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COMMENTARY

Reinventing House Calls: A Simple Solution for Complex Patients?

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When one of the authors was practicing in rural western Massachusetts, he asked an elderly patient—an African-American and a New Englander of many generations—how his family first settled in the area. The patient related the following story:

After the Civil War, my great grandfather attended medical school in the South. Small proprietary medical schools were common in those days, some of them accepting "negro" students.[1] *Upon completing his training, he came up North and settled in Berkshire County, Massachusetts, because he'd heard there was no doctor there.*

The very first day he hung out his shingle, a boy came to summon him to a difficult delivery. He ran a mile, following the boy, to a neighboring farmhouse—only to discover that the "patient" was not a person but a cow. After contemplating the comparative anatomy, he decided to take the case and successfully delivered the calf. Thenceforth, he was the town veterinarian as well as doctor. He eventually bought some land for a farm, raised a family, and practiced contentedly there for the rest of his life.

The story is, among other things, a reminder that in the 19th century most doctor visits (medical and veterinary) were house calls. The patient's home functioned as the modern hospital, with the family serving as caregivers. Doctors came to know the details of their patients' lives quite intimately. Regardless of their provenance or how they were trained, doctors fit quite integrally into the communities in which they lived and practiced.

The story also provides an example of some traditional virtues that may be undervalued by today's physicians: resourcefulness, adaptability, and the willingness to go beyond the comfortable boundaries of standard practice if necessary to help an ailing patient.

The Flexner Report, published in 1910, put an end to proprietary medical schools. It set the current standard for medical education: two years of didactic teaching followed by two years of clinical training under the supervision of qualified faculty. It laid the groundwork for the growth of American medicine as a scientific discipline and paved the way for many developments that followed: the embrace of scientific research by universities, the accumulation of biomedical knowledge and its application to advanced therapeutics, and the growth of medical specialties and the highly technological medicine practiced today.[2]

In the 20th century, the use of telephones and automobiles, the concentration of population in urban areas, the shrinkage of household size, and the construction of modern hospitals rendered the house call obsolete. By mid-century, many physicians were purchasing space in new buildings near hospitals. They made inpatient rounds in the morning and kept office hours in the afternoon. Home visits seemed inefficient, almost primitive. An x-ray machine and a clinical laboratory—the new tools of the trade—did not fit into a black bag. By the 1970s, home visits comprised less than 1% of all patient visits.[3]

Indeed, even those of us in practice today are sometimes disturbed by the pace and nature of change in the social, economic, and policy climate of medical practice. Our patients feel it, too. Some benefit from the advances in knowledge and technology, but just as many have harrowing stories of fragmented care, insensitive providers, and treatments that seemed worse than the disease. Some older patients still remember the friendly reassuring family doctor who made house calls and wonder where he/she went.

In fact, those who have the most difficulty navigating the modern medical system are also those who have been marginalized by the service- and technology-driven economic expansion of the past half century: ethnic minorities, immigrants, the under-educated, and the poor. A large body of evidence points to lower quality of care and worse health outcomes for these groups.[4,5]

These demographic factors, combined with age and chronic illness, define a population that has become increasingly problematic for hospitals and health care providers: high recidivists for whom the failure of chronic disease management has resulted in frequent repeat hospitalizations, heavy use of emergency medical services, and exceedingly high cost of care.[6]

This population has come into focus recently as health care systems try to respond to cost reduction measures imposed by payers. Of particular concern to providers is the new Medicare rule eliminating payments to hospitals for 30-day readmission of patients discharged with pneumonia, acute myocardial infarction, or congestive heart failure.

Work in the field of complexity science provides useful insights that allow us to model the impact of health system interventions on chronically ill patients.[7] Cumulative complexity, as experienced by the patient, consists of the sum of the challenges

continued on page 2

continued from page 1

involved in daily life, including those imposed by illness, treatment regimen, and barriers to care, counterbalanced by the personal, social, and financial resources available to the patient to cope with these challenges.[8]

As cumulative complexity rises, the likelihood of successful illness management falls. This suggests that one way to improve patient adherence to chronic disease management is to simplify care. For some patients, the challenges of making and keeping appointments, leaving the house and getting to the doctor's office, and overcoming the linguistic and cultural differences they may encounter there must be overcome to achieve stable management of chronic conditions.

At our institution, we are piloting a home visiting program targeting chronically ill patients at high risk of readmission. With a team that includes a physician, an advanced practice nurse, a social worker, and a pharmacist, we will provide ongoing continuity care in the home setting to patients facing physical, transportation, or social barriers to office-based care. Our aims are to improve access, coordinate care, and help to address complicating life factors, such as financial and housing instability, caregiver stress, and physical disability, that interfere with effective chronic disease management. We will measure the impact of our intervention on utilization and health-related quality of life.

Home visiting has come back into focus as a promising approach to care delivery, especially in hard-hit ethnically diverse urban communities.[9] The Veterans' Administration has reduced costs with a home-based primary care initiative.[10] Academic medical centers in many areas have reported promising outcomes from home visiting programs.[11,12] More data are needed, but in the current economic climate, home- and community-based programs may move from a peripheral place in medical centers to the cutting edge of health care redesign.

By leaving the comfort of their offices and the convenience of schedule and routine, health care providers are re-learning some old lessons: how to navigate social and economic differences, build trust, and address the perceived (and not always strictly medical) needs of patients and families. They are stepping back into a traditional role as vital now as it was a century ago.

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