

Physician House Calls

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Introduction

Physician house calls, once considered a relic of pre-21st century medicine and a “vanishing practice,” have experienced a remarkable resurgence in interest in the last decade.¹ Between 1998 and 2004, the number of house calls to Medicare beneficiaries increased by 40%, reflecting increased reimbursement schedules for house calls by Medicare, advances in portable medical technology, increased interest among providers, and increased demand by patients.² This chapter will examine the issues surrounding the recent increased interest in physician house calls, discuss the differences between physician house call programs and home-health agencies, and outline how modern house call programs are structured.

Why House Calls? Why Now?

The US population is currently experiencing a demographic shift towards a more aged population. The percentage of Americans over the age of 65, presently under 15%, is expected to increase significantly in the coming decades to 21.8% by 2030, numbering more than 70 million individuals (See the chapter entitled “Aging and Public Health in the U.S” for more information).^{3,4} Older patients tend to have more complicated health problems and physical and cognitive disabilities, making the traditional 15-minute office visit in a community-based primary care physician’s office less than ideal for treating their multiple medical needs, particularly for

patients with disabilities and decreased mobility who must make transportation arrangements to the physician's office.⁵ The short amount of time afforded each patient visit in a high-volume ambulatory care setting is insufficient to address all of the co-existing problems, which likely decreases the effectiveness of the visit and overall patient satisfaction.⁶ In contrast, Landers posits that "lower-volume, time-intensive house call practice is a more appropriate way than the brief office visit to care for older patients who have multiple morbidities."⁷ Others have noted that the home is a well-suited setting to care for the most frail, most complex, and most costly older patients.^{8,9,10}

Health costs expenditures account for over 14.1% of the US national GDP and is projected to rise to 17.7% by 2012 (See the chapter entitled "National Health Care in the US" for more information). In order to stem this dramatic increase, healthcare administrators and researchers are investigating innovative models of care delivery that may be more cost effective than current approaches. One such effort is to reform Medicare's payment schedule in favor of home care, which includes physician house calls and home-health agencies, as home care used appropriately has been demonstrated to decrease hospitalization and nursing home use without compromising medical outcomes.¹¹ Also, costs associated with physician house calls are self-limiting due to intrinsic limits in the use of expensive laboratory equipment and the potentially lower overhead costs, depending on the practice model (See next section for more information). For these reasons, physician house calls and other home-based models of care are attractive as innovative and potentially cost-saving approaches to health care delivery to Medicare beneficiaries.

While Medicare-allowed reimbursement for a home visit is higher than for a similar-level office visit, reimbursements are still financially inadequate and pose a significant barrier to

physicians who desire to provide house call services to their patients¹². However, since 1998 Medicare has made adjustments to reimbursement fee schedules to make house calls less financially burdensome to providers. Medicare increased allowable reimbursement for home visits in 1998 by nearly 50%.¹³ In 2005, the Medicare allowed charge for a detailed visit to an established patient was approximately \$110, and in 2006, Medicare also increased reimbursement for “domiciliary visits,” or visits to patients in assisted-living facilities.¹⁴ Such enhancements to the payment schedule have made house calls more attractive to current providers, reflected in the increase in the number of house calls provide to Medicare beneficiaries, which amounted to over 2 million visits in 2004.¹⁵

Another barrier to physicians incorporating house calls programs into their practice is physician reliance on expensive and hard to transport office-based equipment in diagnosing and treating patients. Many physicians are uncomfortable with treating patients without the use of standard instruments and laboratory equipment found in most physician’s offices. However, advances in technology, such as the development and incorporation of miniature computers, cellular telephones, mobile imaging, portable electrocardiograms, pulse oximeters, mobile laboratories, and other point-of-service diagnostic devices into the house call visit, have decreased this technological barrier and extended the traditional limits of “black bag medicine” beyond the interview and skilled physical diagnosis.^{16,17}

Lastly, physicians practicing in a home setting are able to deliver a level of care that may not be possible in an office setting. One major advantage in practicing in the patient’s home is the ability to evaluate the patient’s living situation and identify environmental health risks, such as insufficient heating, pest infestation, and falling hazards. The visiting physician is also able to meet family members, neighbors, and other members of the caregiving team and evaluate the

social context to the patient's health¹⁸. In addition, house calls may increase overall patient satisfaction due to the increased convenience for the patient, especially low mobility patients who require special transportation arrangements if visiting the physician's office, as well as the decreased power differential between physicians and patients when physicians is received at the patient's home as a guest, versus the patient being a guest in the physician's office. These factors increase the attractiveness of the home care model for primary care physicians, especially family medicine physicians whose specialty has traditionally emphasized the social and environmental context of the patient's health status and illness experience. These family medicine physicians are filling the role historically held by general practitioners in patient homes and thus are leading the resurgence in house calls.

Comparing Physician House Calls & Home-Health Agencies

How are physician house call services different than home-health agency services? Generally speaking, home health agencies provide non-physician health services, including skilled nursing services, home-health aide services, physical therapy, speech-language pathology services, occupational therapy services, and medical social services.¹⁹ Typical skilled nursing services include wound care, patient education, medication management, catheter care, assessments of chronic disease stability, and other.²⁰ Typical physical therapy services include de-conditioning, limb pain treatment, gait abnormality, joint contractures prevention, training and assistance with transfers or fitting devices, and others.²¹ Home care agencies may also employ physicians to oversee care delivery.

