
HEALTH CARE ON WHEELS



OFFICE OF INSPECTOR GENERAL
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HEALTH CARE ON WHEELS

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EXECUTIVE SUMMARY

PURPOSE

This report provides a description of health care providers that serve medically underserved and uninsured populations in public settings, or that make physician housecalls.

BACKGROUND

This is one in a series of reports on mobile health services. Two other reports provide: (1) a national overview of the types and prevalence of mobile health services, the quality of these services, and the degree of regulation; and (2) a description of the prevalence, conduct and regulation of public cholesterol screening.

We conducted these studies in response to a request by the Chairman of the House Subcommittee on Regulation and Business Opportunities. The studies provide information concerning mobile health services: services offered outside the traditional settings of a hospital, clinic, or physician's office.

While gathering background information, we heard of a few providers attempting to improve access to health care by taking their services to patients, rather than waiting for patients to come to them. We decided that these highly innovative services deserved a closer look.

We found in our discussions with these providers that, while the profit motive was clearly at play in some instances, there was also a strong undercurrent of altruism. They believe not only that mobile services such as theirs are viable, but that they constitute the only way that some people will receive any health care at all. They are committed to providing high-quality care, and they also believe that mobile services like theirs can save health care costs, either by preventing or postponing institutional care or by forestalling the development of serious health problems.

METHODOLOGY

We visited a unique unit run by the National Center for Health Statistics. There we learned about the special characteristics of a mobile operation. We conducted interviews with 30 individuals, including Federal officials, the Office of Technology Assessment (OTA), and 19 providers of mobile health services. We also visited three of the housecall providers to observe the delivery of services.

FINDINGS

- A few highly innovative providers, using vans, are going to a wide variety of public settings to deliver health care services to medically underserved and uninsured groups.
- Some providers, including for-profit companies and non-profit hospitals, are making physician housecalls. Most, though not all, are delivering primary care to the elderly.
- Few of the mobile health services described in this report are subject to special State or Federal regulations which address their mobile nature.
- Providers say that the greatest benefit of their mobile services is that they reach people who would not otherwise seek or receive health care.
- Providers believe that, by focusing heavily on prevention, their mobile health services will lead to health care cost savings in the long run.
- Despite the growing interest in providing mobile health services, lack of public recognition and problems related to financing and Medicare reimbursement may limit their future growth.

RECOMMENDATIONS

The Public Health Service (PHS) should study the costs and benefits of mobile vans and physician housecalls. Particular consideration should be given to supporting demonstrations and experimental projects. These should be evaluated with respect to: (1) access to care; (2) the quality of services; (3) the impact of services, including the question of disease prevention; and (4) the costs of service delivery.

In implementing the new physician payment system under Medicare, the Health Care Financing Administration (HCFA) should carefully consider the appropriate weight for payments for physician primary and urgent care housecalls.

COMMENTS

The PHS generally supports our recommendation to study the costs and benefits of mobile vans and physician housecalls. However, instead of initiating demonstration projects, they prefer, through the Agency for Health Care Policy and Research, to solicit applications from the health care research community to study how mobile health services delivery can impact access on health care, particularly for disadvantaged and rural populations.

The HCFA concurs with our recommendation and will evaluate medicare reimbursement for physician housecalls under the new physician payment system.

We wish to thank those in HCFA and PHS who commented on the report. We have made technical changes based on PHS's comments. A complete text of their comments can be found in Appendix C.

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INTRODUCTION

PURPOSE

This report provides a description of health care providers that serve medically underserved and uninsured populations in public settings, or that make physician housecalls.

BACKGROUND

This is one in a series of reports on mobile health services. It constitutes a preliminary look at these types of services. Two other reports provide: (1) a national overview of the types and prevalence of mobile health services, the quality of these services, and the degree of regulation; and (2) a description of the prevalence, conduct and regulation of public cholesterol screening.

This study was conducted in response to a request by the Chairman of the House Subcommittee on Regulation and Business Opportunities, to provide information concerning mobile health services: services offered outside the traditional settings of a hospital, clinic, or physician's office.

While gathering background information, we heard of a few providers attempting to improve access to health care by taking their services to patients, rather than waiting for patients to come to them. We decided that these highly innovative services deserved a closer look.

We found in our discussions with these providers that, while the profit motive was clearly at play in some instances, there was also a strong undercurrent of altruism. They believe not only that mobile services such as theirs are viable, but that they constitute the only way that some people will receive any health care at all. They express a strong commitment to providing high-quality care, despite the difficulties inherent in a mobile operation. They also believe that mobile services like theirs can save health care costs, either by preventing or postponing institutional care or by forestalling the development of serious health problems.

Federal funding of mobile services such as these is minimal at present. The PHS provides grants to approximately 550 community and migrant health centers and other not-for-profit agencies for services to the medically underserved. Include in this figure are 109 Health Care for the Homeless programs created by the Stewart B. McKinney Homeless Assistance Act of 1987. While some grantees have developed mobile programs which use vans and use these funds for the salaries of staff who work in them, PHS appears to have awarded few grants for the actual development of programs using vans. With regard to housecalls, Medicare covers a variety of services provided in the home, over and above the home health care benefit. In 1987, Part B reimbursement for these services totalled about \$1.1 billion, just under 4 percent of all Part B services. However, it is not possible to tell from the data what portion of these services was provided by physicians.

