Revolutionize Home-based Primary Care

Chair: Rebecca Adkins, Jefferson Health

Revolutionize Home Based Primary Care

NAACOS Spring Conf 2026

Chair: Rebecca Adkins

Objectives

1. Understand newest advances in home based primary care
2. What operational/ payment models are best to support home based models
3. Challenges and considerations for programs
4. Q&A

Our Panelists

Dr. Anna Flattau, MD, MSc, MS
Chair Department of Family and Community Medicine- Sidney Kimmel Medical College
VP Primary Care Services- Jefferson Health

Dr. Tom Lally
Chief Executive Officer
Bloom Health Network

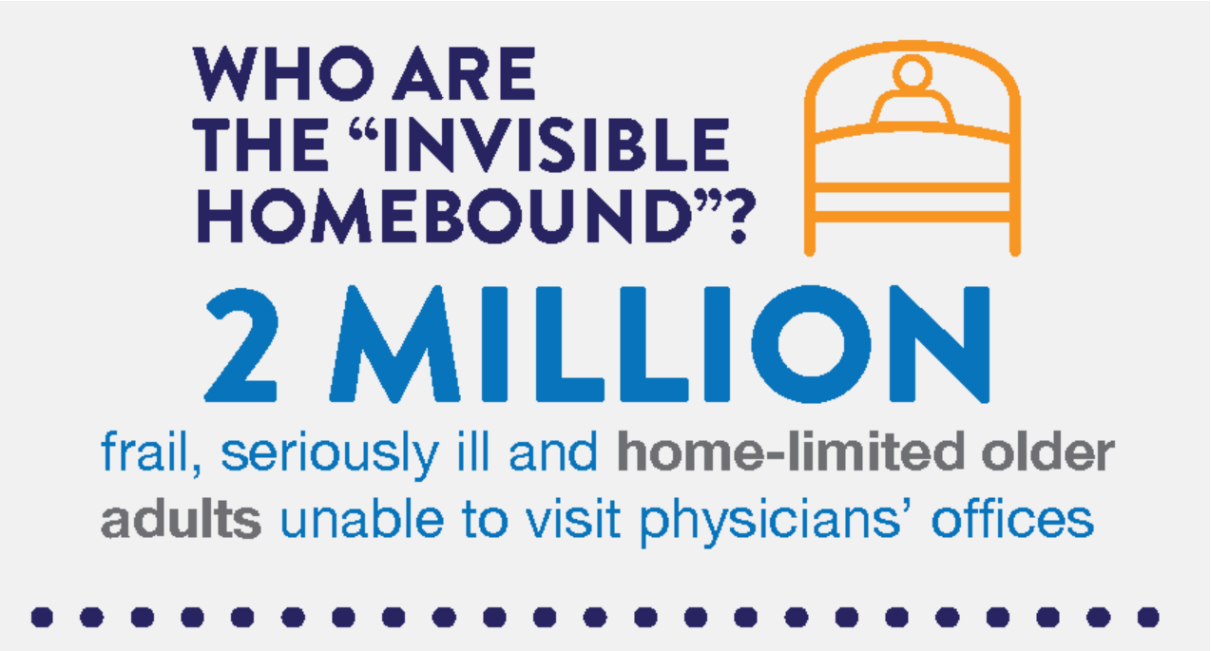
Stephen Nuckolls, MAC
CEO Coastal Carolina Health Care
NAACOS Board Member

Home Based Primary Care

- The American Academy of Home Care Providers reports serve over **100K home bound patients** each year.

- Home based programs allow patients to receive regular care outside of the hospital, preventing them from needing emergency services and reducing their total cost of care.

- Programs often show decreased ED, SNF, specialist, and inpatient utilization.



