

# Transforming Healthcare:

## The Case for Integrated Housecalls

LTCIP, San Diego

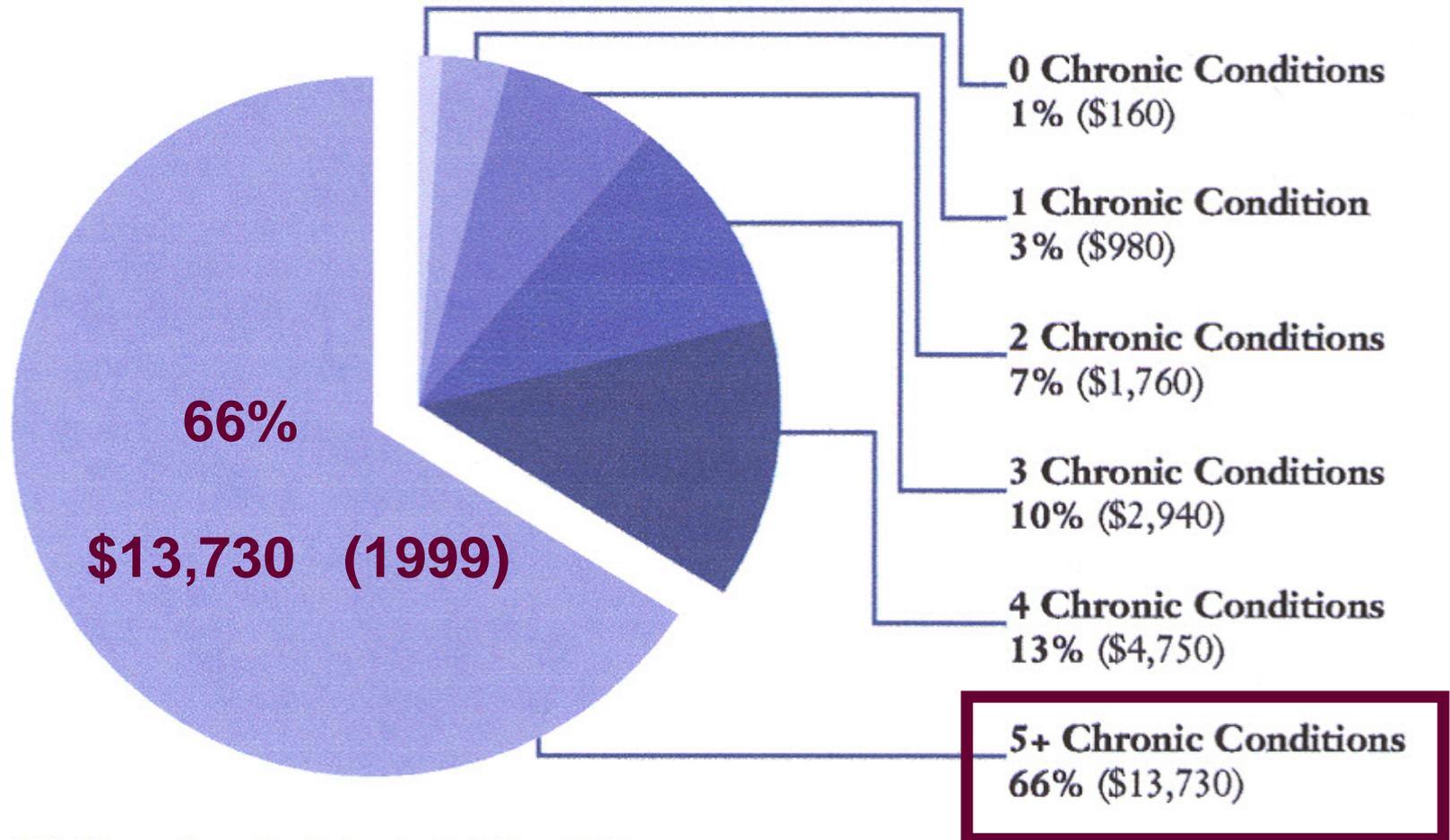
August 21, 2009

# Credentials after 300,000 Housecalls

- 1985: first lab on a housecall
- 1986: first EKG done on a housecall
- 1987: first portable Xray on housecalls
- 1991: oximetry a standard on housecalls
- 1995: first cardiac impedance sent wirelessly
- 1999: first paperless, wireless EMR on HC
- 2006: first BMP and troponin on HC
- 2007: first portable digital xrays on HC
- 2007: first Bluetooth CO Starling Curve sent
- 2007: paperless, wireless, phoneless,  
keyboardless

