

Guidelines for the Medical Management of the Home-Care Patient

American Medical Association Home Care Advisory Panel

Increasing numbers of patients of all ages are receiving needed health care services in non-institutional settings. Acute, subacute, rehabilitative, preventive, long-term, and hospice services are provided in the home under the physician's supervision. The safe and appropriate treatment of these patients involves the physician in a team effort as most home care is provided by nurses, other allied health professionals, and family members. The guidelines cover such areas as the role of the physician; the physician-patient relationship; the elements of medical management in home care, including the evaluation/assessment process, the selection of the interdisciplinary team, and the development of the care plan; patient's rights and responsibilities; the coordination of care; and the use of community resources. (Arch Fam Med. 1993;2:194-206)

In February 1987, the American Medical Association first convened a Panel of Consultants on Home Care to consider educational efforts to assist physicians to better understand their role in the provision of medical care in the home. During this and subsequent meetings the panel has achieved a better understanding of the physician's role in quality home care, and has addressed the need for increased involvement of physicians in home care. To encourage such participation, the panel has developed guidelines for the practice of medicine in the home setting. It is expected that these guidelines will stimulate interest and discussion regarding home care by the physician and will promote better understanding of its purpose and practice. The guidelines should also help define role and responsibilities in the organizational framework of home care and suggest considerations for reimbursement and policy decisions. Finally, they should be useful in designing a curriculum in home care for education and training of physicians at all levels and in recommending an agenda for

future research and development. It must be noted that these guidelines are recommendations formed by a consensus of professionals with considerable experience in home care, and thus do not represent rigid standards.

BASICS OF HOME CARE

Who Needs It

- Forty-four percent of all patients discharged from the hospital by primary care physicians require follow-up medical or nursing care that cannot be provided by family or friends alone (nursing home or home care).¹
- Between 5% and 10% of all patients in a medical practice receive home-care services.¹
- For every patient in a nursing home there are three more severely impaired patients cared for in their own homes.²
- Sixty-five percent of the public in a recent survey stated that they would ask their physician *first* for advice on long-term care needs of a family member.³
- An estimated 20% of patients older than 65 years have functional impairments with

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related home-care needs. Their physicians may be unaware of these needs during the typical office visit.⁴

What Is Involved

- Patient self-care.
- Family, friends, and caregiver assistance.
- Paraprofessional and professional care (see "Selecting an Interdisciplinary Team").

Why It Is Necessary^{5,6}

- Identify new problems not found in the office setting.
- Monitor patient response to plan of treatment.
- Enhance patient ability to live independently at home.
- Limit hospitalizations/nursing home utilization.
- Provide medical/nursing treatments.

When to Start

- Patient and family/friend desire home care.
- Medical conditions can be treated at home.
- Informal and/or professional caregivers are available and able to meet the needs of the patient's condition.^{7,8}

How to Implement

Medical care in the home is a *shared effort* in which the patient has more control than in any other setting. The team may include:

- patient;
- family/informal caregivers;
- hospital discharge planners;
- community agencies/case management services;
- home health staff; and
- physicians (see also "Selecting an Interdisciplinary Team").

ROLE OF PHYSICIAN

It is the role of the physician to prescribe, in consultation with members of the home-care team, a home-care plan of treatment.⁹ That plan may be carried out by the patient

alone, or with family support and/or with professional caregivers. The physician's role includes:

- management of medical problems;
- identification of home-care needs of the patient;
- establishment/approval of a plan of treatment with identification of both short- and long-term goals;
- evaluation of new, acute, or emergent medical problems based on information supplied by other team members;
- provision for continuity of care to and from all settings (institution, home, and community);
- communication with the patient and other team members and with physician consultants;
- support for other team members;
- participation, as needed, in home-care/family conferences;
- reassessments of care plan and outcomes of care;
- evaluation of quality of care;
- documentation in appropriate medical records; and
- provision for 24-hour on-call coverage by a physician.

THE PHYSICIAN-PATIENT RELATIONSHIP

The patient in need of home care usually has multiple complex medical problems that have led to increased dependency on others, including the physician. In addition to medical oversight of the frequently fluctuating pathophysiological condition(s), the physician advises, encourages, and supports the patient's efforts in self-care.

In establishing a close working relationship with the patient receiving home care, the physician will probably include the following in discussions with the patient:

- disease process and treatment options;
- effect of disease and treatment on the patient's daily functioning and life-style;
- expected course of the illness, both short and long term;
- tasks that the patient and/or caregiver will be expected to perform;
- stress and burdens arising from chronic illness and methods to relieve such stress for both the patient and caregiver(s);
- potential for rehabilitation;

American Medical Association Home-Care Advisory Panel

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- importance of monitoring the condition(s) by the patient and/or caregiver;
- early signs of instability or deterioration, which should be reported to the physician;
- improvements in function or condition, which should be reported to the physician;
- the need for outside assistance and roles of home-care staff; and
- patient and caregiver participation in treatment decisions including discussion and documentation of the patient's advanced directives and wishes concerning re-hospitalization, resuscitation, and use of various medical technologies.

