clinicians presented data on how Hospital at Home saved money and increased patient satisfaction. For the Complete Care program, medical cost trend data demonstrated how the 5% of patients that the Complete Care program proposed to serve accounted for 50% of the costs.

The second step for a successful business case is aligning the case to the mission and strategic priorities of the organization. Champions at PHS linked their vision for the program and the data to support that vision to the Triple Aim's goals of improving the quality of care, reducing the cost of care, and improving the patient's experience of care.[5] Linking Complete Care to the strategic goals of the organization and showing evidence of cost savings meant the program was more likely to garner support.

After presenting the data and vision, the third step is to launch a pilot program. The advantage of a pilot is that the risk to the organization is lower because the overall investment is less than it would be for a full program. A pilot must have clearly defined outcomes and must continuously track and measure those outcomes to evaluate performance. PHS clinician champions moved from pilot to program by tracking data on measures such as patient satisfaction, ED visits, hospitalizations, and total cost of care. For example, the Healthcare at Home medical director asked two internal reviewers to complete an initial outcomes study of the house calls program, which involved analyzing patient charts to determine whether a patient would have gone to the ED or been hospitalized if they not had an urgent house call to address their need at home. A conservative estimate of ambulance, ED, and hospitalization costs saved through urgent house calls demonstrated the savings created by the program. A pilot program showing positive results can grow into a full program.

The fourth component of making a successful business case is building a strong reputation. Creating a pilot followed by a full program that showed results in alignment with the Triple Aim helped to build the reputation of Healthcare at Home champions with PHS' senior leadership. Establishing this credibility has enabled the Healthcare at Home team to gain support from senior leadership to start a new pilot, which will hopefully lead to another full program.

Organizational Factors for Success

The culture of PHS has significantly contributed to its success. Emphasizing the Triple Aim and assuming financial risk to improve quality and lower costs are key goals at PHS. These goals have helped the health system create programs for seriously ill patients that provide a foundation for future programs. For example, the Complete Care program benefited from the personnel and health information technology infrastructure of the existing palliative care, house calls, and Hospital at Home programs. The leadership has established a culture that promotes continuous learning and growth. For example, when a pilot is launched, PHS emphasizes the importance of setting clear metrics for evaluation and learning from experience to create a more effective, patient-centered, and financially feasible program.

With the Complete Care program, providers have more autonomy, mastery, and purpose in their work, given the care delivery flexibilities enabled by the program. Amid broader industry challenges related to physician burnout, taking steps to bolster physician morale contributes to better care for patients with serious illness.

Physician and Advance Practice Clinician buy-in is another factor that has contributed to PHS' success. The Complete Care program allows these providers to give their patients the care they need and avoid some of the reasons their colleagues burn out, including not having the resources to adequately care for seriously ill patients.

Specific Organizational Competencies and Example Actions Used to Implement Serious Illness Care Model

Specific Competency*	Example Actions
Care Delivery	
Design systems to address patient needs	Complete Care was originally designed as a home-based program focused on the 5% of Medicare Advantage patients who account for 50% of costs. Complete Care Home patients receive primary, urgent, palliative, and Hospital at Home care in the home. Patient wishes guide the care delivered. An outpatient Complete Care clinic launched in 2018 offers similar high-touch, easy access services to patients who prefer care in a clinic setting, rather than the home.
Design care teams	The care team consists of physicians, nurse practitioners, registered nurses, podiatry nurses, social workers, nurse care managers, and nurse assistants. This care team provides patients with RN case management, social work support, advance care planning, and one number to call 24/7 for help.
Governance	
Identify value-oriented leaders	Value-oriented leaders at PHS have launched pilot programs to care for patients with serious illness, defined clear metrics to assess the pilot's success, continuously evaluated the pilot, made adjustments, and launched full programs from the learnings of the pilot. Each new program creates a more robust foundation for the development of new pilots. For example, initial investment costs of Complete Care — including health information technology infrastructure and staffing — were reduced because it was built on the foundation of existing PHS programs and services.
Commit to pursue value-based care	Programs for patients with serious illness have been driven by the goal to do the right thing for patients and lower the total cost of care. Collaboration between individuals working on the provider and the payer side across the integrated system allows for this alignment of goals. The payer/provider integrated system and full risk that PHS accepts for Medicare Advantage and managed Medicaid beneficiaries has provided the flexibility necessary to design interventions that strive to keep patients out of the hospital and receiving the care they need at home.
Finance	
Monitor performance of value-based contracts	Physicians have a set of quality metrics on which to focus that are aligned across payers and integrated into their EHR.
Health IT	
Develop platforms to house and analyze data	Integrated system allows access to claims data, such as drug spending and durable medical equipment utilization. Integration of Johns Hopkins' ACG® system into both EHR and claims data allows for the identification of patients with rising risk. Recently added software in Epic allows providers to see when a Complete Care patient touches any ED throughout the state.
Enable data sharing and access by care team	Medical director has received training in Epic and works directly with a team of information technology analysts to build custom features in the EHR. One custom feature is a recently-released registry that tracks the acuity level and planned interventions for each patient, and notifies the team when the patient's care does not match those goals. This registry also tracks when patients are seen in the ED or hospital.