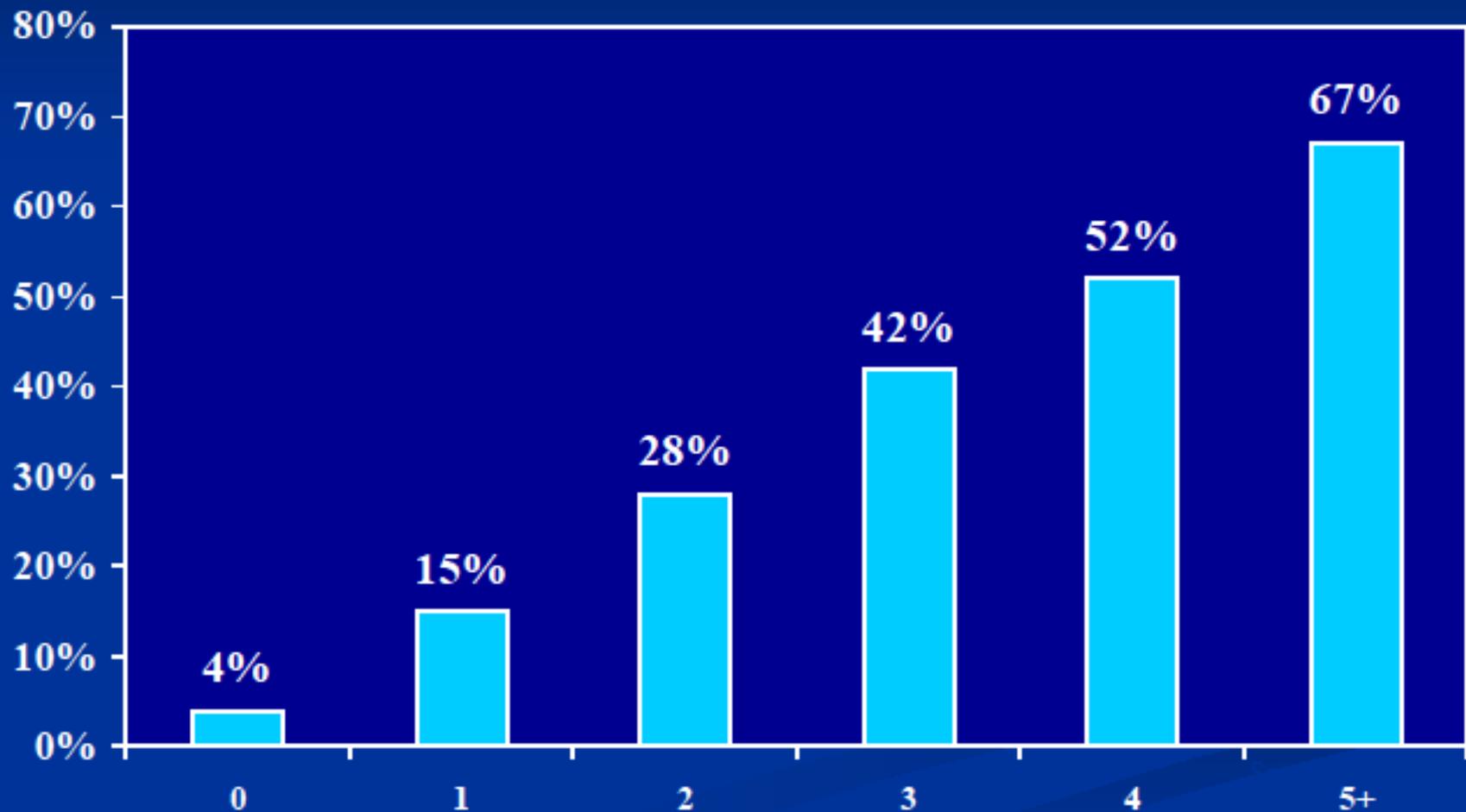
# Two-thirds of Medicare Spending Is for People with Five or More Chronic Conditions