AAHCM
AMERICAN ACADEMY OF HOME CARE MEDICINE

Jefferson Health

Home Care at Jefferson Building “what ought to be”

Thomas Jefferson University

200+ Graduate and undergraduate programs

77,000+ Alumni

17 NCAA Division II teams

8,300+ Students (full/part time)

Over **$200 million** In applied, basic, clinical and scholarly research

1,000+ Patents for new drugs, software innovations, medical devices and diagnostic tools

Data is FY24 - updated January 2025

Jefferson Health

4,350 Employed physicians

13,600+ Nurses (full/part time)

4 Magnet® designated locations

4 Pathway to Excellence® designations

32 Hospital campuses

700+ Sites of care

2,500+ Advanced Practice Clinicians

8.8+ million Outpatient visits (hospital and physician)

Data is FY24 - updated April 2025

Jefferson Health Plans

362,000+ Total members

40+ Years of service

316,000+ Medicaid members

750 Employees

13,000+ Medicare members

20,000+ CHIP members

13,000+ Individual and family plans

Data is 12/24 - updated January 2025

Celebrating 30+ years of nationally ranked care

By U.S. News & World Report

Thomas Jefferson University Hospitals

- 2nd in the Philadelphia metro area
- 3rd in Pennsylvania (tied)
- 2nd in the nation for Ophthalmology (Wills Eye Hospital)

Lehigh Valley Hospital—Cedar Crest

- 1st in the Allentown metro area
- 3rd in Pennsylvania (tied)

Jefferson Abington Hospital

- 8th in the Philadelphia metro area
- 17th in Pennsylvania

Jefferson Moss-Magee Rehabilitation

- MossRehab 10th in the nation for Rehabilitation

THOMAS JEFFERSON UNIVERSITY HOSPITALS

Nationally Ranked in 6 Specialties

- #2 Ophthalmology — WILLS EYE HOSPITAL
- #19 Orthopedics — ROTHMAN ORTHOPAEDICS AT JEFFERSON HEALTH; THE PHILADELPHIA HAND TO SHOULDER CENTER AT JEFFERSON HEALTH
- #22 Ear, Nose & Throat
- #25 Neurology & Neurosurgery
- #35 Pulmonology & Lung Surgery
- #39 Gastroenterology & GI Surgery

HIGH PERFORMING

- Cancer — JEFFERSON HEALTH – SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER
- Geriatrics
- Urology

LEHIGH VALLEY HOSPITAL—CEDAR CREST

Nationally Ranked in 2 Specialties

- #25 Orthopedics
- #42 Pulmonology

HIGH PERFORMING

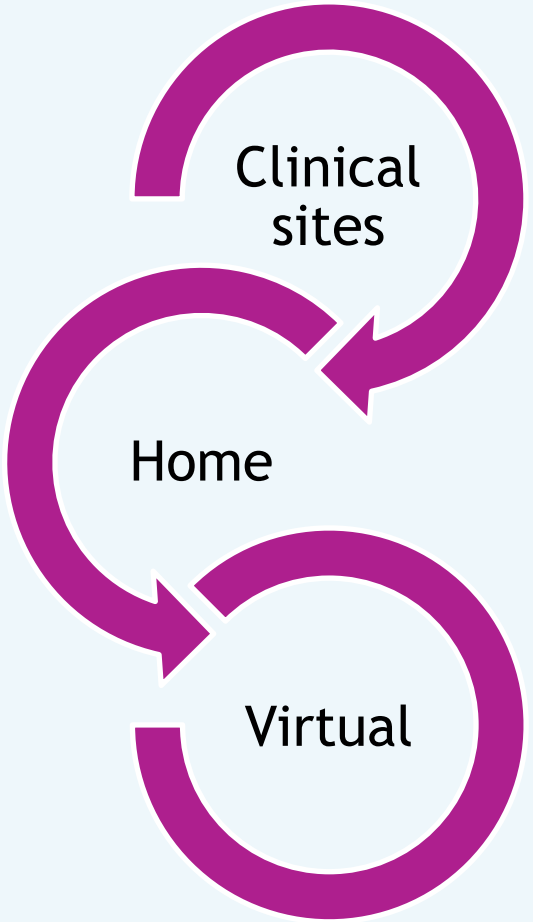
- Cardiology, Heart & Vascular Surgery
- Diabetes & Endocrinology
- Gastroenterology & GI Surgery
- Geriatrics
- Neurology & Neurosurgery
- Urology

Whence the revolution?

