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## Special Article

## A Quality of Care Framework for Home-Based Medical Care

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## A B S T R A C T

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More than 6 million adults in the United States are homebound or semi-homebound and would benefit from home-based medical care (HBMC). There is currently no nationally recognized quality of care framework for home-based medical care. We sought to capture diverse stakeholder perspectives on the essential aspects of quality HBMC and create a quality of care framework for homebound adults. A qualitative analysis of semistructured interviews from purposive sampling of key HBMC stakeholders was performed. Leaders from 12 exemplar HBMC practices (clinicians and administrators), advocacy groups (American Association of Retired Persons, National Partnership for Women and Families, Kaiser Family Foundation), and representatives from 3 key professional medical societies associated with HBMC participated in phone interviews. Semistructured interviews were based on domains of quality developed by the National Quality Forum (NQF) for individuals with multiple chronic conditions. We identified 3 categories of quality HBMC: provider and practice activities; provider characteristics; and outcomes for patients, caregivers, and providers. Within these 3 categories, we identified 10 domains and 49 standards for quality HBMC. These included 3 new domains (comprehensive assessment, patient/caregiver education, and provider competency) as well as specification and adaptation of the NQF Framework for Multiple Chronic Conditions domains for HBMC. Notably, several quality domains emanating from the NQF Framework for Multiple Chronic Conditions (transitions, access, and patient/caregiver engagement) were applicable to HBMC. This quality of care framework serves as a guide for HBMC practices seeking to improve their care quality and as a starting point for health systems and payers to ensure value from HBMC practices with whom they work.

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Approximately 2 million adults in the United States are completely or mostly homebound; another 4.6 million are semi-homebound. As society ages, the homebound population will grow. Homebound older adults often suffer from a constellation of daily challenges, including multiple chronic conditions, functional impairment, frailty, and social

stressors.<sup>1</sup> Homebound adults lack easy access to office-based primary care and are among the costliest patients to our health care system.

Studies show that homebound and seriously ill adults benefit from provision of medical care in the home.<sup>2</sup> Home-based medical care (HBMC) refers to clinical practices that provide physician- or nurse practitioner-led, longitudinal interdisciplinary care to homebound, functionally impaired, and seriously ill adults who have difficulty accessing traditional primary care; it includes both home-based primary care and home-based palliative care.<sup>3</sup> HBMC practices commonly provide enriched care coordination, access to community-based social services, and case management services, serving as the glue for all necessary services provided to the homebound patient.<sup>2</sup> HBMC involves the regular provision of home visits by billing and prescribing clinicians (eg, physicians, nurse practitioners, and physician assistants) and is a Medicare Part B benefit largely supported through evaluation and management

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(E&M) coding. In contrast, skilled home health care is a Medicare Part A benefit provided on an episodic basis by home health agencies to homebound Medicare beneficiaries who have a need for skilled services in the home (eg, nursing, physical therapy). In 2012, the Centers for Medicare & Medicaid Services (CMS) launched the Independence at Home (IAH) Demonstration Project that created a shared-savings payment model for HBMC to provide care to high-need, high-cost, functionally impaired older adults. First-year results demonstrated a Medicare savings of more than \$25 million. Additionally, HBMC reported fewer hospital admissions, and fewer inpatient hospital and emergency department services for conditions such as diabetes, high blood pressure, asthma, pneumonia, and urinary tract infection.<sup>4</sup>

A recent systematic review of HBMC programs found reductions in emergency department visits (15%), hospitalizations (30%), hospital bed days of care (37%-50%), long-term care admissions (10%-20%), long-term care bed days of care (88%), and costs (24%).<sup>2</sup> Satisfaction and caregiver quality of life were better in HBMC than usual care. In addition, a recent comparative effectiveness review from the Agency for Healthcare Research and Quality found that “current research evidence is generally positive, providing moderate-strength evidence that HBMC reduces use of inpatient care.”<sup>5</sup> Studies also demonstrate the overall savings accomplished through HBMC. Skilled home health nursing care, in contrast, has not shown equivalent impact on total cost.<sup>6</sup> Medicare Advantage and Medicare accountable care organizations are increasingly integrating HBMC into services provided to high-need, mobility-impaired patients.<sup>7–9</sup>

In the United States, HBMC practices are diverse in scope, size, and practice styles. The American Academy of Home Care Medicine estimates that there are more than 1000 practices that provide HBMC visits in the US.<sup>10</sup> A recent study involving Medicare claims data reported more than 7700 medical providers billing for home visits in 2013.<sup>11</sup> The gray literature suggests that this number may be increasing rapidly,<sup>7–9</sup> especially in Medicare Advantage markets and in health systems focusing on population health that prioritize optimizing care and reducing unnecessary cost in functionally impaired and seriously ill populations.

