

# The House Call Program

*An Overview for Managed Care Organizations*

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## Overview

Managed Care Organizations (MCOs) have a unique opportunity to develop an innovative, complex case management product, known as *The House Call Program (HCP)*. Focused on providing care to the most fragile, medically complex seniors and others with chronic, debilitating medical conditions, the HCP will enable an MCO to partner with network providers to effectively and profitably manage the quality of care it provides to its frailest and most medically complex enrollees, while also reducing the resources needed to care for them.

## The House Call Program

The HCP is a comprehensive care management program that brings primary care and related health and psycho-social support services into the homes of frail, low-mobility enrollees in an appropriate, coordinated and financially self-sustaining manner. Patient care teams of physicians, mid-level providers (nurse practitioners and physician assistants), and social workers visit frail enrollees in their homes on a regular basis. HCP providers ensure that these enrollees receive appropriate medical and psycho-social support services and coordinate the provision of sub-specialty, outpatient and inpatients services.

HCP team members also provide education and support to caregivers and family members in the challenging and difficult task of caring for their loved ones in the home. This not only reduces their uncertainty and stress, but also ensures that care plans are more knowledgeably and effectively implemented, enabling patients to successfully remain at home.

Currently, all HCPs focus on serving the frail elderly, though the medical model of care and the business model can be readily adapted to serve other chronically-ill, special-needs populations.

## Medical House Calls: Recent Trends Have Created a Unique Opportunity

Recently, a number of trends have created a healthcare environment that supports the development and success of HCPs serving the frail elderly:

- An aging population base in which over 5,500 people turn 65 each day, as well as rapid growth (over 275%) of the “oldest old” (age 85+) between 1995 and 2000;
- Cost pressures that are forcing providers and payers to explore alternative approaches to the care of all high-cost patients, such as risk adjustment of Medicare Advantage premiums;
- Expectations about quality of life in aging and a desire to age and die at home;
- Evolving provider skill sets that have resulted in the growth of geriatrics as a clinical specialty and the integration of mid-level providers; and

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- Technological advances that have allowed the provider's "black bag" to include the portable equipment necessary to conduct a comprehensive medical visit in the patient's home.

Similar trends and public policy developments have created an opportunity for non-seniors who are chronically ill with debilitating conditions to benefit, as well as the payers and providers who serve them.

### **Benefits to Enrollees, MCOs and Participating Hospitals**

The obvious benefits for enrollees who choose to participate in a HCP are an improvement in their health and quality of life, as well as ongoing support for their families and other caregivers.

For its part, an MCO will gain the following tangible benefits:

- *A competitive differentiation in market position and sales due to the exclusive, first-to-market availability of HCP services* – The HCP affords an MCO the ability to set your Medicare Advantage product apart to compete on features and benefits other than price and covered ancillary services, such as vision and dental.
- *Ability to move Medicare FFS patients to a Medicare Advantage product* – Medicare Advantage enrollees receiving house calls are a powerful marketing tool to friends and neighbors in traditional Medicare FFS.
- *A network development tool that enables MCOs to offer participating hospitals more than a reduced fee schedule.*
  - *Improve Capacity Management* - Since HCP patients receive more appropriate, better coordinated care than would otherwise be available to them, network hospitals see a reduction in ER visits, fewer and/or better managed inpatient admissions, and shorter lengths-of-stay.
  - *Capture 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 a network hospital. By serving well-defined neighborhoods, providers maximize patient time and minimize travel time. This arrangement affords the network hospital the option to target specific portions of the service area, including fringe markets where increased market share or competitive positioning is desired.
  - *Generate substantial community goodwill* – the program fits with their not-for-profit mission and is a source of significant goodwill.
- Comprehensive, high-quality and appropriate care for targeted enrollees; which results not only in excellent care coordination and integration for this population, but also reduces inappropriate and redundant services and resulting healthcare costs;

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- Enhanced MC Advantage premiums for HCP enrollees
  - *Hierarchical Condition Categories (HCC)* The HCP greatly enhances more accurate and complete diagnostic coding due to the nature of the visit locale and the training/focus of the providers. More accurate and complete patient diagnosis coding in a given year for a chronic, complex and frail population will increase the HCC Medicare utilizes to calculate premiums for the subsequent year.
  - *AAPC Premiums for Medicare Advantage enrollees in community settings, such as the home, are higher than premiums for those in institutional settings, such as ICFs.* A study published in JAMA indicated that house call programs can effect on average a 37 percent reduction in ICF placement of the elderly compared to those not in a house call program (Stuck A, et al Home Visits to Prevent Nursing Home Admission and Functional Decline in Elderly People: Systematic Review and Meta-analysis, JAMA 2002; 287: 10022-1028).

The use of the HCP as a tool to keep patients in the community or to move ICF patients back into the community will: (1) have a positive impact on the Medicare Advantage premiums for these individuals; and (2) be consistent with and complementary to Federal initiatives, such as Money Follows the Patient, which promote and financially support “back to the community” efforts.

- Tremendous goodwill created in the community at a time when managed Medicare and Medicaid are seeking to improve public perception.

### **The HCP’s Approach to Primary Care**

The HCP takes a holistic view of the family, including the patient, family members and caregivers. Physicians, mid-level providers 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. All inpatient services, sub-specialist visits, ancillaries, diagnostics, home health, hospice, as well as other outpatient and community support services are coordinated for the patient by the HCP. The goal: provide comprehensive care management to the patient and their family/caregiver(s) in order to improve quality and efficiency of care, maximize quality of life and reduce redundant or unnecessary services.

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.

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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 network 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. Mid-level providers 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.

## Results Are Promising

A New York-based client worked with House Call Solutions to develop an HCP to successfully manage a Medicare Advantage population. This health system has a wholly-owned subsidiary (MCO) which provides clinical and administrative services to a patient population of almost 180,000 commercial and Medicare Advantage enrollees. The MCO receives full capitation for Medicare Advantage patients, using an HCP to manage the frailest, most medically complex. In March 2006, MCO analyzed the utilization of 112 Medicare Advantage enrollees for a six month period pre- and post-enrollment in the HCP. Table 1 summarizes the extraordinary results.

**TABLE 1**

<b>Utilization (PPPY)</b>	<b>Percent Change</b>
Hospital admissions	(42.2%)
SNF admissions	(58.5%)

The House Call Program 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.

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