THE WALL STREET JOURNAL.
WSJ.com

THE INFORMED PATIENT | February 4, 2013, 6:54 p.m. ET

Hospitals Try House Calls to Cut Costs, Admissions

By LAURA LANDRO

To keep patients out of the hospital, health-care providers are bringing back revamped versions of a time-honored practice: the house call.

In addition to a growing number of doctors treating frail patients at home, insurers and health systems are sending teams of doctors, nurses, physician assistants and pharmacists into homes to monitor patients, administer treatments, ensure medications are being taken properly and assess risks for everything from falling in the shower to family care-giver burnout. Some are adopting programs called "Hospital at Home" to provide hospital-level care in the home, including portable lab tests, ultrasounds, X-rays and electrocardiograms.

Rubén E Reyes for the Wall Street Journal.

A home-care program paired Verne Wisby, left, who suffers from chronic pain and lung disease, with care-transitions nurse Pamela Sevrence, right.

In large part, the aim is to avoid new financial penalties from the Centers for Medicare & Medicaid Services. Last October, the federal government agency started withholding certain payments to hospitals with higher-than-predicted readmission rates for patients with heart attacks, congestive heart failure and pneumonia. Nearly a fifth of its beneficiaries end up back in the hospital within 30 days, according to Medicare, costing $26 billion annually.

But there is also growing pressure to keep patients from being admitted to the hospital in the first place, especially if they have chronic disease. Such patients, particularly older ones, are more vulnerable to infections and complications like bed sores in the hospital, and are actually safer at home, experts say.

"People may think of the house call as this quaint idea of a doctor heading out in his horse and buggy, but it is an excellent and necessary model for taking care of vulnerable high-cost patients," says Bruce Leff, a professor of medicine at Johns Hopkins University School of Medicine who developed the Hospital at Home model and is president of the American Academy of Home Care Physicians.

Payment models vary. Private insurers who contract with Medicare to offer benefits through Medicare Advantage plans may offer home-based care after hospital discharge. The Veterans Administration has a home-based primary-care program for chronically ill veterans, and some VA centers run Hospital at Home programs. Medicare has also been reimbursing a growing number of physician house calls for fee-for-service beneficiaries and covers a few other home services after hospital discharge. Last year, Medicare began a three-year demonstration project called Independence at Home to test whether home-based care by teams of doctors, nurses and other clinicians can reduce the need for hospitalization, improve patient and caregiver satisfaction and lower costs.

Existing research on house-call programs point to their benefits. A study published last June in Health Affairs showed that costs for patients in a Hospital at Home program at Albuquerque, N.M.-based Presbyterian Healthcare Services were 19% lower than for similar inpatients, in part because of shorter stays, and fewer lab and diagnostic tests. Patients with conditions including pneumonia, congestive heart failure and urinary-tract infections who are sick enough to require hospitalization and live within 25 miles are "admitted" in their home. They are then visited daily by a physician and once or twice daily by nurses who administer infusions and perform routine lab tests and procedures.

Inside a House Call

With 'Hospital at Home' programs, doctors, nurses and pharmacists provide a range of medical care at patients' own residences. Below are a few examples of what they do:

Give medication: Administer everything from intravenous antibiotics and diuretics to inhaled treatments for pneumonia or lung disease.

Monitor medicines: Show patients and families how to administer medicines properly; ensure prescriptions are correct and up to date; check what's in the medicine cabinet for any drug interactions; explain any side effects.

Assess the home: Evaluate how at risk patients are for falls; judge whether they need any special equipment.

Care for the caregiver: Instruct family caregivers on how to look after patients; address caregiver concerns such as burnout with referrals to counseling or community groups; refer

Patient satisfaction scores were also higher. "Patients who have been in the hospital multiple times realize it is not always the healthiest place for them and they are thrilled to be at home instead," says Melanie Van Amsterdam, lead physician for the Presbyterian program and a co-author of the study. They also get more time with doctors, who might spend two hours on an initial visit compared with as little as 10 minutes in the hospital, Dr. Van Amsterdam says.

