



SPECTRUM

Society for Healthcare Strategy and Market Development®

January/February 2007

Care Delivery Models

Return of the House Call: Traditional Concept, Nontraditional Opportunities

Think the house call went the way of the horse and buggy? Think again.

Every day in the United States, 5,600 people turn 65. These individuals and those who follow them can anticipate the longest life expectancy in U.S. history. The fastest growing segment of the older population (65 and over) is the “oldest old” (85 and over), which grew from 3.1 million to 4.2 million during the 1990s, a 38 percent increase, according to U.S. Census Bureau data. An estimated 2 million elderly will be chronically homebound by 2020, according to the American Academy of Home Care Physicians.

The current U.S. healthcare system, focused on acute and episodic care, has difficulty meeting the needs of this population and their caregivers. Because of low mobility and complex medical conditions, the oldest old must make frequent, difficult, and expensive trips to multiple physicians to receive care. The result is fragmented, delayed crisis care, rather than timely, coordinated care. This fragmented approach is costly for all, resulting in:

- Episodic, fragmented, and poorly coordinated care and support for patients and caregivers.
- Extended average lengths of stay (ALOS) and high ER utilization for hospitals and health systems.
- Complex, disruptive office visits for physicians.
- High costs and inappropriate utilization for payers.

To address these issues, a new care delivery paradigm is necessary, one that involves the provision of primary medical care in the home and that works collaboratively with other healthcare providers and psychosocial support systems to deliver comprehensive, coordinated care management.

Over the past five-plus years, the national reemergence of house calls in general as the preferred model of care for specific clinical populations has been the result of the dedicated, collaborative efforts of physicians, midlevel providers, social workers, administrators, consultants and others with a passion for bringing



primary care back home—where it belongs. The house call program (HCP) has leveraged the collective efforts of these innovators to create a sustainable clinical and business model developed specifically to best meet the needs of the frailest elderly in the community.

This hospital-affiliated program has demonstrated a decreased rate of unnecessary ER visits, an ALOS that is two to three days shorter than that of the comparable elderly population, and a percentage of elders who are able to die in the comfort of their own homes that is triple the national average. All of these benefits derive from a financially self-sustaining program that contributes to the sponsor hospital’s bottom line.

The principal goals of the HCP are to:

- Provide high-quality primary medical care and related psychosocial support services in the homes of the frail elderly.
- Improve continuity of care for frail elders by providing or coordinating care in the hospital, as well as working closely with other specialists.
- Provide family member and caregiver counseling

continued on page 2

Society for Healthcare Strategy and Market Development®

President

Ruth A. Colby
Chief Strategy Officer and Vice President,
Business Development
Silver Cross Hospital
Joliet, IL

President-elect

David L. Marlowe
Principal
Strategic Marketing Concepts
Ellicott City, MD

Immediate Past President

Susan M. Alcorn
Chief Communications Officer
Geisinger Health System
Danville, PA

Executive Director

Lauren A. Barnett
Society for Healthcare Strategy and
Market Development
Chicago, IL

Managing Editor

Karen W. Porter
Society for Healthcare Strategy and
Market Development
Chicago, IL

Spectrum is the bimonthly newsletter of and a membership benefit for members of the Society for Healthcare Strategy and Market Development®. SHSMD welcomes unsolicited manuscripts, which will be used on a content and space-available basis. Preferred article length is from 1,000 to 1,500 words, and graphics and suggestions for sidebars are welcome. Please e-mail articles to kporter@aha.org.

The editorial office is located at:

One North Franklin, 28th Floor
Chicago, IL 60606
Phone: 312.422.3888
Fax: 312.422.4579
E-mail: stratsoc@aha.org
Website: www.shsmd.org

Opinions expressed in these articles are those of the authors and do not necessarily reflect the opinions of SHSMD or the American Hospital Association.

©2007, Society for Healthcare Strategy and Market Development. Reprinting or copying is prohibited without express consent from SHSMD.

Return of the House Call: Traditional Concept, Nontraditional Opportunities

(continued from page 1)

and education to empower caregivers and improve the level of support available in the home.

- Provide appropriate medical care to allow elderly persons to die at home, if that is their choice.
- Function as an economically self-sustaining business that contributes to the financial health of the sponsoring hospital or health system through admissions and referrals.

