How to Do a House Call: Tips & Tricks

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  – Consulting Fees: None
  – Other: None

• I do not intend to make therapeutic recommendations for medications that have not received regulatory approval (e.g. off label use)
How to do a house call: tips and tricks
Dr. Mark Nowaczynski

Goal: To review the practice of primary care medicine delivered in an out-of-clinic setting.

Objectives:
1. Participants will understand the challenges of home-based medicine
2. Participants will be able to identify methods of circumventing these challenges.
3. Participants will review the effectiveness of home-based primary care
4. Participants will understand how home-based care impacts patients' health and quality of life
Telemedicine

• good for remote specialist consults
• cannot replace in-person encounters
• can be used to monitor patients
  – but not as a substitute for Home-Based Primary Care
“Technology in general, just like pornography, offers us lousy models for connecting and bonding with other people.”

Dr Sue Johnson, *Love Sense*
Two Conflicting Challenges:

- Growing numbers of *house-bound* patients
- Majority of physicians are *office-bound*
Home-based care, why is it important?

• frail seniors are eventually unable to make office visits to doctors – “lost to follow-up”
• bounce in and out of emergency departments
• more hospital admissions and re-admissions
• more prolonged hospital stays (ALC)
• increased rates of institutionalization
• home care and home-based primary care are highly preventative, and cost-effective
Why should we care?

• demographic tsunami.
In the 2 decades between 2010-2030:

- number of Canadians over 65 will *double*
- number over 85 will *quadruple*
Canada’s Universal Health Care System:

• Designed over 50 years ago
  – average Canadian was 27 years of age

• Today the average age is approaching 50

• Our health care system was not designed to meet the needs of an aging population
Alternate Level of Care (ALC):

- On any given day 15% of acute care hospital beds in Canada are occupied by ALC patients (mostly seniors)
  - (ALC = patients who no longer need to be in hospital, but have nowhere else to go)

- Costs $2.3 billion/year to warehouse seniors in hospitals
  - Equals the entire Ontario home care budget!
Average daily costs:

- Hospital bed $1,000/day
- LTC bed $150/day
- Home Care $50/day
Health Care Spending:

• Today 14% of Canadians are over 65, and account for 45% of public health care spending

• By 2036 seniors will comprise 25% of the population and 62% of health care costs
DON’T LEAVE SENIORS OUT IN THE COLD.

Why a national seniors strategy is important for all Canadians:

Today, 14% of Canada’s population is over age 65. And seniors account for almost half of health costs.

By 2036, those over 65 will make up a quarter of the population — while accounting for 62% of our health costs.

The Canadian Medical Association is working to:

- Make seniors care a ballot issue in the election campaign.
- Persuade the major political parties to include a national seniors strategy in their campaign platforms.

Add your voice:

DemandAPlan.ca

Authorized by the Canadian Medical Association
We need to provide care to seniors differently:

- REDUCE avoidable hospitalizations

- Shift focus of care from hospitals back into the community:
  - Home & Community Care
  - Home-Based Primary Care
  - Home Palliative Care
Supportive Homecare:
Home Based Primary Care:
Interprofessional Care:
House Calls – home-based primary care:

- pilot project 2007, program funding 2009
- *House Calls* provides ongoing comprehensive interdisciplinary home-based primary care to frail, marginalized, cognitively impaired, and house-bound seniors *who would not otherwise have access to primary care.*
  - whose needs cannot be met by typical office-based primary care delivery
  - Home visits become a necessity, not just a convenience.
- embedded in a Community Support Services Agency (SPRINT Senior Care), allowing a comprehensive basket of services to be integrated with primary care delivery.
Do you remember these guys?
House Calls are:

- Low tech, high touch
- adhere to the KISS principle
- HBPC is not unlike the 4077th M*A*S*H approach to surgery:
  - it’s a team effort, close to the front
  - you Dx & treat based on your Hx and Px exam
  - investigations are limited
  - you are not often sending your patient to ER
    - you deal with issues then and there!
  - early intervention prevents deteriorations that result in admissions & readmissions
Who are our patients?

- A heterogeneous group of medically, cognitively and socially fragile elders whose needs are not well served by traditional office-based primary care delivery.

- “House-bound” is a concept
  - Who benefits from home-based primary care?
  - What do our patients really look like?
Who are our patients? - SNAP Tool:

**Medical:**
- CHF
- COPD
- Angina
- OA
- Polypharmacy
- Falls risk
- Degenerative neurological disease
- Recurrent UTI
- Functional ADL limitations

**Cognitive:**
- Dementia
- Delirium
- Anxiety
- Depression
- Schizophrenia
- Axis 2

**Social**
- No family/caregiver/support for ADL or IADL
- Financial difficulties (nutrition/transportation/medication/health supports)
- Social isolation

Patients are identified as truly homebound if they meet at least one criteria from two separate categories.
House Calls 2009 – 2018:

- 2,000+ patients enrolled
- caseload 350 (80 in 2009/2010, 135/yr))
- average age 87-89
- annualized caseload 500-600 (and growing)
- 40% referred from hospital
- multiple comorbidities
- high rate of attrition
- 5,000 medical home visits/year
- 8,000 – 10,000 total home visits/year
House Calls attrition:

• 2 end-points... that constantly remind us of our mortality:
Evidence Supporting *House Calls* Model:

- Study of 150 patients enrolled into *House Calls* following an index acute care hospitalization
  - average age 87
- 125 patients active in program > 90 days
  - 53% fewer hospital admissions per year
  - 67% annual reduction in days in hospital
- Reduction of $17,000/patient/year in hospital costs
- *House Calls* program costs $2,600/patient/year
House Calls Return On Investment (ROI)?

