APRIL 2021

CSB CASE STUDY BRIEF

Home-Based Primary Care – Higher Value Care for Medically Complex, High-Cost Patients: Doctors Making Housecalls

Value-based Care Activity

- Participated in CMMI Independence at Home (IAH) Demonstration model, 2012-2017
  - o IAH was one of the earliest "shared savings" demonstrations. Participating practices were paid on a fee-for service basis throughout each performance year and had to achieve at least a 5 percent reduction in the expected total cost of care to be eligible for a shared savings bonus at the end of each performance year.
  - o Patient participation in IAH was by "enrollment" not "attribution," which curtails favorable risk selection.

Accountable Care Atlas Competency: Ensure Access to Care

BACKGROUND

Acknowledged as a pioneer in the locum tenens industry and dedicated to improving access to health care for the medically underserved (including residents of rural areas), Dr. Alan Kronhaus launched Doctors Making Housecalls (DMHC) in 2002 on the suggestion of his entrepreneurial wife, Dr. Shohreh Taavoni. Together, they built a medical services organization which, at the time of its acquisition by Eventus Whole Health in 2020, employed over 125 clinicians and provided more than 200,000 primary care visits per year, with approximately 80 percent to patients living in about 400 senior living communities throughout the Carolinas, and 20 percent to those living in their own home.

Originally, DMHC's mission was to improve access to care for frail elderly patients by seeing them onsite in their own environment instead of waiting for them to show up in a medical facility. But the mission soon evolved to improving clinical outcomes and reducing costs for medically complex, high-cost patients, regardless of age, by providing what Dr. Kronhaus likes to call "proactive primary care." By providing care that is proactive, comprehensive, and assiduously well-coordinated, DMHC's practice model is designed to improve outcomes and reduce costs primarily by reducing unnecessary emergency department (ED) visits and hospitalizations.

APPROACH

The guiding philosophy of DMHC is to deliver the right care (i.e., proactive, comprehensive whole-person care), in the right place (i.e., where patients live or work), at the right time (i.e., before a problem or change of condition prompts the need to see a doctor; ideally, same or next-day) to medically complex, vulnerable patients. Care is provided by primary care clinicians and mental health professionals who also coordinate the services provided by subspecialists, home health agencies and hospice, when appropriate.

Patient visits typically last between 20 to 90 minutes. The duration and frequency of visits are determined by the needs of the patient, not the dictates of a clinician schedule or the number of exam rooms available, as may be the case with a traditional brick-and-mortar practice. Visits can also be attended by family or facility caregivers and are supplemented by a wide range of ancillary and supportive services, as well as mobile imaging and lab work.

Good clinicians are the engine of the DMHC machine. To ensure that its employed clinicians are satisfied in their work, effective in meeting the needs of patients, and compliant with the guidelines of all payors, DMHC created a new job role for clinicians, what Dr. Kronhaus calls "residentialists." Teams of administrative and support staff, known as organizers or coordinators, are centrally located and are key actors in improving the efficiency, job role, and satisfaction of DMHC

ABOUT DOCTORS MAKING HOUSECALLS

Doctors Making Housecalls (DMHC) delivers proactive home-based primary care services in over 400 senior living communities in the Carolinas. Operating this innovative care model since 2002, DMHC was a standout amongst the 14 organizations who participated in the CMS Innovation Center (CMMI) Independence at Home Demonstration (IAH) model, earning an incentive payment in each of the five years of the model, delivering excellence in cost, utilization, and quality outcomes from the very first year of participation. DMHC was acquired by Eventus WholeHealth in November 2020.

KEY LEARNINGS

- While DMHC was initiated and scaled up successfully under a fee-for-service payment model, home-based primary care is ideally situated for success in value-based contracts and as part of Accountable Care Organizations.
- Home-based primary care is a delivery model primed for proliferation, but there can be a steep curve to sustainability. Know the important quality and financial metrics and the leading indicators for success and select the right partner with a shared vision and existing supports for infrastructure to accelerate and smooth implementation and scale-up.
- The financial viability of a home-visit practice can be achieved most efficiently by providing the service in venues where there is a substantial number of patients for the clinician to see during each visit.

residentialists. A clinician-focused model, the ratio of clinician to ancillary staff is roughly 1:1.75, which is well below the ratio reported by other advanced primary care practices.

