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Housecalls Are Back and Booming. Are They a Threat to PCPs?

Neil Chesanow | July 20, 2016

An Old Idea With a Technological Twist

Last year, Tom Rodgers, senior vice president at McKesson Ventures in San Francisco, was returning home with his family from a weekend vacation. His young son had a painful earache and they were stuck in traffic on the Golden Gate Bridge.

So Rodgers used his smartphone to download the app of a company named Heal. He then entered his son's symptoms and other details into the app and requested a housecall.

Fifteen minutes after the family arrived home, a pediatrician and a medical assistant knocked on their door. They had arrived in their company's Heal Mobile, a Toyota Prius, with pretty much all of the diagnostic equipment and medical supplies an office-based pediatrician would stock. They also carried an iPad loaded with the company's electronic health record (EHR) and e-prescribing software.

"They spent an hour at the house," Rodgers recalls. "They had great bedside manner. It was a great experience."

Rodgers has health insurance, but Heal didn't accept it. It wouldn't have mattered if it did; as with many patients, his is a high-deductible plan and the deduction hadn't been met. Still, the fee was reasonable—$100, about the cost of an office visit—if, that is, he could have gotten an appointment when one was needed.

Although virtual video visits with physicians are surging in popularity, many doctors remain skeptical about their benefits. To practice good medicine, these skeptics insist, nothing replaces a hands-on visit.

Now, an industry that offers the convenience of seeing a clinician in the flesh, often within an hour of making a request, without the patient having to leave the house, hotel room, or office, is flowering.

Startups offering housecalls on demand are springing up nationwide. Heal has been in business less than 2 years, yet it already serves five regions in California. Pager is located in New York City. RetraceHealth is based in Minneapolis. Mend and PediaQ serve the Dallas–Fort Worth area. And there are many others.

But not everyone is convinced that Uber-like housecalls have an enduring place in today's healthcare system. The concept has its critics, including doctors who have actually done it. And even though venture capitalists, who are investors, may like what they see, some are not sure that the economics of this business model can be sustained over time.

What is the business model? Which conditions are treated? What is the appeal for clinicians who do this? Can it be profitable to dispatch doctors—or nurse practitioners (NPs)—on time-consuming trips to visit patients, rather than the other way around? They can typically see about one patient per hour, whereas an office-based doctor can see four or more in the same period of time. Is it safe for clinicians to go into strange neighborhoods and strangers' homes? Is this yet another threat to office-based primary care physicians? Let's take a look.

Different Operational Strategies

Many firms offering housecalls on demand are fairly new to the business. Most offer free apps that patients download to their smartphones and can use to request a housecall.

Some apps connect a patient directly with an on-call clinician. Other apps, particularly those from larger firms, allow patients to view clinician headshots and professional information—education, specialty, years in practice, and patient reviews— and choose a specific clinician.

To request a visit, patients enter their personal and health information, including presenting symptoms and their location, into the app. It generally takes only a minute or two to receive a response.

A housecall request does not always go directly to a clinician. Some apps route the request to a command center, where a nurse does triage. This can involve a brief video chat with a patient, conducted through the app, to determine whether a housecall is necessary. In some cases, patients can choose a video or phone session with a clinician instead of a housecall, which is more immediate and costs less.

The clinician's safety is gauged during these patient interactions. If there is any doubt, the company might send two people, at least in theory. Although provider safety has not been a problem to date, according to spokespeople from several firms, it is not taken for granted.

In general, clinicians are dispatched to housecalls in company-owned vehicles. Most travel solo, but with a backpack equipped with wireless diagnostic equipment, medical supplies, often medications, and a tablet loaded with EHR and e-prescribing software.

Some firms dispatch only physicians on housecalls, others send only NPs, and some deploy one or the other, depending on the shift. If NPs are sent on housecalls, a physician at a remote location is generally available—through text, phone, or video chat—for consultation if the need arises.

