BAYADA Support: Expanded care at home
Medicare Care Choices Model (MCCM)

In 2015, the Centers for Medicare and Medicaid Services (CMS) funded this 5-year study because it wants to know: Can in-home hospice-like care help chronically ill patients who are still receiving curative treatments?

- CMS enrolled 140 hospices nationwide
- CMS hopes to enroll 150,000 patients

The model recognizes the patient’s struggle in having to choose between palliative and curative care during difficult times. It is designed to:

- Increase access to supportive care services provided by hospice;
- Improve quality of life and patient/family satisfaction;
- Inform new payment systems for the Medicare and Medicaid programs.
  - Decrease ED and urgent visits
  - Reduce hospitalizations
Medicare Care Choices Model

• In 2016, the first phase began, and hospices started to enroll their first patients. It was slow-going at first, as educating the medical community is largely up to the local hospices. Our first patient came on service in April, 2016.
• Since then referrals have blossomed!
• Participating hospices receive payment under the model through the standard Medicare claims process.

Who benefits from MCCM?

• Patients with Medicare (or dually eligible patients) who have a life-limiting illness. For the purposes of the study, they must have Cancer, COPD, Congestive Heart Failure, or HIV/AIDS.
  – Who are getting curative treatments—chemo, radiation, cardiac rehab, respiratory rehab, other treatments inside or outside of the hospital.
  – They don’t have to be homebound. They can live in NH or VT.
  – Patients who could benefit from skilled nursing visits, med management, 24/7 access to RN triage, phone calls and social work visits, and help sorting out their options and making sense of what’s happening to them.
  – Someone who could benefit from case management or care coordination among their many providers and among family

Potential indicators for MCCM eligibility:

• Repeat hospitalizations
• Decrease in functional capacity
• Dyspnea, on O2
• Chemo and/or radiation
• Comorbidities such as DM2
• A “sense” by provider that EOL is near. (Would it surprise you if this patient died in the next 6 months?)
Is this evidence-based care?

“Research has shown that providing palliative care earlier, rather than later, in the course of these [serious] illnesses leads to better health outcomes, higher satisfaction with care, and reductions in health care costs….”

—Archives of Internal Medicine, 2008, plus “Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer,” New England Journal of Medicine, 2010

The American Society of Clinical Oncologists recommends that all patients with metastatic NSCLC be offered palliative care along with standard cancer therapy beginning at the time of diagnosis.

Why did BAYADA want to participate?

Frequently Asked Questions

What does it cost the patient?
➢ Nothing! No deductible, no co-payments

Is it sustainable?
➢ Yes, and no...

What does this mean to providers?
➢ Fewer crises calls, fewer urgent visits
➢ Providers can “send” an RN into the home (planned visits, not emergency/urgent calls)
➢ Shared data (e.g. utilization, events and outcomes) on patients enrolled in MCCM
How does it actually work?

How does BAYADA Support help patients and providers?

<table>
<thead>
<tr>
<th>Feature</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/7 access to BAYADA triage nurse</td>
<td>Fewer ED visits and readmissions</td>
</tr>
<tr>
<td>Home visits by skilled RN</td>
<td>Scheduled RN visits to high-risk patients</td>
</tr>
<tr>
<td>Better med adherence</td>
<td>In-home med management and education</td>
</tr>
<tr>
<td>Shared decision making—RN or SW coordinates</td>
<td>Social worker helps patients during this difficult time</td>
</tr>
<tr>
<td>the patient’s wishes and expectations with</td>
<td></td>
</tr>
<tr>
<td>specialists and with PCP.</td>
<td></td>
</tr>
<tr>
<td>Hospice/Palliative care certified MD support</td>
<td>Evidence-based pharmacologic input for pain and symptom management</td>
</tr>
</tbody>
</table>

Referral has been easy as pie!
Since April 2016

- 69 referrals from many sources—
  - PCPs, Specialists (oncologists, heart failure docs, pulmonologists, Palliative Care providers, in-patient case managers and ambulatory case managers/RNs, social services (Support and Services at Home, Senior Solutions), Parish/Community Nurses
- 24 patients came on service
- 144 in-home visits made

Year One data:

1 died on service (sudden cardiac arrest)
  - but with a thorough discussion of treatment preferences, spiritual needs and family issues addressed at the beginning of service, so the family felt supported even though the death was a surprise.
11 "graduated" to hospice services
10 went directly to hospice services
24 didn’t qualify
2 didn’t accept MCCM service

BAYADA patients compared to national sample

- 39% Cancer
  - Compared to MCCM total 61%
- 72% COPD
  - Compared to MCCM total 23%
- 5% CHF
  - Compared to MCCM total 24%
- Average Age: 74 vs 76
Sample patient interactions

<table>
<thead>
<tr>
<th>Patient</th>
<th>In home visits</th>
<th>Calls to/from pt</th>
<th>Calls on pt's behalf</th>
<th>Pt call to hotline</th>
<th>Interactions with PCP</th>
<th>ER</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>4</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>D</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Of all MCCM patients in the US, only 19% went to the ER during the first year, compared to 100% prior to becoming an MCCM patient.

Questions

BAYADA Support
tapgar@bayada.com
kbarnum@bayada.com
(802) 526-2380