Percent of Medicare Spending per Person by Number of Chronic Conditions  
(Average Annual Expenditure)

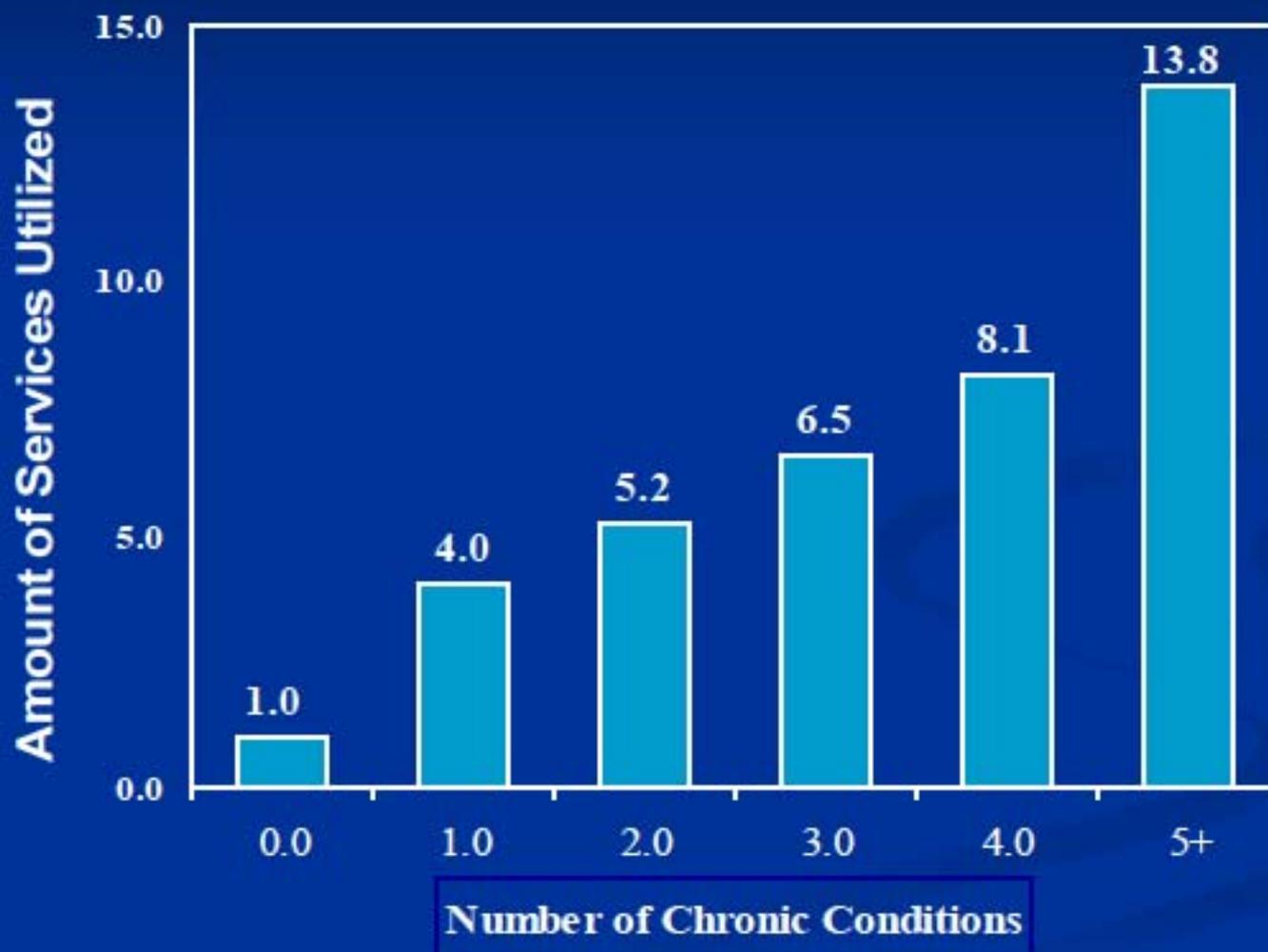


Source: Medicare Standard Analytic File, 1999.