In recent years, commercial payers and Medicare have been moving toward systems of care that reward value rather than volume of services. The Medicare Access and CHIP Reauthorization Act (MACRA) legislation of 2015 emphasized value-based care and tied payments to meeting quality of care standards and quality improvement activities. Although these policy changes are laudable, a focus on value and quality-based reimbursement puts HBMC providers and practices at a significant disadvantage. HBMC providers and practices must use currently available endorsed quality metrics such as Physician Quality Reporting System (PQRS) or Group Practice Reporting Option (GPRO) quality measures. Although CMS and the National Association for Homecare have sought to address quality in skilled home health nursing care, these measures were not developed for medical practices providing care in the home and, in fact, cannot be reported by billing providers through MACRA. Existing measures for ambulatory medical practices (and therefore HBMC providers) were largely developed for people who were less medically fragile or with only a single disease or condition. When applied to the homebound population, many of these metrics have the potential to cause harm by incentivizing inappropriate care (eg, cancer screening for patients with limited life expectancy for whom screening tests can have untoward complications). In addition, many of these metrics place an additional burden on patients and families and may not balance the social context in which many adults made decisions about their health.<sup>12,13</sup> To date, no set of nationally recognized quality measures has been created for HBMC, nor has a quality of care framework been developed to support measures focused specifically on HBMC.

When the IAH program was initiated, it became clear to HBMC providers, CMS, and other payers that quality measures for HBMC were insufficient.<sup>11</sup> Therefore, we engaged in a systematic assessment of key stakeholder perspectives on quality of care for HBMC to inform the development of a quality framework and set of measures for medical practices more aligned with the home care setting. We describe the qualitative work conducted to elucidate these perspectives and the resulting quality of care framework that emanated from this work.

## Methods

### Participants

We purposively sampled key informants from HBMC practices and advocacy and professional societies. We recruited leaders from 12 HBMC practices (clinicians and administrators) that were diverse in geographic location, practice type (Veterans Health Administration, private, academic, not-for-profit, and for profit), and participation in the IAH Demonstration Program. To integrate an array of medical provider, patient, and caregiver perspectives, we also purposively recruited 3 advocacy groups [the American Association of Retired Persons (AARP), the National Partnership for Women and Families, and the Kaiser Family Foundation], and representatives from 3 relevant professional medical societies associated with HBMC (the American Geriatrics Society, the American Academy of Hospice and Palliative Medicine, and the American Academy of Home Care Medicine). Stakeholders from the 3 patient advocacy groups had personal experiences with HBMC and/or were informal caregivers themselves. All (100%) of those invited agreed to participate in the study. A separate study sought to capture patient and caregiver perspectives and is reported elsewhere.<sup>14</sup>

### Data Collection

Two researchers (C.R. and B.L.) conducted semistructured interviews with participants by telephone. The interview framework was based on domains of quality for people with multiple chronic conditions developed by the National Quality Forum overall National Quality Strategies<sup>15</sup> (safety, care coordination, prevention and treatment, person/family-centered care, cost and affordability) and specific measure concepts for those with multiple chronic conditions<sup>16</sup> (function, transitions, access, patient/caregiver engagement, health outcomes, avoidance of inappropriate care, cost, and shared decision making). Stakeholders were asked to comment on the domains or measure concepts regarding their applicability to HBMC, or their need for additional refinement and adaptation. Participants were then asked to identify subcategories (or standards) of quality of care for HBMC within each domain (see Table 1 for interview framework).

With the permission of participants, all but 1 interview was audio-recorded and transcribed; 1 participant was not recorded, and notes were taken by hand. Transcripts were e-mailed to the participants for member-checking, including review, revision, and additional reflections. Ten of the 19 participants edited or revised their transcripts; these revised transcripts were used in the final database for analysis.

### Analysis

We conducted template analysis, a qualitative approach that combines content analysis and grounded theory.<sup>17</sup> This hybrid approach allowed for deductive and inductive analysis. We deductively approached the data with the NQF Multiple Chronic Conditions Framework and inductively used participant responses to refine the framework, refine domains, and offer new categories of measures.

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