



**American  
Academy of  
Home Care  
Physicians**



## **A Policy Brief from the American Academy of Home Care Physicians**

### **Your Readmissions Reduction Program: Is Medical House Call Transitional Care The Missing Link?**

You know your hospital statistics. Are you higher or lower than the 20% national average? You know your objectives in relationship to the Medicare financial penalty due to start in 2013.

You know that the factors associated with readmissions include the presence of two or more chronic conditions, patient (and physician) confusion about what medications to take at home, ineffective patient and caregiver education, lack of communication between the hospital and ambulatory care settings, lack of timely post-acute follow-up with primary care providers, poor or absent support system and home, lack of transportation, poverty and psychiatric illness.

You may have tried a variety of programs, sometimes at considerable hospital expense. Perhaps you have redesigned inpatient processes to improve the discharge process, or adopted a formal care transition program following the Eric Coleman model. However, despite the fact that you know that there is no one predictive model for hospital readmission, you do know that these programs have not been successful with the sickest, most vulnerable elderly patients. These patients are “frequent flyers” in your ER, with readmissions numbering three or more in any given year.

These patients often “fail” traditional programs. Access to physician office care is too difficult and cognitive impairment prevents education and compliance. Their family caregivers do not know who and when to call as the first change of condition occurs, so they call 911 and the cycle starts again. To care for these patients, you need to consider adding the missing element: co-management with a medical house call provider on a transitional basis, with an option of permanent care.

While physician, NP and PA practices and teams do not exist in all communities, they can be found in many communities in private practice, or as salaried parts of integrated health systems and academic medical centers. Importantly, these providers can not only take care of beneficiaries in the community as they do today, they can also become a vital part of your readmissions strategy. The results from existing programs show significant results ranging from 6 percent to as much as 95% reduction in readmissions.

Best of all, these programs can be flexibly tailored to meet the needs of the hospital. Medical house call providers can lead your entire multi-part readmission program connecting all the dots, or take care only of a targeted group of patients.

And, if private practice provider teams are used, the direct cost to the hospital may be relatively low, depending on the scope of service desired. Also, managed care may cover some or all of the incremental costs. Secondary benefits such as reduction in length of stay and hospital associated complications are not uncommon. In fact, you may be able to facilitate contracts with managed care or grants from CMS that could completely fund the required support. For more information, go to [www.aahcp.org](http://www.aahcp.org) or call Constance Row, Executive Director at 410-676-7966. The attachment gives examples of existing programs.

## **Sample Readmissions Reduction Programs Using Medical House Calls to Provide In-home Primary Care**

### **1. Kevin Jackson, MD. Private Practice, Phoenix, Arizona**

In his IPC managed care program, Dr. Jackson's team of house call providers provides 24 hour response time for patients who will not last a weekend without being readmitted. The results—readmissions for his program are about half that of the hospital average—7.5% versus 14%. He is paid a negotiated rate by managed care for these services.

### **2. David Jones, MD. Private Practice, Palo Alto, California**

Dr. Jones is part of a grant-supported transitional care program providing service to a community hospital in which the patients are seen by a physician prior to discharge, within 48 hours of discharge, and then in a transitional care program usually lasting 30 days after discharge. Permission to enroll patients prior to enrollment is obtained from primary care providers, and care is transitioned back to these providers when appropriate. His program has reduced readmissions for this group of the sickest patients to 14% on a 30-day basis.

### **3. Ina Li, MD Christiana Health Care System, Integrated Health Care System, Wilmington, Delaware**

Dr. Li operates both a House Calls program and a program called Bridge aimed at bridging the gap for the frail elderly during transitions of care. The Bridge program is designed to improve transitions of care for geriatric patients who have been hospitalized three or more times in the past year. An intensive nurse practitioner home visit is provided within 24-48 hours post discharge with follow-up visits until the patient can safely be discharged back to the primary care provider or incorporated into the house call program. A social work referral is also provided if needed. After enrollment in the program, Bridge patients decreased their number of ED visits by more than 50%, and readmissions were reduced to 50% lower than a matched comparison group. Also, median LOS was one day lower for the Bridge group than the non-Bridge comparison group. Like other house calls programs, the longitudinal house calls program also shows a marked impact on readmissions. Thirty-day ED visits and inpatient admissions were reduced by 26% and 34% respectively. Reduction in LOS was also noted.

### **4. Yale Sage, President, American Physician House Calls, Transitional Care Program Dallas, Texas**

Mr. Sage's medical house call company provides a transitional care program is currently serving 11 hospitals in the Dallas/Fort Worth area, serving principally the low-income, dual eligible population reflecting an average age of 76, with four chronic conditions, two co-morbidities, and difficulties with ADL's. In this 60-day program, patients are referred at discharge, admitted to the practice, and a physician conducts an initial assessment within 24 hours. A combination of clinical care and case management is provided, including coordination of needed social service supports. Payment is through capitation with several insurers. Two outcome studies have been conducted. In the first, a 65% reduction in readmissions was recorded; in the second, a 95% reduction was recorded.

5. Mike Tudeen, President, INSPIRIS, Managed Care, Brentwood, Tennessee

Mr. Tudeen's company, INSPIRIS, is part of United Health Care. One division provides a house call program called Transitions which bridges the gaps in care between the acute facility, skilled facility, and home. The impact on readmissions has been marked. Whereas, the average Medicare Advantage plan reflects a 21% readmission rate, patients in the INSPIRIS Transition Program reflect a 13.9% readmission rate.

6. Peter A. Boling, MD, Virginia Commonwealth University, Academic Medical Center, Richmond, VA

Dr. Boling's academic medical center has the longest experience—25 years—of any of the programs, operating a house calls program and a Mary Naylor-model Transitional Care Program. The house calls program is comprehensive, offering medical as well as social service support with a home-based primary care team offering a continuum of care including office, inpatient consults, house calls, transitional care, nursing home and PACE, all subsidized by the medical center. Their house calls program reduces readmissions rates by about half of the hospital rate. It reduces hospital LOS by 2.5 days. They find that many Transitional Care patients need house calls as more than 50% cannot go back to clinic based care. Thus, they believe that medical house call programs are essential for the sickest 3-5% of patients which represent 30% of insurer's costs, and that such programs reduce readmission rates by half.

7. Theresa Soriano, MD, Mount Sinai, Academic Medical Center, New York, NY

Dr. Soriano's medical center operates a variety of readmissions reductions programs, and Dr. Soriano has recently been asked to bring her medical house call expertise to optimize the Preventable Admissions Care Team (PACT) clinic, an NP and SW primary care clinic which includes home visits as needed to provide intensive primary care to the health system's highest risk patients. This program, in addition to the large house calls program (Visiting Doctors), serve as major components of multiple programs being leveraged to strengthen the overall quality and utilization statistics for patients of the medical center which has applied for ACO status. Mount Sinai's PACT program has reduced readmissions by 43% and emergency department visits by 70% for the patients served. And patients receiving home-based primary care through the Visiting Doctors program are admitted half as often after enrollment as compared to prior to Visiting Doctors program enrollment.