# People with Multiple Chronic Conditions Are More Likely to Have Activity Limitations



# Number of Unique Doctors Increases with Number of Chronic Conditions



# People with Multiple Chronic Conditions Use the Most Services

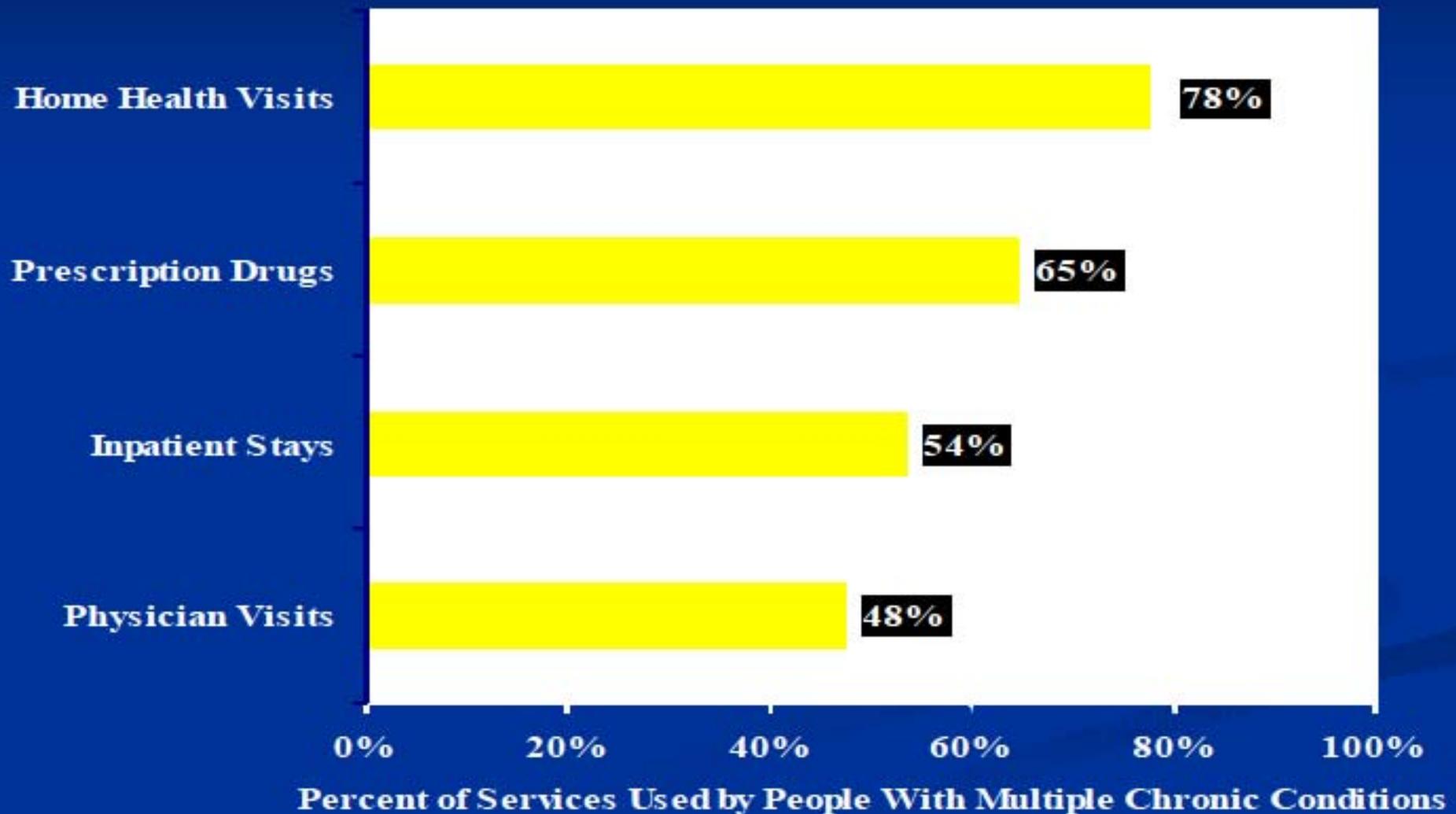
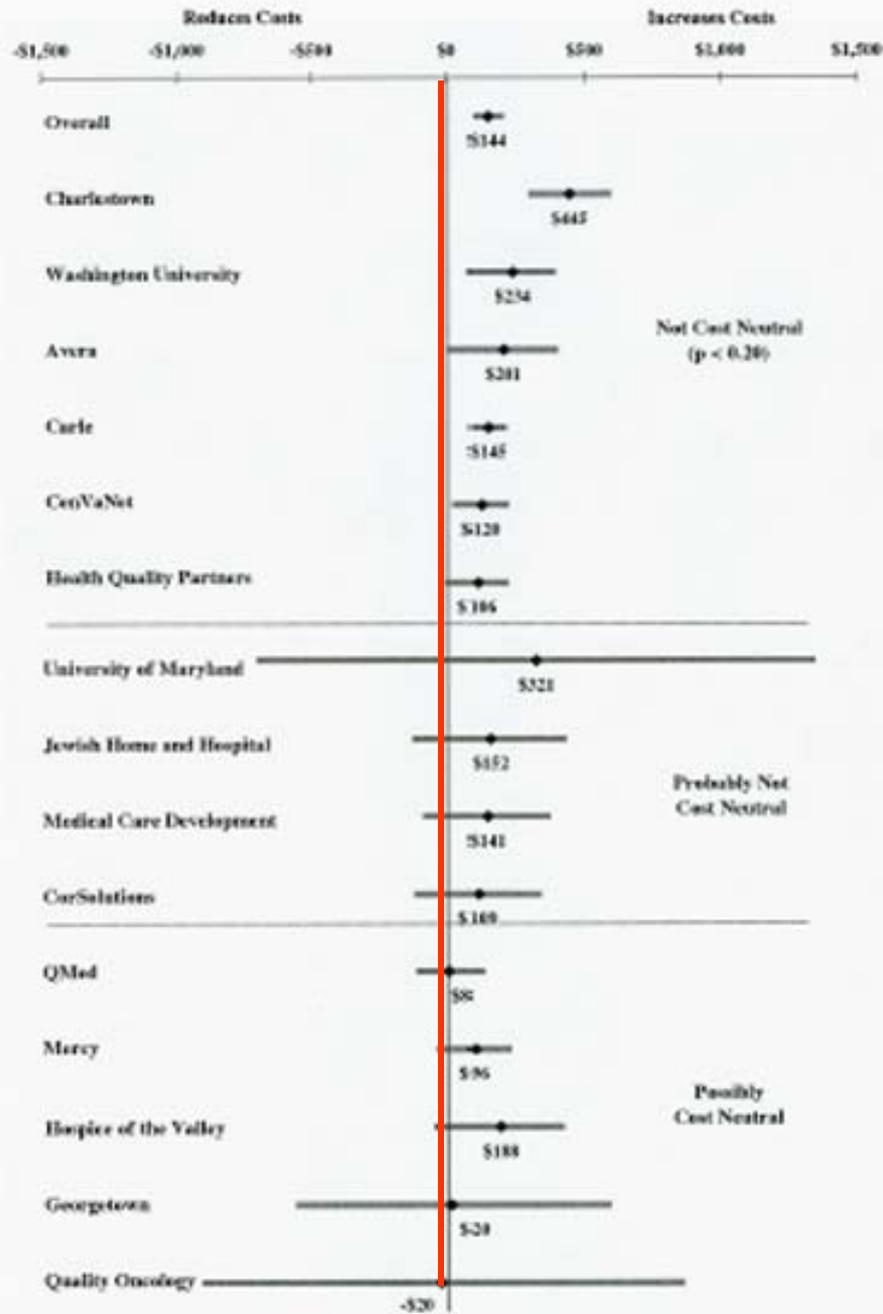