Clinicians are usually a mix of full- and part-time staffers, and are generally paid competitive hourly rates. The firms pick up the tab for malpractice insurance.

Most firms offering housecalls on demand focus on urgent care, as do firms that offer video chats with clinicians, but some are branching out into primary care by offering services such as physicals, wellness exams, and flu shots.

These firms are not necessarily in competition with local physicians; they provide service after hours or when office-based physicians tend to be booked solid. Hours of operation are typically 8 AM to 8 PM. And some firms offer ongoing primary care to people who don't have a regular primary doctor—quite a few app users don't—or who are dissatisfied with the doctor they have.

A growing number of housecalls firms take insurance. Insured patients pay standard office copays rather than out-of-pocket rates. If a patient is uninsured or has a high deductible, rates generally range from $50 to $200, which is about the cost of an office visit, less than an urgent-care visit, and considerably less than the trip to the emergency room (ER) if one is paying cash.

What Do the Housecall Firms Offer?

Housecall startups are tinkering with different market strategies, types of services, clinical staffing mixes, and rates, and have different business goals. Consider five of the fastest-growing firms.

Heal, Serving Los Angeles, Orange County, San Francisco, Silicon Valley, and San Diego

Heal serves five regions of California: Los Angeles, Orange County, San Francisco, Silicon Valley, and San Diego. It employs nearly 100 family doctors, internists, pediatricians, and emergency physicians on a full- or part-time basis. The firm recently raised $5 million in seed money.[1]

Nephrologist Renee Dua, MD, and her husband founded Heal in 2015 after spending half the night in the ER with their sick son, only to be sent home because, they were told, the child's illness wasn't serious enough for him to be admitted. "There has to be a better way to see the doctor," Dr Dua thought.

Heal's smartphone app does not yet offer video chat, but it is on the company's radar. Heal doctors are chauffeured from housecall to housecall by medical assistants in company Priuses and perform basic tasks, such as taking a patient's vital signs, but they do not carry medications.

The company does not dispatch NPs.

"We have a distinct belief, perhaps because I am a doctor, that the relationship between a patient and a healthcare provider should be with a physician," Dr Dua says. "Physicians have the most and best training, and that initial visit, where you're really getting to know your patient in depth, and the patient feels least vulnerable and most able to express themselves, should be with a doctor."

Although Heal's doctors handle the usual urgent-care complaints, they also do well-baby exams, physicals, flu shots, and family health assessments. And for patients who don't have a primary doctor, Heal actively seeks to fill that role. (If a patient does have a primary doctor, Heal will forward housecall visit notes, if asked.)

The cost per patient is a flat fee of $99; there is no surge pricing during rush-hour visits or weekend premiums. Some insurers, but not all, cover the fee. Over 80% of Heal patients use insurance to pay for a housecall, Dr Dua reports.

Heal makes housecalls from 8 AM to 8 PM, 7 days a week. According to Dr Dua, a Heal doctor generally shows up within an hour.

Can sending a doctor on a $99 housecall, less than the cost of many office visits, be profitable? It can, Dr Dua insists. Being in-network with some insurers increases the volume of housecall requests. And 40% of Heal patients are repeat customers, she says.

"We're looking to build a relationship with the family," Dr Dua explains. "While we're taking care of Mrs Smith, she will often say, 'Wow, this is phenomenal. Can you take a look at my husband?' We charge $99 per patient, so that can be a very profitable hour for us."

Because Heal, like other housecall startups, is a virtual business, overhead is low. There is no Heal building, so no monthly rent to pay.

Mend, Serving the Dallas–Fort Worth Area

Emergency physician Jonathan Clarke, MD, started Mend in the Dallas–Fort Worth area in 2015. It has already tripled in size, and now covers an area of 900 square miles.

The company provides urgent care, and patients generally range in age from 1 to 64 years. A Mend housecall can be requested with a smartphone app, by email, or by phone.