METHODOLOGY

During pre-inspection, we visited a unique mobile unit run by the National Center for Health Statistics, which gathers data on the health status of Americans through direct physical examination. There we learned first-hand about the special logistical characteristics and requirements of a mobile operation.

Other information was gathered through interviews with 30 individuals, including officials in PHS, the OTA, and 19 providers of mobile health services. We also visited three of the housecall providers, to observe the delivery of services and talk with patients and staff.

Appendix A contains a list of the providers contacted in the inspection.

FINDINGS

A Few Highly Innovative Providers, Using Vans, Are Going To A Wide Variety Of Public Settings To Deliver Health Care Services To Medically Underserved And Uninsured Groups.

Some providers across the country are using specially equipped vehicles, which they commonly call "vans," to provide access to health care to people who cannot or will not come to traditional stationary facilities for help. Some vans visit the homeless at shelters and transitional hotels, food pantries, parks, and "streets under bridges" in cities. Others serve migrant workers at the camps where they live during the growing season. Still others go to people in rural areas, low income housing units, churches, and "crossroads - anywhere there are people." Regardless of the type of provider or target population, respondents seem to share this philosophy: "If they don't come to us, boy, we go to them!"

The providers we contacted, most of them not-for-profit, include community and migrant health centers, hospitals, county health departments, a social service agency, and a private company. Most have used vans for less than 2 years, although one has served runaway teens with a van for 17 years.

Most vans operate a few days a week, visiting sites on a scheduled basis. Outreach workers publicize the van extensively and set up appointments, often with the help of staff from other community agencies. The service area is usually the county or city where the provider is based, although one doctor described her service area as the "boondocks of Montana," and a migrant program covers a 72,000 square mile area with a target population of 95,000.

Most providers use vans to extend their services to patients who cannot or will not come to their permanent facilities for help: "The van extended the walls of the hospital to the edge of the county." Some are also beginning to use their vans in "off" hours on a pilot basis to reach different patient populations. For example, a program which serves homeless children has just begun to serve foster children as well. Another program that serves runaway teens takes their van to elementary schools during the day, to conduct a 6-week drug education program for students.

Other providers are using vans to experiment with new approaches to delivering care. A midwestern university is developing a van program to reach pregnant women in the inner city to try to reduce infant mortality. In the east, a private company visits a few communities on a scheduled basis to dispense methadone to heroine addicts from a van. The idea of using a van arose as an alternative to building a stationary clinic, which community residents opposed. The director says that the van not only eliminates the need for patients to travel far to receive their dosage, but also frees them from drug dealers or addicts who may prey on them at a stationary site.

Most programs provide some sort of health assessment and triage. But almost everywhere the key services are screening and health education, both focused heavily on disease prevention.

Patients seen by these mobile programs reportedly present myriad health problems, most of them chronic rather than acute. Elderly patients in rural areas often suffer from heart disease, diabetes, or high blood pressure. Migrant workers and the homeless present a variety of maladies including wounds and abrasions, foot and skin infections, respiratory and gastrointestinal problems, and malnutrition. Homeless children frequently suffer from chronic ear infections. Many patients, adults and children alike, are not immunized, or are underimmunized, and subject to a host of diseases.

Almost all programs provide screening of some sort: to detect high blood pressure, hearing and vision problems, diabetes, cholesterol, colo-rectal cancer, cervical cancer (Pap smears), dental problems, or even sexually transmitted diseases or human immunodeficiency virus (HIV). Dipstick urinalysis (done on board) and blood work-ups are common. Samples are analyzed at a hospital or stationary lab.

Many programs perform a health assessment, such as a nursing physical, to evaluate acute or chronic illness. Some provide OB-GYN exams, pregnancy tests and well-baby care, and others provide dental exams and treatment. Many also provide triage or treatment in some form; the most sophisticated of these programs is described by its administrator as “a pediatric clinic on wheels.” Most programs dispense a few simple over-the-counter medications such as aspirin or antacids, and provide patients with prescriptions for other medications.

Immunization of both adults and children is a key service of many programs. Many respondents stressed the importance of immunization in terms of preventing disease.

No matter what the mix of services, respondents almost everywhere say that “teaching is probably our biggest thing.” Respondents say that patient education is important because “it’s preventive” and helps patients avoid more serious problems in the future: “We want to get people sooner rather than later.” Staff discuss diagnoses and prescribed regimens with patients, hand out printed information, and teach about hygiene, diet and nutrition, or “safe sex.” They talk to admitted drug users about drug treatment and “the needle issue.” They may distribute toothbrushes and toothpaste, combs, or vitamins in conjunction with their teaching.

A key component of every program is referral, not only to follow-up medical care but also to non-medical support services.