- Cost of combined interprofessional and medical care provided by House Calls
  - $2,600/patient/year
- House Calls saves $5-10M/year in hospital and institutional care
- Hundreds of thousands of dollars of Home-Based Primary Care prevents millions of dollars in hospital and institutional care
House Calls: Teaching & Training:

• Clinical Placements (OT, SW, RN, NP, MD)
• Sept 2009 – present:
  – 100’s of trainees have had placements with House Calls

• Former Family Medicine residents who trained with House Calls now provide ongoing home-based geriatric primary care.
How are house calls done?:

- Equipment
- The Clinical Encounter
Equipment - what’s in the bag?
Medical equipment:
Mobile office:
The Clinical Encounter:

- History
  - Supports in place?
    - Caregivers, family, neighbors
    - CCAC & home care supports
  - POA?
    - PGT
The Clinical Encounter:

• History

• Medication review and reconciliation
  – physically look at pill bottles or blister-packs
  – have your patient show you what they are actually taking
I am a big fan of blister-packs:

- simplify administration
- increase patient compliance
- easy to monitor compliance
- medication review and reconciliation at a glance
- PSWs can assist with blister-packs, but not pill bottles
**Blister-pack:**

*Your health. Made easier.*

<table>
<thead>
<tr>
<th>Time</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 AM - 10 AM</td>
<td>Breakfast/Dinner</td>
</tr>
<tr>
<td>11 AM - 1 PM</td>
<td>Lunch/Dinner</td>
</tr>
<tr>
<td>7 PM - 8 PM</td>
<td>Supper/Supper</td>
</tr>
</tbody>
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**Medication Organizer**

Gestion de médicaments

**Name:**

**Date:** July 22

**shoppersdrugmart.ca**
Falls prevention is key:

- Hip # - 50% mortality within 6 months

- “OT Magic”
  - Home care referral for ‘home safety & mobility’
The Clinical Encounter:

• History
• Medication review and reconciliation
• Physical exam
  – Percuss!!!
  – Mobility & transfers
  – Cognitive assessment
    • MMSE, MOCA, Mini-Cog
The Clinical Encounter:

• History
• Medication review and reconciliation
• Physical exam
• Examine surroundings
  – fridge biopsy
  – cleanliness (smell), infestations
  – sleeping, bathroom
  – equipment (walker, wheelchair, Saska pole etc).
  – stairs, railings, little rugs, safety, falls risk etc.
What were the 2 most important things we needed to do for this woman?
Sometimes the post powerful intervention of all
- is to order Meals on Wheels!
The Clinical Encounter:

• History
• Medication review and reconciliation
• Physical exam
• Examine surroundings
• Investigations
  – can order lab to collect blood & urine
The Clinical Encounter:

- History
- Medication review and reconciliation
- Physical exam
- Examine surroundings
- Investigations
- **Diagnosis**
  - problem list
The Clinical Encounter:

- History
- Medication review and reconciliation
- Physical exam
- Examine surroundings
- Investigations
- Diagnosis
- Treatment
  - medical, rehab, social, supports & services etc.
  - future care planning, advanced directives, POA
TORONTO, ON

Aging with Grace

Dr. Samir Sinha is only in his 30s, but already he is a leading expert in elder care. As the Director of Geriatrics for Mount Sinai and the University Health Network Hospitals, Dr. Sinha is applying innovative ideas to caring for the country’s oldest individuals — ideas that help people live long, happy lives in their own homes. "With centenarians representing one of the fastest growing groups, we need to start ensuring that older people get the right care in the right place at the right time," says Dr. Sinha.

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ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION
Case Study:

- Clarence H.
Referral Info:

- Referred by Meals on Wheels
  - MOW volunteers noticed progressive decline.
- Clarence consented to physician home-visit
- 90 yrs old.
- Lives alone.
- House-bound.
1<sup>st</sup> visit

- Clarence is a bright, articulate, and cognitively intact retired accountant.
- Stubborn and fiercely independent.
- House is neglected and dirty
- has been living here for over 70 yrs.
- Widowed x 30 yrs.
- Limited supports
  - step-grandson does weekly shopping.
Past Medical History:

• No family physician contact x 30yrs.

