ARTICLE OPERATIONS

How Home-Based Primary Care Can Reduce Expensive Hospitalizations

by Paul Di Capua, Jay Mathur, Vivek Garg and Sachin H. Jain
It’s common knowledge that health care spending in the United States is on target to reach 20% of GDP — and that the 5% of patients who are the most expensive to treat account for 50% of all health care spending. These patients tend to be frail and elderly and have multiple chronic illnesses; many have unmet behavioral and mental health needs as well. A CareMore Health program in Connecticut
has proven that an approach can reduce the expensive hospitalizations that largely drive the high cost of caring for these patients. How? By treating these patients at home.

For more than a quarter century, CareMore Health, the care delivery organization where we are physicians, has successfully built a model to treat high-cost, high-needs patients. In communities across the country, CareMore invests the capitated payments it receives from Medicare and Medicaid in prevention and early intervention programs, and on supplemental benefits that fee-for-service programs typically don’t cover. Under this model, CareMore spends half of what traditional Medicare programs spend on the sickest patients. Much of the savings result from keeping patients healthy enough to avoid high-cost hospitalizations.

In 2017, CareMore entered the Connecticut market with the goal of bringing our model to high-cost, high-needs patients in the Nutmeg State. As we’d done in other markets, we looked at opening office space in locations that would be convenient for our patients. So we mapped our patients’ home addresses. That’s when we noticed an interesting trend: Many of them lived in clusters, often within a 30- to 45-minute drive of one another.

The map sparked an idea. High-cost, high-needs patients tend to spend almost all of their time at home. They’re often elderly seniors who live alone. Many lack access to reliable transportation or report that they can’t get convenient, immediate appointments with doctors. We asked ourselves: Instead of demanding that patients come to us to receive care, what if we instead went to them?

In doing so, we reasoned, we could eliminate barriers to access. But to be successful, we’d have to restore the lost practice of making house calls. After all, gone are the “Marcus Welby, MD” days of charming doctors showing up on doorsteps with black medical bags in their hands. Except for the basic services offered by home care agencies, health care in the United States has largely abandoned using the home as a viable site for care.

Under CareMore’s model, which we launched in Connecticut in 2017, the members of what we call the “Home Team” provide integrated physical and mental health care to our patients in the space where everyone feels most comfortable — their homes.

We treat the patients we see at home just as we would in a medical office setting. We fine-tune medications, examine and dress wounds, and make diagnoses. But Home-Based Integrated Care is so much more than that. Our care teams are made up of primary care physicians, nurses, case managers, medical assistants, social workers, and other professional caregivers who work in concert to provide comprehensive preventive, chronic condition, urgent, and post-discharge care. When we visit patients, we assess their mental and physical health. We ensure that they’re filling prescriptions and taking their medications appropriately. If they’re not, we’ve developed strong relationships with local pharmacies who deliver pre-packaged medications to our patients and can ensure timely alterations in medication regimens.
Seeing patients at home adds a certain familiarity to the doctor-patient relationship, often with positive results. Prior to meeting us, Oscar*, who suffers from multiple chronic diseases, including advanced kidney disease, was in the emergency room almost weekly. At our initial visit with Oscar, we used his kitchen strainer to explain how his kidneys filter blood. During a series of conversations in Oscar’s living room, we spoke with one of his close friends from church, his personal care assistant who is with him every weekday, and his brother in Puerto Rico. Together we created a medical regimen focused on aggressively managing Oscar’s diabetes and blood pressure, two factors that often cause kidney damage. Today, Oscar’s kidney function has stabilized.

In our patients’ homes we can readily view the “social determinants of health” — the economic and social conditions that can significantly influence a patient. In her home, we learned that Lucy* is socially isolated, with no regular contact with others. We surmised that her social isolation was at the root of many of her behavioral health issues and introduced a social worker to connect her with community-based organizations that brought her into contact with others. In the 18 months that she has been our patient, Lucy has yet to be readmitted to the hospital. Had we not visited Lucy at home, it’s not clear that we’d have recognized the underlying social dynamics that were affecting her health.

These anecdotes demonstrate our success; so do the numbers. We recently compared the 10-month period after we launched Home-Based Integrated Care in Connecticut (from September 1, 2017 to June 30, 2018) to the previous 10-month period (from September 1, 2016 to June 30, 2017) for the 105 patients who had engaged with CareMore and continuously had the same health plan throughout the whole period. During that time, hospital admissions and emergency room visits were down 12.5% and 27.2%, respectively. Those numbers demonstrate that we are succeeding in our goal to reduce hospitalizations and produce better outcomes at a lower cost. Today, CareMore serves 2,100 patients in Connecticut solely under the Home Integrated Care model.

Obviously, one’s home is not the perfect setting for all medical care. If you break your arm, you should get it x-rayed in an urgent care center. And if you need open-heart surgery, there’s no question that it should be performed inside a controlled operating room environment.

Nevertheless, our health system has created a hospital-based delivery system focused on acute illness at the expense of growing and building systems of care to manage chronic illness. As the cost of caring for the frail and elderly approaches 10% of our GDP, we as a country need to reflect on how our health system is largely failing these patients at great expense. The vast majority of hospitalizations, which cost $3,000 to $4,000 per day or more, are for exacerbations of chronic illness that could have been treated more effectively and less expensively had the patient’s care team taken a personalized approach to managing the patient’s condition.

What we’re doing in Connecticut is actually quite old-fashioned. Doctors used to make house calls all the time. They were comfortable walking into their patients’ homes; they and the members of their community knew each other and trusted each other. What the modern, transactional health system
has done is more than just create a cumbersome system riddled with inefficiencies, high costs and mixed results; it has removed health care from our communities.

So we’re putting it back. And pretty soon, we think others will too.

*All names have been changed.

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