Respondents say that while most of their patients do not need hospitalization, many do need follow-up medical care of some kind. Providers have developed networks with other health care providers and social service agencies to ensure that their patients get the referrals they need. Where possible, staff refer patients to the provider’s stationary facility. But they also refer them to other providers such as physicians or city and county clinics. They try to ensure follow-up by making appointments for patients, recontacting

them to remind them of appointments, and giving out bus tokens, taxi vouchers, or actually taking patients to appointments. One program accepts up to three collect calls a month from a patient who wants to ask questions or discuss problems.

Many patients, particularly the homeless, are also referred to support services which can help them get back on their feet: housing, employment assistance and mental health services, for example. Providers have solid ties with other community agencies; some respondents commented to the effect that their mobile program is "a community effort from beginning to end." Sometimes there are formal contracts and written procedures. For example, a university program to combat infant mortality has written memorandums of agreement with hospitals and community agencies that will serve as official co-sponsors of the van program. For the most part, however, providers say that they have had informal but close working relationships with other agencies for years, and "we know our system pretty well."

Appendix B contains a description of other typical operating characteristics of these providers.

It is expensive to establish mobile health programs. Start-up funds usually came from local sources, including private donations. In some programs, Federal funding covers some of the operational costs, usually a portion of staff salaries.

Discussions revealed that it can cost \$100,000 or more to purchase and equip a van, and prices are increasing. One respondent said that their van had cost \$47,000 in 1982; when it was refurbished in 1987, she learned that the same van, bought new, would cost three times that much. Maintenance is also expensive. The director of the program which has used vans for 17 years reports that maintenance costs between \$2,000 and \$5,000 a year, depending on the age of the van. To control costs, respondents emphasize that it is important to find someone who "is in love with the van" and will take meticulous care of it. "You've got to be on top of it."

In starting up their programs, most providers bought and retrofitted vehicles with funds from local sources: agency grants, hospitals, universities, city, State or county funds, or corporate or foundation grants - in one case, the local foundation of the wife of a U.S. Senator. A few vehicles were donated to providers - by local health departments, a rancher, and even a famous singer-songwriter. Only one provider in our sample had received Federal funding to purchase a vehicle. Operating funds also frequently come from local sources, although community and migrant health centers which receive funds from PHS sometimes use them to pay the salaries of staff who work in a van. A few programs receive some Medicaid reimbursement.

Most of these programs provide services free of charge or for a nominal fee. In Arizona, a doctor reported that patients have paid him in everything from pocket change to tortillas.

Some Providers, Including Both For-Profit Companies And Not-For-Profit Hospitals, Are Making Physician Housecalls. Most, Though Not All, Are Delivering Primary Care To The Elderly.

One private company has made physician housecalls for 5 years, providing primary care to the elderly.

A company in Kentucky provides physician housecalls in three cities under a franchise arrangement. Its founder and president says that a franchise is easy to administer as well as a good tool to ensure quality control.

The president has extensive experience in home health care and established her service to provide access to care to the homebound elderly, a population which, she says, poses special problems for physicians: "Every doctor has patients who are homebound, and it's been the doctor's dilemma for some time how to accommodate those patients. Every home health agency needs a company like mine to fill the gap."

The service operates 12 hours a day, 7 days a week, with a 24-hour answering service. Eighty-five percent of the patients are Medicare recipients; one-third of these Medicare patients also receive Medicaid.

Most patients are referred by their primary care physicians. Contracted physicians, usually family practitioners and internists, use their own cars to visit homes, carrying only a bag. Each physician visits between 8 and 10 patients a day, providing primary care. A clinical laboratory and a radiology service that also make home visits provide back-up, furnishing test results the day of, or the day after, a visit. The president says that this arrangement has worked very well. Physicians do not carry drugs, but call in prescriptions to pharmacies that deliver. At the end of each visit, the physician completes a chart, as would be done in a regular office, and a copy is sent to the referring physician.

The president described several measures which have been instituted to monitor quality of care on an ongoing basis: (1) a medical director in each office is responsible for overseeing care; (2) a retrospective peer review of services is conducted monthly; and, (3) patients are phoned 2 weeks after a call to evaluate the outcome. In addition, the president recognized that primary care physicians might be concerned lest visiting physicians "steal" their patients, so visiting doctors are not allowed to give patients their addresses and phone numbers or follow them into the hospital. For patients who need hospitalization but have no personal physician, the company has a panel of physicians who have agreed to accept referrals.

She reports that community acceptance of her service has been good. From the patients' perspective, "it's a very popular service." Recruitment of visiting physicians has been easy, since, in her view, "many physicians today prefer to work in health maintenance organizations (HMOs), group practices and other alternatives to private practice." In the State where she operates, she can guarantee physicians an annual salary of over \$70,000 for 8 calls a day, 5 days a week. Demand is reportedly growing. The president projects that, in one city alone, visits will grow from 12,000 in 1988 to as many as 20,000 in 1989.

Some hospital-based programs are also making housecalls, to deliver primary care to the frail elderly.