• Fractured ankle 4 yrs. ago
  – seen in ER & Fracture Clinic.
  – hospital SW referred him to MOW.
Observations & Recent Hx:

• Thin and frail.
• Poor mobility – wall and furniture walking.
• 2 story house, bathroom & bedroom 2\textsuperscript{nd} floor, steep staircase, no hand rail.
• Increasing fatigue x months
• Tires easily, SOB, SOBOE, nocturia x 4 or 5.
Physical Exam:

- RR 24/min
- H&N: N.
- Chest: mild bibasilar crackles
- BP: 140/80, HR 100, irreg irreg
- CVS: JVP 5-6cm>SA, HJR +ve, normal HS, no M, ++pitting to knees.
- Abdo: N.

Impression: CHF, a.fib, frail, falls risk.
Initial treatment & Investigations:

• Start bisoprolol 2.5mg qAM
• Start furosemide 10mg qAM
• Urgent B/W drawn by MD
• Refuses PSW support.
• Will “think about” OT referral for home safety assessment & falls prevention.
One week later: 2\textsuperscript{nd} visit

- Pt reports “feeling a little less tired – more get-up and go”.
- Reports decreased SOB but “easily tired when I do anything protracted”.
- Decreased SOA
O/E:

- RR: 16-20/min (down from 24/min)
- BP: 110/70, HR 70 (irreg/irreg)
- Chest: clear
- CVS: JVP 3-4cm>SA, pitting ½ to knees.
Blood Work:

- Normal lytes U&Creat.
- Normal Hgb, TSH etc.
- **Glucose 20**
- HgA1c 0.110
Additional Medical Management:

- Start metformin 500mg with supper
- Start ramipril 1.25mg qAM
- Start ASA 81mg od (refuses anticoagulation)
One week later: 3rd visit:

- Tolerating Rx.
- Energy level improved – “not bad, I have been able to move around”.
- No SOB, decreased SOA.
- Decreased nocturia to 1/night - “vastly improved”.
- Feeling better – “my acuity is a bit more sharpened”.
O/E:

- RR 16/min
- Chest: clear
- BP: 130/70, HR 70
- CVS: JVP 3-4cm>SA, pitting ½ to knees.
Additional Medical Management:

- Increase ramipril to 2.5mg qAM
- Increase metformin to 500mg bid
- Continue furosemide 10mg, bisoprolol 2.5mg, EC ASA 81mg.
Globe
Toronto

Medicine comes home

Old-school doctors bring the house call back into Ontario’s health system

BY DEB ARCHER

When Clarence Howe’s wife died, he stopped seeing doctors. That was in 1978. When he was referred to Dr. Mark Nowaczynski by a social services agency last fall, the doctor says, “He was dying”—suffering from diabetes, atrial fibrillation and congestive heart failure.

But Dr. Nowaczynski, a general practitioner who has made house calls his specialty, gave the 91-year-old new medicines, and last week he was very much alive. Persevering through the stress of his job, he had recently decided to stop taking his pills when Dr. Nowaczynski dropped by his house last Friday.

“They lessen the bowels. And I’m very much against running to the bathroom all the time. Maybe I’ve lived my life and I should just end it,” he said in a chippy tone.

“Well,” Dr. Nowaczynski said, “I can’t keep you from dying, but I can help you avoid a bad death.” Mr. Howe was coaxed into taking three of his four pills, excluding the one that’s the most likely bowel culprit.

This kind of personal care is highly unusual in today’s Ontario, and Dr. Nowaczynski has spent nearly a decade crusading to bring house calls back into mainstream family medicine. Now, his dream may come true. Three years after vowing to reform the way health care was delivered to seniors, the Ontario Ministry of Health says that, as early as this spring, it will introduce new rules that will allow doctors to bill for more house calls.

Physician Mark Nowaczynski, right, has made a specialty of house calls to patients like Clarence Howe. Partly thanks to his efforts, the province is poised to increase funding for this kind of care.

See DOCTORS on page M6
One Week Later:

• “Overall I feel Ok”.
• No SOB, walking better, denies SOBOE.

O/E:
BP: 110/65, HR 70 irreg irreg
Chest: clear
CVS: JVP 3cm>SA, mild pitting 1/3 to knees.
Eventually Agrees to OT Assessment:

- Refuses to try walker.
- Refuses to install hand rail.
- Accepts to live at risk with increased falls risk.
Over Next Two Years:

- Compliant with Rx
- CHF & NIDDM well controlled
- Refuses any additional supports
- Refuses all OT recommendations
House Calls:

- respectful and dignified
- patient centered
- a lovely way to combat ageism
- advocate for your patients
- become a role model
  - take medical students and residents with you on home visits
Advantages to the provider:

• very satisfying
  – Provide care to those who would otherwise have great difficulty accessing care
• really get to know your patients & families
• visits are largely provider driven
  – YOU control who you visit
• escape the clinic and the “worried well”
• get to know your city
• improve your parking skills
• do some walking & cycling
Some parting thoughts:

• Main entry Points into the Health Care System:
  – ERs & hospitals
  – Medical offices & Outpatient Clinics

• What about home???
  – Home Care
  – Home-Based Primary Care
  – Palliative Care at home
Where and how do you want to live out your days?