For additional information about this and other USF GWEP offerings, email amaynard@health.usf.edu

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ABCs of Housecall Medicine: A Primer

Lucy Guerra MD MPH FACP FHM
Division Director, Internal Medicine
University of South Florida
Learning Objectives

- To understand why the housecalls are increasing in number as a form of patient care
- To understand the demographic population served by housecalls
- To understand the benefits of housecalls
- To understand the logistics of a housecall visit
Background
"Blast" from the Past….
Marcus Welby MD

- https://youtu.be/9YYTxUWHYOE
The Mission of House Calls

1. Improve the quality of life of homebound patients
2. Improve the quality of life of caregivers
3. Decrease health care costs by enabling patients to remain at home and avoid expensive emergency departments, hospitals and nursing homes

Three Reasons for the Decline of the House Call

1. Increased office/hospital based technology
2. Fear of increased liability
3. Financial disincentives
Dying Art?

- 1930 40% of patient encounters occurred in the home
- 1980 1% were house calls
Yet, Now it is the Fastest Growing Service Industry in US

- Since 1998 300% increase in home care employment
- Expenditures increased from $1 billion to $18 billion from 1980-1996
- >7 million individuals receive home care in the US
- For every patient >65 in a nursing home, 3 other similar patients are cared for at home
Why do Home Visits?
The Return of the House Call

Why?

- Demographics: Aging of Society
- Health Care Reform: The Affordable Care Act
  1. Readmission Reduction
  2. Accountable Care Organizations
  3. Independence at Home
- Medicare and Medicaid Fiscal Crisis
- Recent evidence of the value of house calls
The Need for Personal Assistance With Everyday Activities Increases With Age

Percentage of persons needing assistance with everyday activities, by age: 1990-91
(Civilian noninstitutional population)

- 85 and over: 50%
- 80-84: 31%
- 75-79: 20%
- 70-74: 11%
- 65-69: 9%
- 15-64: 2%

Exploding Homebound Population!
For half of the patients readmitted within 30 days, there was no bill for a physician visit during that time.
Doctor Reasons

- Feels good (1 study = 70% of the time JAGS 48:677-681)
- Comprehensive care
- Learn a lot that can’t be learned in the office (e.g. patient’s environment, support systems)
- Decrease excessive use of medical services
- Relationship building
- Assess adherence issues
- Cost containment - Less overhead
- Good PR for you
- Increase patient diversity
Patient Reasons

- Patients living longer and live at home longer
  - 13% of the U.S. is > 65, and by 2025 it will grow to 20%
  - 2030 >70 million US citizens will older than 65*
- Discharged from hospitals sooner
- Ease for patient (immobile, infirm)
  - 36% of 75-85 year olds can’t walk 1 block*
- Patients desire home care
- Technologies and therapies are available for home use

* Unwin AFP 2011;83(8):925-931
Technology is Not a Barrier

Liability is Not a Barrier
Medicare Part B billings

- 1999 1.4 million visits
- 2009 2.3 million visits
- Why?
- Change in regulations
- 50% increase in reimbursement rates
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Medicare House Call Codes/Payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1997 New</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99341</td>
<td>$62.51</td>
<td>99341 (20)</td>
<td>$57.53</td>
<td>$58.99</td>
<td>$27.95</td>
</tr>
<tr>
<td>99342</td>
<td>$77.71</td>
<td>99342 (30)</td>
<td>$77.58</td>
<td>$85.34</td>
<td>$37.40</td>
</tr>
<tr>
<td>99343</td>
<td>$101.62</td>
<td>99343 (45)</td>
<td>$110.19</td>
<td>$139.16</td>
<td>$54.90</td>
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<tr>
<td>99344¹</td>
<td></td>
<td>99344 (60)</td>
<td>$140.50</td>
<td>$193.94</td>
<td>$70.55</td>
</tr>
<tr>
<td>99345¹</td>
<td></td>
<td>99345 (75)</td>
<td>$166.24</td>
<td>$233.70</td>
<td>$85.55</td>
</tr>
<tr>
<td>1997 Estab.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>99351</td>
<td>$46.66</td>
<td>99347 (15)</td>
<td>$45.43</td>
<td>$59.39</td>
<td>$24.25</td>
</tr>
<tr>
<td>99352</td>
<td>$59.37</td>
<td>99348 (25)</td>
<td>$65.54</td>
<td>$89.64</td>
<td>$31.30</td>
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<tr>
<td>99353</td>
<td>$74.80</td>
<td>99349 (40)</td>
<td>$94.92</td>
<td>$135.18</td>
<td>$47.50</td>
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<tr>
<td></td>
<td></td>
<td>99350 (60)</td>
<td>$136.00</td>
<td>$189.15</td>
<td>$68.85</td>
</tr>
</tbody>
</table>
What is “home” to you? To others?
What is a Home?