We visited two not-for-profit hospitals that have been making housecalls to the frail elderly for 4 to 5 years. At one hospital, the program is a component of the hospital's multi-faceted senior services program, at the other, the program is a department of the hospital. Both programs were established upon the recognition that there was a large and growing population of homebound elderly who needed primary care. The administrator of one program, which began as a model with a special grant from a community agency, said: "We realized that we had an underserved population with disjointed care."

Patients are the frail, homebound elderly: anyone over 65 "who cannot or will not go out and has a physical or psychosocial disability." Many are in their 80s and 90s. Two of the patients seen during our visits were a woman in her 80s who takes 14 prescription medications due to her heart condition and numerous other health problems, and a diabetic man in his 60s recovering from a recent heart attack, who had an ulcer on his foot. All of the patients we saw were being cared for by a family member or other live-in caregiver.

About a quarter of the patients are referred by physicians, the rest by community agencies, friends, or family. A physician and nurse with experience in geriatric medicine use vans to visit homes on a scheduled basis, delivering primary care. A portable x-ray service provides back-up, and blood and urine samples are analyzed back in the hospital. One program initially did some lab work in the van but gave it up after a year, not satisfied with the quality of test results and finding that they needed to do more types of testing than was possible within the confines of the van. Neither program dispenses prescription drugs, although one respondent noted that they are considering doing so.

Charts are kept at the hospital, carried to homes and updated back at the hospital following visits. One program also keeps a folder in the home with progress notes, updated by the team as well as visiting nurses, which respondents find helpful in coordinating care. One van has a telephone, which staff say is indispensable in communicating with patients and caregivers as well as responding to pages from the hospital.

Staff examine and treat patients, review medications on the spot, counsel and support caregivers, and assess the living situation of patients. They often pick up subtle clues on how a patient is doing. One nurse found handmarks on the wall which indicated that a patient had become unstable on her feet. And a physician noticed that a patient plagued by persistent pneumonia was using the same bottle over and over to refill a nebulizer. The bottle contained bacteria. The doctor said: "I wouldn't have known had I not seen it."

Delivering care in the home poses special problems such as poor lighting or marginal hygienic conditions. A doctor noted: "I may have a sterile field, but I can't control the roaches." Also, it can be emotionally wrenching for staff to see patients crying from

loneliness, or to tell a patient that he must go to a nursing home. A program director said: "You must have a dedicated group of physicians. It's not for everyone."

Despite the problems, respondents believe that "we are providing better care, and can do a better job in the home setting. We know how they (the patients) get by day to day, why they may be depressed. We observe the social issues." They demonstrate excellent rapport with patients and seem to enjoy their work. "You get out of the office, get to know your patients, have tea with them, kiss them good-bye." Patients and caregivers seemed to like the service and be grateful for it.

Respondents say there is another key facet to the success of their programs: close coordination with community agencies that provide non-medical support services to patients. They say that this "holistic" approach to meeting both the medical and social service needs of their patients helps keep them at home as long as possible, avoiding unnecessary, and expensive, hospital or nursing home care.

Demand for services is reportedly strong and growing. One respondent projected 1,500 visits for 1989, and another noted that her program's patient load grew from 600 in 1984 to a projected 1,300 in 1988. "There's a huge demand out there. We could be swamped." They will add a second van soon.

A private company in the West runs a "comprehensive housecall" service, using a specially equipped van to visit people of all ages in their homes to provide urgent care.

We visited a company in California developed by a physician who saw the need for a service which provided physician care in the home for patients who were injured, chronically ill, or suffering from non-life-threatening medical problems. He labels his service a "comprehensive housecall."

The founder describes his service this way: "I built a van that gave a doctor his tools and put emergency physicians into the van. We can take an x-ray, and do an EKG and blood tests and have the results immediately. We can sew up somebody's wounds, give injections and dispense medications." A specially trained technician works with the physician.

The company has a non-financial contract with a local hospital, where it is based. The hospital's name appears on the van, and the service refers some patients who need hospitalization to them. The service operates 12 hours a day, 7 days a week, and serves the entire community. Patients may call for help themselves or be referred by their physician.

The van carries extensive diagnostic and treatment equipment, and 55 prepackaged medications. The physician uses a cellular phone to talk with patients and the base office while under way. Charting and billing are completely computerized, which the president considers one of the best and most unique features of the service. The physician dictates a chart in the van at the end of each visit. It is transcribed back at the hospital and copies are sent to both the patient and his or her primary care physician. The computer also generates coded bills ready to be dropped in an envelope and mailed.

SOME OF THE PATIENTS WE MET WERE: (1) a man in his 70s who had fallen at home and cut his head; the cut was sewed up in a 23 minute call, avoiding an emergency room visit; (2) an 81-year-old woman living alone, recovering from a broken pelvis; an x-ray taken with the patient lying on her bed showed that she was healing satisfactorily; and, (3) a frail 80-year-old heart patient and his wife. The technician processed a cholesterol test while the doctor treated a wound, reviewed a blood pressure log kept by the wife, and discussed the drug regimen. He found that the patient was taking the wrong dosage of one of the medications.

