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The New Old Age
Caring and Coping

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# Why House Calls Save Money

*Dr. Jack Resnick, an internist in New York, believes that if the frail elderly are treated at home by doctors making house calls, as they did in the good old days, then medical outcomes will improve and Medicare costs can be reduced. Dr. Resnick hosted one of the community health care forums arranged by the Obama transition team on Dec. 29 at the Good Shepherd Community Center on Roosevelt Island in New York City. The following week, Dr. Resnick brought his message to the state capitol in Albany, where he met with health officials responsible for long-term care policy.*

*Dr. Resnick's own anecdotal experience with house calls has been documented in various medical journals, which report that keeping geriatric patients out of the hospital reduces costs between 30 and 60 percent. With Medicare cost-containment high on the agenda of the incoming administration, I asked Dr. Resnick to share his thoughts. For a different perspective on house calls, you can hear first-hand from his patients at theroosevelt doctor.com. — Jane Gross*

Eleven years ago, I started a general internal medicine practice on Roosevelt Island, a small community in the East River connected to Manhattan by subway and an aerial cable car. The island, a planned community started in 1975, had set aside apartments for the homebound, disabled and frail elderly. Soon after I opened my practice, I started getting requests for house calls from people who had been medically isolated — some for decades. I now spend almost a third of my time on house calls to 50 of these people. Most are homebound, quite a few are on respirators, all have multiple chronic illnesses.

My patients have taught me a lot — about how to treat them in particular and about the American health care system in general.

We all recognize that the American health care system is broken and needs to be fixed. Most of the discussion of health care reform focuses on its financing: the uninsured, the underinsured and the difficulty that even the insured face in negotiating its complexities. But even if every American were insured, the system would continue to deliver inadequate care at exorbitant cost. While solving the problem of the uninsured is necessary, it is far from sufficient.

Here are the two changes needed to address the system's failures.

First, everyone must have a single doctor in charge of his care. This doctor should know

the person intimately, have immediate access to all of his medical information and must be available around the clock.

Second, much of health care that is now delivered in institutions — hospitals and nursing home — should be provided at home.

I've come to these conclusions over the last decade treating my severely ill patients on Roosevelt Island. Early on, I would try to hospitalize my patients when they developed a severe illness. They would resist mightily, and I soon understood why. They all had had experiences as in-patients and knew well the perils of the hospital. I quickly discovered that a hospital stay for these people almost always left them worse off than before they had been admitted.

The price of getting some intravenous antibiotics for pneumonia, for example, often included bedsores, antibiotic-resistant hospital-acquired infections, medication errors, delirium and dementia.

It's not unusual for one of my patients to wind up in a hospital without my knowledge after a call to 911. In those instances, they almost always wind up in a nursing home after the treatment of their acute illness. Soon, their hospital-acquired confusion and delirium — generally a temporary state — turns into "dementia" because the nursing home doctors label them that way. Several times I have had the good fortune of finding one of these "demented" people in a nursing home and seen them return to normalcy within a few weeks of returning to the familiar environment of their home.

I've worked very hard to move more of health care into the home. I encounter many barriers.

· Intravenous medication — While it is not difficult to arrange intravenous medication at home for people who need expensive chemotherapy drugs, providing life-sustaining intravenous saline and sugar water on an urgent basis is extremely difficult because the companies that provide both are not set up for on-the-spot delivery. The providers of home-based intravenous treatments make their money on the payments they receive for the substances they infuse. Expensive cancer drugs are much more lucrative than simple antibiotics and salt water.

· Caregivers — The home health aides and attendants are crucial to the survival of my patients. Many times I've seen my charges deteriorate rapidly when a reliable aide leaves their service. One of my patients had been cared for by the same aide for eight years. When the aide had to take a medical leave for a gynecologic procedure, the patient deteriorated rapidly and developed life-threatening urinary tract infections. Even more dramatic was his return to health when, after a three-month absence, his aide returned. Within two weeks, an almost fatal illness had turned around and he was back to his usual self. These caregivers are woefully underpaid and underutilized. They need improved pay

scales, broader training, increased responsibilities and a career ladder that will attract and keep them in this vital profession.

· Exercise and physical therapy — Among the most destructive limitations on care at home for the chronically ill are the rules surrounding physical therapy. Patients can only get physical therapy after they have suffered some loss of function. Their exercise program ends when they have gained back as much function as possible. No maintenance therapy is allowed by Medicare. Inevitably, without exercise they lose function again, and a new round of rehabilitation starts. Unfortunately, each of these cycles usually ends with the patient at a lower level of functioning than at the beginning of treatment. It's truly penny-wise and pound-foolish to not provide a constant exercise program.

· Electronic medical records — Several years ago I invested in an electronic medical record for my practice. Now, wherever I am — in a patient's home, on rounds in the hospital, or visiting my grandchildren in Boston — all of their information is in front of me. This is one barrier I've successfully removed. I recommend E.M.R.'s highly to all.

· Early advance planning — I've started putting a lot of energy into getting my patients to talk to their family, friends and caregivers about how they want to be treated. Too often a well-meaning but frightened person calls 911, and one of my patients winds up worse off as they encounter the mishaps of institutional care. Getting all of these concerned people to have early discussions with my patients about how they want to be treated has begun to pay off in longer lives, less illness and more happiness.

· Real-time audio-video access — I've begun to investigate how the Internet can improve care at home. Live Webcam access would allow me to better assess a patient's urgent problem and provide reassurance at a time of great stress. It would allow close monitoring of someone getting acute treatment in the home. And it would make it easier to have a consultant evaluate one of my homebound patients without requiring arduous transportation via ambulance or ambulette.

How do we pay for all of this? Studies have shown that good home-based care dramatically reduces the amount of time people spend in hospitals. A small fraction of the savings generated would cover all of the costs these changes would require.

An even larger question is how do we find physicians who want to commit themselves to such a career, with its huge demands on their time, energies and emotions. The answer is simple. Let them share in those savings so that they earn as much as their colleagues in other specialties.