- Home!
- Nursing home
- Group home
- Independent living home
- Assisted living home
- Family member’s home
- Visiting family member
Types of Housecalls: Three examples

- Protocol phone triage
- Care coordination
- Mixed model
Other examples of telehealth:

<table>
<thead>
<tr>
<th>Site</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Cost/Savings</th>
<th>comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners Healthcare</td>
<td>CHF hospital f/u</td>
<td>51% reduction in readmission</td>
<td>net savings: $8,155 per patient</td>
<td>Increased patient independence</td>
</tr>
<tr>
<td>Centura Health</td>
<td>All admissions</td>
<td>62% reduction in readmission</td>
<td>Savings about $1500 per patient</td>
<td></td>
</tr>
<tr>
<td>CMS pilot (1700pts)</td>
<td>Disease specific (DM, COPD, CHF)</td>
<td>Claims billing</td>
<td>Savings of 7-15% pppy</td>
<td>Cost about $120/mth</td>
</tr>
</tbody>
</table>

A. Broderick and D. Lindeman, Scaling Telehealth Programs: Lessons from Early Adopters, The Commonwealth Fund, January 2013

B. Integrated Telehealth And Care Management Program For Medicare Beneficiaries With Chronic Disease Linked To Savings Laurence C. Baker et al Health Affairs September 2011 30:91689-1697
# Telephone triage: Safety and outcomes

<table>
<thead>
<tr>
<th>Data</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochrane review 2009</td>
<td>- Phone triage decreases need for visit without increasing ED use</td>
</tr>
<tr>
<td>NHS (National Health Service)</td>
<td>-- safe</td>
</tr>
<tr>
<td></td>
<td>-- may reduce ED use</td>
</tr>
<tr>
<td></td>
<td>-- reduces cost (usually through decreasing doctor visit)</td>
</tr>
</tbody>
</table>

Telephone consultation and triage: effects on health care use and patient satisfaction (Review) : Copyright © 2009 The Cochrane Collaboration. Published by JohnWiley & Sons, Ltd.
Who?
Who?

“Homebound” Status

- Do not have to be bedridden
- Need intermittent skilled nursing, PT, OT
- Inability to leave home or leaving home requires a considerable effort
  - Wheelchair, walker
  - Blind
  - Demented
  - Post hospital stay – still debilitated
  - Psych illness
  - Can’t leave home without assistance
  - Medical contraindication to leave home
Homebound patients

- Can leave home to:
  - Visit the doctor
  - Go to church
  - Attend adult day care
  - Go to family event
  - A haircut
  - Walk around the block
What to do during the visit?
Home Visit Assignment

- Select a patient
- Set up visit
- Perform visit
- Dictate note including function, safety, other aspects of contextual visit
- Highlight goal setting with patient
- Companion (short) essay:
  What did you learn that you could not learn in the office?
  How will you now care differently for your patient
  Write about one (or more!) success you had during the visit
What to do

- I – Immobility
- N – Nutrition
- H – Housing
- O – Other people
- M - Medications
- E – Examination
- S – Safety
- S – Spiritual Health
- S - Services

**Function**

- ADLs, IADLs
- Fall prevention
- Cognitive
- Psychosocial
- Nutrition
Who else can help?