To ensure high-quality services, the medical director routinely reviews all charts using procedures followed in hospital emergency rooms. A detailed log is kept of all medications dispensed. In the van's mini-lab, detailed quality assurance procedures are followed and a second set of controls is run against hospital values to ensure accuracy. Laboratory equipment is as fail-safe as possible, much of it with solid state circuitry, and some was redesigned for use in the van. The van was designed around the equipment, and is insulated and climate-controlled.

The president believes that other features of his service also enhance the quality of services: (1) medical risk is greatly decreased because physicians can diagnose and then treat immediately; (2) seeing patients' living situations first-hand often provides important information for both diagnosis and treatment; and, (3) supplying patients with a complete, readable copy of their charts is invaluable in helping them comply with prescribed regimens.

Besides offering high-quality care, the president believes that "the comprehensive housecall" leads to significant cost savings by enabling patients to avoid visits to the emergency room or ambulance rides. To illustrate, he points to his company's agreement with the hospital's Medicare HMO. The service will visit HMO patients, upon referral from their physician, who face a non-life-threatening emergency, at a flat fee of \$200 per visit. The HMO paid almost a million dollars last year for unauthorized emergency room visits for its patients. Besides keeping patients within the hospital network, this arrangement is an attempt to cut those costs. The flat fee will not only save an average of \$70 per patient as compared with last year, but in some cases will save \$272 which the HMO would pay for an ambulance ride.

Patients reportedly have responded very positively to the service, although the president has found a need to market more aggressively than he expected to potential patients. Some elderly people fear alienating their primary care physicians by using his service. Others are proud, and afraid of being seen as sick or old if a van appears at their house. Still others assume that the service is too expensive for them. As for younger people, many have had no prior experience with housecalls or are reluctant to let people into their homes.

The president believes that his type of service can be used in a number of ways, such as providing care to workers who are injured on the job, providing aftercare to patients discharged from the hospital, and providing primary care to the seriously or chronically

ill. The company is poised on the brink of a multi-million dollar national expansion. It was featured on a national television program in August 1989 and has also been the subject of articles in national publications.

Few Of The Mobile Health Services Described In This Report Are Subject To Special State Or Federal Regulations Which Address Their Mobile Nature.

In response to questions concerning how they are regulated, respondents at all but two programs which target the medically underserved or uninsured pointed out that, as medical facilities, their institutions already comply with State licensure requirements and guidelines and are subject to routine inspection. When asked how they safeguard the quality of their mobile services, they said that they apply the same protocols and procedures used in their stationary facilities. They added that nurse practitioners or physician assistants who work on vans are backed up in accordance with State law by a physician at a stationary site.

Two programs did have to meet special regulatory requirements: (1) the methadone program obtained a State license in order to comply with Federal requirements; the director noted that State regulators were somewhat nonplussed by the mobile operation: "They couldn't fit us into a box;" and (2) a program which serves homeless children went through the State's certificate of need (CON) process; the administrator said that State officials were very "supportive." (State CON requirements vary widely, although all programs require that health care facilities justify to the State the need for purchasing major medical equipment or building new additions or modifying their facilities. The CON process is slowly being phased out. It exists in 38 States.)

With respect to the housecall services, only the company in Kentucky is subject to any regulation as a mobile service, per se. It went through the State CON process and is licensed as a mobile health service. The president said: "It was easy to represent the need for a housecall service in the CON process." She endorses CON because it "provides a measure of protection to the public." In contrast, the president of the other company said that, while he has inquired about regulation with several public agencies and private insurers, "there has been nothing in any form for Medicare, malpractice insurance, workman's comp, insurance for the office or personnel, or certification that's ever come up that allows me to describe what I do. It means you could slide all the way through the surface and no one would ever know administratively that you're on four wheels."

Providers Say That The Greatest Benefit Of Their Mobile Services Is That They Reach People Who Would Not Otherwise Seek Or Receive Health Care.

Providers believe that their mobile programs overcome immobility, physical and mental frailty, poverty, language or cultural barriers, and fear or mistrust of providers which serve as barriers to accessing health care for some people.

Providers who work with the medically underserved express concern about the growing number of Americans who find it difficult to access health care: (1) people in rural areas, especially the elderly, many of whom are immobilized by chronic illness and live in

isolated areas with few health care providers; (2) the “working poor” or “notch population,” who lack health insurance or adequate coverage, do not qualify for Medicaid, and often postpone seeking health care because of the expense; and, (3) homeless people, for whom the need for health care is often overshadowed by the search for food and shelter; respondents describe the lives of the homeless as “chaotic,” and express special concern about homeless children, whose parents, they say, often fail to recognize that the children need care.

These providers say that mobile services enable them to reach people with “really desperate health care needs” who have often lost their trust of community agencies and refuse to actively seek help. One said that “the van has brought a lot of disenfranchised people back into the health care system who need it.” They also point out that vans serve as an entree to non-medical services which can help people get back on their feet. For example, the director of a program for runaway teens calls her mobile program “the best outreach we do.” To illustrate, she said that while the van had about 2,300 medical visits in 1988, there were over 7,000 non-medical visits, where teens were counseled or referred elsewhere for housing or other help.