> "Organizations are tools for shaping the world as one wishes it to be shaped."
> -- Charles Perrow, *Complex Organizations* (2014)

Let's reimagine us:

- **We are a million-person primary care and population health system**, supported by 32 hospitals and 700 sites of care.
- We design creatively and freely to deliver on individual, household, community, and public health needs.
- We commit to deeply understanding the various mechanisms of health care financing, recognizing that these are the building materials out of which we will construct our patient-centered programs.



What matters about home-based (and all) primary care?

Person-Centered Primary Care Measure

HOW WOULD YOU ASSESS YOUR PRIMARY CARE EXPERIENCE?				
My practice makes it easy for me to get care.	Definitely	Mostly	Somewhat	Not at all
My practice is able to provide most of my care.	Definitely	Mostly	Somewhat	Not at all
In caring for me, my doctor considers all factors that affect my health.	Definitely	Mostly	Somewhat	Not at all
My practice coordinates the care I get from multiple places.	Definitely	Mostly	Somewhat	Not at all
My doctor or practice knows me as a person.	Definitely	Mostly	Somewhat	Not at all
My doctor and I have been through a lot together.	Definitely	Mostly	Somewhat	Not at all
My doctor or practice stands up for me.	Definitely	Mostly	Somewhat	Not at all
The care I get takes into account knowledge of my family.	Definitely	Mostly	Somewhat	Not at all
The care I get in this practice is informed by knowledge of my community.	Definitely	Mostly	Somewhat	Not at all
Over time, my practice helps me to stay healthy.	Definitely	Mostly	Somewhat	Not at all
Over time, my practice helps me to meet my goals.	Definitely	Mostly	Somewhat	Not at all

Measures — The Larry A. Green Center (green-center.org)

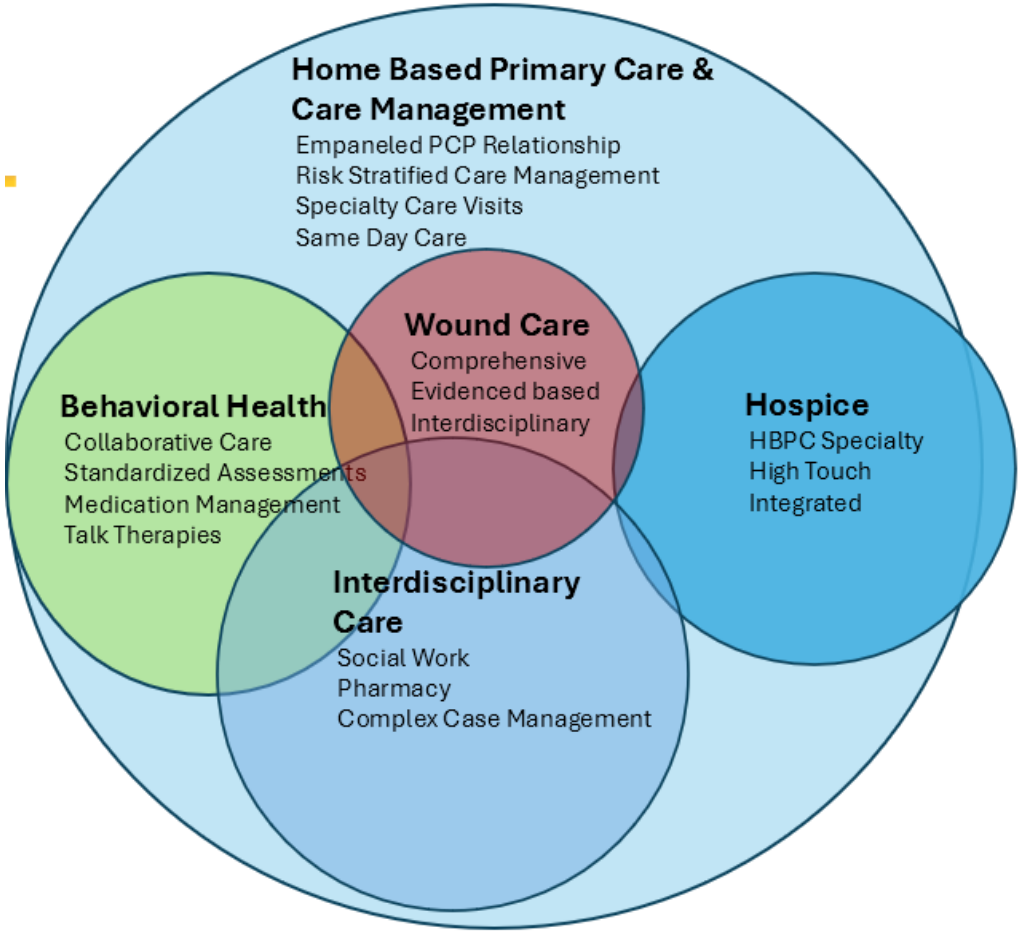
When is home care the right Primary Care choice?