Mend employs 15 full- and part-time NPs and physician assistants (PAs), as well as three medical directors (all emergency physicians). All have at least 5 years of experience in urgent care or emergency medicine.

It is primarily NPs and PAs who are dispatched on housecalls. The physicians generally provide medical supervision, although they do field about 10% of the calls themselves, Dr Clarke says.

Mend is open from 8 AM to 8 PM. "We see folks in office buildings, high-rise apartment buildings, and convention centers," says Dr Clarke. "We've even seen people in public parks." Clinicians travel solo in company vehicles, primarily subcompact Honda Fits.

"We have most of what you'd find in an urgent-care setting," Dr Clarke explains. "We have a nebulizer and a cautery machine. We do epistaxis management and laceration repair. We have orthopedic splints, crutches, and slings."

"We carry a number of medications," Dr Clarke continues. "For most medications you would receive as a prescription, we can dispense the first dose in the home setting, whether it's oral, inhaled, or injectable medications. Then we typically arrange to have the prescription sent to the patient's pharmacy of choice, but we also have several delivery options."

"We're not providing any bloodwork or x-rays," Dr Clarke adds. "Within our scope of practice, we don't need to. We use clinical prediction rules—like, for example, the Ottawa Ankle Rules. Our provider may say, 'I believe you may have an ankle fracture. As long as it's not grossly deformed or displaced, we're going to splint that with a posterior splint and give you a set of crutches, which are in the vehicle, and then arrange a follow-up visit with an orthopedist in 5 to 7 days.'"

"This is exactly the standard of care you'd receive in an emergency room," Dr Clarke reflects, "except that you'd get an x-ray,

they'd say, 'I think your ankle may still be broken,' and you'd get a $2000 to $3000 bill."

Mend charges $50 for the first visit and $199 for subsequent visits.

"The price is all-inclusive," Dr Clarke says. "It covers your first dose of most medications, any supplies needed onsite, and prescription delivery. Subsequent visits are comparable to what an ER copay would be, or an urgent-care visit if you had a high-deductible plan or were paying cash."

There is a $50 charge per additional patient per visit, a $25 charge for a flu shot, and a $50 charge for a physical. Mend does not yet accept insurance, but that will soon change, Dr Clarke says.

Last year, Children's Health, an integrated delivery system that includes three pediatric hospitals in North Texas, became a majority stakeholder in Mend.[2]

"We are integrating with their health system, with things like a nurse advice line and 24-hour customer support with insurance integration," Dr Clarke says, "so we should be in-network with several major insurers by the end of the year."

Pager, Serving Manhattan and Brooklyn

Pager, the brainchild of former Uber chief technology officer Oscar Salazar, began operation in 2015. It employs 35 full- and part-time clinicians (10 of whom are physicians), who typically moonlight from their regular hospital jobs; they are paid market rates. They primarily offer urgent care to adults and children.

A first-time in-person visit costs $50; subsequent visits cost $200. Housecalls, made using Pager's smartphone app, are triaged by a registered nurse who conducts a video chat to determine whether an in-person visit is needed. A patient can also opt for a $25 phone or video session.

Clinicians travel by Uber-dispatched cars or public transportation, whichever makes sense at the time. Currently, housecalls are limited to Manhattan and Brooklyn, but Pager has expansion plans in the Tri-State area.

Doctors, NPs, and PAs travel solo, with backpacks equipped with an injectables kit, suturing kit, otoscope, stethoscope, other equipment, bandages, and 20 commonly prescribed urgent-care medications, says executive vice president Andrew Chomer.

If a patient requires additional doses of medication or different drugs, the Pager clinician, using a company-issued tablet, sends an e-script to partner ZipDrug, an on-demand prescription medication service; delivery takes about an hour.

Housecalls are offered from 8 AM to 8 PM 365 days a year. A physician is always on duty, so NPs or PAs on a housecall can consult by text, phone, or video chat. A tablet is used to enter visit notes into the firm's EHR, and the notes can be shared with a patient's primary doctor, if requested.