FIGURE VI.1

COST NEUTRALITY DURING THE 1ST 25 CALENDAR MONTHS OF PROGRAM OPERATIONS



Decreased Costs

Increased Costs

Medicare  
Care  
Coordination  
Demo  
3-07

# Outcomes Research on Cost Reduction Programs

- **Home Health (nursing) PPS** (OASIS datasets 2000-2004)
  - ER admit rate increased from 25% to 28% in 5 years
- **HMO (Medicare Advantage)** (CMS, August 18, 2009)
  - Tripled healthcare inflation rate from FFS in ten years (Commonwealth Report)
- **Call Center/DSM Tools** (CCC Demo, 2008)
  - No savings in 15/15 centers
- **Physician Direction in Office** (PGP, August 20, 2009)
  - No savings in 8/10 large groups in year 1
  - Year 3 savings in 5/10, most in one group

# Health Reform Paradox: You must select the right patients and...

## Increase in home visit costs

- U. Penn +10%
- Va. Com U. +24%
- VA HBPC +460%
- Nev. SHMO +42%

## Decrease in total costs

- (45%)
- (68%)
- (24%)
- (13%)

# Independence at Home is Different!

## Sec. 1302 Medical Home

- Call Center focus
- Protocol driven
- HIT optional
- Increased payments
- Any medical provider
- One chronic disease
- Proven not to save \$\$
- No housecalls required
- No satisfaction required

## Independence at Home

- “physician directed”
- “physician directed”
- Mandatory HIE
- Guaranteed 5% savings
- Strict eligibility standards
- Complex eligibility criteria
- Proven to save \$\$
- Housecalls 24/7 available
- Requires patient approval

# The Enemy





# Point of Care Tools



# Technology Challenge



CD

(Connectile Dysfunction)

- Asynchronous field performance
  - Random disconnects
  - Slow Upload / download speeds

# San Diego: Digital Leader?

- Veterans: Vista
- Sharp: Cerner
- UCSD: EPIC
- Kaiser: Kaiser
- Scripps: Centricity
  - Scripps Mercy, CV: Stentor for DICOM images
  - Scripps Mercy, Hillcrest: Dominator for DICOM
  - P.S. None work offline in a patient's home!

# For Example...

Call Doctor Medical Group, Inc.  
5030 Camino de la Siesta Suite 208  
Digital Mobile X-Ray Beta Trial



- Wireless diagnosis in Rep. Markey's office while in Washington

DICOM image: 30Mb  
With compression: 10Mb  
Lossy jpeg: 3Mb  
Janus DICOM in PDF: 250kb

# The EMR Legacy Problem

- \$100M buys a lot of legacy loyalty
- EMRs send, but won't receive PHI (pay to play)
- Virtually all based on client/server, cabled networks
- Middleware required for interchange
- Attempt to use EMR to control physician loyalty
- Attempt to use EMR to control patient loyalty
- Becoming a “trusted site”
- Adoption rates:
  - Before ARRA's EMR Bonus Promise: 14%
  - A year after ARRA's Bonus Promise: 14%

# The Obama Opportunity

- ARRA/Hitech Act
- Transitional Care
- House Reform
- Independence at Home Act-S1131, HR 2560
- EMR Stark exemption
- Forces EMR adoption
- Forces housecalls
- Cuts Home Health \$37B
- Forces in-home therapies
- De-funds re-admits
- Includes IAH Act
- Mandates 5% savings
- 80% of gainshare goes to housecall providers
- HH pays 85% HIT costs

# Lessons Learned for Mobile HIT

- File size is the key issue!
- Patients want information, not transportation!
- What an EMR doesn't do can be as important as what it does do
- MD-friendly means no training, little scrolling, using conventional tools (e.g. Outlook, PDF, tiffs)
- Don't compete with the big boys (client/server won't work, anyway)
- Critical features like GPS, routing, imaging, reporting are unique to the mobile field

# HIT Standards Committee 8.20.09

- Focus now on Meaningful Use, not CCHIT
- MU focus is on private, secure, “interoperability”
- Recognition that EMR closed shop architecture is the problem, not the solution
- Established glidepath for easy adoption to 2013
- Will now create user tools for self testing
- Consideration of “attestation” of MU for bonus
- Enabled PDFs specifically recommended for interoperable exchange, even unstructured
- CPOE not till 2013, DSM tools in 2015

# What We Can Do Now in San Diego

- Share private, secure networks across industries
- Exchange PDFs, tiffs, gifs, and jpegs
- Use physician housecalls for medical direction
- Reform 911 protocols
- Focus on the high-cost patients
  - Five+ chronic conditions, and
  - Two+ problem ADLs, and
  - Recent visit to ER/Rehab/SNF/HHA
- Focus on acute/urgent in-home interventions
- Enjoy the practice of medicine again!

“and into whomsoever’s house I may enter,  
may I see the man....just the man”



# References

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[www.janushealth.com](http://www.janushealth.com) [for mobile provider HIT]