MEDICAL MANAGEMENT IN HOME CARE

The crux of appropriate medical management in the home is the use of the physician's skills to optimize the patient's independence, and to minimize the effects of illness and disability in the patient's daily life.

Evaluation for Home Care

A subtle, but critical distinction between medical management in the home, and medical management in the hospital, clinic, or office, is the emphasis that should be placed on the patient's functional abilities. The success of the care plan usually depends on the patient's ability to carry it out. The physician's support and encouragement is an essential factor in patient compliance with the care plan.

A series of assessments¹⁰⁻¹² are generally required to evaluate the ability of the patient and/or the caregiver to implement the care plan. In addition to the traditional history and physical examination, the physician usually performs brief screening tests in the following areas and refers the patient to the appropriate member of the health care team for in-depth evaluation, as indicated.

Patient Assessments

Functional Assessment. Against the backdrop of the disease process, the physician must assess the patient's ability to perform activities of daily living (ADL) and the more complex instrumental activities of daily living (IADL). A functional assessment includes the following:

Activities of Daily Living (ADL)

Ambulating
Bathing
Toileting
Dressing
Feeding
Transferring
Continence

Instrumental Activities of Daily Living (IADL)

Taking medications appropriately
Using the telephone
Arranging transportation
Doing housework
Shopping
Handling finances

Sensory Assessment

Vision
Hearing

A screening functional assessment should include both a subjective report from the patient (and/or family) and the physician's observations during the physical examination. Screening of vision and hearing should be included in the functional assessment. When limitations are identified in daily functioning, the patient may require professional home-care services, and should be referred for more detailed assessments. These assessments will examine not only the severity of the functional disability (eg, patient is independent, needs minimal assistance, or needs moderate assistance) but also the cause (physical limitation, pain, or lack of motivation) and method to overcome the disability (potential for change with rehabilitation, use of assistive devices, or necessity of reliance on others).

Mental/Cognitive Assessment. This assessment is needed to establish the ability of the patient to follow/implement the directed care plan.^{13,14} Elements to be observed and evaluated include:

- cognitive ability and educational achievement;
- recent change in cognition;
- use of alcohol or drugs that affect cognition; and
- decision-making capacity.

Psychosocial Assessment.^{15,16} Elements to be observed and evaluated include:

- nature and quality of interactions with others;
- affect and mood; and
- cultural, ethnic, or religious influences on health-care behavior, beliefs, preferences, and expectations.

Nutritional Assessment.¹⁷ There is a potential for malnutrition in the socially isolated or disabled population. Assessment should include:

- changes in body weight;
- eating habits: preferences, frequency, and content of meals;
- fluid intake;
- oral health/dental needs;
- ability to swallow; and
- access to shopping assistance and the ability to purchase and prepare food.

Medication Use and Compliance.¹⁸⁻²⁰ Assessment should include:

- all medications (prescription, over-the-counter, and sub-

- stances of abuse such as ethanol) present in the home;
- numbers/names of physicians prescribing for the same patient;
- patient's current usage and problems with compliance;
- written instructions;
- patient's understanding of the function of medications, desired outcomes, and potential side effects; and
- patient's understanding of how to handle medication errors.

Caregiver Assessment.²¹⁻²³ Assessment of burden of caregiving includes:

- number of hours of caregiving work per day;
- nature of tasks to be completed; and
- psychological stress related to nature of illness and necessary care.

Assessment of the caregiver's ability includes:

- positive attitude about the responsibility;
- emotional competence and stability;
- physical capacity to meet caregiving needs;
- other responsibilities that may affect the caregiver's availability;
- past history of family relationships and traditions;
- number of available caregivers;
- willingness and ability to learn and apply knowledge; and
- willingness and ability to work with the other members of the home-care team.

Environmental Assessment.²⁴⁻²⁶ This includes:

- safety of the area for patient care activities (barriers, hazards, and cleanliness);
- telephone availability and accessibility;
- access to toilet, food, water, and medication;
- access to emergency services, emergency response/alert systems;
- alternative source of electricity if life-support equipment is needed;
- adequate fire safety plan;
- adequate storage space for supplies and equipment;
- adequate space for caregivers; and
- adaptations needed in terms of special equipment, furniture arrangement, and remodeling.

Community Assessment. This includes the following:

- safety of neighborhood for patient care;
- communication as needed with local police, fire, utilities, highway departments, and emergency medical services; and
- resources available (See "Community Resources").

