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House Calls

Portland Hospital Gives Acutely Ill A Homecare Option

To Free Up Valuable Beds Care Is Brought to Patient; An Alternative for Elderly

Mr. Willer Breaks the Rules

By GAUTAM NAIK
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PORTLAND, Ore. -- Paul Willer, who recently suffered his second heart attack, looked away as a nurse gingerly stepped over a mound of unwashed clothes on the floor to administer an intravenous drug. If the nurse noticed the spider web dangling on the window above the bed, she ignored it.

Paul Willer

Mr. Willer suffers from a dangerous condition known as congestive heart failure. He was receiving pretty standard medical treatment, but in a highly unorthodox setting: amid the clutter and dust of his own bedroom.

"When you're in your own bed, you mend better," reckons the burly, 55-year-old Coast Guard veteran.

He may be right. Mr. Willer is one of several hundred patients who have had life-saving treatment at home under an unusual program run by the U.S. Veterans Administration medical center in Portland.

Other home-based programs in the U.S. tend to serve early-discharge patients who can be safely monitored at home. By contrast, the Portland program was designed specifically as a substitute for hospital treatment.

Part of a fledgling movement called "home hospital," it offers sophisticated medical oversight -- including nurse and doctor visits, X-rays and other tests -- to patients willing and able to receive such care in their own beds. The approach also has been tried in the U.K., Israel and Italy. In Australia, a similar project in the state of Victoria treats about 250 patients a day.

The program in Portland has successfully treated more than 300 home-based patients since 2001. The average length of "stay" for the at-home patients is a little more than three days, compared with an average of about four days for patients choosing to stay at the hospital. Because the hospital often operates at full capacity, the home program frees up valuable beds.

"I don't think we can continue to provide hospital care the way we have" in the U.S., says Scott Mader, the geriatrician who oversees the program at the Portland VA. "We need new models."

At a time of soaring health-care costs, the get-well-at-home program illustrates how hospitals are struggling to solve a two-pronged problem. In the U.S., the cost of hospital-based treatment for the elderly keeps rising. And as baby boomers continue to age, cost pressures and demand for beds will only intensify.

Results from a U.S. home-hospital study, published in the December 2005 issue of Annals of Internal Medicine, showed solid savings. The study, which included the Portland VA and two other facilities, found that the price tag for treating similarly ill patients at home was $5,081, or a third less than the $7,480 cost of treating a patient in a hospital bed.

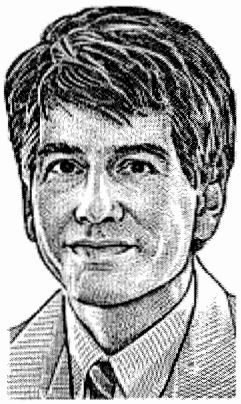
Within the medical establishment, such programs are still a novelty. Carmela Coyle, senior vice president for policy at the American Hospital Association, was not familiar with the VA's at-home effort, although she says it sounds "innovative." In order for similar projects to take off, she says she believes they "would have to guarantee the same level of safety, quality and continuity of care" that patients get in a traditional hospital.

To be eligible, patients need to have one of four specific ailments, meet certain medical criteria and have a safe home environment. When a patient agrees to forego a bed at the Portland VA -- so far 75% of viable candidates have agreed to do so -- a small "strike force" swings into action. The patient is sent home, typically with various medicines, oxygen tanks, and sometimes, a mobile X-ray machine. A nurse visits every day to perform tests, provide IV infusions and monitor medications. As a backup, a physician is on 24-hour standby for emergencies. After recovery, most patients are "discharged" without having to step outside the bedroom.

Promising Alternative

Doctors say the program offers a promising alternative for elderly patients, who tend to deteriorate sharply in a hospital setting because of falls, infections, delirium and even loneliness.

"It's not a slam dunk that frail, older patients are going to come out of the hospital system and not be injured in some way," says Bruce Leff, a geriatrician at the Johns Hopkins University School of Medicine in Baltimore. Whenever possible, he says, "we want to help the elderly avoid hospitals."



Bruce Leff, MD

The home-hospital movement got its U.S. start in the mid-1990s at Hopkins when Dr. Leff and some colleagues there reviewed the medical literature and picked four potentially deadly illnesses that they believed could be safely treated at home. These included congestive heart failure and cellulitis, which is a painful inflammation of the skin that often requires close monitoring and intravenous antibiotics.

The idea was that whenever a patient with one of the conditions showed up in the emergency room, the person was evaluated as a potential candidate for home-based hospitalization. If they agreed, they'd be sent home, often in an ambulance, along with necessary medical equipment and drugs.

When Dr. Leff pitched the plan to Johns Hopkins's institutional-review board, "They said 'You guys must be crazy,"' he recalls. "They thought the model was inherently unsafe."

To overcome the board's objections, Dr. Leff agreed to some rules. Patients could only enroll between 6 a.m. and 10 p.m., when doctors and nurses were more likely to be available to accompany a patient home, and a nurse would stay with a patient for at least the first 24 hours. Patients also needed to live no more than 10 miles from the hospital. Those who changed their minds could go into a hospital bed, no questions asked. "There was an eject seat and patients could pull the cord," says Dr. Leff.

Hopkins' two-year pilot study starting in 1996 suggested that home treatment was as safe and satisfactory as hospital care. With lower overhead -- such as room costs, electricity and meals -- and fewer costly tests to administer, the program, which tracked 17 patients, was also found to be about 60% cheaper.

