

# The House Call Program

*An Overview for Hospitals and Health Systems*

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## Introduction and Overview

The House Call Program (HCP) model of care was developed as the way to best meet the needs of the frailest, sickest elderly in the community. This hospital-affiliated program evolved based on the single premise of meeting the needs of the sickest and frailest elderly through regular primary medical care home visits. Our clients have found that the HCP has grown to become a tremendous success, boasting a decreased rate of unnecessary emergency room visits, an average length of stay for hospital admissions that is almost three days shorter than the comparable elderly population and a percentage of elderly who are able to die in the comfort of their own home 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. As one client states:

"Norton Healthcare's purpose is to provide quality health care to all those we serve, in a manner that responds to the needs of our communities and honors our faith heritage. The House Call Program allowed us to continue this tradition by providing primary medical care in the homes of the frailest, most medically complex elderly in our community. We aspire to set the standard for care and community service in our area of the country and believe that this model of care can be a highly appropriate model for the frail elderly population we serve.

In addition to meeting a significant community need, the House Call Program contributes today to the financial strength of the health system and will most likely be economically self-sustaining when it reaches full patient census. Norton Healthcare enthusiastically recommends the House Call Program to any health system looking to better serve the elderly of its community in a financially responsible manner."

**Robert W. Powell, MD**  
*Medical Director  
Norton Hospital  
Louisville, KY*

The principal goals of the HCP are to:

- Provide high-quality primary medical care and related psycho-social support services in the homes of the frail elderly who have great difficulty accessing primary care;
- Improve the continuity of care for frail elders by providing care in the home and in the hospital, as well as working closely with other specialists who treat the patient;
- Provide family member and caregiver counseling and education to empower caregivers and improve the level of support available in the home;
- Provide appropriate medical care to allow an elderly person to die at home, if that is their choice; and
- Function as an economically self-sustaining business that contributes to the financial health of the health system through admissions and referrals.

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## The Issue

Many of the frail elderly have complex and chronic diseases that require management. These individuals need regular, coordinated medical care the most and are the least able to obtain it. This occurs for a variety of reasons. Many elderly are disabled and need assistance with the activities of daily life which makes it difficult to leave home at all, let alone to get to a physician's office. Many elderly have limited income. Navigation of the public transportation system presents unique challenges. Some elderly persons do not have adequate family or caregiver support systems to provide the necessary assistance. If available, care for these frail elderly is particularly stressful and demanding, impacting the caregiver's personal and professional life.

As a result of these and other factors, the frail elderly do not visit a primary care physician on a regular basis. They typically do not see a physician until they arrive at the emergency room due to an acute illness or exacerbation of a chronic condition.

## The HCP's Approach to Primary Care

The HCP takes a holistic view of the family, including the patient, family members and caregivers. Physicians, nurse practitioners (NPs) and a social worker visit patients in their homes to provide high-quality primary medical care and related psycho-social support services that would otherwise be impossible or very difficult to access. Because the clinicians treat the patients at their home, they have access to a tremendous amount of information about caregiver abilities and the home environment. This enables the clinicians to make more-informed medical decisions than would otherwise be possible. Additionally, HCP providers offer the appropriate medical oversight needed for an elderly person to die at home, if that is their choice.

The HCP is comprised of one or more care teams, each of which cares for 400 – 450 patients with 1.0 FTE physician, 2.0 FTE NPs, a program coordinator and, often, a social worker. Some programs have chosen to utilize two physicians, each making house calls for half of their time, with the remainder of the time filled with inpatient and nursing home services, teaching, and in some instances, a limited office-based practice.

Physicians provide the initial visit in the home, as well as visits to perform procedures or to evaluate patient progress. Physicians also follow their house call patients when they are admitted to the hospital either through direct care or by working closely with hospitalists. This care delivery model provides exceptional continuity of care, shorter hospital stays, and appropriate follow-up care in the home.

