House Call Logistics

1. Formulating a Business Plan

1. Mission and Vision (Example)
   i. Mission: HomeCare Physicians’ mission is to provide compassionate, comprehensive, state-of-the-art medical house calls to improve the quality of life of homebound patients and their caregivers while reducing costs by enabling patients to age in place and avoid costly hospitalizations and nursing home placements.
   ii. Vision (2002): HomeCare Physicians’ vision is to replicate the highest quality house call medicine across the country.

2. Product
   i. Urgent Care / Chronic Care / Transitional / Teaching
   ii. Non-Profit vs. For Profit
   iii. Fundraising/Grants
   iv. Independent /Affiliated
   v. Benefits to house call program
   vi. Support Services: Operations; Legal; Financial; HR
   vii. Physician phone consults
   viii. Benefits to health system
   ix. Public relations
   x. Downstream Revenue (Referrals, home health / hospice, ancillaries)
   xi. Cost avoidance (30 day readmissions, at-risk contracts, uninsured)
   xii. Decreased hospital mortality

3. Regulatory Requirements (examples)
   i. There must be a medically necessary reason for the house call but the patient does NOT need to be homebound. Specifically, the patient does not need to meet Medicare’s definition of homebound where it must take a “taxing” effort to leave the home and leaving home is infrequent. The patient can leave the home for adult day care, church, doctor visits, etc. For Medicare certified home health they must meet the definition.
   ii. The reason for the house call must be documented at every visit.
4. Market Analysis
   i. Market Demand
      1. 8% ≥ 65 y/o need assistance with ≥ 3 ADLs (3-4 ADL deficits = 5%; 5-6 ADL deficiencies = 3%; Total 8%)
         http://www.agingstats.gov/Main_Site/Data/2012_Documents/Health_Status.aspx
      2. One doctor 300 patients, Nurse Practitioner/Physician Assistant 200 patients
      3. “Competition”: Can use for referrals outside your service area

5. Management Team

6. SWOT Analysis
   i. Strengths
   ii. Weakness
   iii. Opportunities
      1. Impact families/patients/caregivers/communities
      2. Economic: Readmission reduction, ACOs, At-risk contracts
      3. Teaching
      4. Research
      5. Public relations
   iv. Threats: Community Physician perceived threat/fears; provider supply;

7. Finances (Revenues/Costs)
   i. Revenues
      1. Medicare/Medicaid/Insurance
      2. Medical Directorships of ALFs, Home Health, Hospice
      3. Health System Support
      4. Philanthropy/Grants
   ii. Costs
      1. Providers (Physician/NP/PA)
      2. MSW??
      3. 0.5 FTE per RN per 1 FTE Physician/0.2 RN per NP/PA
      4. 1 FTE Office person per fulltime provider
      5. Supplies/Point of Care Testing
      6. Purchase care vs. pay mileage

2. House Call Program Logistics: Initial Considerations
   i. Geography
   ii. Time allocation (Full-time/Part-time)
   iii. Established patients only vs. New patients
   iv. Medical assistants vs. on own
   v. Teaching

