

**GWEN W. OLDENQUIST, MD**Division of Geriatric Medicine and
Gerontology, Johns Hopkins University,
Baltimore**LINDA SCOTT, MSHA, RNC**

Johns Hopkins Home Care Group, Baltimore

THOMAS E. FINUCANE, MDDivision of Geriatric Medicine and
Gerontology, Johns Hopkins University,
Baltimore

Home care: What a physician needs to know

■ ABSTRACT

When elderly patients might benefit from home care, a key question is whether Medicare will pay for it. We describe what physicians can do to avoid the pitfalls in qualifying appropriate patients for Medicare's Home Health Services and hospice programs, and the basic features of these two programs. We also describe the experience and methods used in prototype programs that provide home-based hospital-level care, and that revive a supposedly lost art: physician house calls.

■ KEY POINTS

Medicare pays for short-term home care provided by certified home health agencies, for transition from a hospital or a skilled nursing facility, for observation of the stability and continued recovery of the patient, and for continuation of a skilled treatment.

Medicare also pays for hospice care for terminally ill patients who elect to emphasize palliation in preference to treatments to prolong life.

A meta-analysis showed that home-based assessments improve the likelihood that elderly patients will remain at home instead of going into a nursing home.

PHYSICIANS CAN HELP AVERT DENIAL of home health and hospice benefits for eligible patients by learning the Medicare meaning of key terms, and by following a number of critical steps.

■ NEED IS INCREASING

Medicare is trying to balance the benefits of its home health and hospice programs against their cost in the face of a rising prevalence of chronic disease.

In a few centers, innovative programs are being tested that bring hospital-level care into the patient's home, and that employ a method new to most physicians today—house calls.

Societal trends augur a crisis in informal care-giving for the rapidly growing numbers of older Americans. Not only do illness, disability, and dependency increase with age, but changes in the family structure diminish the likelihood that a family member is available to provide care. Families are getting smaller and more mobile, and are more often broken. More women, traditionally the care givers in the family, now work outside the home.

■ MEDICARE HOME HEALTH CARE ELIGIBILITY REQUIREMENTS

Medicare is primarily intended as an insurance policy against acute illness. Accordingly, in an effort to shorten or avoid hospitalization, it pays for some home care for acute illness under its Home Health Services benefit.

To receive Medicare reimbursement, a home health agency must have a physician certify the following:

- The patient needs intermittent skilled nursing services or therapies

- The services are needed because the patient is homebound
- The services provided are reasonable and necessary (based on section 204 of the Medicare Manual)
- A plan of care is established and reviewed by the physician (HCFA 485 form)
- Care is provided while the patient is under the care of a physician.

In addition, federal law now requires all Medicare Home Health Service agencies to fill out an extensive report at the time of admission and every 2 months for all adult, nonmaternity patients.

Because the cost of the Medicare Home Health Services program is rapidly increasing, regulatory oversight has become increasingly intense, and paperwork requirements have expanded greatly.¹

Definition of 'skilled'

Medicare defines skilled care as care that requires special training to perform safely and effectively, generally by a registered nurse or therapist. Patients who require skilled care are described as having a "skilled need."

Although experience in our geriatrics programs reveals a great need for services such as assistance with personal care (bathing, dressing, mouth care), shopping, meal preparation or transportation, social services, and occupational therapy, these services are not authorized under Medicare unless the patient qualifies for "skilled care."

The types of skilled care that Medicare defines fall into four categories:

- Observation and assessment (eg, for a patient starting a new and complex medication regimen)
- Teaching and training
- Therapy
- Management and evaluation of a care plan.

Observation and assessment. Once the physician refers the patient to a home health agency, a registered nurse observes the patient for signs and symptoms that require physician intervention or medication changes, and educates the patient. The registered nurse also helps the patient establish a safe medication routine to promote long-term compliance. He or she can also perform venipuncture to start an IV or to draw blood for tests.

Teaching and training may include teaching the patient or family to give subcutaneous or intravenous medications, educating a patient with newly diagnosed diabetes or heart failure, or training a patient or care giver to care for ostomies or wounds.

Therapy refers to services indicated for decreased function due to orthopedic or other surgical procedures, strokes or other neurological events, or severe deconditioning from hospitalization or illness. Therapy that is eligible for coverage includes services provided by social workers, nursing assistants, and occupational therapists, provided that the patient already has a skilled need (see above). These personnel can help the patient obtain medications or food, cope with a new chronic illness, care for a dependent family member, or arrange long-term assistance. Therapy also encompasses administration of parenteral medications, care of wounds, and several skilled procedures such as tube feeding, catheter changes, ostomy care, and psychiatric evaluation and therapy by a registered nurse.

