Home-Based Primary Care:
An Innovative Practice Model For Reducing Costs and Improving Quality of Care

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"Better care at lower cost" has been the mantra of the health care industry for decades. The case for delivering high-value care has gained greater cachet over the past decade [1, 2], with added impetus from the Patient Protection and Affordable Care Act of 2010 and the ensuing creation of the Center for Medicare and Medicaid Innovation [3]. But the transformation to higher-value care has been hampered by a paucity of practice models offering a suitable operational framework for such care and by the absence of payment arrangements that create compelling incentives for clinicians to practice parsimoniously [4].

Doctors Making Housecalls (DMH) is a private medical group that has pioneered the innovative practice model formally known as home-based primary care. Encompassing the greater Triangle, Triad, and Charlotte areas, this growing practice specializes in caring for frail, elderly patients with complex needs—the 5% of Medicare beneficiaries who account for more than 50% of Medicare expenditures. DMH's staff of 45 full-time clinicians includes primary care physicians, physician assistants, and nurse practitioners who make roughly 65,000 home visits a year; each clinician cares for a panel of 150 to 200 patients. Twenty percent of the practice's patients live in private residences, and 80% live in assisted living communities where the practice provides onsite care to residents who choose DMH clinicians as their primary care providers.

DMH currently serves over 115 assisted living communities throughout the state. Its rapid growth within such facilities has occurred in part because comprehensive onsite medical care improves the health of residents and allows them to age in place with as much dignity and independence as possible; as such, it postpones or eliminates the need for transfer to a nursing home. For facilities, onsite care reduces the cost of transporting residents to physician offices, and it eliminates the need for facility personnel to get orders and approvals from offsite clinicians who may be unfamiliar with the facility's needs.

A growing body of evidence supports the contention that DMH's practice model significantly reduces the cost of care while improving quality of care and patient satisfaction [5, 6]. Those claims are being further tested in a nationwide project of the Centers for Medicare & Medicaid Services (CMS) called the Independence at Home Medical Practice Demonstration Program [7]. Established by section 3024 of the Affordable Care Act [8], the Independence at Home program also tests a novel compensation arrangement that combines fee-for-service payments with a shared savings bonus. For a participating medical practice to earn a bonus, the total cost of care for patients enrolled in the demonstration program must be at least 5% less than the expected cost of care under usual circumstances. The practice must also satisfy numerous quality measures specified by the demonstration program.

The 18 medical practices participating in the demonstration program, including DMH, share a cost reduction strategy that starts by visiting patients where they live to eliminate the formidable barriers to access that keep frail elderly patients from connecting with their primary care providers. Given better access, clinicians can see patients often and in depth, actively manage multiple comorbid conditions, and provide care that is proactive and prevention-oriented rather than reactive and crisis-driven. By keeping patients on an even keel, minimizing crises, and reducing the risks and high costs associated with unnecessary emergency department visits and hospitalizations, the home visit strategy has the potential to save money. It may also minimize the number of untoward clinical events that befall frail elderly patients during a hospitalization or a sojourn in the emergency department.

The benefits of shifting the locus of care out of institutions and into the patient's home extend beyond eliminating barriers to access. Clinicians can obtain better information from patients who are more relaxed and forthcoming by virtue of being seen in their own environment. They can more accurately assess the patient's compliance with medication regimens—by tracking down medication vials, if necessary. Environmental hazards can be identified and rectified, and coordination of care becomes easier when all members of the multidisciplinary health care team can convene "at the bedside." Home visits also reduce the burden on family caregivers by eliminating the need to transport the patient somewhere to receive physician and ancillary services, which often requires taking time off from work and long waits with loved ones who cannot be left alone in outpatient venues of care.

DMH clinicians provide comprehensive, ongoing care in the patient's home, including all laboratory and imaging services that may be required, with the exception of computed tomography and magnetic resonance imaging. The practice has no vested interest in ancillary services, which are provided on a contract basis by firms with whom the practice has vendor agreements. Those services include plain-film radiographs, ultrasonography, electrocardiography, and cardiac impedance studies, as well as phlebotomy services and specimen transport. DMH also coordinates services across all venues and levels of care. For example, our clinicians can visit patients within 48 hours after an

emergency department visit or hospital discharge, which enables the clinician to reconcile medication regimens and intervene at the earliest signs of a change in the patient's condition. This strategy has the potential to dramatically reduce the number of readmissions within 30 days of hospital discharge.

There is also a strong business case for the new job role created by the home-based primary care practice model—often referred to as a "residentialist." On a fee-for-service basis, our clinicians earn in the top 5% of primary care providers in similar communities, and our practice is more profitable overall than the typical primary care office practice, primarily because we have learned to use cutting-edge technology to operate efficiently and effectively, with about 20% less overhead. In addition, DMH physicians document their clinical encounters in a comprehensive way that supports billing for the highest level of service appropriate to the encounter. We have also demonstrated the ability to earn significant additional income from CMS's Medicare Shared Savings Program, which bolsters the total compensation of DMH's clinical staff and should allow us to attract the additional providers needed to deploy the service on a much larger scale.

Home-based primary care could do more than merely "bend the cost curve"—it could break its back [9], even while improving quality of care and patient satisfaction. NCMJ

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