3. House Call Program Logistics: Preparation
1. Identify patients in advance
2. Marketing/Community Education (IAHCC can help):
   i. Home health and hospice agencies
   ii. Area Agency on Aging / Social service agencies (e.g. Meals on Wheels)
   iii. Physicians
   iv. Hospital discharge planners
   v. Networking organizations (Geriatric Case Managers)
   vi. Ask all the above whom to contact
3. Learn about community/ancillary resources
   i. Home Health Agencies and Hospices (they are great resource to learn about the following)
   ii. Durable medical equipment companies
   iii. Other professionals that make house calls (dentist, podiatrist, audiologist, optometrist, beautician)
   iv. Phlebotomy, X-ray, Ultrasound, Pharmacy delivery
   v. Area Agency on Aging (meals on wheels, homemaker services, ramps, public aide assistance, utility assistance, respite programs, etc.)
   vi. Social Services
4. House Call Program Logistics: Staffing
   1. Program Coordinator
      i. Main contact with homebound patients
      ii. Schedules patients in close proximity
      iii. Facilitates house call efficiency (gathers information prior to visit, sends out advance packet, communicates any special needs)
      iv. Orders home health and outpatient testing
      v. Fills out durable medical equipment (DME) forms and refills medications
   2. Medical Assistance (accompany provider on house call—most programs do not have for financial reasons)
      i. Maps out patients and determines route, times appointments and calls patients 1-2 days in advance
      ii. Drives team to house calls (GPS)
      iii. Assists doctor with house calls by taking vitals, drawing blood, vaccinations, performing ancillary tests, paperwork
      iv. Orders/Restocks supplies at end of day
      v. Maintains cars
      vi. Assists in office with calls, faxing, scanning
   3. Making the House Call
      i. Patients/families called two days in advance and given a 2 hour window visit time and any special instructions for the visit (meds out, fast, etc.)
      ii. Map in every chart or global positioning system
      iii. Black bag: see handout
iv. Duplicate instruction sheet— copy given to patient, original faxed to home health agency
v. Patients are given a follow up time frame (e.g. 4-6 weeks, 3-4 months) which allows flexibility to schedule patients in geographic proximity
vi. Blood drawn is spun en route to the next patient
vii. Calls can be made in the car to home health personnel or to the next patient to begin history taking
viii. Restocking is critical at the end of the day so all needed supplies are available for the next day’s house calls (does not matter how well stocked office is!)

4. Billing
i. Billing is done similarly to office visits using the house call EM codes and is based on the level of history, physical exam and medical decision making
ii. When more than 50% of face to face time is spent in health related counseling, total time can be used to determine the code
iii. The prolonged service code (99354) is used when total face to face time is >30 minutes over the expected code time (usually when dealing with end-of-life discussions)
iv. The place of service code for house calls is 12 for house calls and 13 for assisted living facilities

5. Information to track:
   i. Sex, Age, Caregivers, ADL deficiencies, Length of stay, reason for discharge (better, moved away, nursing home, death)
   ii. Patient and Family/Caregiver satisfaction
   iii. Hospitalizations/Prevented Hospitalizations (difficult to track-mostly anecdotal)
   iv. Home Health and Hospice Referrals
   v. Death: Place (Home, Hospital, Nursing Home), percent on hospice and length of stay

6. Forms (Examples):
   i. Medical history:
      http://www.homecarephysicians.org/Downloads/Forms/MedicalHistory%20revised%20June%202012.pdf
   ii. Intake:
      http://www.homecarephysicians.org/Downloads/Forms/PtIntakeFormrevised%206-9-11.pdf
   iii. Medical Records Release:
      http://www.homecarephysicians.org/Downloads/Forms/Authorization%20to%20release%20medical%20information%206-28-12x.pdf
   iv. Communication Choices (who can leave medical information with):
v. Consent for Treatment/Acknowledgement of Receipt of Privacy
   Notice/Assignment of Benefits/Authorization to Disclose Medical Information
   for Payment/Payment Agreement:

7. Other Resources:
   i. American Academy of Home Care Medicine (AAHCM) www.aahcm.org
   ii. Making Home Care Work in a Medical Practice (AAHCM)
   iii. Making House Calls a Part of Your Practice (AAHCM)

8. Patient Assistance Fund: Fundraise to pay for medical needs patients cannot afford

9. House Call Teaching Points
   i. Better care for homebound patients and caregivers
   ii. Functional, environmental, psychological, cognitive and nutritional assessments
       (e.g. refrigerator Bx)
   iii. Resources available for homebound patients and their caregivers
       (Multidisciplinary Team)
       1. Federal (Medicare home health, hospice, DME)
       2. State (AAA, meals on wheels, homemaker services, respite, home
          maintenance (ramps, grab bars), Emergency Response System)
       3. Audiologists, dentists, podiatrists, optometrists, beauticians
   iv. Importance of transitions of care/hospital discharge instructions
   v. End-of-life care
   vi. Cost-avoidance: Reducing polypharmacy, decreasing acute care needs and
       nursing home placement