Financial Assessment.²⁷⁻³⁰ This includes:

- eligibility of patient to receive care under Medicare/Medicaid/Veterans Affairs or other public programs;
- resources for private funding for necessary care, including insurance;

- impact on family resources from inadequate coverage; and
- ability of patient and/or caregivers to handle financial matters.

Evaluation/Assessment Process

For some relatively functional patients, home-care needs may be adequately defined in an office setting. However, for most patients, in-home assessments are preferable and may even be critical.^{31,32} In-home assessments can be highly efficient ways to save time in diagnosis, medical decision making, and communication among all team members. These assessments may be performed by physicians or by other health care professionals who are in close communication with the physician, depending on the circumstances. The timing and frequency of assessment and reassessment will vary among patients. The following are general guidelines.

The guidelines for frequency of continuing assessments are as follows.

- Physicians should know the current status of their patients.
- The number of home visits by the physician or others should meet the requirement that the physician be familiar with the patient's current status.
- Patients with complex, deteriorating, or fluctuating conditions require more frequent visits. The number should be at least comparable with the frequency of the visits required to treat that condition in another setting.

The following circumstances may require a physician's visit:

- discrepancies in the patient's reported functioning;
- acute declines in health or function in frail patients;
- unexplained failure to thrive;
- unexplained failure of the care plan;
- request for physician evaluation in the home by another team member; and
- need for a patient/family meeting to make an important decision.

The quality of care evaluations include the following:

- The physician should inquire regularly from patient and caregiver about the quality of other professional services and the adequacy of the home-care plan. Expressed concern or dissatisfaction may require reevaluation, including a possible visit.
- The physician should inquire regularly from members of the home-care team³³ about the patient's response to services and treatment, and the need to reduce or increase services based on the patient's condition. Concerns or inconsistent reports may require a reevaluation, including a possible visit.

Communication and Coordination of Services

The primary care physician's activities include the following.

- Establish and maintain communication with the other physicians involved in the patient's care, and become familiar with the details of their treatment plans.
- Provide/arrange for 24-hour physician coverage for all homebound patients (including coverage when the physician will be out of town). Arrangements for unstable home-care patients may require that detailed instructions be communicated to the covering physician, in a manner similar to that used for coverage of hospitalized patients. The patient, the caregiver, and the home health agency must know how to reach a covering physician on a 24-hour basis.
- Maintain organized records on home-care patients. Charts should include copies of all orders signed; evaluations and reports from team members; notes from all telephone conversations; and names and addresses of all organizations, personnel, and consulting physicians involved in providing patient care.
- Communicate promptly with the home health-care staff and all others who are providing services.^{34,35} Telephone calls from home health agency staff or patients should be returned in a timely fashion based on the urgency of the situation by the primary care or covering physician. A system for immediate response to urgent calls should be established. A plan should be established to answer nonurgent calls appropriately.

Written communication is essential for documentation of home-care; all forms of reports need to be signed and returned promptly to ensure continuous appropriate patient care. In addition to meeting federal and state requirements, it is helpful for the physician and home-care agency to establish a plan regarding content, frequency, and response time for written communications.

Interdisciplinary Team

One unique aspect of home-care is the nature of the collaborative team effort.³⁶⁻³⁸ While interdisciplinary teams work closely together in rehabilitation centers and geriatric assessment units, such coordinated efforts are based on jointly developed comprehensive care plans and individual and quite separate professional roles in carrying out the appropriate treatment.

In the home-care situation, the individual professional roles overlap in a set of shared tasks. The five shared tasks listed below are part of the physician's role in the home-care as well as part of every other home-care professional's role. This situation has developed because of patient need and the intermittent, part-time provision of professional home-care services.

The patient and/or family/friend caregiver has 24-hour responsibility for providing care, while the home-care professional rarely spends more than an hour for a visit, and may not visit more than two to three times per week. Unlike the hospital situation, in which other team members are readily at hand, the home health profes-

sional is alone in the home with the patient and must often provide, in addition to the planned professional interventions, a general review of the entire team's home-care program.

The Team Approach. The review of the team program at each home-care visit should include:

- a brief assessment of the overall effectiveness of the comprehensive home-care program;
- assessment of patient and caregiver interactions and satisfaction with the home-care program;
- identification of any new problems;
- notification of appropriate team member(s) for follow-up of new problems; and
- encouragement and reinforcement of instructions from other team members.

Because usually only one member of the team is in the home at a time, that member must be aware of the total home-care plan of treatment and be able to evaluate, advise, or assist the patient and/or caregiver as needed. Thus, a physical therapist may need to take the pulse or blood pressure and discuss medication compliance or psychosocial problems during a therapy session or a speech pathologist may review the diet, food preparation, and shopping while providing therapy for a swallowing disorder. The nurse and home health aide may work with the patient on transfer techniques or bathing and dressing skills, following the therapy program.