A Holistic Approach to Primary Care

The HCP takes a holistic view of the family, including the patient, family members, and caregivers. Physicians, midlevel providers (physician assistants and nurse practitioners), and a social worker visit patients in their homes to provide high-quality primary medical care and related psychosocial support services that would otherwise be very difficult to obtain. Because clinicians treat patients in the home, they have access to a tremendous amount of information about caregiver abilities and the home environment. This enables clinicians to make better-informed medical decisions than would otherwise be possible.

The HCP is composed of one or more care teams, each of which cares for 400 to 450 patients with 1.0 FTE physician, 2.0 FTE nurse practitioners or physician assistants, a program coordinator, and often a social worker. Physicians provide the initial visit in the home, as well as visits to perform procedures or to evaluate patient progress. Physicians also follow their HCP patients when admitted to the hospital, either through direct care or by working closely with hospitalists. This involvement provides exceptional continuity of care, shorter ALOS, and appropriate follow-up care in the home.

The average patient is seen about once a month, with a physician visiting every third or fourth time. Nurse practitioners or physician assistants conduct most routine and necessary urgent visits. A major component of most visits is the counseling of caregivers about managing the complexities of the patient's condition. If necessary, a social worker will become involved to help coordinate appropriate psychosocial support services and provide counseling.

Technology has made this approach to medical care possible. The clinicians carry with them a modern version of the physician's "black bag." It contains portable versions of all the technology available in an urgent care center and weighs less than 18 pounds.

Patients are offered a choice of institutional, specialist, and allied health providers should the care plan require such services. For the vast majority of patients, the choice is clear: use of sponsor-affiliated providers and services results in enhanced coordination of care and significantly simplified arranging of services. Using sponsor-affiliated providers significantly increases the quality of care while decreasing patient and caregiver stress and uncertainty.

Financial Considerations

A clinical team, as described above, generates sufficient revenue to be financially self-sustaining caring for a patient load of 400 to 450 active patients and making 8 daily visits per 1.0 FTE provider. The targeted frail elderly are eligible for Medicare, which will reimburse for medical services provided in the home. Reimbursement for home visits is approximately 30 percent to 35 percent higher than reimbursement for office visits.

Recently, Medicare has designated an additional category of reimbursement based on location: the domicile/residence facility, which includes such facilities as group homes and assisted living facilities. Reimbursement for domicile/residence facility visits is approximately 25 percent to 30 percent higher than for office visits. This change makes visits to these facilities financially feasible and expands the target base of patients for the HCP.

The structural options for housing the HCP providers are varied, with healthcare organizations selecting the arrangement that best fits their particular circumstances. Among the options available are (1) direct hospital employment, (2) employment within a medical group owned by the hospital, or (3) employment by a private medical group closely aligned with the hospital. Regardless of the structure, the HCP brand is typically owned by the sponsor hospital.

Benefits to the Sponsor Organization

The HCP provides three key economic benefits to the sponsor:

- 1. More efficient use of the DRG case rate.** Inpatient admissions are typically direct to a selected unit and are supported by an extensive knowledge of the patient's condition and a focused, purposeful care plan. The end result: an ALOS that is one to three days shorter than the typical inpatient stay for this target population, due not only to superior clinical management, but also to the ability to discharge the patient to a stable, well-known home environment. A shorter length of stay translates into a much more efficient deployment of the Medicare DRG case rate.
- 2. Improved capacity management.** Another key benefit of the reduced ALOS is the superior management of a critical hospital resource: bed capacity. The opportunity cost of a frail senior occupying a bed that could otherwise have been used for another admission is significant. Not only is timely



discharge to a stable, well-functioning home environment better for the patient, it also is the optimal use of bed capacity within the institution.

3. Enhanced market share. The HCP care teams provide primary medical care in the homes of the frail elderly living in the neighborhoods that make up the service area of the sponsoring hospital. This allows the program to target specific portions of the service area or to access or strengthen fringe markets in order to increase market share or secure the market against competitors, as well as to enhance case mix index because of the increase in highly complex patients.

As with any new program or service, the start-up period requires investment and support from the sponsor. The strategic and financial benefits, when coupled with a grants program, permit the sponsor to implement and sustain a HCP with limited net cost to the institution and significant long-term financial benefits. Many philanthropic foundations have refocused their missions to include financial support for issues related to healthcare access, quality, and affordability for the elderly.