Corporate clients are key to Pager's growth; 25 firms are already on board, Chomer says. Pager clinicians will come to a patient's office not only for urgent care, but also for physicals, wellness exams, and flu shots. For companies seeking to reduce employee absenteeism, paying $100 for a physical or $25 for a flu shot is cost-effective.

Pager does not currently accept insurance, but hopes to be an in-network provider with several carriers before the year is out, Chomer reports.

This month, Pager will become a provider for a physician group in Florida that has risk-bearing contracts with Medicare Advantage plans, underwritten by commercial insurers, seeking to reduce urgent-care and ER visits for "unplanned or urgent-care needs in a chronic-care population," Chomer says.

It remains to be seen whether Medicare beneficiaries will be comfortable with Pager's smartphone app and video triaging prior to a housecall. But if the experiment works, accountable care organizations and patient-centered medical homes will become prime prospects.

As of March, Pager had raised $10.4 million in venture capital funding.[3]

PediaQ, Serving the Dallas–Fort Worth Area

PediaQ, which has been operating since 2015, offers urgent care to children, "because adults don't have the immediacy of needs and they don't get sick quite as frequently as kids do," says CEO Jon O'Sullivan. "Once we're established and we've generated the awareness and acceptance of our model and it becomes more mainstream, that will afford us the ability to expand to adults."

"We offer access to primary care when you can't get into your pediatrician's office," Sullivan says. Housecall hours are 2 PM to 10 PM on weekdays and 8 AM to 10 PM on weekends, when pediatric offices aren't open or when getting a timely appointment is difficult.

"It's very important for us to develop good relationships within the pediatric community, to gain their support, and to make them understand that we are not competing with them," O'Sullivan stresses. "We only offer services for episodic or urgent care. We don't do well visits, immunizations, or things like that."

Initially, PediaQ offered housecalls until midnight, but no longer. Finding clinicians who would work after 10 PM proved difficult, and the firm discovered that when parents put a child to bed later in the evening, "as long as they can get that child to sleep, even though the child may be sick, they want that child to rest and sleep," O'Sullivan says. "Even if a child wakes up at 2 or 3 in the morning, a parent will typically try to get them to go back to sleep and take them to the doctor the next day, or, if it's really bad, they'll take them to the ER right away. We found that only 5% of our visits were occurring after 10 PM."

A standard visit costs $150, about what local pediatricians charge. A visit to a local urgent-care center averages $250 to $300, O'Sullivan says, and an ER visit typically costs more than $1500 if a patient is paying out of pocket.

Other PediaQ rates include $50 for each additional patient per housecall, $25 for onsite tests, $35 for inhalants, $50 for lab work, $40 for medical adhesives for wound repair, $40 for injections, and $35 for prescription pickup. Housecalls made on holidays carry a $50 surcharge.

PediaQ takes insurance from several major carriers, whose members pay an office copay for the basic fee plus a $25 "convenience fee" to cover clinician travel time. Discussions with other insurers are in progress. "We need to demonstrate to them that people want this and that it can be cost-effective" in reducing preventable ER and urgent-care visits, O'Sullivan says.

To remain cost-effective, PediaQ uses NPs rather than physicians for housecall visits, he says. The company employs seven full-time and 15 part-time NPs. Most have at least 5 years' experience treating pediatric patients.

"If we were to find a pediatrician who was really good and was in practice for 5 years, they'd probably have a pretty busy practice and be making $250,000 to $300,000 a year," O'Sullivan says. "We don't want to be a concierge model and charge someone $300 to $400 for a housecall."

A typical housecall lasts 20 to 30 minutes, which is "two to three times longer than you would get in an exam room," O'Sullivan says. Total time, including travel, is about an hour.

Since September 2015, PediaQ clinicians have seen more than 2500 patients, O'Sullivan says. "We started in one North Texas community and we grew to five others. In April, we expanded into North Houston. We will continue that expansion in the fall."

