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Key Metrics for Demonstrating the Value of Home-Based Primary Care (HBPC) Programs

Purpose

This resource is intended to help clinicians and practices determine metrics for evaluating operational efficiencies, productivity, and patient outcomes. While not an exhaustive list, HCCI recommends selecting a core set of measures from the following key data areas to demonstrate the value of your HBPC program. The staffing and operational metrics will help you evaluate the workload of your practice and guide strategic decisions on growth and performance.

Staffing and Productivity Metrics:

- Clinician-to-Patient ratio (i.e., active panel size per clinician)
- Staff-to-Clinician ratio, including FTE breakdown
- Average expenses per clinician and staff member
- Billing trend report by clinician and the practice as a whole (e.g., bell curve reports)
- Incoming daily call volume
- Number of visits per day and month, by clinician, and the practice as a whole
- Message volume per clinician or care team (consult your Electronic Health Record (EHR) vendor to determine the reporting capabilities available to assist in determining the percentage of time clinicians spend on documentation, orders, and other tasks.)

Operational Metrics:

- Average number of travel miles driven per day
- Black bag expenses (equipment and supplies)
- After-hours/on-call page volume (number of calls daily, weekly, monthly)
- Active empaneled patient census for the HBPC program (ongoing)
- New patients per month, by clinician, and for the practice as a whole
- Incoming referrals per month, by source
- Employee satisfaction

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Utilization and Outcome Metrics:

- Immunization rates (e.g., flu, pneumonia, COVID-19), completion and compliance rates
- Depression screening, completed once annually, or as clinically warranted
- Fall risk assessment, completed once annually, or as clinically warranted
- Mini-Cog (screening for cognitive impairment in older adults), completion once annually, and also for new enrollments
- Smoking cessation, if applicable
- Alcohol abuse (AUDIT C), annual screening rate
- Opioid Risk Tool (ORT), annual screening rate)
- Completion of opioid contract for all patients on long-term opioid use
- Hospital admission/readmission rates and main diagnosis for each admission
  - In 2014 a study analyzed the 30-day readmission rate for a cohort of 583 HBPC practices which all had 200 or more active patients. The rate of 30-day readmissions per 100 Index Discharges was 16.8%. When determining satisfactory performance, practices should compare their readmission rates against a population of comparable high-risk Medicare beneficiaries rather than national readmission rates. Refer to the following American Geriatric Society[1] and National Institute of Health[2] publications for reference .
- Reduction in 30-day hospital readmissions
- Reduction in acute care utilization (e.g.., ED visits and hospitalizations 6-12 months before/after HBPC)
- ICU stays 30 days before death
- Hospitalizations 90 days before death
- Total number of deaths at home vs. hospital or Skilled Nursing Facility (SNF)
- Percentage of patients who expire on hospice
- Average hospice length of stay (longer hospice utilization or percentage of utilization can be beneficial to demonstrate earlier referral to hospice services and is particularly valuable for hospice and palliative organizations focused on reaching patients further upstream.)
- Referrals to home health and hospice or percentage of HBPC panel active with home health or hospice
- Days at home (Aim to demonstrate a high percentage of days not in an inpatient setting.)
- Number of days from referral to first visit (average and mean wait days)
- Number of days from post-acute discharge to transitional care management (TCM) visit (average and mean wait days; please note that as a best practice, post-discharge patients should be seen within 7 days from discharge)
- Medication reconciliation completion at post-discharge visit
- Patient and caregiver satisfaction 90th percentile or above.)

Clinical Quality Metrics for Home-Based Primary and Palliative Care:

- **The National Home-Based Primary Care Learning Network:**[3] The Learning Network strives to create a quality improvement framework focused on meaningful metrics relevant to the homebound and medically complex population to promote high-quality, evidence-based medical care.

  The Learning Network has identified quality measures used in current Center for Medicare and Medicaid Services (CMS) quality programs that can be used by home-based primary care practices.

  Please explore the National Home-Based Primary Care Learning Network[4] resources for more information.

[1] https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.15314?casa_token=byjKpTqeUJQAAAAA%3AZcWtCljdBLcnectgP8wUdvyP8992mR-Zrop98Ejm6G3SE0-3_bhX0VNBvHUUyVGlvZnwEBJ4ZEBzogg

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5348286/

[3] https://improvehousecalls.org/

[4] https://improvehousecalls.org/quality-improvement/the-learning-network/

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In addition, two measures for home-based medical care have been endorsed by the National Quality Forum.[5] These measures are:

- **Functional Assessment** ([Basic and Instrumental Activities of Daily Living (ADLs)]) for home-based primary care and palliative care patients: defined as the percentage of actively enrolled home-based primary care and palliative care patients who received an assessment of Basic ADL and an Instrumental Activity of Daily Living (IADL) assessment at enrollment and annually.
- **Cognitive Assessment** for home-based primary care and palliative care patients: defined as the percentage of newly enrolled and active home-based primary care and palliative care patients who received an assessment of their cognitive ability.