Housecall providers say that housecalls fill a large and growing gap in health care, especially given the increasing numbers of elderly in the population. One respondent noted further that, “I think doctors are becoming more interested, also, given the growth of the older population.”

Providers Believe That, By Focusing Heavily On Prevention, Their Mobile Health Services Will Lead To Health Care Cost Savings In The Long Run.

Those who target the medically underserved believe that their services save health care costs in the long run by preventing disease or the development of serious health problems which would require emergency care or hospitalization. “The van has prevented the flooding of emergency rooms with sick people because we have treated them before they got worse. I think we have saved immeasurable dollars.” In discussing the cost of health care provided to indigents, a January article in the *Washington Times* said that, across the U.S., “such care cost hospitals \$8.3 billion in 1988 - almost a three-fold increase over 1980.”

These respondents also tout the benefits of using vans for health education: “As far as prevention, if you don’t have a way to go to the people, especially if they aren’t reading papers and watching TV and getting mail, you’ve got to have a van.” They point to pregnant teens, or people with AIDS, as examples of people who will not visit traditional providers, and say: “You’ve got to get out there to where they are.”

Housecall providers contend that, if globally accepted, housecalls could lead to significant cost savings relative to institutional care by: (1) keeping patients out of the hospital or nursing home as long as possible; (2) enabling some patients to avoid unnecessary ambulance rides or emergency room visits; and, (3) providing aftercare to hospital patients, allowing for earlier discharge.

Despite The Growing Interest In Providing Mobile Health Services, Lack Of Public Recognition And Problems Related To Financing And Medicare Reimbursement May Limit Their Future Growth.

To date, the types of mobile health services described in this study appear to be few in number and at an embryonic stage of development. Respondents seek recognition that their services are both necessary and effective, not only from the general public, but from the health care community, the insurance industry, and government agencies. Many express disappointment that their programs remain largely unknown outside the geographic areas they serve.

With respect to providers who target the medically underserved, we talked to PHS staff in the Bureau of Health Care Delivery and Assistance, Division of Primary Care for their opinions regarding the viability of such services and their attitudes towards funding them. On the question of viability, these respondents expressed mixed opinions, especially about the delivery of primary care by mobile programs. While they acknowledge the existence of a growing transient population for whom traditional medical models are not appropriate, they also look somewhat askance at mobile programs because "people need access (to care) all the time." Mobile programs, by their very nature, do not provide such continuity of care.

While it appears that these reservations, along with concerns about the costs of mounting van-based programs, have led the office to deny most of the requests received to date for funds to purchase vans, this may be changing. The FY 1991 budget projects a \$2 million increase in funding for community and migrant health centers. The funds are for the purchase of vehicles which will increase access for mothers and pregnant women to prenatal and other health care services (so called "Mom Vans"). This is part of a special maternal and child health/infant mortality initiative on access.

All of the housecall providers say that low reimbursement, especially Medicare reimbursement, hampers their expansion. They say that Medicare reimbursement rates are inadequate because they fail to take into account their special administrative costs, such as screening and otherwise handling calls, or developing and monitoring contracts with staff physicians. The president of the comprehensive housecall company said further that Medicare reimbursement codes are "totally inappropriate" because they are based on the assumption that the physician is providing primary, not urgent, care.

The issue of inadequate Medicare reimbursement is particularly important to the hospital programs, since the bulk of their reimbursement comes from Medicare and Medicaid. One respondent said that it has been hard to interest some physicians in working for the program because Medicare reimbursement is lower for her program's housecalls than for home visits made by the local visiting nurse agency. Both programs survive because of supplemental grants from local agencies and the willingness of the hospitals to carry the deficit, perhaps in part because, according to respondents, the programs generate admissions.

The presidents of both housecall companies said that they have made numerous attempts to discuss reimbursement with both Government agencies and insurers, but that, in the words of one, "it was not of great interest to them." In their view, until existing reimbursement mechanisms, especially Medicare, are adjusted to match the special characteristics of their services, physician housecalls will not become a viable form of health care delivery.

RECOMMENDATIONS

The PHS Should Study The Costs And Benefits Of Mobile Vans And Physician Housecalls. Particular Consideration Should Be Given To Supporting Demonstrations And Experimental Projects. These Should Be Evaluated With Respect To: (1) Access To Care; (2) The Quality Of Services; (3) The Impact Of Services, Including The Question Of Disease Prevention; And, (4) The Costs Of Service Delivery.

The Secretary has established three special initiatives which we believe are relevant to the services described in this report: (1) make long-term reforms in the health care system to improve access overall; (2) improve access to health care for minority women and children; and, (3) better assist homeless families and children.

All of the respondents in this study believe that their mobile services improve access to health care, and are cost-effective in doing so. While some of them say that they have data which, they believe, support that contention, none has yet conducted a controlled study documenting the actual costs and impact of their services.