- Cost-efficient care teams with the right range of interprofessional skills
- “Sliding scale” of home vs telehealth interactions
- If not supported by FFS, then need careful patient selection

When can home care supplement traditional or virtual primary care?

- Transitions of care support
- Complex patients
- Patients who are not improving with usual care
- Clinical Risk Assessments

Bloom Healthcare Overview



WHO WE SERVE
~10,000 high-needs patients
Mean age ~80+
Median 6.8 conditions | ~33 months life expectancy

MODEL
Longitudinal, in-home primary care
Empaneled PCP + care management
~3-year relationships

INTEGRATED CARE
REACH ACO, High Needs
Behavioral Health, Wound Care
Interdisciplinary Care Management
Hospice

WHY IT WORKS
High frequency + risk stratified
Fully integrated (not fragmented)
Aligned to total cost of care

bloom healthcare

Building a Sustainable Home-Based Primary Care Program for High-Need Patients

Stephen W. Nuckolls, MAC, CEO
Coastal Carolina Health Care, P.A.
Coastal Carolina Quality Care, Inc.

April 24, 2026

CCHC Coastal Carolina Health Care, P.A.
Advanced Medicine. Trusted Care.

Coastal Carolina Health Care, PA

60+ Providers (>50% PCP)

- Internal Medicine
- Family Medicine
- Emergency Medicine
- Cardiology
- Hematology/Oncology
- Gastroenterology
- Neurology
- Pulmonary/CC
- Rheumatology
- Endocrinology
- Podiatry
- Psychiatry
- Sports Medicine

18 Clinic Locations

- Urgent Care
- Imaging Center
- Sleep Lab
- GI ASC
- Physical Therapy

Concentrated/Rural Market

70% of PCP Patients in Total Coast of Care Contracts

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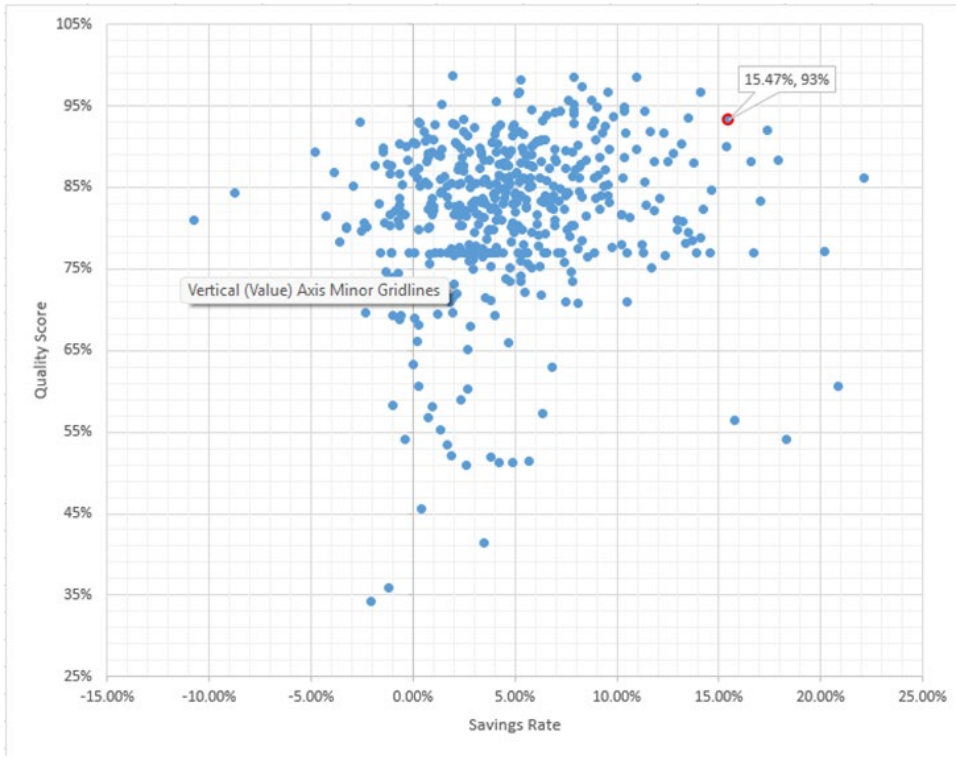
CCHC Overview