Mercy Health, a not-for-profit health system in Cincinnati, Ohio that owns six hospitals, was able to reduce its 30-day readmission rate to 14.5% as of November,

caregivers for financial assistance; watch out for possible neglect or abuse.

Conduct diagnostic tests: Take X-rays, ultrasounds and electrocardiograms to track recovery and monitor symptoms.

Dress wounds, other care: Change dressings and keep an eye on bed sores and surgical incisions for infection; elevate extremities for problems such as cellulitis (a skin infection causing inflammation); adjust urinary catheters as needed.

Manage pain: Consult with patients on pain levels; prescribe medications; refer patients to pain specialists where necessary.

Monitor vital signs, such as weight and blood pressure.

Improve lifestyle: Help patients boost their overall well-being, e.g. quit smoking, exercise regularly, lose weight, keep up with physical therapy programs.

from 16.9% in 2011, with a Care Transitions program that assigns nurses to high-risk patients to keep them out of the hospital.

Verne Wisby, 68, suffers from chronic obstructive pulmonary disease, a lung disease linked to smoking that can cause respiratory infections and breathing trouble. He also has arthritis and chronic pain from a childhood auto accident that broke his legs and hips and crushed his pelvis. He was admitted to the hospital last April after he came to the ER with a flare-up of his COPD, but within a month of his release, he was readmitted for a seizure.

At discharge, Mercy paired him with transitional care nurse Pamela Sevrence. On her first visit to his home, he was feeling so discouraged by his many medical problems, they both recall, he told her, "I'm just going to sit here till I die."

Ms. Sevrence worked with him to quit smoking within 30 days, and instructed Mr. Wisby and his wife Bonnie in the use of oxygen and medications to avoid flare-ups in his lungs. She also fielded calls from Mrs. Wisby whenever a problem came up. Ms. Sevrence lined up a new primary care doctor and a neurologist, as well as a pain specialist.

"She gave me hope, encouragement, and support," says Mr. Wisby. "I have no plan to go back in the hospital."

Health plans are also using claims data to identify patients at high risk for rehospitalization and helping coordinate care at home "so patients don't slide back," says Karen Ignagni, chief executive of America's Health Insurance Plans, an industry association.

For example, insurer Aetna is contracting with home health agencies to expand a transitional care program for customers of its Medicare Advantage plan in a number of communities around the country. A pilot for the program reduced readmissions by 20% and saved $439 per member. "It is costly to send nurses into the home, but not nearly as costly as readmissions," says Aetna national medical director Randall Krakauer.

Cigna Medical Group, the medical practice unit of Cigna HealthCare of Arizona, with 25 health centers in the Phoenix area, has a Home-Based Care Team that includes

nurse practitioners and physician assistants. Robert Flores, the group's medical director of population health management, says primary care physicians use the team to help them manage patients at high risk of hospitalization or re-hospitalization who can't easily get to a doctor's office. "We have lots of patients who would have undoubtedly ended up back in the hospital had the team not been in their homes," Dr. Flores says.

The home team has helped Sandi Roland of Mesa, Ariz., care for her 84-year-old father, Charles Wilburn, who came out of a six-week hospital stay two years ago for multiple health problems. Ms. Roland says complications from that hospital stint left him in worse shape than when he was first admitted. A nurse practitioner came regularly at first to help with bed sores, and check his blood and lungs, and a physical therapist helped with rehabilitation.

"For me as a caregiver, it gives me so much support and puts me at ease that if things were to go wrong I would call and they would come at any time," Ms. Roland says. The nurse still follows up with a call every six weeks and her father has not returned to the hospital.

Write to Laura Landro at laura.landro@wsj.com

A version of this article appeared February 5, 2013, on page D1 in the U.S. edition of The Wall Street Journal, with the headline: Hospitals Try House Calls To Cut Costs, Admissions.