

House Call Programs as an 'Extender' of Senior Centers
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Health systems need to transform from a *reactive* system – responding mainly when a person is sick – to a *proactive* system – keeping the person as healthy as possible. This goal can be achieved when health systems partner with community based organizations such as local senior centers to enhance the care given to the community.

Christiana Care Health System (CCHS) in Delaware is putting this model into practice by supporting medical offices in two senior centers opening in September 2007. However, senior centers and outpatient medical offices are dependent on the participants traveling to them and not the other way around. For my project as a Practice Change Fellow, I propose to develop a house call program that will extend social and medical services into a patient's home when he/she can no longer come into the office. In short, health care follows the patient.

Currently, there is a small panel of house call patients existing mainly for educational purposes for the family medicine residency program. I will attempt to grow this practice through the assistance of two other faculty members, social workers, and a geriatric nurse practitioner. These positions will be filled through internal funding, external grants, and student learners. We are growing this practice in a most needed time as two solo practitioners who were doing house calls have both left the area in the past year. In addition, the visiting nurse association and discharge coordinators in our system are also eager for us to become fully functional as they too recognize the lack of medical and social services received by a patient who is homebound.

Our initial goal is to have each of the three physicians dedicate one half day a week for house calls. As more referrals come in, we will slowly increase our dedicated time to two-three half days a week. The nurse practitioner who will conduct most of the routine and necessary urgent visits will see patients on a daily basis. The social workers will do in home assessments as necessary. Exceptional continuity of care and discharge planning will be delivered by the multi-disciplinary house call team. Benefits to the system include shorter average length of stay, increase bed capacity, and overall cost savings.

Please [email Ina](#) with any questions or comments regarding this project.