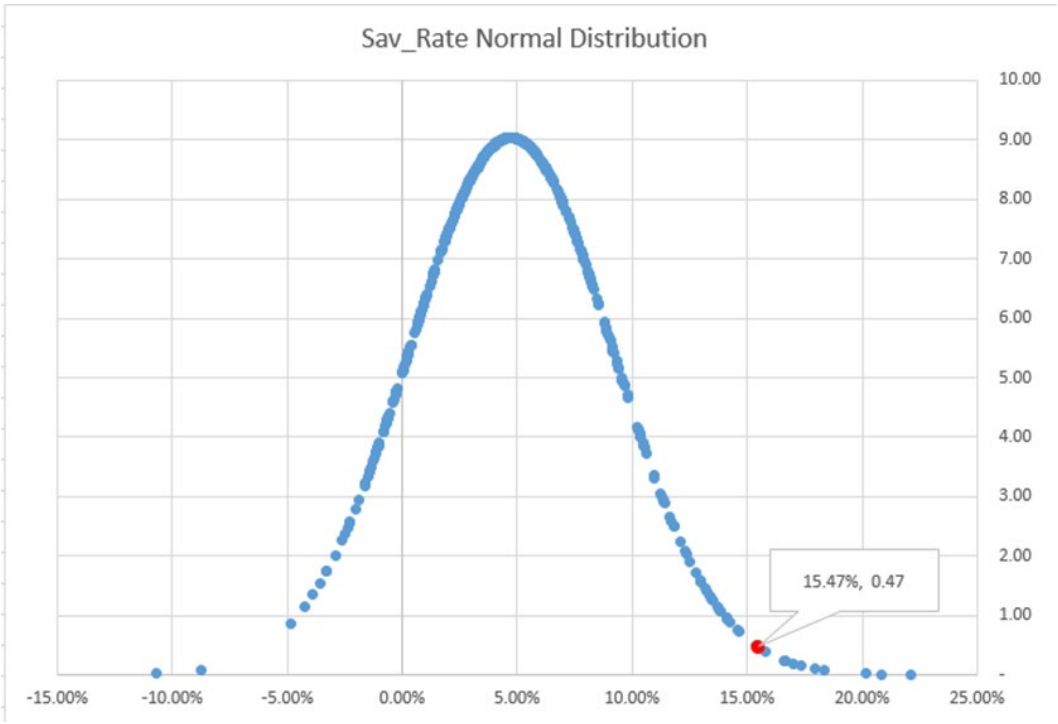
- Entered MSSP April 1, 2012 – Exited December 31, 2024
- Joined Commonwealth's REACH ACO January 1, 2025
- 70% of our 40,000 PCP's patients are in Total Cost of Care contracts (Medicare, BCBS, Humana, Aetna, UHC)
- Partnership with "Enablement Companies" to Increase Total Cost of Care Coverage.

