

Health Care for Homebound Geriatric Patients: Perspective from the Front-Line

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The Problem: A minority of our elderly patients, those with the greatest burden of chronic disease (i.e. our homebound geriatric population), in their last six months of life, use a disproportionately large share of the health care budget compared to other segments of the population. There is little prospect of restoring them to independent living and to less intensive health care maintenance.

This situation is often exacerbated because these persons, due to their “invisibility” from ambulatory society and even the medical profession, do not receive timely medical care to head off developing medical problems. They are often isolated and disenfranchised, and their physicians may not have seen them for years because they are unable to leave their homes and their physicians can’t or won’t come to them. By the time their health has deteriorated to an advanced stage (the condition in which hospital emergency rooms usually find them), these patients are often on a downward slope from which they may be only partially or not at all extricated. They often wind up consigned to a nursing home or return to the unforgiving home environment that allowed their terminal disease and/or disabilities to progress to the point of no return. Alternatively, they may be admitted to a hospital for well-meaning but misguided “care,” giving the patient, their families, and even their physicians the mistaken expectation of some beneficial result. Unless the patient has a fixable acute complication of his/her chronic illness, this expectation will rarely be achieved.

As a physician approaching retirement, I have had the opportunity and privilege of providing care to the homebound elderly. The patients whom I treat – the urban poor – are usually insured by Medicare directly or by Medicare or Medicaid HMOs. They often live in senior apartment housing or, occasionally, individual houses. Their homes are often in substandard conditions, despite their efforts to keep their homes and themselves meticulously clean. My patients often live alone, or have family caregivers either living with them or frequently visiting them. They may be malnourished if they lack

sufficient funds to afford food or are unable to get to a market. Some who can obtain food may be unable to prepare it themselves due to physical or cognitive disability.

The homebound elderly, unlike their ambulatory brethren, are dependent and lonely. Although they may previously have been independent and gregarious, they have retreated into their homes because they are physically disabled (due to stroke, amputation, chronic lung or heart disease, arthritis, etc), cognitively or emotionally disabled (due to dementia or depression), afraid or ashamed to socialize (due to incontinence, falls, deafness or blindness), or unable to use public transportation.

Home visits to the homebound elderly involve a very different approach from hospital-based medicine, which today deals largely with acute medical problems. Home visits by mature clinicians, nurse practitioners, and social workers experienced in dealing with chronic disease, can identify early medical problems which can be treated before they fester and become irreparable. The home visit clinician can perform a careful and complete history and physical examination, an environmental assessment (i.e. determine the patient's financial resources, food availability, presence or absence of alcohol, relations with and effectiveness of caregivers, if any) and, most importantly, develop a feeling of intimacy and trust with the patient and caregivers. The clinician can also ascertain possible elder abuse or neglect and can marshal community or other support services to insure that caregivers have the backing to continue their role. Finally, using their knowledge of home care and community organizations, they can obtain laboratory tests, EKGs, a variety of X-rays and ultrasound imaging studies, and can also provide a variety of professional services (i.e. charitable food delivery organizations, physical and occupational therapy, podiatry, psychiatry, audiology, and eye exams) that can be performed in the patient's home. This type of physician-patient relationship can be fostered more quickly and strongly, and the patients' problems grasped more readily in their home environment where they evolved.

A Solution: Retired physicians are in a unique position to affect the quality of care for aging populations. It is not unusual for retired physicians to state that they miss patient contact and have little opportunity to use their skills and experiences. I propose that we take advantage of our retired colleagues' often non-verbalized needs and create a win-win situation by asking them to provide home care for our needy, homebound geriatric population. These clinicians, trained in an era when high-tech diagnostic tools were not yet commonplace, relied for their effectiveness primarily through understanding the course of clinical disease and by spending time with patients, and getting to know their histories well, and providing a thorough examination. Such assets would be particularly valuable in the care of our elderly, homebound population, people who fondly recall

when physicians, unimpaired or influenced by financial demands or restrictions imposed, were able and willing to spend precious time with their patients.

Implementation of such a plan would require: 1) identifying and reaching out to retired physicians, 2) providing physicians with adequate social service, nursing, clerical support and community linkages, 3) giving the physician a brief, but intensive course in the medical and social problems of the elderly homebound (which are often different from those of the ambulatory elderly) and, 4) giving these physicians verbal praise and some financial incentives.

Benefits of this plan would include: 1) gratitude of a well-deserving but neglected segment of our population, 2) restoration of the ideals and goals so well expressed in the Hippocratic Oath, and 3) enormous cost savings by instituting efficient home visits and hospice care rather than transferring patients to emergency rooms, subjecting them to hospitalization that will have little beneficial effect on their medical, social or psychological welfare, or consigning them to nursing homes which the elderly almost universally despise and fear. Community-based solutions are consistent with the principles of programs such as Rx for Pennsylvania. Through collaborations with existing medical and geriatric organizations and support from national and community-based agencies, this type of program has the capacity to revolutionize the quality of care for the homebound elderly.