



Programs Bring Care to Homebound Seniors

M. J. Friedrich

FOR ERIC HARDT, MD, ANOTHER “day at the office” often takes place outside the walls of his workplace, in a gritty Boston neighborhood. Today, he’s in one such neighborhood, to make home visits to 4 elderly patients who would have great difficulty getting to the clinic at Boston Medical Center.

Hardt grabs his bag and heads to his first appointment. The patient, a lively woman in her 90s, still lives in the same neat and inviting apartment she moved into decades earlier but became a home care patient a few years ago when forgetfulness—the first sign of early dementia—stopped her from coming into the clinic. Before he begins her examination, Hardt banters back and forth with the patient and her friend, a woman from the neighborhood who regularly looks in on the elderly woman.

Hardt determines that the patient has lost weight recently, and her blood pressure is sky-high. A quick “kitchen biopsy” reveals little food in the refrigerator and an unopened bottle of blood pressure pills. Her recent dietary and medication lapses signal the advance of dementia, notes Hardt.

The neighbor has brought some protein shakes, and these, together with a daily pill dispenser, can help address these problems and keep Hardt’s patient in her home for now. Another member of the home care team will be by in a few days to check on the woman and follow up on Hardt’s orders. Meanwhile, he’s off to his next house call a few blocks away.

A DOCTOR IN THE HOUSE

Hardt has worked in this neighborhood for 24 years as part of Boston University (BU) School of Medicine’s Home Care Program, administered through Boston Medical Center. Hardt is clinical director of the program, which was established in the 1870s and is the old-

est continuously functioning physician home visiting program in the country.

“On home visits we get better data about functional status, compliance with meds, the family situation, and we’re more efficient in implementing plans,” said Hardt. “We think it’s easier to understand and manage the conditions of our patients when we see them at home than if we saw them in the clinic.”

The house call program takes a team approach to caring for patients. Six attending physicians, along with several nurse case managers and nurse practitioners, make house calls. About 3 or 4 geriatric fellows also make home visits as part of their training. There is a strong educational component to BU’s house call program, which introduces virtually all BU medical students as well as many residents to home care.

The house call program is part of a continuum of geriatric care that includes an office practice and nursing home and hospice care, all overseen by Hardt. This allows coordinated care of patients in all settings, notes David Kornetsky, administrative director of BU’s Geriatric Services.

There are at least 2 million homebound seniors in the United States (Levine SA et al. *JAMA*. 2003;290[9]:1203-1207). As the population ages, the number of homebound elders with multiple chronic conditions will increase, and so will the need for physician-based home care.

The Boston program is one of a number of house call programs associated with academic medical centers around the country that contain clinical service and educational components. Each has grown organically from the needs of patients as well as the circumstances and personalities at these institutions.

RETOOLING FOR A NEW AGE

Physician-based home care is certainly not a new phenomenon but rather the retooling of an old practice for a new age. It’s a type of care that patients say they prefer. For example, Bruce Leff, MD, associate professor of medicine at Johns Hopkins University School of Medicine, Baltimore, and associate director of Hopkins’ Elder House Call Program, reported that a model of home care he and his colleagues designed, called Hospital at Home, was associated with greater satisfaction for patients and their family members compared with acute hospital inpatient care (Leff B et al. *J Am Geriatr Soc*. 2006;54[9]:1355-1363).

Similarly, at the Mount Sinai Visiting Doctors Program in New York City, more than 50% of patients who die while being cared for in the program die in their homes, according to their wishes, vs 20%, which was the average for people in the United States in the late 1990s (Flory J et al. *Health Aff [Millwood]*. 2004;23[3]:194-200).



Ana Blohm, MD/The Mount Sinai Hospital

A physician from the Mount Sinai Visiting Doctors Program in New York City examines one of her patients at the latter’s home.



The Mount Sinai program is the largest academic-based home visit program in the country and serves more than 1000 patients in East Harlem, said Theresa Soriano, MD, PhD, director of the program. The 12 clinicians in the program make more than 5000 visits every year to patients older than 18 years throughout most of Manhattan.