Healthcare Systems Demonstrate Results

The Baylor Health Care System, based in Dallas, Texas, studied the financial impact of a house call program on hospital economic performance. The study of 432 low-mobility seniors was conducted from July 2001 to January 2002. Half received traditional office-based care (control), and half received care through a house call program. Table 1 summarizes the results of the analysis.

Montefiore Medical Center in the Bronx, New York, has developed an HCP to successfully manage a Medicare Advantage (managed care) population. Care Management Organization (CMO), a Montefiore subsidiary, provides clinical and administrative services to a patient population of 179,000 commercial and Medicare Advantage members. CMO receives

Table 1. Utilization and Financial Metrics, House Call Program vs. Office-based Care

	Control Group (Office-based Care)	House Call Program
ER visits	0.24/patient	0.12/patient
Admissions	No statistically significant difference	No statistically significant difference
Average length of stay	8.48 days/admit	5.64 days/admit
Margin per admission	(\$1,576)	\$934

Source: Baylor Health Care System. Abstract 21, presented at the American Geriatrics Society Annual Meeting, May 16, 2003.

continued on page 4

Return of the House Call: Traditional Concept, Nontraditional Opportunities

(continued from page 3)

Table 2. Hospital and Skilled Nursing Facility (SNF) Utilization Before and After House Call Program (112 patients)

	Pre-House Call Program	Post-House Call Program	Absolute Change	Percentage Change
Total hospital days	820.0	503.0	(317.0)	-38.7%
Total hospital admissions	102.0	59.0	(43.0)	-42.2%
Hospital admissions per patient per year	2.9	1.7	(1.2)	-42.2%
Hospital average length of stay	8.0	8.5	0.5	6.0%
Total SNF days	2,148.0	703.0	(1,445.0)	-67.3%
Total SNF admissions	41.0	17.0	(24.0)	-58.5%
SNF admissions per patient per year	1.2	0.5	(0.7)	-58.5%
SNF average length of stay	52.4	41.4	(11.0)	-21.1%

Source: Montefiore Medical Center, Care Management Organization analysis, January 2006.

full capitation for Medicare Advantage patients and uses an HCP to manage the frailest, most complex of them. CMO analyzed the utilization of 112 Medicare Advantage patients for a six-month period before and after enrollment in the HCP. Table 2 summarizes the extraordinary results.

University Hospitals/Case Western Reserve University Case Study

The HCP at University Hospitals/Case Western Reserve University (UH/Case) went live on April 1, 2005, with three part-time physicians, one certified nurse practitioner, and a program coordinator, serving eight zip codes in the Cleveland area. For the 12-month period ending July 31, 2006, the team had 162 active patients and completed 1,512 home visits, with estimated average net revenue of \$81.17 per visit.

The planning and design phase of this HCP took place over four months. UH/Case received a foundation grant to cover this phase, and UH matched the grant dollar for dollar. Implementation of the HCP began in November 2004, with two foundations providing philanthropic grants to cover implementation and start-up expenses.

Today, the program continues to grow with a goal of increasing the patient base to 400 active patients. The program is well on its way to achieving financial sustainability.


While the HCP respects a patient's right to choose, HCP patients overwhelmingly request UH-affiliated programs and services. The use of sponsor-affiliated providers and services results in enhanced coordination of care, significantly simplified arranging of services, and increased quality of care, while reducing patient and caregiver stress and uncertainty.

UH/Case is in the process of designing and implementing a formal interdisciplinary education curriculum to further educate those serving this population.

The team at UH/Case has found that the following concepts are key contributors to the success of an HCP:

- Hire passionate, empowered team players with a “start-up” mentality.
- Do sweat the details—this is a small PCP (primary care physician) practice.
- Recognize that marketing and community outreach are key.
- Ensure that patient visits include medical care, education, and counseling.
- Build the HCP's reputation for service and compassion.

Summary

Demographics, economics, technology, and societal expectations have converged to create a unique opportunity. A health system-based model is best positioned to maximize savings and serve the community. The HCP is a self-sustaining program that not only provides a tremendous community service for the target population, but also generates significant goodwill and serves as an engine of economic growth for the sponsoring institution. 

Written by:

Brent T. Feorene

President, House Calls Solutions
Westlake, OH

440.871.2756

e-mail: bfeorene@housecallsolutions.com

www.housecallsolutions.com

Steven H. Landers, M.D.

Medical Director
University Hospitals/Case

Western Reserve University House Call Program, Cleveland, OH

216.844.8395

e-mail: steven.land@uhhospitals.org

www.uhhospitals.org