The Physician's Role. Although home visits by physicians are generally less frequent than those made by other team members, written and oral communications keep the physician fully informed in the following areas:

- the implementation and effectiveness of the home program;
- any changes in the patient's condition; and
- the need for corresponding changes in the care plan.

Physicians are generally active members of interdisciplinary teams based in hospitals, where they see the other health professionals on a day-to-day basis. In contrast, physicians often feel estranged from members of the home health-care team whom they only know as disembodied voices over the telephone.

It takes time and effort to develop a closer working relationship with the home health team, but the rewards include better patient care. Although, there are growing numbers of physician-led home-care teams,^{39,40} the usual model is one in which the physician relies on the home health nurse to be the liaison, team leader, and coordinator, in addition to performing the regular nursing activities.

Selecting an Interdisciplinary Team

In addition to the seven services covered under the Medicare home health benefit (skilled nursing; home health

aide; physical, occupational, and speech therapy; nutritional guidance; and medical social services), there are many other health professionals and paraprofessionals who provide services for patients receiving home-care. A short, incomplete list might include physicians, nurse practitioners, physician assistants, respiratory therapists, laboratory technicians, vocational and educational rehabilitation personnel; podiatrists, pharmacists, psychologists, dentists, audiologists, optometrists, personal care assistants, homemakers, chore-housekeepers, home repairmen, volunteers, and friendly visitors.

In some cases the home health nurse acts as case manager and coordinates all the other practitioners. In other cases it is easier for a community agency social worker to act as a case manager and perform the coordinating and liaison with physician functions. In either situation, physicians want to know the quality, reliability, and accountability of the organizations and individuals to whom they refer their patients.

Choosing a Home Health Agency. Physicians should select a home health agency with the same care that they use in selecting the hospitals with which they are affiliated.^{41,42} It is useful to review the organizations as if going through a credentialing process. Many physicians will need to use several agencies to ensure geographic coverage for all their patients. Physicians may choose to become familiar with some of the following:

- agency reputation;
- management/direction of the agency: background of board of directors, key personnel, director of nursing, and medical director;
- composition of the Professional Advisory Board;
- annual evaluation/report;
- evaluation process for policies and procedures/protocols;
- accreditation: Medicare certified,⁴³ Joint Commission on Accreditation of Health Care Organizations or National League for Nursing (Community Health Accreditation Program) accreditation;
- quality assurance activities: clinical record reviews, audits, supervisory capacity (number of nurses per nursing supervisor);
- professionalism of care as illustrated by review of a complete chart of a patient referred from the physician's practice;
- availability of on-call coverage by nurses and other staff 7 days a week, 24 hours a day;
- agency policies for coverage of underinsured or uninsured patients;
- response time for newly defined home-care need;
- capacity to provide full range of services and depth of experience.

On-site visits to a home health agency may be helpful and may include some or all of the following:

- meeting with the director of nursing and other staff in-

cluding the medical director, if available;

- review of the process of referrals, admissions procedures, and communications procedures; and
- review of sample charts.

Useful physician activities that can strengthen team work include the following:

- volunteer to serve on the agency's clinical review, quality assurance, or other committees affecting clinical care; and
- volunteer to give lectures at agency in-service educational programs for nurses and other professional staff.

Other Organizations Providing In-Home Services. The same care and attention to quality should be part of the process in selecting organizations to provide services such as:

- laboratory;
- pharmacy;
- homemaker services;
- private-duty nursing services;
- durable medical equipment; and
- specialized high-technology services.

Although Medicare does not certify many of these providers, some have state licenses, and others may have received accreditation from the Joint Commission on Accreditation of Healthcare Organizations or the National League for Nursing (Community Health Accreditation Program). All these home-care organizations will keep records on each patient that will be more extensive than the forms that they send to the physician for signature.

Development of the Care Plan

The written patient care plan is developed by the physician in collaboration with other members of the home-care team as needed and may include some or all of the following:

1. A description of medical condition/need for home-care that includes:

- diagnosis/pathophysiological conditions;
- medication regimen;
- severity of illness/recent hospitalization;
- requirements/parameters for monitoring illness and response to treatment;
- expected course of illness/prognosis; and
- rehabilitation potential.

2. Results of assessments that include:

- functional assessment/limitations in ADLs and IADLs;
- cognitive assessment/mental status;
- environmental assessment/hazards and barriers to safe ADL;
- caregiver assessment/availability and ability; and
- nutritional assessment/special dietary requirements.

3. Long- and short-term goals of treatment/expected outcomes.

4. A plan for individual team member activities that includes:

- description of interventions/treatments needed;
- frequency of interventions/treatments; and
- anticipated duration of interventions/treatments.