The program was founded in 1995 by three internal medicine residents at the Mount Sinai Hospital (Smith KL et al. *J Am Geriatr Soc.* 2006;54[8]:1283-1289). According to David Muller, MD, dean of medicine at Mount Sinai School of Medicine and one of the founders, seeing patients at home was a way to "humanize" the residency training experience, which can be grueling for both residents and patients.

Boston University's program, one of the few in the country at the time, provided a place to learn about setting up a house call program for the frail and elderly. But the residents received their first instruction in how to make home visits from the Little Sisters of the Assumption, an order of nuns who are all nurses. Having provided home care in East Harlem for more than 60 years, the sisters knew that many of their patients had no access to a physician, said Muller.

"The incredible irony was that the majority of these patients were right here in the community, maybe even across the street from the medical school," said Muller.

EFFICIENT CARE

An important part of home visits is an environmental and safety assessment. Eliminating risks for falling, arranging for repair to a dilapidated building, or getting electricity turned back on can be just as important as medical care to the health of the patient, said Soriano.

"Sometimes it becomes our role to advocate for these changes even though it's not a medical issue," she said. As she pointed out, making sure a patient with diabetes takes insulin is a moot point if the refrigerator doesn't work to keep the drug chilled.

George Taler, MD, director of the Medical House Call Program at the

Washington Hospital Center in Washington, DC, would agree. In his early days of practicing geriatric medicine, Taler said, he might do a fine job medically of treating his patients with multiple chronic conditions in the office, but he rarely had the opportunity to discuss their care with their caregivers or to see what hurdles they needed to overcome to receive the needed care.

This lack made it difficult for him to see if his recommendations for what needed to be done for his patients outside the office were feasible or achievable. House calls just seemed a much better way of taking care of these very ill patients, he said.

Taler admits that when he began this work, he thought this approach was less efficient than an office-based practice because of travel time and time spent talking to caregivers. "But now I've changed my tune," he said.

Several recent studies have recognized the cost savings and the potential for improved care through physician house call programs (Leff B et al. *Ann Intern Med.* 2005;143[11]:798-808; and studies presented at an April 2006 meeting at George Washington University, Upending the Triangle [<http://www.aahcp.org>]).

"As it turns out, house calls are an extraordinarily efficient way of practicing medicine, as long as the bottom line is controlling the health of the population under your care," said Taler. The challenge, he said, is to combine the two goals of excellent patient care and cost-effectiveness.

INDEPENDENCE AT HOME

Meeting this challenge is something that Taler and other house call physicians have been working on for some time. Their work has manifested as a legislative proposal called Independence at Home that is currently making its way into Congress.

The concept focuses on a small but expensive segment of the over-65 population. "Two thirds of Medicare spending is for people with 5 or more chronic conditions, who represent roughly 10% of the Medicare population," said Taler, refer-

ring to a Congressional Budget Office report based on 2005 data from the Centers for Medicare & Medicaid Services. "This new legislation creates systems that can meet the needs of these patients, and it is financially sustaining," he added.

Peter Boling, MD, director of long-term care and geriatrics at Virginia Commonwealth University, Medical College of Virginia, Richmond, and director of Virginia Commonwealth's House Calls Program, also has worked on this legislation. He noted that one of its goals is to draw more and better people into the field by providing financial incentives.

"Right now, medical students who we train in making house calls look at what I do and think it's lovely, but they're coming out of medical school with a lot of debt, and they're sensitive to price," said Boling. "If they're going to work hard to take care of the chronically ill, they need to have an incentive to do so."

Another goal is to create a system of care that allows physicians to care for patients across transitions and to be able to track them when they need to go into other settings of care.

"This legislation really speaks to all of what we do as house call physicians, including that which is less obvious than home visits," said Rebecca Conant, MD, assistant clinical professor of geriatrics and director of the Housecalls Program at the University of California, San Francisco. She pointed out that much skill and time are required to coordinate the services needed to keep frail elders at home and, when a patient does go into the hospital or nursing home, to smooth those transitions. "None of this is recognized or compensated under our current system," she said.

"It's only by managing these patients in a very holistic way, by maintaining relationships with caregivers, by trying to provide great care in the least expensive venues when appropriate, that we'll have any hope of providing the right kind of chronic disease management while containing costs for this small but expensive group of patients," said Hopkins' Leff. □