We recommend that PHS conduct demonstration projects and controlled studies of a broad range of mobile services: services to underserved populations, including the working poor, homeless, migrants and people in rural areas; and housecalls, including their use in the provision of hospital aftercare. The following factors, at a minimum, should be assessed: the number and types of patients served and the health problems they present; the cost of service delivery; the quality of services; and, the impact of services, especially the degree to which they prevent disease, and prevent or delay a need for institutional care.

In Implementing The New Physician Payment System Under Medicare, HCFA Should Carefully Consider The Appropriate Weight For Payments For Physician Primary And Urgent Care Housecalls.

The housecall providers contacted for this study all say they experience problems relative to inadequate Medicare reimbursement. We recommend that HCFA, when implementing the new physician payment system under Medicare, should determine if reimbursement for physician housecalls, as they are described in the report, is fair and appropriate.

COMMENTS

The PHS generally agrees with this recommendation. However, instead of supporting demonstration and experimental projects, they would prefer to support further research and examine more case studies of mobile providers such as described in this report. To accomplish this, they intend to solicit, through the Agency for Health Care Policy and Research, applications focusing on how mobile health services delivery can impact on health care, particularly for the disadvantaged and rural populations.

The HCFA agrees with our recommendation and will evaluate the appropriateness of reimbursement for physician housecalls under the new physician payment system. The complete text of the PHS and HCFA comments, can be found in Appendix C.

APPENDIX A

List of Providers Contacted

Alameda County Health Care Services	Oakland, CA
The Bridge Over Troubled Waters	Boston, MA
CALL-DOC Medical Group, Inc.	San Diego, CA
Cook County Department of Public Health	Maywood, IL
Doctors to Your Door	Louisville, KY
Habit Management Institute	Boston, MA
Highland County Health Department	Hillsboro, OH
Illinois Migrant Council	Chicago, IL
Indiana University Maternal Outreach Mobile	Bloomington, IN
Montana Migrant Council	Billings, MT
Mt. Vernon Neighborhood Health Center	Mt. Vernon, NY
New York Children's Health Project	New York, NY
St. Francis Hospital	Evanston, IL
St. John's Hospital	Cleveland, OH
Peekskill Community Health Center	Peekskill, NY
Plan de Salud del Valle	Ft. Lupton, CO
Swope Parkway Health Center	Kansas City, MO
University of Arizona Rural Health Clinic	Tucson, AZ
Private Physician (anonymous)	North Dakota

APPENDIX B

Typical Operating Characteristics of Mobile Health Services in Public Settings

Vehicles

Vehicles, often referred to as "vans" by providers no matter what the type, include specially designed or retrofitted vans, recreational vehicles, school buses, and even trucks. Most are brightly painted with the provider's name or logo. This often attracts considerable attention and even curiosity on site, which helps draw in some patients who might normally be reticent to seek help. Vans typically contain an interview or waiting room; one or two examination rooms; a laboratory area with a sink, centrifuge and supplies; and, a bathroom or changing room. Often, one area is designated for counseling or patient education, and there may also be a separate office where records are kept.

Some vans carry a portable dental x-ray, and one carries ultrasound equipment for examining pregnant women. Some have phones, which staff use to consult with physicians back at a stationary site or to make follow-up appointments. Most vans have a generator, although providers prefer to connect to power at a stationary site because generators are often noisy and expensive to run. Most vans also have air conditioners, heaters, and water tanks, though the water is mostly used to wash hands and equipment rather than for drinking. Only a couple of vans have a wheelchair lift; some respondents say that lack of a lift has been a problem in serving the elderly or handicapped.

Staffing

Core staff often consists of a nurse practitioner or physician assistant, with physician back-up at a stationary site; an intake-worker or clerk, who may also drive the van; and, a nurse. Physicians, dentists and dental hygienists, community health workers, health educators, outreach or social service workers, drug, alcohol, and mental health workers, and even nutritionists work on vans. So do medical, dental or nursing students; in Arizona, a female pre-med student both administers the program and drives the 33' ten ton truck. Some programs also use volunteers, whether health professionals or community residents.

When asked what attributes are necessary for staff who work on vans, many respondents made comments such as this: "It takes a really special person to work this unit - good communication skills, good sound knowledge, a strong ego and the ability to use their skills without someone else to critique for them . . . staff have to be willing and enjoy what they do." Staff reportedly view problems as a challenge and "love working in the van." A physician described her work as: "an adventure . . . very 'frontier' . . . sort of a pioneer, covered-wagon feeling."

Logistical and Administrative Problems

While all providers carry some sort of vehicle insurance, in some cases the cost of malpractice insurance is prohibitive. One project director said that some physicians will not volunteer their services on the van because the program cannot afford malpractice insurance. Elsewhere, a State university assumed title to the vehicle so that staff who work in it can be insured under the school's policy.

Logistically, the most common problem of operating in a van is an obvious one: lack of space. Scheduling and traffic control are critical to ensure that the flow of patients through the van is smooth. Sometimes, intake or counseling must be done outside the van, such as in a transitional hotel for the homeless, to relieve congestion in the van.

There are other problems as well. For example, since most vans observe a somewhat complicated schedule of dates and sites, scheduling and coordination by administrators "can be a lot of work," and very time-consuming. However, it appears that this becomes easier as support staff become more familiar with a program and administrators find more efficient ways to plan.