PediaQ had raised $1.2 million in venture capital funding as of November 2015.[4]

RetraceHealth, Serving Minneapolis

When his 1-year-old son was seriously ill, health economist Thompson Aderinkomi took him to a clinic four times over several weeks before pneumonia was finally diagnosed; the visits cost him $7500 out of pocket.

RetraceHealth was born in 2013 out of the frustrations of that experience. It primarily provides urgent care to patients of all ages, says Aderinkomi, who is the company's CEO.

Patients are socioeconomically diverse. "We have people who live in the wealthy part of the city; we have people who live in the not-so-wealthy part of the city," he says. "We have people who are very tech-savvy and people who are not."

Visit volume has quintupled since 2015, Aderinkomi reports.

RetraceHealth primarily employs NPs, most of whom work full time.

"Nurse practitioners are part of what makes this model economically feasible," Aderinkomi explains. "Their salary is much lower than a physician's and their malpractice insurance costs less than a physician's. When you're in a state where they can operate independently, you're essentially buying the same insurance a doctor gets for a fraction of the price."

"Studies show that nurse practitioners have the same outcomes as medical doctors, or better, and nurse practitioners have higher levels of patient satisfaction," Aderinkomi continues. "Add it up and it just makes sense."

To request a housecall, a patient looks at the smart calendar on the firm's website and clicks on an open time slot, which brings up an online form. After the patient provides name, phone number, and email address, he or she downloads a video chat app. A video session with a RetraceHealth NP precedes all housecalls to determine whether an at-home visit is necessary.

Sometimes a videoconference with an NP is preferred or all that is required; if so, the fee is $60 if a patient is paying out of pocket. A home visit costs $150, but if the visit includes lab work, the price is $190. An in-home x-ray, conducted by a technician with a portable x-ray machine, costs $160. An ultrasound also costs $160, and vaccinations are at cost.

About 50% of RetraceHealth patients already have a primary doctor, and the firm will forward visit notes if the patient asks. But many of those patients "are switching to us," Aderinkomi says. For $300 a year, a family can receive unlimited primary care—which is less than what concierge doctors typically charge but akin to the rates charged at some direct primary care practices.

RetraceHealth accepts some insurance, including Blue Cross and Blue Shield of Minnesota, which is also an investor in the firm. Insured patients pay only a copay for services.

Earlier this year, RetraceHealth received a $1 million cash infusion from Blue Cross; Health East, a four-hospital system based in St. Paul; and health services giant McKesson.[5] In June, the firm secured another $7 million in venture-capital funding.[5]

Going on Housecalls: Two Physician Perspectives

Pediatrician Sam Kim, MD, MBA, and family physician Michael Oppenheim, MD, both work part time for Heal in Los Angeles, but their perspectives on the experience are very different.

Dr Kim, who is turning 36 this year, is employed at an outpatient group practice in California's San Fernando Valley. "The idea of a medical startup piqued my curiosity," he says, "and when I initially spoke to Dr Dua about her vision for Heal—how it was trying to disrupt the status quo and how healthcare is delivered to the population—I thought it was very interesting. So I jumped on board, and it's been working out really well."

"In a brick-and-mortar practice, it's more about efficiency of care and going from patient to patient," Dr Kim explains. "In my practice, I still feel like we give our patients excellent care; I'm not rushing anybody and I'm trying to answer all their questions and provide a high level of service. But in the end, it's more about numbers. If you want to survive as an outpatient physician, unfortunately, the reality of the situation is that you need a certain patient volume to make sure that your lights are on and your doors stay open. You're kind of beholden in that way to make sure that your practice is as busy as can be."

"With Heal, we can provide a longer visit and more satisfaction while meeting all a patient's healthcare needs," Dr Kim says. "By seeing the patient in the comfort of his or her own home, there's no apprehension about going to the doctor's office, and thinking, 'This is where all the bad stuff happens.' It makes the whole visit a lot easier and less stressful."