DMHC clinicians also work with facility staff to ensure any care planning or medical record review required by regulation are completed timely and accurately. When patients fall or otherwise have a concerning change of condition, DMHC clinicians can collaborate with paramedics or nursing staff based on a validated and published protocol to assess patient needs and prevent unnecessary emergency department transport as medically appropriate. The ability to treat-in-place and preclude unnecessary and costly and ED visits and hospitalizations provides a win-win-win for patients, families, and senior living communities.

In a natural evolution of the care delivery model, DMHC also contracts with employers to provide onsite primary medical care for employees. The convenience factor of no travel, no waiting rooms, and no need to take time off makes the attractive concierge-like onsite service a coveted employee benefit, while endeavoring to increase worker productivity and reduce the company's healthcare costs by focusing proactive primary care services on the highest-need employees.

RESULTS TO DATE

Due to their extensive experience in the market, DMHC was an immediate success in the IAH model. They achieved all six quality measures (48-hour follow up after discharge from the ED or hospital; medication reconciliation done on follow-up visits; end-of-life preferences documented in the medical record; ED visits for ambulatory care sensitive conditions; hospital days for ambulatory care sensitive conditions; and all-cause 30-day hospital readmissions) from the first year of participation – an accomplishment achieved by fewer than one fourth of IAH participants – and DMHC earned incentive bonuses in each of the five years of the model.

"Home-based primary care could do more than merely 'bend the cost curve' — it could break its back, even while improving quality of care and patient satisfaction." - Dr. Alan Kronhaus

TOOLS AND VENDOR PARTNERS

By necessity, DMHC was an early adopter of a fully-implemented electronic health record (EHR), initially utilizing a cloud-based system that enabled distal clinicians and centrally-based organizer and coordinator staff to document and track patient needs and outcomes in the same system. Dr. Kronhaus built user-friendly workflow templates in the EHR to promote efficient documentation that complies with medical record and reimbursement regulations. These templates also serve clinical decision support and quality-enabling functions and facilitate the delivery of customized, proactive care.

Lab and imaging services are outsourced to specialty care partners. Orders and results are transmitted from and to the EHR via bi-directional electronic interfaces with those care partners. While platforms have changed over the years, the EHR remains as the information backbone that powers the DMHC model of care. The current platform includes a patient portal for secure access and communications, as well as a risk scoring module that ensures each patient's risk profile is characterized accurately, which is critical for the determination of appropriate capitated rates in value-based contracts.

CHALLENGES WITH IMPLEMENTATION

Initially, building momentum for the new home-based primary care services through a direct-to-consumer marketing was a challenging and costly process for DMHC. A serendipitous conversation with an assisted living facility staffer who had vacant space specially designated for an on-site medical clinic sparked a mutually-beneficial alliance and formed an efficient, business-to-business model for promulgating the service to, eventually, more than 400 similar residential communities and their residents across the Carolinas. In this arrangement, DMHC clinicians did not become the de facto "house doctor," residents had to choose DMHC as their source of primary care.

The challenge of providing proactive care increased exponentially as the practice's size and geographic footprint grew. For example, DMHC could not rely on electronic systems to reliably alert the practice when its patients were admitted to or discharged from the ED or hospital, because no such systems existed. Therefore, to identify changes in condition significant enough to warrant ED or hospital admissions, and to visit patients promptly following discharge, DMHC staff made regular phone calls to partner facilities. This was especially critical during IAH participation, as follow up within 48 hours of discharge was one of the key quality measures of the model.

Contributors

Dr. Alan Kronhaus, MD
Co-Founder of Doctors Making Housecalls

Kimberly Mueller
Senior Research Analyst
Accountable Care Learning Collaborative