- **Independence at Home Clinical Quality Metrics:**[6] Independence at Home (IAH) is an Alternative Payment Model (APM) which tests the effectiveness and cost savings of comprehensive home-based primary care programs. Practice performance is measured on the following key quality metrics:
  - Follow-up contact within 48 hours of hospital admission, hospital discharge, or emergency department visit
  - Medication reconciliation in the home within 48 hours of hospital discharge or emergency department visit
  - Annual documentation of patient preferences
  - All-cause hospital readmissions within 30 days
  - Hospital admissions for ambulatory care sensitive conditions
  - Emergency department visits for ambulatory care sensitive conditions
- **Primary Care First (PCF):**[7] A newer APM that began in 2020 and offers payment reform for advanced primary care practices in certain regions to be paid on quality outcomes rather than on volume. The following key clinical quality metrics are how the performance of practices in risk groups 3 and 4 (i.e., average attributed patient HCC Score 1.5 > 2.0) is measured.
  - Advance Care Plan (Years 1-5)
  - Total Per Capita Cost Measure (Years 1-5)
  - Consumer Assessment of Healthcare Providers and Systems Satisfaction Surveys (CAHPS; Years 1-5)
  - Days at Home (Years 2-5)
- **Global & Professional Direct Contracting Model (GPDC):**[8] A risk-sharing APM aimed at reducing expenditures and preserving or enhancing quality for traditional Medicare beneficiaries. The first performance year for this model was 2021, 53 Direct Contracting Entities (DCE's) are currently participating. Please note no new applications or cohorts are currently being accepted for this model while The Centers for Medicare & Medicaid Innovation (CMMI) review all of its current APM's and decide how to proceed. Organizations interested in supporting this model should look for partnership opportunities with existing DCE's in their region. The following quality metrics were proposed by CMS but are subject to change as this model evolves. Refer to the GPDC Quality Measurement Methodology paper[9] for additional information.

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[5] https://www.qualityforum.org/Home.aspx

[6] https://innovation.cms.gov/innovation-models/independence-at-home

[7] https://innovation.cms.gov/innovation-models/primary-care-first-model-options

[8] https://innovation.cms.gov/innovation-models/gpdc-model

[9] https://innovation.cms.gov/media/document/dc-model-quality-methodology-paper

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- **Medicare Shared Savings Program (MSSP):**[10] The **MSSP program** is governed by CMS and offers eligible entities an opportunity to form or join an Accountable Care Organization (ACO) with the goal of incentivizing the transition to value-based care by lowering total cost of care for Medicare beneficiaries and creating shared saving opportunities for successful performance for quality coordinated care. Providers select a set number of clinical quality and other performance metrics (at least one outcome metric) to be scored and measured on each performance year. The program is currently in a framework transition period to try and improve accuracy and reduce the participation burden for clinicians. For CY 2023 CMS is proposing to require one population health measure be selected to be reported on either:
  - **Hospital-Wide, 30-day, All-Cause Unplanned Readmission** (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS)* OR
  - Clinician and Clinician Group **Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions***
  - * As of this publication, these are proposed measures only.
  - **Click here**[11] to review eligible measures for the current performance year
  - **2021 Quality Measure List**[12]

Initial Performance Year:

- **Risk-Standardized All-Condition Readmission (ACR)** measures how many hospital stays result in a readmission within 30 days after patient discharge.
- **All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC):** measures unplanned hospital admissions among Medicare FFS beneficiaries 65 years of age and older with multiple chronic conditions.
- **Days at Home for Patients with Complex, Chronic Conditions (DAH, under development):** measures the number of days that adults with complex, chronic disease spend at home and out of acute and post-acute care settings; this measure will apply only to High Needs Population DCEs.

Proposed measures for 2nd Performance Year (Depending on type of DCE):

- **Timely Follow-Up After Acute Exacerbations of Chronic Conditions (Timely Follow-Up):** is defined as the percentage of acute events related to one of six chronic conditions where follow-up was received within the timeframe recommended by clinical practice guidelines in a non-emergency outpatient setting. Acute events are those that required either an emergency department visit or hospitalization. The six chronic conditions include hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, and Type I/II diabetes mellitus.
- **Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey:** Measures patient/caregiver experience of care by the DCE. Patient/caregivers will be asked to rate clinicians on the following within a CAHPS® survey:
  - Receiving timely care, appointments, and information
  - How well clinicians communicate
  - Patient's rating of clinicians
  - Health promotion and education
  - Shared decision making
  - Health & functional status
  - Stewardship of patient resources
  - Courteous and helpful office staff
  - Care coordination
  - Advance care plan

[10] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram

[11] https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2021

[12] https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2021

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