"This model allows a physician the freedom to really dig in and not only talk with the parents and the patients, but also to do true anticipatory guidance," Dr Kim says. "Even if the patient just has a cold or congestion, a minimum visit is half an hour. I end each visit by asking, 'Are there any other questions I can answer for you?' And then patients are thinking, 'Oh, there's one last question.' Until you get that full patient satisfaction, you don't have to leave. I really like that."

Dr Oppenheim, who is 76, has been going on housecalls for more than 30 years. He is the doctor hotels in Los Angeles call if a guest falls ill, and he has done video chat housecalls. Heal is one of two Uber-like firms he has worked for that offer housecalls

on demand.

Ironically, the very thing that Dr Kim likes about working for Heal—that he can lavish attention on a patient who may only have a cold or congestion, which would be a luxury in an office setting—doesn't sit well with Dr Oppenheim.

"In my hotel business, I always talk to patients before I see them," Dr Oppenheim explains. "I ask them what the problem is and discuss it. My advice is free. Over half the time, I don't make a housecall. If the patient just has a cold, I tell them it's just a cold and they probably don't want to spend the money to have me come and see them. If they've forgotten their medicine, which travelers often do, I don't stick them for a housecall. I just tell them to go to a pharmacy and have the pharmacy call me and I'll approve it over the phone."

"Working for these Uber services, I have to make every visit they assign," Dr Oppenheim laments. "All I learn is a symptom: 'The patient has a cough or an allergy.' As a result, I often walk into situations where a housecall isn't appropriate. For example, 'Granny hasn't seen a doctor in 30 years. Could you check her out?' Many patients have problems I could have handled over the phone, and others require more than a housecall could provide."

"The Uber-housecall trend will continue," Dr Oppenheim predicts. " People love convenience. They love it more than quality. And it's cheap. Nobody is complaining that Uber drivers earn less than traditional cab drivers because Uber drivers are cheap. Everybody wants cheap."

Critics of the Uber-Housecall Concept

If Dr Oppenheim has mixed feelings about housecalls, the feelings of other doctors are decidedly unmixed.

"I don't think you're going to find a self-respecting doctor willing to exercise the kind of judgment and treatment necessary to properly care for patients for what these companies are willing to spend," asserts internist Alan Kronhaus, MD, from Durham, North Carolina.

"I believe in the Uber service as it's constituted," Dr Kronhaus adds. "It's just not applicable to medicine."

New York pediatrician and preventive specialist Jay Parkinson, MD, seconds that. Dr Parkinson claims to have invented the idea for housecalls on demand in 2007, although his was a one-doctor startup. He launched a website from which patients could book appointments, and website-generated email informed him when he had a new patient.

The venture quickly gained media attention. Within a month, 7.5 million people had visited his site. His practice was almost immediately full, he told Medscape.

Then came the hard part: actually delivering care, which he did on foot, by bicycle, or by public transportation. But "the practice wore me down, both physically and financially, and therefore psychologically," Dr Parkinson says, even though, as a physician, he was used to working 70- to 80-hour weeks.

He charged $100 a visit, payable through PayPal, but "the travel time between patient apartments and my apartment or the pharmacy to pick up supplies and refrigeration-sensitive vaccines limited me to a maximum of eight patients, or $800, a day," he recalls.

In addition, "50% to 60% of my day was spent on supply logistics and traveling between apartments, not seeing patients."

"Short of teleportation, the doctor housecall will always be an irresponsibly massive reduction in primary care efficiency," Dr Parkinson now believes, especially with a shortage of primary doctors.

"Every second a doctor is not seeing patients is wasted time," he adds. "Doctors already spend roughly 40% of their day documenting and doing other administrative tasks. To waste the other 50% to 60% of your day traveling between patients is a 50% to 60% reduction in efficiency."

He does not think that the new crop of housecall startups will be able to maintain their low rates over the long haul, even with venture-capital backing.