The average patient is seen about once a month. Depending on the medical needs of the individual, they will be seen by the physician every third or fourth visit. NPs conduct most routine visits, as well as urgent visits, as needed. A major component of most visits is counseling caregivers regarding management of the complexities of the patient's condition. If necessary, a social worker will become involved to help coordinate appropriate psycho-social support services.

# The House Call Program

*An Overview for Hospitals and Health Systems*

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

## **Financial Sustainability and The HCP Structure**

A clinical team as described above generates sufficient revenue to be financially self-sustaining caring for a patient load of 400 – 450 active patients and making 8-10 visits per 1.0 FTE provider per day. Almost all of the targeted frail elderly are eligible for Medicare, which will reimburse for medical services provided in the home. Reimbursement for home visits is approximately 30-35% higher than reimbursement for office visits. Recently, Medicare has segregated out an additional category of reimbursement based on location, domicile/residence facility, which includes such facilities as group homes and assisted living facilities. Reimbursement for domicile/residence facility visits is approximately 25-30% higher than for office visits. This change makes visits to these facilities financially feasible and expands the target base of patients for the HCP. Previously, services provided at these locations were considered office- or institutional-based and reimbursed at these lower levels. Medicaid waiver funding supports the expense of the social worker in many states.

Malpractice liability for a home visit practice has the same cost as an office-based practice. Additionally, preliminary studies have shown a lower claims incidence for home-based providers. Therefore, future malpractice premium increases for home visit practices are projected to lag behind premium increases for office-based practices.

The structural options for housing the HCP providers are varied, with health systems selecting the arrangement that best fits with their particular circumstances. Among the options available are: (1) direct hospital employment; (2) employment within a hospital's home health agency; (3) employment within a medical group owned by the hospital; and (4) employment by a private medical group closely aligned with the hospital with an appropriate professional services agreement with the hospital. Regardless of which entity employs the providers, the HCP brand is typically owned by the sponsor hospital.

## **Benefit to the Sponsoring Hospital and Health System**

The HCP provides two key economic benefits to the sponsor: (1) more efficient use of the DRG case rate payment; and (2) enhanced market share in portions of the service area.

### ***Efficient Use of DRG Case Rate/Capacity Management***

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 1 – 3 days shorter than the typical inpatient stay for this target population, due to not only the superior clinical management, but also the ability

# The House Call Program

*An Overview for Hospitals and Health Systems*

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to discharge the patient to a stable, well-known home environment. A shorter length of stay translates into superior capacity management for the sponsor hospital, as well as a much more efficient deployment of the Medicare DRG case rate.

## **Enhanced Market Share**

The HCP care teams provide primary medical care in the homes of the frail elderly who live in the neighborhoods that comprise the service area of the sponsor hospital. By serving well-defined neighborhoods, providers maximize patient time and minimize travel time. This arrangement affords the sponsoring institution the option to target specific portions of the service area, including fringe markets where increased market share or competitive positioning is desired. Even institutions that have robust occupancy rates find it very attractive to be able to target specific zip codes to strengthen a fringe market or secure themselves against in-roads by competitors. For example, an HCP team can be deployed in secondary markets that a hospital or health system wants to strengthen.

In addition, due to the increase in admissions from the targeted zip codes, the strategic placement of a care team also results in an enhanced case mix index due to the increase in highly complex patients.

These strategic and financial benefits, when coupled with a grants and giving program, permit the sponsor to implement and sustain a HCP with little to no net cost to the institution and significant long-term financial benefit. Many philanthropic foundations have re-focused their missions to include issues related to health care access, quality and affordability for the elderly. In each of the HCPs that has requested assistance, we have successfully worked with the hospital's development office to secure funding to offset in part or in full the start-up costs of the HCP. Total grant funds committed per HCP have ranged from a low of \$250,000 to a high of \$850,000.

## **Next Steps**

The HCP is a self-sustaining program that provides a tremendous community service for the target population, as well as generates significant goodwill and serves as an engine of economic growth for the sponsoring institution. To learn more about the HCP or arrange an executive education session, please contact Brent T. Feorene at 440/871-2756 or [bfeorene@housecallsolutions.com](mailto:bfeorene@housecallsolutions.com).