5. Medical equipment and supplies needed.

6. A mini-care plan for the caregiver that

- anticipates needs such as respite care;
- provides periodic assessment of ability to continue; and
- allows for continuing physician-caregiver counseling.

7. Hospital to home discharge plan.³² The home patient care plan can be developed during an office visit, but more commonly follows hospitalization. In the latter case, the care plan should be developed *before* the patient leaves the hospital during the hospital's discharge planning process (although there will be continuing adjustments and changes as needed in the days and weeks to follow). The physician's role in this process includes the following:

- Refer the patient for discharge planning early in the course of the hospitalization.
- Initiate the necessary assessments (see "Evaluation for Home Care").
- Establish clear parameters for continued care, signs, and symptoms to be monitored and reported; expected outcomes; and potential problems.
- Establish contact with the home health staff (and any other organizations that will be providing services to the patient at home such as laboratory, pharmacy, home-maker services) during the referral process, determining time and frequencies for verbal and written reports.
- Provide the home health nurse who will be caring for the patient with a thorough synopsis of the patient's condition. It is very helpful if the patient can be sent home with a copy of the hospital record discharge summary that contains more information than the usual transfer forms and is often immediately available.
- Review the discharge plan with the patient and/or caregiver before they leave the hospital, including (1) the need to fill and take prescriptions as ordered; (2) the expected course of the illness; (3) the date of the next physician visit; (4) description of other home-care providers; and (5) how, when, and with whom to get in touch for specific problems.

Alternatives to Home Care

Some conditions may make the continuation of home-care inappropriate. The physician should be sensitive to the emotional and physical well-being of the caregiver, the safety of others in the home and visitors, and the continued willingness of the patient to participate as a partner in the home-care plan.

Home care may no longer be appropriate when:

- goals of treatment have been reached and the patient and/or caregiver is independent;
- changes in the course of illness make the home an in-

appropriate site for care;

- patient/caregiver refuses to continue home-care;
- patient is nonresponsive to home-care interventions;
- there is caregiver burnout or loss of caregiver with inability to obtain alternate caregiver;
- there is evidence of patient abuse or neglect that has not responded to home-care interventions;
- there is gross noncompliance;
- safety of patient or provider is threatened; and
- irresolvable problems persist between patient/caregiver and home-care team.

Termination of home-care requires the physician to offer another strategy for care. The physician continues to provide medical management throughout the patient's course of illness unless discharged by the patient. Other care settings/strategies may include:

- acute or chronic care hospital;
- outpatient services/clinic programs;
- nursing homes;
- continuing care facility (board and care, life-care community, and licensed adult home);
- day care;
- other family care options;
- group home with shared services;
- foster homes;
- respite care; and
- hospice care.

The physician may not discontinue treatment of a patient as long as further treatment is medically indicated unless provisions are made for the patient to obtain alternative physician services or the patient refuses all further treatment.

PATIENTS' RIGHTS AND RESPONSIBILITIES

Patients' Rights

Patients of in-home services and their caregivers possess certain basic rights and bear particular responsibilities. These include the right to⁴⁴:

- be treated with dignity and consideration, respect, and with timely attention to his or her needs;
- have their property treated with respect;
- confidentiality of all information related to care within required regulations;
- be fully informed of the care and treatment that will be provided by the physician and others, how much it will cost, how payment will be handled, and whether the patient is responsible for any payments;
- discuss benefits, risks, and costs of appropriate treatment alternatives;
- receive guidance from their physicians as to their recommended course of treatment;
- be advised of potential conflicts of interest that physicians may have, and of the right to receive independent professional opinions;

- freedom of choice in care providers, to receive care from professionally competent personnel, and to know the names and responsibilities of people providing care;
- accept or refuse treatment or other forms of health care recommended by the physician, and to be informed of the consequences of this action;
- participate actively in the design of a care plan, and to help update it as needs change;
- experience continuity in the health care that is provided;
- be informed by a home health agency of anticipated termination of agency service and to be referred elsewhere; and
- have the freedom to make a complaint or recommend changes in services, or in agency policy, and know how to do so.

Patients' Responsibilities

The patient is in control of many aspects of health care rendered in his or her home. With that control, concomitant responsibilities arise that must be met if the patient is to achieve the desired health-care benefits. These include the responsibility to:

- remain under a physician's care while receiving home-care services;
- inform the home-care team of any changes in physicians involved in the patient's care;
- provide the physician and the agency with a complete and accurate health history;
- provide the physician and the agency with all requested insurance and financial information;
- sign the required consents and releases for insurance billing;
- participate in the care by asking questions and expressing concern;
- provide a safe home environment in which care can be given and allow necessary changes in the home environment;
- cooperate with the physician, the agency staff, and with other caregivers by compliance with the therapy agreed on;
- accept responsibility for any refusal of treatment;
- treat the physician and other health professionals with respect and consideration; and
- advise the physician or agency administrator of any dissatisfaction or concerns about care provided.

