

2014

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Patia Wiebe-Wright

Western Washington University, [patia.wiebe-wright@wwu.edu](mailto:patia.wiebe-wright@wwu.edu)

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## Recommended Citation

Wiebe-Wright, Patia (2014) "House Calls: Reviving a Lost Practice," *Occam's Razor*: Vol. 4 , Article 8.

Available at: <https://cedar.wwu.edu/orwwu/vol4/iss1/8>

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# HOUSE CALLS: REVIVING A LOST PRACTICE

BY PATIA WIEBE-WRIGHT



58 Over the past several decades, medical treatment in the United States has become increasingly institutionalized. As medical technology has become more sophisticated patient treatment has moved from homes to hospitals and clinics. In the 1930s, house calls accounted for 40 percent of a physician's interaction with patients; by the 1980s, however, house calls had decreased to one percent of interactions (Emanuel, 2013). For the frail and seriously ill, arranging transportation to medical appointments can be a serious trial. When people suffer from chronic

diseases such as heart conditions, diabetes, dementia and other such illnesses, inadequate medical attention often results in unnecessary emergency room visits. Providing home-based primary care and other forms of home visits for these patients would lessen the burden on caregivers and help patients receive regular health screenings. In managing the health of chronically and seriously ill patients, frequent health screenings are critical in preventing hospitalization by providing early detection of a worsening condition. Not only does home-based primary care improve the quality

of care for patients, but a resurgence of the practice also has potential cost saving benefits. As our population ages, our health care system must adjust to meet the needs of this population. Home visits could be a viable way to achieve this goal.

When doctors didn't have many diagnostic tools, they could bring their supplies in their iconic black bags. However, the advent of electrocardiograms (EKGs) and magnetic resonance imaging (MRIs) machines severely restricts transportation of medical devices. As a result, patients must travel to these diagnostic tools to have their condition assessed as opposed to diagnosis occurring in a patient's home (DeCherrie, Sariano, & Hayashi, 2012). For chronically and seriously ill patients whose condition is already known, routine primary care visits could easily take place in their own home. Most often, routine health screenings in primary care visits involve reviewing a patient's overall health, including any changes in their condition by checking vital signs, drawing samples for blood work, etc. The medical technology required for these types of routine health screenings is easily transportable, making it possible to occur in a patient's home (Raunch, 2013). For the ten percent of patients that must manage serious and chronic illnesses, home-based primary care would provide relief from constant trips to doctors for health checks, which would help improve the frequency and the quality of their care (Meier, 2010, pg 4).

According to a report by the Organization for Economic Co-operation and Development (OECD), despite spending nearly \$3 trillion annually in medical expenses the United States has the highest rate of preventable mortality among OECD countries (OECD Indicators, 2011). Additionally, 7.2 percent of unnecessary health care spending in the United States is caused by conditions which could have been avoided with preventative measures (Institute of Medicine, 2012). This is partly because the United States is the only industrialized country that relies on institutions for the vast

majority of care for frail or seriously ill patients. Countries such as Canada, the United Kingdom and Denmark rely on well-developed home and community-based services to provide care for these kinds of patients (The American Academy of Home Care Physicians, n.d.). In the United States, at least two million people over the age of 65 are permanently homebound and many represent the high cost users of Medicare. It's estimated by the American Academy of Home Care Physicians that home-based primary care could save Medicare 20-40 percent for these patients. While the initial cost of a house call would cost more than a visit at a doctor's office, house calls would prevent unnecessary emergency room and hospital visits, which would save money. In fact, the cost of 10 preventive house calls is equivalent to one \$1,500 emergency room visit (The American Academy of Home Care Physicians, n.d.).

Other than facilitating more preventative care, another advantage of home-based primary care is that it gives health professionals a chance to assess the living conditions of their patients. Clinics and hospitals remove people from the context of their daily lives, making it difficult to understand this factor, which could affect their health. Administering care in the patient's home provides health care professionals

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with many clues about a patient's lifestyle, values and needs (Meier, 2010, pg 304). For patients with multiple chronic conditions, this type of intimate knowledge is crucial for health care professionals to provide adequate treatment. Further, house calls make it easier for health care professionals to teach patients how to handle chronic problems. For example, it is easier to demonstrate the best diet for a diabetic in the patient's regular environment (Emanuel, 2013).