- Family members
- Office nurse
- Visiting nurse
- Social worker
- OT/PT
- PharmD
- Geriatrician or FP interested in Geriatrics
- Psychologist/Behavioral Health
- Chaplain
- Hospice team member
- Elder services
- “Good old days” health care was not a ‘team sport’: there was one all-knowing doctor who lived in the town, did house calls and was on call 24/7.
Why Team Based Care?

- Today, a driving force behind health care practitioners’ transition from being soloists to heading a health care team, is the complexity of modern health care: U.S. National Guideline Clearinghouse now lists over 2,700 clinical practice guidelines.
# What to take “Black Bag”

- Stethoscope
- Oto/ophthalmoscope
- BP cuff (many sizes)
- Thermometer
- Tongue depressor
- Sterile cups
- Dipsticks/guaiac cards
- Lubricant
- Latex gloves
- Tape measure
- Reflex hammer
- Suture kit materials
- Sharps container

- Scissors
- Toe nail clippers
- Scale
- Med samples/vaccines
- Peak flow
- Glucometer
- Cellphone

**Optional**
- Pulse oximeter
- EKG machine
- Nebulizer
Issues?

- Poor nutrition
- Immobility
- Infection
- Contractures
- Little to no supports
- Anything else?
Certification/Recertification

- **Document:**
  - Sign “Home Health Certification and Plan of Care”
  - Agree that skilled services are needed
  - Attest patient is homebound
  - Must see patient within 60 days then q 6 months
  - Consider brief note in chart
More on billing

- **Office**
  - Established patient
    - 99213 = $121
    - 99214 = $181
    - Preventive Care
      - 40-64 y/o = $266

  1 hour = $568

- **Home**
  - New Patient
    - 99342 $78
    - 99343 $126
    - 99344 $165
  - Established patient
    - 99348 = $79 (145)
    - 99349 = $115 (229)
    - 99350 = $160

  1 hour = $374
Effectiveness of Home Care
Improvement in Care – Level B evidence

- Home assessment of healthy elderly patients found 4 new medical problems and 8 new health related recommendations
  
  Ramsdell et al, J Am Geriatric Soc 1989

- Home visits have been found to reduce mortality, re-hospitalizations, and nursing home admissions

  Bouman A et al, BMC Health Serv Res 2008
  Stuck AE et al, JAMA 2002
  Elkan R et al BMJ 2001
  Levine SA, et al JAMA 2003
Prevention

- Home preventive visits:
  - delay the onset of disability
  - improve accuracy of medical information

*J Am Geriatr Soc 1999*

*J Gen Intern Med 2001*
# End-of-Life Care

<table>
<thead>
<tr>
<th>HomeCare Physicians Patient Deaths 2003-2013</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2049</td>
<td>100%</td>
</tr>
<tr>
<td>Home</td>
<td>1,521</td>
<td>74%</td>
</tr>
<tr>
<td>Hospital</td>
<td>389</td>
<td>19%</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>102</td>
<td>5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>37</td>
<td>2%</td>
</tr>
</tbody>
</table>
HomeCare Physicians and End-of-Life Care

- 9/1/12-8/31/13 215 deaths
  - 79% died at home
  - 71% where on hospice
  - Average length of stay 2.1 years
  - Median length of stay 0.56 years
  - 25 died in first 30 days
    - 23 (92%) died at home

- 25.1% of the $556 billion Medicare dollars goes to care in last year of life

- Riley, Lubitz; *Health Services Research* 4/2010
Home care medicine in America

Since 1984, the American Academy of Home Care Physicians has served the needs of thousands of physicians, other providers and agencies interested in improving the medical care of patients in the home. Click here to learn more about AAHCP.
References/Acknowledgements

- Unwin BK, Tatum PE. House Calls. AFP 2011;83(8):925-931.
GOD BLESS OUR HOME