COORDINATION OF CARE/CASE MANAGEMENT

There is a remarkable array of goods and services available for the patient receiving home-care. The term "case management" has evolved to include those activities necessary to determine the patient's needs, arrange for and coordinate the appropriate services, and monitor the effectiveness of services and reassess them as needed.⁴⁵

In the ideal, the goal of all health care is the patient's independence in self-care, ie, the patient becomes his or her own "case manager." When the patient's health problems worsen and the patient becomes dependent on others, assistance with case management decision making may be necessary. The levels of case management are as follows:

- The patient is his/her own case manager.
- The patient needs the assistance of family members or significant others for planning/coordinating care.
- If problems are too complex for the family to deal with, the patient-family-professional team must coordinate care.
- For the most complex levels of care, a multidisciplinary professional team is needed to assist the patient and family. *Such a team should have a designated case manager/team leader.*
- Flexibility is needed to move between levels of case management with the ultimate goal of patient independence and continuity of care.

Surveys indicate that 80% of patients requiring care in their home receive all their needed assistance from families and friends.⁴⁶ The physician may be the only health professional who provides care and advice in these cases.

- Most patients and families turn to their physician for advice when they perceive the need for additional resources.
- Physicians are a crucial link to community resources.
- Physicians need to become familiar with the one or two telephone numbers they need to access community resources.

COMMUNITY RESOURCES

The first step in sorting through the variety of goods and services available for a patient receiving home-care is to place a telephone call to the "Information and Referral" services available throughout the United States through the Network on Aging, established by the Older Americans Act of 1965 (see the directory that follows).

The goal of the Older Americans Act is to remove the barriers to economic and personal independence and to assure the availability of appropriate services for older individuals (aged 60 years or older) who need them. For patients younger than 60 years, contact the state departments of human resources, social services, or vocational rehabilitation. Although the federal or state funding sources are different for different age groups, the local providers of services are often the same. Through state and local Information and Referral services, the physician and patient/caregiver can gain access to national and local disease-specific charitable organizations and advocacy groups that can provide additional resources. Under the direction of the US Administration on Aging there are (1) 57 state units on aging; (2) 670 area agencies on aging; and (3) over 2000 local service provider agencies.

There is tremendous local variation in the availabil-

ity of services, but all areas will have information and referral services, and some or all of the following.

Access Services

These include the following:

- information and referral;
- case management;
- transportation;
- escort services; and
- outreach services.

Community-Based Services

These include:

- adult day care;
- senior centers;
- congregate nutrition programs;
- elder abuse/protective services;
- respite services;
- legal assistance;
- employment services;
- housing services;
- rehabilitation services including vocational rehabilitation and special education;
- volunteer programs;
- health/fitness programs;
- foster grandparents;
- energy assistance;
- self-help/support groups;
- counseling;
- crime prevention/victim assistance; and
- senior companions.

In-Home Services

These include:

- home health services such as skilled nursing, physical and occupational therapy, speech therapy, medical social services, nutritional guidance, and home and health aide;
- hospice services;
- homemaker/personal care services;
- chore/housekeeping;
- home repair;
- home-delivered meals/meals-on-wheels;
- medical equipment and supplies;
- friendly visitor; and
- telephone reassurance.

Services to Residents of Nursing Homes and Other Care-Providing Facilities

These include:

- long-term care ombudsman program; and

- support for elderly victims of Alzheimer's disease and their families.

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This report is not intended as a standard of medical care. Standards of medical care are determined by the facts and circumstances of an individual case. Standards change as the art of medicine, scientific knowledge, technology, and patterns of practice evolve. This report reflects the views of experts and the medical literature as of January 1992. These guidelines have been endorsed by the American Academy of Home Care Physicians.

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Location of Aging Services and Resources

The following directory lists the telephone numbers for the State Units on Aging, state or national toll-free numbers, and special hot lines. If no toll-free number is available, contact the State Units on Aging.

Alabama

Commission on Aging Suite 470, 770 Washington Ave, Montgomery, AL 36130; (205) 242-5743.

Information and Referral: In state: (800) 243-5463.

Alaska

Older Alaskans Committee, PO Box C, Juneau, AK 99811-0209; (907) 465-3250.

Arizona

Aging and Adult Administration, PO Box 6123-950A, Phoenix, AZ 85005; (602) 542-4446.

Information and Referral: Maricopa County/Northern Arizona: (800) 352-3792; Pima County/Southern Arizona: (800) 362-3474.

Arkansas

Division of Aging/Adult Services, PO Box 1417, Slot 1417, Little Rock, AR 72201; (501) 682-2441.