Within the health care field, there are two exciting developments aiding in the creation of an institutional framework for providing home-based primary care. First, in addition to changing the way health care is managed in the United States, the Patient Protection and Affordable Care Act (ACA) has helped fuel discussion on how health care can be improved. In an effort to improve the cost, quality and access of health care, increased attention is being paid to the service delivery component of health care. Treatment of chronically and seriously ill patients represents the largest portion of health care spending in the United States. In order to develop cost saving methods that don't reduce the access or quality of care available to chronically and seriously ill patients, emphasis has been placed on improving service delivery to these patients in future health care reform (Johnston, 2013). Second, palliative care has become a growing part of health care in the United States. As a specialized medical care for patients with serious and chronic illnesses, palliative care focuses on providing symptom, pain and stress relief to improve the quality of life for the patients and their families (Johnston, 2013). Furthermore, palliative care emphasizes preventative care, thus enhancing communication between patients and health care professionals, continuity of care, and treatment accessibility for patients with long term illnesses (Meier, 2010).

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Despite a lack of institutional framework to support them, the number of health workers who make house calls has risen steadily since 2005. Currently, about 3,000 primary care physicians and other health professionals now make house calls full time (Hawthorne, 2013). One such nurse practitioner is Jody Hoppis, who serves patients in Bellingham, Washington. Hoppis visits patients at their homes using her bicycle for transportation with the help of a specially designed bicycle trailer to carry her supplies. Hoppis started "Mobile Medicine" in 2008, and the practice's low overhead costs allow her to spend up to an hour with each patient, significantly longer than the average 15 minutes in a typical clinic setting (Kahn, 2010). With this innovative practice, Hoppis can perform physical examinations, diagnose and treat illnesses and chronic health problems, order and interpret diagnostic tests and refer patients to specialists in the comfort of a patient's home (My Mobile Medicine, n.d.).

Aside from home visits such as Hoppis', another innovative practice is using webcams to connect patients with health care professionals. Carena is a private company based out of Seattle that contracts with companies like Microsoft and Costco to provide house calls under their insurance plan. Carena uses the latest technology to provide the same



services as old fashioned house calls but with a slight twist. While the company does perform traditional house calls, it is particularly innovative in its use of webcams, removing the need for either the patient or health care professional to travel for a simple screening. Patients can contact a doctor or nurse practitioner 24 hours a day via webcam or phone to determine if a condition requires a visit to the emergency room, or if the situation can be handled at home (Carena n.d.). Carena low-cost assessment methods could provide significant savings if a similar program was adopted by Medicare and Medicaid. According to Carena, about 75 percent of calls are resolved via webcam and only 25 percent require an in person visit to a doctor or emergency room (Eduardo, 2013). For some elderly patients, the technological literacy required to operate a webcam means programs like Carena might not be a viable option. However, for more technologically savvy caregivers or patients, it could provide a valuable, cost reducing service.

For more intensive home care, John Hopkins University has begun a “Hospital at Home” program. The program provides in home treatment for a condition that would otherwise require acute hospital in-patient care such as pneumonia and heart failure. Hospitalization is often difficult for the elderly, as they are highly susceptible to functional decline, infection and other consequences (Leff et al., 2005). In academic studies by the National Center of Biotechnology Information, the Cochrane Collaborations and Annals of Internal Medicine results have been inconclusive regarding the benefits of this program over traditional hospitalization. However, Hospital at Home patients were less like to suffer from delirium or be prescribed sedative medication. Additionally, no study has discovered detrimental effects of the program, and patients who receive Hospital at Home care report higher satisfaction with their treatment than those receiving care in hospitals (Shepperd et al., 2009). This is crucial because high stress in patients is detrimental





to health and recovery (Meier, 2010). Even if Hospital at Home does not save money or improve outcomes, the patient satisfaction it provides makes the program an excellent form of care. Also, with hospital treatment in the home, family members and other caregivers are able to stay with the patient more easily.

The ACA has provided some incentives and means to implement the return of house calls. The Independence at Home Demonstration was created by the ACA to test home-based primary care provided through Medicare and Medicaid. The Demonstration is “testing a payment incentive and service delivery model that uses primary care teams led by a physician or nurse practitioner to deliver timely, in-home care to Medicare beneficiaries with multiple chronic illnesses and functional impairments” (Frequently Asked Questions, n.d.). Conducted by the Center for Medicare and Medicaid Innovation, the Independence at Home Demonstration provides incentives for health care providers who reduce Medicare expenditures while meeting quality standards. Currently, there are 18 practices and consortia across the United States that participate in the Independence at Home Demonstration. Established in 2012, the three-year demonstration will report to Congress in 2015 on the long-term potential of providing home-based care through Medicare and Medicaid. While the program is still in the early stages, preliminary testing suggests that if 1.5 million eligible beneficiaries were to access effective forms of Independence at Home, it could result in significant savings for Medicare (DeCherrie, Sariano, & Hayashi, 2012).