"The venture-capital subsidy will run out shockingly fast," Dr Parkinson predicts. Once housecall visits are no longer subsidized, he is convinced, their cost will "be more like $499 or $599"—so primarily for affluent patients.

A Venture Capitalist's Perspective

McKesson Ventures, the venture-capital arm of the healthcare giant McKesson, views "alternative-care delivery models" as a growing trend, says senior vice president Tom Rodgers.

"At commercial payers and the Centers for Medicare & Medicaid Services (CMS), the jury is still out on whether these firms lower costs to the system," Rodgers says. "Are the people who use these services going to get healthy anyway, and you're just increasing overall utilization? Or are you really substituting lower-cost care? I think time will tell. That is a reason CMS and most commercial payers haven't included these services in their networks, and why telehealth is still more of a retail market. Payers want data before they give their endorsement."

"I paid $100 for my last Heal visit," Rodgers recalls. "They sent a doctor and a medical tech to my home, and they were there for 40 minutes. I don't know that the math works that well when you try to scale that."

"RetraceHealth came up with what we think is a more scalable approach, which is to keep the more expensive clinicians centralized and on the phone or doing video, and always making sure you've got somebody operating at the top—not the bottom—of their license," Rodgers says. "So you have nurse practitioners to do the initial triage and consult. And then you send, when necessary, the highly empathetic home health agents to people's homes."

"Retrace," he says, "will deploy a phlebotomist, a social worker, a home health tech, or maybe a nurse practitioner, depending on what is needed, but it will always be the lowest-cost resource who can operate at the top of their license."

"If this model has any chance of working and scaling economically, you must get the recipe right," Rodgers says. "For now, when people are spending venture dollars, that means focusing on top-line growth and optimizing the consumer experience. But very quickly you will need to show that the economics work."

The larger question, Rodgers maintains, is "How does this care model bend the cost curve? How can this model be leveraged to enable better chronic-care management? That's where the real costs are, and where the patients are—as opposed to consumers who may be sick today but not tomorrow."

Housecalls for Chronic-Care Patients

Doctors Making Housecalls (DMH), a primary care group based in Durham, North Carolina, has specialized in making housecalls to complex, frail, largely elderly patients for 14 years. It isn't an Uber startup and it has no app. The more than 75 participating doctors and other clinicians are contacted by phone.

"We specialize in caring for patients onsite in assisted-living communities," explains CEO Dr Kronhaus. "Just as hospitalists go from room to room in a hospital, we're 'residentialists,' going from room to room in communal settings."

"We see relatively few patients per day—10 to 15," he says. "In a private residence, it's even less—maybe five to eight patients per day."

"The most frequent number of comorbid conditions for a resident in assisted living is eight," Dr Kronhaus reports. "In addition to multiple physical conditions, there's a very significant burden of mental illness in many of our patients. We actively manage patients' problems—I call it 'proactive primary care'—instead of reacting and waiting for a crisis, like most physicians are forced to do, in which case the patients never make it to the doctor's office. They get shipped off to the emergency room, and then often to an acute-care hospital and rehab. This is very expensive and often can be prevented."

Unlike the new housecall firms, which are seeking acceptance from commercial insurers—some with early but limited success—DMH is in-network for most commercial insurers; about 30% of its patients are in Medicare Advantage plans, Dr Kronhaus says.

Moreover, the practice has gained acceptance from CMS and sees regular Medicare patients. DMH has just begun its fifth year

as a CMS Independence at Home Demonstration, and is the only practice specializing in housecalls in the program.[6]

"CMS hasn't given any of the practices in the project a dime to fund receivables," Dr Kronhaus says. "But we do get a share of the savings. We probably save CMS several thousand dollars for a patient who costs about $40,000 a year."

Transitioning From Urgent to Chronic Care

DMH was managing chronic-care patients long before app-based housecalls appeared. But one former housecalls-on-demand firm— Atlanta-based MedZed, which began operation in 2014—has made the transition from seeing urgent-care patients on an ad hoc basis to seeing chronic-care patients.