Information and Referral: (501) 682-8150.

California

Department on Aging, 1600 K St, Sacramento, CA 95814; (916) 322-5290.

Colorado

Aging and Adult Services, 1575 Sherman St, Fourth Floor, Denver, CO 80203-1714; (303) 866-5931.
Information and Referral: (303) 866-3851.

Connecticut

Department on Aging, 175 Main St, Hartford, CT 06106; (203) 566-8645.
Information and Referral: In state: (800) 443-9946; out of state: (203) 566-7772.

Delaware

Division on Aging, 1901 N Dupont Hwy, New Castle, DE 19720; (302) 421-6791.
Information and Referral: In state: (800) 223-9074.

District of Columbia

Office on Aging, 1424 K St NW, Second Floor, Washington, DC 20005; (202) 724-5622.
Information and Referral: (202) 724-5626.

Florida

Program Office of Aging and Adult Programs, Building 2, Room 237, 1317 Winewood Blvd, Tallahassee, FL 32399; (904) 488-8922.
Hot Line–Elder Abuse: In state: (800) 962-2873.

Georgia

Office on Aging, Suite 633, 878 Peachtree St NE, Atlanta, GA 30309; (404) 894-5333.

Guam

Division of Senior Citizens, PO Box 2816, Agana, GU 96910; (671) 632-4141.

Hawaii

Executive Office on Aging, Suite 241, 335 Merchant St, Honolulu, HI 96813; (808) 548-2593.
Information and Referral: In state: (800) 468-4644.

Idaho

Office on Aging, State House, Room 108, Boise, ID 87320; (208) 334-3833.

Illinois

Department on Aging, 421 E Capitol Ave., Springfield, IL 62701; (217) 785-2870.
Information and Referral: In state: (800) 252-8966; out of state: (800) 252-8600.
Hot Line–Nursing Home: In state: (800) 252-8966.

Indiana

Division of Aging Services, PO Box 7083, Indianapolis, IN 46207; (317) 232-7020.
Information and Referral and Hot Line–Abuse and Nursing Homes: (800) 545-7763.

Iowa

Department of Elder Affairs, Suite 236, 914 Grand Ave, Des Moines, IA 50309; (515) 281-5187.

Kansas

Department on Aging, 112-S Docking Office Bldg, 915 SW Harrison, Topeka, KS 66612-1500; (913) 296-4986.
Information and Referral: In state: (800) 432-3535.

Kentucky

Division of Aging Services, CHR Building-6th W, 275 E Main St, Frankfort, KY 40621; (502) 564-6930.
Information and Referral: In state: (800) 372-2973.
Hot Line–LTC Ombudsman: In state: (800) 372-2991.

Louisiana

Office of Elder Affairs, PO Box 80374, Baton Rouge, LA 70806; (504) 925-1700.

Maine

Bureau of Elder/Adult Services, State House Station 11, 35 Anthony Ave, Augusta, ME 04333; (207) 626-5335.
Hot Line–LTC Ombudsman: In state: (800) 452-1912.

Maryland

Office on Aging, Room 1004, 301 W Preston St, Baltimore, MD 21203; (301) 225-1100.
Information and Referral: In state: (800) 243-3425.

Massachusetts

Executive Office of Elder Affairs, 38 Chauncy St, Boston, MA 02111; (617) 727-7750.

Information and Referral: In state: (800) 882-2003; TDD: (800) 872-0166.

Hot Line–Elder Abuse: In state: (800) 922-2275.

Alzheimer's Information: In state: (800) 351-2299.

Michigan

Office of Services to the Aging, PO Box 30026, Lansing, MI 48909; (517) 373-8230.

Minnesota

Board on Aging, 444 Lafayette Rd, St Paul, MN 55155; (612) 296-2770.

Information and Referral: In state: (800) 652-9747.

Hot Line–LTC Ombudsman: In state: (800) 657-3591.

Mississippi

Council on Aging, 421 W Pascagoula St, Jackson, MS 39203; (601) 949-2070.

Information and Referral: In state: (800) 222-7622.

Hot Line–Personal Care, Nursing Home, Hospital Complaints: In state: (800) 227-7308.

Missouri

Division on Aging, PO Box 1337, Jefferson City, MO 65102; (314) 751-3082.

Information and Referral: In state: (800) 235-5503.

Hot Line–Elder Abuse: In state: (800) 392-2272.

Montana

Governor's Office on Aging, State Capitol Building, Capitol Station, Room 219, Helena, MT 59620; (406) 444-3111.

Information and Referral: In state: (800) 332-2272.

Nebraska

Department on Aging, PO Box 95044, Lincoln, NE 68509; (402) 471-2306.

Nevada

Division for Aging Services, Suite 114, 340 N 11th St, Las Vegas, NV 89101; (702) 486-3545.