Medicare eligibility rules for the two types of services differ. Medicare rules do not require that the patient be homebound to receive a home visit by a physician; the visit only needs to be "medically necessary".²² However, in order to qualify for home-health agency services, the

patient must 1) be confined to the home, and 2) require skilled nursing or therapy services.^{23,24}

Confinement to the home is defined by Medicare rules as “having a condition due to an illness or injury that restricts their ability to leave their place of residence, except with the aid of supportive devices, such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person or if leaving home is medically contraindicated.”²⁵

Medicare payment systems for the two types of services also differ. Physicians are reimbursed per patient visit and procedure performed. In contrast, home-health agencies receive a predetermined set payment amount from Medicare per patient and are expected to provide all required services for 60 days. Patients may be recertified for enrollment if they remain eligible for home health care at the end of the 60 day period, and continuous episode recertifications are permitted without limit.²⁶

Modern House Call Programs

Although physician house calls are an attractive, innovative method of health care delivery, the financial barriers to incorporating house calls into a physician’s practice can be significant. House call visits are time intensive. On average, house call visit lasts 30-45 minutes, which, when travel time is factored in, results in a 50-75% reduction in the number of patients the physician can see when compared to the same amount of time spent seeing patients in an office setting.²⁷ The decreased volume of patients per day translates into decreased payments and lost revenue. To compensate, cost cutting measures must be implemented in many areas to make the house calls financially feasible for the physician, including cutting overhead costs, minimizing staffing, increasing travel time efficiency, and incorporating billable procedures.

Many different models exist for how house calls are incorporated into the physician's practice. The traditional and most prevalent model is the incorporation of house call services into a pre-existing office-based practice. For example, a physician may reserve 1 half-day a week to visiting established patients who are homebound. In this model, the physician's office-based practice provides the financial stability needed to support the house calls portion of his practice, as well as provide laboratory and staffing support. On the other end of the spectrum, a physician may have a practice that is comprised exclusively of house calls. The physician may have an office that serves as the center of operations but does not provide any on-site medical care, or the physician may have no office site at all and instead work completely out of his or her vehicle. The latter model has the benefit of significantly decreasing overhead costs, but has the disadvantage of limiting the types of services the physician is able to offer.

House call programs may employ staffing in addition to the physician. Under Medicare rules, visits by nurse practitioners and physician's assistant are reimbursed at 85% of the allowed amount reimbursed for a physician house call.²⁸ Including these staff into the practice reduces the burden on the physician without excessively decreasing revenue. Because staffing is often minimal, physicians can also partner with home-health agencies to broaden the caregiving team, which may include home nurses, home-health aids, physical therapists, occupational therapists, dietitians, and social workers. Interactions and partnerships with home-health agencies and hospice professionals, such as certifying home care plans and providing oversight of patients receiving nursing and rehabilitation services, are billable to Medicare, making this an attractive option.^{29,30}

Other strategies to increase the financial feasibility of house call services include reducing inefficiency in the transit between patient homes, and incorporating billable procedures

into the physician's practice. Travel costs can be reduced by clustering patient visits by geographic area, stream-lining the travel route, and implementing electronic navigation devices.³¹ Procedures which are easy to perform in a home setting, such as wound debridement and joint injections, can also be incorporated to increase the practice's revenue stream.³²

Case Study: University Hospitals/Case Western Reserve University House Call Program

An example of an existing house call practice is the University Hospitals/Case Western Reserve University House Call Program, based in Cleveland, Ohio. University Hospitals of Cleveland (UH) is a large private teaching hospital affiliated with Case Western Reserve University (CWRU). The UH/CWRU Department of Family Medicine House Call program was launched in 2004 with a three-fold mission:

“To improve the health and well being of frailed (sic) and low-mobility older adults and their caregivers by providing excellent, family centered, home-based primary medical care;

“To enlighten the practice of home-based primary care through clinical research;

“And to educate residents and health professional students in the art, science, and potential benefits of health care in the home.”³³

The program was initiated to address the health needs of elderly, low-income, low-mobility individuals in the Cleveland community, many of whom have multiple physical and psychological chronic co-morbidities. The physician works closely with a nurse practitioner and coordinates care with home health companies and community aging agencies.³⁴ Each patient is assigned to a board-certified family physician and a nurse practitioner, and visits are typically 30-40 minutes long.³⁵ The program is based in the UH/CWRU Department of Family Medicine, which houses the offices of the physician, the nurse practitioner, and the program coordinator.

The program generates revenue through Medicare reimbursements and is financially supported by the larger hospital and research grants. Care is provided exclusively in the home setting, with no medical services provided in the office, which serves only as a center of operations. However, because the house call program is housed within the larger hospital system, the physician has access to hospital-based laboratory and imaging services. In addition, home care patients who require hospitalization or outpatient hospital services receive care at the main hospital, and care is coordinated with the house call physician.³⁶ Eligibility is limited to seniors who have limited mobility, agree to have a house call program physician and nurse practitioner as their primary care providers, are willing and able to assist in their care along with care givers, and are able to maintain a safe environment in their homes. For more information regarding the UH/CWRU House Call Program, visit the CWRU Department of Family Medicine website at <http://casemed.case.edu/dept/fammed/>.

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