Still, the idea needed to be tested on a larger scale in order to gain credibility. Hospitals in Maryland, including Johns Hopkins, were not ideal for a continuing program because most facilities in the state operate on a fee-for-service basis: they can collect from insurers only when they fill a hospital bed. Nor would Medicare directly pay for patients treated at home because the law requires Medicare-funded treatment to occur in an actual hospital. Dr. Leff realized that the at-home model was more likely to be embraced by managed-care plans, which try to provide appropriate care but often in lower-cost settings.

In 2000, Dr. Leff approached various U.S. hospitals to see if any were willing to give the home hospital experiment a try. Three partners eventually signed up: The first was Univera Healthcare and Independent Health in Buffalo, N.Y., which treat managed-care patients at a single site. The second, also a managed-care plan, was Fallon Health Care System in Worcester, Mass. The Portland VA, which is funded by the federal government, was the third.

A twenty-two month study was funded by the John A. Hartford Foundation. Among the findings: Aside from costing less than similarly afflicted hospital patients, those treated at home had shorter "stays," fewer procedures, less delirium, and reported greater overall satisfaction.

After the trial ended, the facility in Worcester bowed out, partly because of a shortage of nurses. The Buffalo hospital has since continued to build on the at-home model, mainly by focusing on patients with congestive heart failure. At Portland, hospital administrators decided later to modify the program by accepting early-discharge patients as well as new arrivals. Because of the change -- which now includes two admittance and evaluation charges for some patients -- the hospital says that its at-home group costs just as much to treat as those who stay in-facility. The VA has not measured the cost savings resulting from patients treated entirely at home, as it did previously.

Nevertheless, the hospital values the program for its other benefits: since it is almost always operating near capacity, the program frees up scarce beds for more urgent patients. "If you can manage some patients at home, you can free up beds for more acutely ill patients," says Dr. Mader. Treating patients at home, he adds, is a lot cheaper than expanding hospital capacity by building a new wing.

Tough Cases

In its current incarnation, "Project at Home," as it's officially known, has tackled some tough cases. One patient didn't have a phone, and would tap on his ceiling with a broomstick. It was his way of asking his upstairs neighbor to call the program nurse on his behalf.

Only one patient died while being treated at home, the result of a heart attack. After studying the case, the VA's peer-review committee concluded that the level of care provided "was adequate" and the patient could just as easily have succumbed while in a hospital bed, says Dr. Mader.

Mr. Willer, the heart patient, used to work for the Coast Guard and now is employed in the medical-records department of the Portland VA. After his first heart attack in January, he was admitted to the VA hospital, treated and eventually discharged.

On March 13, he showed up again at the VA emergency room, complaining about a shortness of breath and a sense of "fullness" in his belly. He was briefly admitted to the intensive-care unit, where doctors helped unclog his arteries and decided that he was out of immediate danger. But he was also diagnosed with congestive heart failure. When the heart is weakened from a heart attack, it can no longer pump effectively. Consequently, a large quantity of fluid can collect in the heart and lungs -- the physiological equivalent of a flooded car engine.

This time, Mr. Willer got a choice: Did he want to be hospitalized at the VA, or would he prefer to receive similar treatment at home? "I want to go home," he says he told a doctor without hesitation.

Since he doesn't have a home telephone, the VA program loaned him a cellular phone so that he could reach program staff in case of an emergency. On the way home, Mr. Weller, who likes to dress up in women's clothing, broke the program's straight-to-bed rules. He had his wife, a nurse, stop at a store so he could buy a pair of tan pumps that were on sale for $30. "I simply had to have them," he said later, proudly showing them off.

Soon, he was in his bedroom with an IV connection in his arm, and other supplies provided by the hospital. At 8:30 the next morning, a representative from a private company, hired by the program, arrived at his door, extracted some of Mr. Willer's blood, and dispatched it to a lab. A doctor would later review the findings.

At 10 a.m., Eileen Espe, a short-haired nurse with a no-nonsense style, made her first visit to Mr. Willer's home. "It's an interesting place," she muttered, out of Mr. Willer's earshot, referring to the piles of clothes in the bedroom, the dirt-encrusted rugs and a moldy odor that pervaded the house.

When Mr. Willer boasted to Ms. Espe about his shoe-buying excursion, she wasn't amused. Under the rules of the program, she said, hands on hips, "you're basically under house arrest."

She then got down to business, discussing her patient's medications, taking his blood pressure and checking his lungs with a stethoscope. She lectured him about salty foods and advised him to eat vegetables. And she administered an intravenous dose of Lasix, a diuretic that would help his body excrete excess fluid.

Mr. Willer suddenly broke down. "I never realized I was this close to death," he said, sobbing, as the nurse put an arm over his shoulders and calmed him.

The nurse used a cellphone to call a doctor at the VA to discuss the results of the blood tests and other medical data. The doctor, Maggie George, decided that Ms. Espe had things under control, and she didn't have to pay Mr. Willer a visit.

Ms. Espe advised her patient that if he felt uncomfortable at night, he could call the 24-hour line that connects to a member of the home-hospital staff. "But if it's a crushing pain in your chest," the nurse added matter-of-factly, "call 911."

The next day, another nurse found that Mr. Willer was still retaining lots of fluid in his heart and legs. She administered another dose of Lasix, a diuretic. About 24 hours later, on March 19th, the nurse dropped by again. By then, Mr. Willer's blood-sugar levels had improved significantly, though he still had some swelling in his lower legs. He received another shot of Lasix.

But he also insisted on being discharged because he wanted to work the next day, as he had run out of paid sick days. He was officially discharged, though nurses say that ideally they'd have kept him in the program for another day or two.

Was he happy with the treatment he received at home? "I was," said Mr. Willer, who has returned to better health. Pausing, he added a caveat: "But I wouldn't recommend anyone get so sick that they actually need the program."

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