Information and Referral: In state: (800) 243-3638.

New Hampshire

Division of Elderly/Adult Services, 6 Hazen Dr, Concord, NH 03301; (603) 271-4680.

Information and Referral: In state: (800) 852-3345.

Hot Line–LTC Ombudsman: In state: (800) 442-5640.

New Jersey

Division on Aging, 101 S Broad St, CN 807, Trenton, NJ 08625; (609) 292-4833.

Information and Referral: In state: (800) 792-8820.

New Mexico

State Agency on Aging, Fourth Floor, 224 Palace Ave, Santa Fe, NM 87501; (505) 827-7640.

Information and Referral: In state: (800) 432-2080.

New York

Office on Aging, 2 Empire State Plaza, Albany, NY 12233; (518) 474-3585.

Information and Referral: In state: (800) 342-9871.

North Carolina

Division of Aging, 693 Palmer Dr, Raleigh, NC 27603; (919) 773-3983.

Information and Referral: In state: (800) 662-7030.

North Dakota

Aging Services, State Capitol Building, 600 East Blvd, Second Floor, Bismarck, ND 58505; (701) 224-2577.

Information and Referral: In state: (800) 472-2622.

Ohio

Department of Aging, 50 W Broad St, Ninth Floor, Columbus, OH 43266; (614) 466-5500.

Hot Line–Nursing Home Complaints: In state: (800) 282-1206.

Oklahoma

Aging Services Division, PO Box 25352, Oklahoma City, OK 73125; (405) 521-2281.

Hot Line–Elder Abuse: In state: (800) 522-3511.

Oregon

Senior and Disabled Services Division, 313 Public Service Bldg, Salem, OR 97310; (503) 378-4728.

Information and Referral: In state: (800) 232-3020.

Pennsylvania

Department on Aging, 231 State St, Harrisburg, PA 17101-1195; (717) 783-1550.

Hot Line—Alzheimer's: In state: (800) 367-5115.

Paid Prescription Problems: In state: (800) 225-7223.

Hot Line—Fraud and Abuse: In state: (800) 992-2433.

Puerto Rico

Governor's Office for Elderly Affairs, Call Box 50063, Old San Juan Station, San Juan, PR 00902; (809) 721-5710.

Information and Referral: (809) 721-4560.

Rhode Island

Department of Elderly Affairs, 160 Pine St, Providence, RI 02910; (401) 277-2880.

Information and Referral: In state: (800) 322-2880.

Hot Line—Alzheimer's: In state: (800) 244-1428.

South Carolina

Commission on Aging, Suite B-500, 400 Arbor Lake Dr, Columbia, SC 29223; (803) 735-0210.

Information and Referral: In state: (800) 922-1107.

South Dakota

Office of Adult Services/Aging, 700 Governor's Dr, Pierre, SD 57501; (605) 773-3656.

Information and Referral: (605) 773-3656.

Tennessee

Commission on Aging, 706 Church St, Suite 201, Nashville, TN 37243; (615) 741-2056

Texas

Department on Aging, Capitol Station, PO Box 12786, Austin, TX 78741-3702; (512) 444-2727.

Information and Referral: In state: (800) 252-9240.

Utah

Division of Aging/Adult Services, 120 North 200 W, PO Box 45500, Salt Lake City, UT 84145-0500; (801) 538-3822.

Vermont

Department of Aging and Disabilities, 103 S Main St, Waterbury, VT 05626; (802) 241-2400.

Information and Referral: In state: (800) 642-5119.

Virginia

Department for the Aging, 10th Floor, 700 E Franklin St, Richmond, VA 23219; (804) 225-2271.

Information and Referral: In state: (800) 552-4464.

Hot Line—Nursing Home Complaints: In state: (800) 552-3402.

Virgin Islands

Senior Citizens Affairs, Department of Human Services, 19 Estate Diamond, Fredericksted, St Croix, VI 00840; (809) 772-4950, extension 46.

Washington

Aging and Adult Services, Administration, Mail Stop QG-16, Olympia, WA 98504; (206) 493-2500.

Information and Referral: In state: (800) 422-3263.

Hot Line—Nursing Home Complaints: In state: (800) 562-6028.

West Virginia

Commission on Aging, Holly Grove-State Capitol, Charleston, WV 25305; (304) 348-3317.

Information and Referral: In state: (800) 642-3671.

Wisconsin

Bureau on Aging, PO Box 7851, Madison, WI 53707; (608) 266-2536.

Hot Line—LTC Ombudsman: In state: (800) 242-1060.

Hot Line—MEDIGAP Claims: In state: (800) 242-1060.

Wyoming

Commission on Aging, 139 Hathaway Building, Cheyenne, WY 82002; (307) 777-7986.

Information and Referral: In state: (800) 442-2766.

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