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Trying out a new Medicare concept: House calls

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In Penn's program, which was selected to participate in the Medicare experiment, physician Bruce Kinosian (right), visits patient James Singleton, 81, at his West Philadelphia home. (CHARLES FOX / Staff Photographer)

GALLERY: Nurse practitioner Jean Yudin, of Penn's Schnabel...

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By Curtis Skinner, Inquirer Staff Writer

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David Carolina, 76, was rushed to the emergency room and admitted five times in the first 10 months of last year - four times in a two-month span - with heart and respiratory failure and flare-ups of gout. He is morbidly obese and has diabetes, sleep apnea, and chronic obstructive pulmonary disease.

Carolina is a very sick man. But he's happy.

Since October, his poor health has qualified him for a new government experiment involving an old idea: His doctors make house calls.

In the last 10 months, an ER visit led to a hospital admission only once. And despite limited mobility, he can now - with the help of a new lift installed on his porch - make it to his weekly Saturday night poker games.

"I was going and seeing maybe four or five doctors before," Carolina said the other day in the living room of his West Philadelphia home. "And now they come here. It's much easier for me."

The program - called Independence at Home - is part of Obamacare. It provides incentives for selected primary-care providers who are able to save money by making time-consuming home visits to medically complex patients. These patients are often in such serious condition that they find it difficult, if not impossible, to get to scheduled appointments. As a result, they may put off needed treatment until an emergency lands them in an expensive hospital bed.

House calls were long the main point of contact between patients and doctors. But in recent decades, low reimbursement rates, among other things, have encouraged physicians to maintain high-volume offices, making house calls hard to squeeze in. Very ill patients sometimes fall through the cracks.

The cost to the government for these gaps in treatment are huge. In 2010, Medicare paid more than three times more for beneficiaries with six or more chronic conditions than for the average recipient. As a group, they made up 14 percent of the total Medicare population, but accounted for almost half the total spending.

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For its home-visit experiment, the Centers for Medicare and Medicaid Services contracted with 20 providers or groups nationwide with up to 10,000 of Medicare's sickest patients. The idea is that encouraging providers to invest up front in house calls and other home services that don't generate extra revenue will improve care and avert more expensive treatments down the road.

If the participating practices hit quality benchmarks and consistently save money, they share those savings with the government. That's the incentive. If they don't meet the benchmarks and consistently save money, they're out.

"It's a good example of cost containment and quality," said Rep. Allyson Schwartz (D., Pa.), who recently sponsored a bill that would begin to convert Medicare from traditional fee-for-every-service model and toward new payment scenarios like Independence at Home.

A Republican-sponsored bill based on some of the same principles recently made it out of the House Energy and Commerce Committee. The Republican bill doesn't cite home-based primary care specifically, but Schwartz is hopeful that its passage shows there is support for the concept.

Obamacare already authorizes the secretary of the Department of Health and Human Services to expand the project if it is shown to improve quality at the same or lower cost, or to lower costs with the same or better outcomes.

The University of Pennsylvania's Schnabel In-Home Primary Care Program is part of a Mid-Atlantic partnership that was chosen last year as one of the 20 experiments nationwide. Schnabel has been making house calls for two decades, and currently serves about 200 patients, largely in West Philadelphia. About 50 of them are in the demonstration project; most are older than 80 and eligible for both Medicare and Medicaid, due to their age and income.

The patients are visited every six weeks - more often if there is a problem - by one of the four physicians or two nurse practitioners who make house calls. The team includes social workers, home health aides, and registered nurses, and can link patients with specialists to perform tests, such as echocardiograms, in the home. Aides and registered nurses see patients more frequently, sometimes daily.

While these services might seem to be expensive, the Penn program's internal analysis showed nearly a 50 percent reduction in Medicare costs compared to a control group, said Bruce Kinosian, one of the physicians.

Kinosian spends a half day a week making house calls, about 20 in a month. On a recent visit to Carolina's West Philadelphia home, he noticed water buildup in the man's lungs and an eight-pound weight gain literally overnight (another member of the team had weighed him the night before).

The doctor rifled through the cupboards.

"What did you have for dinner last night?" he asked. "Not any of this Rice-A-Roni, right? Since we've talked about your salt intake. . . ."

Before leaving, Kinosian prescribed an extra diuretic to remove excess water - one of 15 pills Carolina takes daily.

Performance figures for the national experiment aren't available yet. But similar programs across the country might hold clues.

Hospital administrators participating in what are called Accountable Care Organizations - another government initiative that changes the model of care to hold providers accountable for patients' health, rather than simply paying for each service - have raved about house calls as cost savers.

The visiting physicians "made a very significant contribution to our overall savings, for which we are very pleased," said Stuart Lockman, president of the Michigan Pioneer ACO.

Still, evidence on cost-effectiveness is, for now at least, mixed. While some studies of Veterans Administration home-care programs have shown savings, for example, a randomized study of 16 VA programs published seemingly opposite findings in a 2000 paper in the Journal of the American Medical Association.

It showed better patient and caregiver satisfaction for nonterminal patients, as well as better general health and mental health for terminal participants, compared to those getting traditional care in the VA or private sector. But it came at a price: a 12.1 percent higher average cost after one year.

"A lot of these programs provide access to people who don't have access to good primary care. And providing access can show a blip in cost early on," said Bruce Leff, associate director of the Johns Hopkins University School of Medicine's Elder House Call Program and president of the American Academy of Home Care Physicians.

He added that two larger, more definitive studies recently showed savings, and predicted that data from the current Independence at Home experiment would bolster findings of cost reductions.

David Carolina is happy just to be healthier than he was a year ago.

"This is my home. I've been here for 50 years," Carolina said. "All I can say is the whole program is very good for me."

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