Why We Chose Value Based Care Path

- Mission alignment by linking rewards to better health and lower costs
- Belief we had the market position and clinical infrastructure to succeed
- Funding from CMMI made the initial investment feasible

2024 MSSP: Quality and Cost





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Select MSSP Quality Measures

	2013			2023			2024		
	CCQC Score	ACO Mean	%ile Rank	CCQC Score	ACO Mean	%ile Rank	CCQC Score	ACO Mean	%ile Rank
Mammography Screening	91.22	62.05	100%	94.66	80.36	100%	94.53	80.93	100%
Colorectal Cancer Screening	88.94	59.30	100%	93.73	77.14	100%	90.20	77.81	97%
% of Pts W/DM & A1c >9	11.03	22.11	92%	4.12	9.84	98%	3.07	9.44	99%
Hypertension	69.22	67.79	55%	91.79	77.80	100%	94.59	79.49	99%
Source: CMS Public Use Files									

Select MSSP Utilization Rates

		Performance Year						Change ('11-'24)	
	2011	2013	2017	2019	2021	2023	2024	#	%
Hospitalizations	318	270	244	247	211	206	206	(112)	-35%
ED Visits	620	560	574	530	442	458	460	(160)	-26%
Notes:									
(1) Rates computed by CMS.									
(2) 2011 figures based on previous retrospective allignment model.									
(3) Per 1,000 Person Years.									

Why We Built Home-Based Primary Care

A strategic response for a high-need, high-risk population

- Traditional office-based care was not enough for part of our attributed population
- Frail, home-limited patients often cycle through crises, ED use, and hospitalization
- Families need a clear plan, a reliable clinician, and someone to call
- In a value-based model, better care for this population is both a mission issue and a cost issue

Why it mattered to us

- **Mission** - Care for patients others may see as too hard or too costly
- **ACO Impact** - Reduce avoidable utilization and improve total cost of care
- **Continuity** - Keep fragile patients connected to our system and clinicians
- **Quality and Risk Codes –** Capture Dx Codes

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Our Home-Based Primary Care Model

Lean team, high-touch care

1.0 FTE NP
Program lead and primary relationship clinician

0.50 FTE PA
Support visits and coverage

Supervising geriatric physician
Experienced clinical guidance

Integrated with CCM
Routine coordination and shared workflow

Key operating facts

85
Approximate active panel size

100%
Patients enrolled in CCM

90–100
Visits per month today

$210
Average revenue per visit

Selecting the right Providers is critical

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What the Program Actually Does

Clinical stabilization

- Prevent avoidable admissions
- Manage symptoms and medications
- Address decline early

Crisis Planning

- Who to call
- What to do / what not to do
- Reduce default 911 or ED use

Goals of care

- MOST forms and difficult discussions
- Comfort measures when appropriate
- Identify when hospice fits

Coordination

- Family and caregiver communication
- Community resources and APS
- Living arrangements and lab logistics

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Why Integration With CCM Matters

- Provides continuity with PCP office and team
- Care managers help our NP and PA work to top of their license by handling
  - Referrals
  - Orders
  - Prior authorizations

Economics: Direct Revenue & VBC Savings

Direct program economics

Item	Monthly	Annual
NP cost	$14,583	$175,000
PA cost (.50 FTE)	$7,292	$87,500
Supervising MD	$250	$3,000
Travel	$1,000	$12,000
Total direct cost	**$23,125**	**$277,500**
Revenue at 90 visits/mo	$18,900	$226,800
Revenue at 100 visits/mo	$21,000	$252,000

~110
Visits/month needed for direct break-even

$24K–$51K
Estimated annual shortfall on visit revenue alone

This is why we should not judge the program as a standalone FFS service line.

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What Success Looks Like

- Keep patients out of the hospital
- Give families someone to call
- Create clear crisis plans
- Use MOST forms and goals-of-care discussions earlier
- Bring hospice in at the right time
- Coordinate living arrangements, labs, and community support

The broader goal: embrace a complex patient population others avoid; care for them well.

Lessons Learned

1. Selecting the right lead clinician is critical
2. Integrate tightly with CCM rather than building a separate silo
3. Do not judge the model on fee-for-service revenue alone
4. Families need someone to call and someone to guide hard decisions
5. Capturing diagnosis codes for both quality exclusion and risk adjust purposes is meaningful
6. Providing appropriate care to this population can increase quality and reduce costs