"The easiest place for me to get experience and start to use technology was in a direct-to-consumer business focused on young children," recalls Scott Schnell, MedZed's CEO. Internist Neil Solomon, MD, the medical director, envisioned a firm focused instead on chronic-care patients, a more complex undertaking, but he did not join MedZed until mid-2015, when he began spearheading the transition.

MedZed's model is designed to do what venture capitalist Tom Rodgers maintains that a firm offering housecalls must do to succeed long term: bend the cost curve. To that end, of the 25 people that MedZed employs, about half are clinical staff—NPs, licensed vocational nurses (LVNs), and registered nurses. The rest are support staff.

"Physicians are often not the best ones to help patients pay attention to self-care, nutrition, medication adherence, motivational communication, and related issues," explains Dr Solomon. "They're not trained to do it. It's not their initial predisposition. And it becomes rather expensive to ask them to do those things, which is why a lot of doctors don't do them in their offices today."

"In addition, putting a doctor in a car on the road is a very expensive use of their time," Dr Solomon continues, "and it's not something doctors would like or want to do. So if we can create a business model that allows us to see more patients by using lower-level, lower-priced care providers in the home, it allows people to practice at the top of their licenses, and that allows us to scale the business."

A MedZed NP and an LVN visit a new patient to establish a personal relationship. Thereafter, it's usually the LVN who goes on the housecall, toting a backpack filled with wireless diagnostic equipment, supplies, and a tablet.

The first part of a visit is devoted to data collection and conversation with the patient. For example, how is the patient doing with smoking cessation? Are there any changes in health status? In medication status?

In the second part of a visit, the LVN links to the NP at a remote location. The NP uses video chat to review the data the LVN has collected and conducts a remote physical examination of the patient with the LVN's help.

In the third part of a visit, the LVN reviews with the patient the care plan the NP has prescribed and ensures that the patient is able to adhere to it. For example, if the NP has prescribed more exercise, the LVN might map out a walking route and might even walk the route with the patient to ensure that it is doable.

MedZed's primary client is a managed care company called SynerMed, located in Monterey Park, California, which has 1 million members throughout the state. SynerMed contracts with MedZed and reimburses MedZed for the housecalls it provides to SynerMed members.

"We've had conversations with risk-bearing delivery systems," says Schnell. "Hospitals also have an interest, because they're concerned about readmission rates and being penalized. We've had conversations with insurers with Medicare Advantage plans. We're also talking to insurers about providing primary care to their members who are not attributed to a primary care doctor today."

In 2015, MedZed raised $3.2 million from investors.[7]

An Enduring Concept?

Whether the housecall revival will prove cost-effective is an open question. DMH, a traditional primary care practice that focuses on making housecalls to very sick patients, has been part of the CMS Independence at Home Demonstration for more than 4 years. The agency is still collecting and evaluating data; it's a slow process.

Los Angeles Times business columnist Michael Hiltzik, an outspoken critic of Uber housecalls, questions whether the Uber model is appropriate for healthcare.

"The real question is whether healthcare harbors the same inefficiencies that Uber has exploited," Hiltzik writes.[8] "That involves the question of whether healthcare is a service that can be reduced to fundamentals like local transportation. Is diagnosing or treating a disease the same thing as driving a car?"

Even those who have invested in Uber-housecall firms, like Tom Rodgers of McKesson Ventures, are cautious in their forecasts.

"The actuaries inside commercial payers and CMS will tell you that the jury is still out on whether they lower costs for the system," he says. "The economics for the housecall model," he admits, "are a challenge."

But RetraceHealth's Thompson Aderinkomi, for one, has a different perspective.

"It's not surprising that there are critics," he says. "But they're singing the same song that has been sung about every major innovation since the beginning of time. They'll be silenced once the model takes off. Every new thing looks like it won't work at first—until it does."

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