



## **'Home Sweet Home'**

# **FPs Fulfill Professional Goals, Patient Needs With House Calls**

By [Leslie Champlin](#)

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Trained in an environment where the norm included dashing from exam room to exam room, "putting out fires" among chronically ill patients by cramming as much patient history taking, physical examining and lab study ordering as possible into each 15-minute visit, Steven Landers, M.D., decided there was a better way to provide patient care -- he could take the care to patients in their homes.

House calls provide a 360-degree view of factors that affect a patient's overall health, says Thomas Cornwell, M.D., whose practice consists solely of in-home care.

And that's just what Landers did when he completed his residency. He took on the responsibilities of medical director of the [Case Western Reserve University/University Hospitals of Cleveland House Call Program](#) (PDF file: 2 pages / 1.4 MB. [More about PDFs.](#)) and began providing in-home medical care to elderly and disabled patients who could not get to a physician's office.

In time, Landers began to view the house call as an "escape fire" -- a concept made famous by Don Berwick, M.D., M.P.H., president, CEO and co-founder of the Boston-based Institute for Healthcare Improvement. In a 2002 Commonwealth Fund monograph, "[Escape Fire: Lessons for the Future of Health Care](#)," (PDF file: 27 pages / 428 KB. [More about PDFs.](#)) Berwick, who also is clinical professor of pediatrics and health care policy at Harvard Medical School, Boston, discusses problems with the health care system and describes potential reforms using the analogy of firefighters deliberately burning a patch of forest to form a refuge in case the flames ahead of them get out of hand.

"I have come to think of home visits as an escape fire for improving care for vulnerable elders," said Landers, who also is assistant professor of family medicine at Case Western Reserve University School of Medicine.

## **Growing Need**

Millions of Americans of all ages cope with debilitating, chronic conditions that can prevent them from getting the primary care they need, said Constance Row, executive director of the [American Academy of Home Care Physicians](#). Most of the patients that physicians in her organization care for are elderly and have multiple chronic conditions that limit their mobility, said Row. The younger patients often have neuromuscular disorders, such as muscular dystrophy, multiple sclerosis, amyotrophic lateral sclerosis or cervical spine

injuries.

"They are too disabled and ill to access office care," said Row. "So they are left with the option of the emergency room and hospitalization as their source of care. By then, they are already in an acute exacerbation of their chronic illness, which could have been dealt with earlier and, in many cases, prevented."

Moreover, reliance on the emergency department fails to bring these patients fully into the health care system, according to Thomas Cornwell, M.D., founder and medical director of [HomeCare Physicians](#) in Wheaton, Ill.

"These are the sickest patients in our society, and they are getting the least amount of primary care," he said. "These patients are medically disenfranchised. Even if they get to the emergency room, if they're not admitted, the hospital (ER) will discharge them and tell them to go to their doctor (for follow-up), even though these patients don't have a doctor."

The answer, said Landers, Cornwell and Row, is physician care in patient homes. By making house calls, the family physician removes barriers to care, gets a comprehensive view of all the factors that affect each patient's health, and more fully incorporates the patient and in-home caregiver as members of the care team.

In addition, the range of medical services these patients need and their virtually total dependence on the house-call physician combine to expand that physician's expertise and practice, said Cornwell.

"Out of necessity, you become *it* for these patients," he said. "I'm a better cardiologist and rheumatologist than I ever thought I'd be because I have no choice. Very few specialists make house calls. So I know I'm really helping these people."

### **360-Degree View**

House calls enable a physician to get a 360-degree view of factors that affect their patients' overall health.

"You can see how they manage their medications, make sure they have enough food and the right kind of food, and see any environmental hazards," said Landers. "And you get a view for the life of the caregiver, what their daily tasks involve. Here's where you can give support to the caregiver."

Moreover, the house call often can identify additional diagnoses that may be missed in an office visit -- even a comprehensive visit, said Cornwell. He cited a 1989 study that showed, according to Cornwall, "even after a complete office-based comprehensive geriatric assessment, a geriatric nurse specialist following up with a house call found, on average, two new diagnoses and made an average of four additional recommendations."

House calls also allow for an environmental assessment to examine safety factors, identify simple changes that can ease activities of daily living, and assess the patient's cognitive and emotional status, said Row.

"If the doctor sees stacks of papers all over the house and no food in the pantry, he may determine that the patient is demented," she said. "That may never come out during an office visit."

Equally important, the house call can ensure complete medication reconciliation, according to Row. Often, chronically ill patients fail to bring the full panoply of medications they use

with them to the office visit, or they may fail to mention the homeopathic or over-the-counter medications they also take.

"I can tell you many stories about patients whose symptoms of weakness and falling were due to taking both the name brand and the generic brand of the same medication without realizing they were the same," said Cornwell. "By educating them to take just one, all of their symptoms resolved. I also had one patient who said she did not believe in medicine, but she had a Rubbermaid container with over 100 vitamins and food supplements."

A thorough review of the contents of the patient's medicine cabinet resolves those issues.

## Enhancing Therapies

House calls also afford the chance to more effectively encourage or augment rehabilitative therapies, said Landers, citing the case of a stroke patient who needed physical therapy to recoup use of her right hand.

He recounted a story about a physician who, on noticing some plants in a patient's home, encouraged the woman to fill the house with plants. The work of transplanting, pruning and otherwise caring for the plants provided an enjoyable form of physical therapy, helped stave off depression and nurtured the patient's relationship with her grandchildren, who lessened the caregiver's burden by sharing plant care with their grandmother.

"That was something you could miss in a sterile office environment," said Landers.

The house call also supports patients' in-home caregivers, said Cornwell. They no longer must take time from work to transport the patient to the doctor's office. They learn how to work with their loved one's medical technology and what symptoms to watch for to prevent acute complications. They understand they can call the physician rather than emergency response teams when an issue develops.

"Education for the caregiver is a really important element," said Cornwell. "Knowing that what they are doing (to care for their loved one) is right is a *big* thing. We train nurses' aides and nurses on caring for these patients, but we don't give caregivers much training on how to use a feeding tube or how to check a diabetic patient's blood sugar. And knowing that their doctor is a phone call away -- knowing that calling 911 is *not* their only answer -- is big."

## Getting Paid

Payment for house calls improved dramatically in 1998 when CMS adjusted the Medicare physician fee schedule by adding higher-level codes -- two for new patients and one for established patients -- for house calls. Despite some changes in the payment system, Medicare payment for house calls now is comparable to that for office visits.

For example, national Medicare payment data for the office-based CPT code 99213, which assumes a 15-minute face-to-face encounter, is \$59.50; for the comparable home-based CPT code, 99348, payment is \$66.32. National payment data for the office-based CPT code 99215 is \$122.03, and for the comparable home-based CPT code, 99350, payment is \$150.83.

According to the 2007 Medicare schedule, payment for CPT 99345 -- the highest level for a house call to a new patient -- is \$186.08; the payment for CPT 99205 -- the highest-level new patient office visit -- is \$175.47. The rate for a detailed follow-up office visit -- CPT 99214 -- is \$90.20, while a detailed follow-up house call visit -- CPT 99349 -- pays

\$102.32.

Demand for house calls is likely to increase as the U.S. population ages. The number of people with multiple chronic conditions is expected to grow from 60 million in 2000 to 81 million by 2020, according to the [Partnership for Solutions](#). Currently, at least 2 million Americans are chronically homebound, according to the American Academy of Home Care Physicians. That number, too, is expected to rise as Americans age.

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