Recordkeeping is also a challenge. Many providers keep duplicate records, storing the original record at their home base and a copy in the van, which is manually updated after a visit. Recordkeeping can become backlogged given the crush of patients. Records also require considerable storage space, which is at a premium in a van. For these reasons, many respondents are computerizing, or plan to computerize, their records. Two of them say that they have heard of companies which are developing computerized recordkeeping systems specifically for use by providers serving transient populations.

Inclement weather, insects, and bad roads must be contended with. Mechanical problems are often a headache. Many providers described problems with generators, which they say are noisy and prone to breakdown. To bring the point home, one respondent jokingly said: "Sometimes we yell 'Kill it!' because we can't hear a patient's heart People wonder what's happening to the patient back there!"

Some respondents report that other providers who are interested in developing mobile programs such as theirs have been discouraged to learn of both the expense and the work involved.

APPENDIX C

HCFA and PHS Comments



Memorandum

Date **JUN 11 1990**

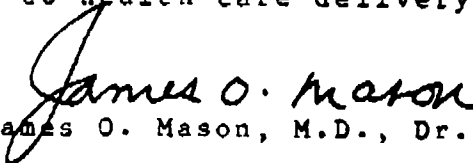
From Assistant Secretary for Health

Subject Office Of Inspector General (OIG) Draft Report "Health Care on Wheels," - OEI-05-89-01332

To Inspector General, OS

Attached are the PHS comments on the subject OIG draft report.

We generally concur with the report's recommendation to study alternative approaches to providing health care particularly to the underserved populations. In that regard, the Agency for Health Care Policy and Research will inform the health care research community that it is accepting applications on innovative approaches to health care delivery.


James O. Mason, M.D., Dr.P.H.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE (PHS)
ON THE OFFICE OF INSPECTOR GENERAL (OIG)
DRAFT REPORT "HEALTH CARE ON WHEELS"
OEI-05-89-01332, FEBRUARY 1990

General Comments

We generally agree with the intent of the report to improve access to health care services. While mobile health services have been used and studied in the past, they have not been rigorously evaluated in terms of their impact on health benefits and on costs. Consequently, further examination of mobile health services delivery is warranted because of the emergence of populations and problems which differ in kind, severity or magnitude from those in earlier years. Also, there have been technological advances in health care since the earlier services were delivered and their impact on the effectiveness and efficiency of such services must be considered.

OIG Recommendation

The PHS should study the costs and benefits of mobile vans and physician housecalls. Particular consideration should be given to supporting demonstrations and experimental projects. These should be evaluated with respect to: (1) access to care; (2) the quality of services; (3) the impact of services, including the question of disease prevention; and (4) the costs of service delivery.

PHS Comments

We concur with the intent of this recommendation to study the delivery of health care services on wheels. However, we believe it is too early to give particular consideration to supporting demonstration projects as the report recommends. Rather, we believe that targeting descriptive research projects and case studies for support is more appropriate at this stage. For example, we should seek to know:

How extensive the services are? How many patients are served? What are the characteristics of the patients and of the providers? What areas are the services located in? To what extent is follow-up care, where indicated, actually provided? What are the funding sources? What quality assurance measures are employed? What is the quality of care provided? How do these factors vary in different models of health service delivery?

The Agency for Health Care Policy and Research (AHCPR) is accepting applications on various innovative approaches to health care and AHCPR plans to inform the health service research community of this through program announcements. In particular, AHCPR's program priorities in research on rural health care and on health care for the disadvantaged (including the elderly, the handicapped, and the poor) encompass issues of access which may be addressed by mobile health service delivery.

Technical Comments

Page 1, last paragraph, line 3 should read "109 Health Care for the Homeless Programs are funded by the Public Health Service under the Stewart B. McKinney Homeless Assistance Act of 1987".

Page 7, first paragraph, line 1 states that "... 2 programs run by not-for-profit hospitals ..." the report should clarify whether one or two different hospitals are being referred to in the next sentence beginning with "One is a component ..."

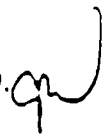


MAY 2 1990

Memorandum

Date

By

Gail R. Wilensky, Ph.D. 
Administrator

Subject

OIG Draft Report - Health Care on Wheels, OEI-05-89-01332

To

The Inspector General
Office of the Secretary

We have reviewed the subject draft report. This report provides a description of health care providers that serve medically underserved and uninsured populations in public settings, or that make physician housecalls.

The report recommends that in implementing the new physician payment system under Medicare, HCFA should carefully consider the appropriate weight for payments for physician primary and urgent care housecalls. We agree with this recommendation.

We also believe that there are potentially significant costs to Medicaid as well, given recent Omnibus Budget Reconciliation Act of 1989 expansions of the Early and Periodic Screening, Diagnosis and Treatment programs and maternal and child benefits. It would be helpful if the report could also evaluate the impact of mobile health services on these Medicaid programs.

Thank you for the opportunity to comment on this draft report. Please advise us whether you agree with our position at your earliest convenience.