In the 21st century, the challenge for US health care will be to find ways to better care for the ever-growing homebound population. As of 2005, there were 2 million permanently homebound individuals, half of whom were age 65 or older. The homebound elderly population will increase to 3 million in the next decade. Millions more will be homebound temporarily, recovering from acute illnesses. By 2030, individuals aged 65 or older will be 20% of the US population. Many of these individuals will have multiple medical and psychiatric conditions, with resultant limitations in ambulation and transfers. In addition, the elderly are showing an increasing preference for being cared for in their homes. The cost of nursing home care continues to increase. As a result, there has been a decline in the number of nursing home beds per capita. Thus, the demand for care of the homebound individuals, especially the elderly, will continue to increase significantly.

Historically, the US health care system has not been able to meet the needs of the homebound elderly. Despite improvement of care by home health nurses, social service agencies, and in-home hospice programs, there remains an important gap in services; namely, the lack of access to primary care physicians. The lack of primary care has contributed to the increasing use of the emergency room, hospitalizations, and decreased caregiver well-being. Home care, especially with physician involvement, has demonstrated multiple benefits. Studies evaluating the benefit of home care have demonstrated reducing nursing home admissions, improving functional status, and reducing mortality. A systemic review showed reduced nursing home admissions when more than 9 follow-up visits were used, improved functional status when a multidimensional geriatric assessment program was performed, and reduced mortality in individuals 73 to 77 years of age. Chronic conditions, such as congestive heart failure, have been successfully managed at home with the use of home care. Patients with heart failure undergoing a home care intervention were less likely to be hospitalized, and when hospitalized, spent shorter times in the hospital. Home-based primary care programs have demonstrated reduced hospitalizations and emergency room visits, and reduced costs of caring for their patients.

US health care spending, especially Medicare spending, has increased significantly over the years. Older adults with 5 or more chronic conditions account for two-thirds of Medicare expenditures, and many are among the homebound population. A large percentage of Medicare spending is due to caring for elderly individuals during the last year of their lives. The excessive cost of care of these individuals is because of recurrent hospitalizations for the same condition. But, prolonged hospital stays, especially in the intensive care unit, contribute as well. With the passage of the Affordable Care Act in 2010, there has been increasing push to hold physicians and hospitals accountable for the medical costs their patients accrue. In addition, physicians and hospitals will be rated on quality measures, such as chronic disease management, readmission rates, length of hospital stays, and hospital mortality. The Centers for Medicare and Medicaid Services (CMS), especially the Center for Innovation, is testing various models of physician and hospital reimbursement, including accountable care organizations. The panel of patients that CMS will assign affordable care organizations (ACOs) will unknowingly include homebound patients. Homebound patients that each ACO will serve could impair the ability of the ACO to reduce medical expenditures below the benchmark that CMS assigns to them and affect their ability to meet quality measures expected of them. CMS and private insurance companies are also encouraging physician groups to establish medical homes as a way to reward physicians financially for their ability to improve patient access to care, reduce utilization of care, and improve quality of care. Physicians who are a member of an ACO or who operate a medical home should perform home visits to their homebound patients to reduce costs and maintain the quality of care they give to their patients.

Homebound patients face an increasing dilemma of worsening isolation from the medical care they deserve. Home health care has been the main source of care that homebound patients receive in the absence of physician home visits or office visits. Before 1997, patients could receive home care with or without prior hospitalization. Some received care lasting more than 6 months at a time. The cost of home care to Medicare grew exponentially from $3.9 billion in 1990 to $17.2 billion in 1997. Congress enacted the Balanced Budget Act in 1997 limiting home care services to postacute care. In 2000, home health care payments were changed to a prospective payment system. The reduction in home care funding has resulted in the closure of more than 1000 home agencies, resulting in some rural areas to not have access to any home health care. There has been a negative impact on home care patients as a result of fewer home care services. Increased emergency room use and possible increased
mortality was documented by one study.40 Patients enrolled in Medicare advantage, who have less home health care coverage from their insurance, have also experienced poorer outcomes.41

All patients, including the homebound elderly, will have a harder time finding a primary care physician in the future. Fewer graduating medical students over the years have chosen general internal medicine or family practice as a career. Inadequate reimbursement and long working hours are cited as main reasons for this decline in primary care training. The number of patients in need of a primary care physician will increase exponentially over time.42 This will only further exacerbate the isolation homebound patients will experience from receiving any health care. In 1998, Congress increased the funding for physician home visits. One study showed physician house calls doubled from 2000 to 2006; however, the percentage of physicians making house calls decreased by 7.2%. The number of physicians performing house calls and the number of house calls performed must increase significantly to meet future demand.43 Congress has enacted the independence at home study to determine if home-based primary care groups can successfully reduce health care costs and maintain quality of care to warrant the government increasing funding for physician home care. If successful, CMS may improve funding for physician home visits to attract more physicians to perform them.44

Most medical schools have not provided adequate home care training for medical students and residents.45 A survey of home care education in medical schools showed only 3 medical schools had large home care programs that provided teaching for their medical students, residents, and fellows. A larger number did provide some home care lectures for students and residents. Many medical schools offer 1 home visit for students.46 Subsequently, 10 US medical schools received funding from the John A. Hartford Foundation to develop curricula in home care.47 There are no Accreditation Council for Graduate Medical Education guidelines requiring home visits for internal medicine residency programs. Family medicine residents are required to perform 2 home visits. Geriatric medicine fellows are required to perform home visits, as well.48 Medical schools should expand their current home care programs. This will increase homebound patients’ access to a primary care physician and improve teaching to medical students, residents, and fellows. Home-based primary care programs, such as the one at Mount Sinai Hospital, have demonstrated improvement in the health of the patients they serve, reduced caregiver burden, and reduced health care costs through reduced hospitalizations and emergency room use. Home-based primary care programs are financially viable when the financial benefit to the medical school and hospital are taken into consideration. Medical schools should provide formal teaching of home care through lectures, as well as home visits. Internal medicine and family medicine residents should be encouraged to perform home visits as part of their outpatient longitudinal care experience. It has been demonstrated that residents who saw patients in their homes were more likely to perform home visits in their practices.49 During the 21st century, medical schools should take the lead by emphasizing physician home care as a viable career choice for future physicians to meet the need of current and future homebound patients.

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