The Department of Veterans Affairs has implemented a successful home-based primary care program for those who “have complex health care needs for whom routine clinic-based care is not effective” (Hughes, Weaver, & Giobbie-Hurder, 2000). According to a 2009 study, the number of days spent in hospitals and nursing homes was cut by 62 percent and 88 percent for patients treated by this program, respectively. Total health care costs for these patient’s treatment also dropped by 24 percent (Beales & Edes, 2009). Additionally, a randomized multicenter trial of the program by the Journal of the American Medical

Association showed significant improvements for terminal patients in their emotional and social functions, bodily pain, mental health, vitality and general health compared to a control group receiving traditional care. Furthermore, the program enhanced the quality of life and health of the patient's caregivers. Improved conditions for non-terminal patients and their caregivers were seen as well, especially for readmissions in severely disabled patients (Hughes, Weaver, & Giobbie-Hurder, 2000). Operating in 75 percent of Veteran's Affairs facilities, the success and satisfaction reported by patients offers a guiding model for the Independence at Home Demonstration.

The United States' health care system was designed to provide care for isolated episodes of intensive, acute care. While it provides the best care in the world in this respect, it lacks effective systems for the frail and chronically ill who require constant, low-intensity support. Patients with five or more chronic conditions are the fastest growing portion of the Medicare population and even slight cost reductions in treating these patients could result in significant savings (Raunch, 2013). In fact, it's estimated that a five percent reduction in end-of-life costs would save Medicare \$90 billion over ten years (Raunch, 2013). House calls, particularly home-based primary care, could provide these savings and improve the quality of life for the frail and chronically ill. Those who are homebound or have limited mobility often don't see a health care professional regularly. Hospitalization is a costly and stressful experience, and intervening with home-based primary care can help ameliorate some of these problems.

Furthermore, emergency house calls offer an alternative to hospitalization. Avoiding traumatic or disruptive hospitalization not only prolongs life, but improves it as well. The acute care model is not designed to handle declining patients. Often, these patients are only briefly stabilized, and some even leave the hospital in a worse

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condition than before their treatment. Hospital care operates through inertia; once a patient is admitted, life preserving treatments are often administered with little consideration for quality of life. However, 78 percent of elderly patients would give up months or even years of their lives in exchange for better management of pain and discomfort, personal control over medical decisions and familiar surroundings (Bryce, Loewenstien, Arnold, Schooler, Wax, & Angus, 2004). Additionally, at least 70 percent of people in North America die in some type of institution (Meier, 2010 pg. 299). Yet, over 80 percent of patients say that they wish to avoid hospitalization and intensive care during the terminal phase of illness (Raunch, 2013). The frail and chronically ill would benefit from health care professionals performing emergency house calls in which hospitalization is not the primary response.

For a patient in distress, their only option is to call 911, which sweeps them into the acute-care system. In her book *Knocking on Heaven's Door*, Katy Butler suggests the idea of a 811 number patients and caregivers could call. Instead of an ambulance, this number would send a team of doctors or nurses specialized in managing frail and chronically ill patients to provide help and assess the situation (2013, pg.

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269). Instead of sending dying patients to the ICU, health care professional would provide them reassurance and pain management, which are elements of a “good death”. A study by the Journal of the American Medical Association found patients and caregivers defined a good death as one that is free of unnecessary distress and suffering which includes receiving mindful care and support. Additionally, most people wish to die in a familiar setting with loved ones at their side (Connors et al., 1995). Creating these conditions is best achieved in a home, not a hospital.

Discussion about the idea of what constitutes a good death is not a new one, but the discussion is reopening in the modern age. Since the dawn of modern medicine, Americans seem to have adopted the idea that death can be infinitely postponed if the correct treatments are performed at the right time (Butler, 2013). Acknowledgement that death is inevitable has given rise to elements of the medical system such as palliative and hospice care. This type of care seeks not to stop death at all costs but rather focuses on what it means to have a good death. Increasing home care for elderly and chronically ill patients would transfer the place of medical care from a hospital or clinic into their home. In turn, this encourages practices which allow people to make their final passage in the comfort of their

home. While many cultural conceptions about death will ultimately need to change before Americans accept death as a part of life and not a failure in treatment, home care is a step in the right direction towards providing people with good deaths.

Overwhelming evidence suggests that seriously and chronically ill patients would benefit from providing home-based primary care. This type of care would also increase the scope and accessibility of medical treatment in their own home. House calls would not only provide them with improved forms of care in the earlier stages of an illness but would also create a better pathway to death. Furthermore, the rise in home care programs and professionals shows that if Medicare and Medicaid structure their reimbursement scheme to better accommodate in home medical care, the services would be utilized. Not only would in home medical care provide superior care quality, but subsequent reduction in hospitalization could result in significant monetary savings. Because of the clear benefits in cost, quality and access, increasing in home medical care should be a priority in future health care reforms.

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