* Competencies drawn from the *Accountable Care Atlas* published by the Accountable Care Learning Collaborative.

Implementation Challenges

One of PHS' challenges is that the Complete Care program is only available for patients for whom the system is fully at risk. The capitated payment in the full risk model allows PHS to focus on the total cost of care for that population of patients. As a result of the intensive wrap-around approach, patients experience fewer hospitalizations and ED visits, thereby lowering the cost of care. Physicians want to provide all patients with the highest quality of care available, but it is logistically cumbersome to figure out which patient with which health plan is eligible for which intervention or program. Segmenting patients by insurance type also limits the overall effort to bend the cost curve, contrasts with physicians' passion for helping all patients, and creates more administration burden.

Although more than 60% of PHS' revenue is capitated, the remainder is still in the fee-for-service model. Therefore, the system straddles both the value- and volume-based worlds, which can cause challenges when tracking and measuring performance. For example, PHS has more full-time equivalents caring for fewer patients in the Complete Care program than in a traditional model, which could make the program compare poorly on financial metrics if financed through a fee-for-service model. Due to the reality of operating in both the value and fee-for-service worlds, PHS believes it is important to know how and when to "speak both languages," or to succeed in both payment structures.

Given New Mexico's rural environment, geography presents another challenge. Many Healthcare at Home programs are limited to the Albuquerque metro area, where more than one-third of the state's population lives. Providing that level of intensive in-home care is not feasible in more remote areas due in part to insufficient numbers of health care providers and low population density. Even providing care in the more populated metro area of the state can mean significant drive time for the care team. With patient visits in the home being longer than a typical 15-minute office appointment, mapping the most efficient route between home visits is important for containing costs.

Contextual factors affecting the ability to spread the model.

Contextual Factors	Description
Institutional	PHS' integrated system allows payers and providers to have aligned incentives that focus on lowering the total cost of care by reducing unnecessary ED visits and hospitalizations. Because the system is fully at-risk for its Medicare Advantage and Medicaid managed care plan patients, it has more flexibility to offer home-based interventions like the Complete Care program. PHS was also able to develop and implement the Complete Care program because of its strong foundation of other home-based interventions that the system had developed in years prior.
Local Market	Even though PHS operates in an economically challenging environment, the hospitals in its system often have high demand, which creates additional incentives for providing care outside the hospital in lower cost settings.
Regulatory	After the Pioneer ACO program ended, PHS opted not to join another Medicare ACO, citing the enhanced flexibility it has as an integrated system to improve care and lower costs. The system's historical low health care spending would also make achieving shared savings in the Medicare Shared Savings Program challenging.

Policy Challenges

One significant policy challenge for PHS is that Medicare does not fund this high-cost team-based home care, either as a house call or a palliative care program, nor does it pay for Hospital at Home admissions. Without reimbursement for these services, PHS cannot offer home-based care to fee-for-service Medicare beneficiaries and patients often have no choice but to access care through the usual, episodic model, calling 911, and incurring an expensive and potentially avoidable hospitalization.

PHS participated in the Pioneer ACO program, but has not rejoined another Medicare ACO program. While PHS still participates in ACO arrangements, it has transitioned to a more general accountable approach with coordinated care and financial risk through its integration as a payer and provider. Some of these long-standing efforts to lower the total cost of care have deterred further ACO involvement; since the system has such low health care costs, there is little room for it to improve under a historical benchmark.

Summary

PHS' integrated system, physician champions, and incremental approach to developing programs have enabled the health system to develop a robust offering of programs designed to meet the needs of patients with serious illness and reduce the total cost of care. A series of successful business cases have allowed PHS to scale its interventions for patients with serious illness and offer a spectrum of care that includes palliative and hospice care, as well as primary, urgent, and even hospital-level care in the home. Aligning payer and provider incentives, as well as encouraging a culture of continuous learning and commitment to the Triple Aim, have created the necessary environment for these programs to succeed.

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