Management and evaluation of a care plan. Although physicians need to be familiar with Medicare home health coverage and eligibility criteria, they should be able to rely on the home health agency to assist in developing an appropriate care plan for a particular patient.

Definition of 'intermittent' services

Medicare reimburses home health services it considers "intermittent," provided the physician certifies that the patient is homebound. Intermittent services cannot total more than 35 hours per week. "Intermittent" can also refer to services provided in visits, rather than hours. Visits usually cannot occur daily, or if daily, as in the case of a patient with a wound, a "predictable and finite end point to daily care" must be documented on the HCFA 485 form. The wound does not have to heal, but nursing visits must decrease either by teaching the patient or family member the care, or by using a wound care technique that requires less frequent nursing intervention.

Medicare will not reimburse the home health agency for care if daily nursing services are ordered without an end point, or if the fiscal intermediary believes the end point is not reasonable.

**Medicare only
pays for well-
defined skilled
care services**

Medicare's focus: Acute illness

Medicare is intended primarily as an insurance program against acute illness. Under its home health services benefit, Medicare pays for home care for acute illness in an effort to shorten or eliminate hospitalization.

Use of the benefit is growing rapidly, fueled in part by Medicare's own prospective payment system under which hospitals have an economic incentive to send patients home "quicker and sicker."¹⁷ In addition, last year Medicare instituted a prospective payment system for home health agencies.

REAL-WORLD DEMAND FOR LONG-TERM CARE

Poised against Medicare's intended focus, however, are a tremendous number of chronically ill elderly people living at home with problems that are both medical and social, such as chronic recurrent pressure ulcers and medication noncompliance.

In 1993, most Medicare Home Health Service visits were provided to patients who received the service for more than 6 months, and the high use of these services in certain metropolitan areas was not associated with fewer or shorter hospitalizations.¹⁸ According to the 1996 National Home and Hospice Care Survey, 70% of elderly patients who had been discharged from a home health program had used it for 60 days or less. On the other hand, 60% of elderly patients currently in the program had been using it for longer than 90 days.

The average length of service among the patients was 336 days (338 days for women, 331 days for men).¹⁹

One result of this mismatch between Congressional intent and real-world demand is that spending on Medicare Home Health Services has varied regionally more than any other Medicare benefit.¹⁸

ECONOMIC AND ETHICAL ISSUES

From an economic standpoint, health care for the homebound is cost-effective only if it reduces other costs, chiefly nursing home or hospital care costs. Twenty-five years ago Brickner et al²⁰ characterized the problem generically, describing the many patients entering their house call program as people who "would in all likelihood have died in their homes alone, without being found, at great financial savings to the community." Twenty years and billions of dollars later, Gurley et al²¹ reported a large series of "persons found in their homes helpless or dead."

In addition, unique ethical problems arise in the care of homebound patients. A common perplexing example is the frail elderly person with failing cognition who is determined to remain at home, but who is year by year more at risk of an accident and less able to evaluate the risks of remaining at home.

Definition of 'homebound'

Medicare provides a very specific definition of "homebound" that is outlined in the Home Health Agency Manual (all the emphases in the following list are Medicare's):

- A person *does not* have to be bedridden to be considered as confined to the home
- The condition of the patient should be such that *there is a normal inability to leave the home*
- Leaving the home would *require a considerable and taxing effort*
- Absences from home are infrequent and are usually to receive medical care.

Definition of 'reasonable and necessary'

A skilled need must be "reasonable and neces-

sary." A vitamin B₁₂ injection is a skilled procedure, but it would not be reasonable and necessary if given in an unusual dose or for a condition for which it is not indicated, such as insomnia. If a patient "has a skilled need," services can be provided by qualifying disciplines, which include nursing, physical therapy, and speech therapy. These are covered under Medicare Part A and are reimbursed at 100%. Occupational therapy, social work, and home health aide services can also be provided and covered under Medicare Part A.

HCFA 485 form: The physician's care plan

The Health Care Financing Administration (HCFA) 485 form is the physician's plan of care. It lists primary and secondary diagnoses

of the patient, medications and diet prescribed, activities permitted, and specific services to be provided.

The form contains specific sections called “locators” that contain specific sets or types of information. For example, locator 5 is the home health agency’s Medicare provider number. Locator 17 is the patient’s allergies.

The physician should specifically review locators 21 and 10. Locator 21 describes the services to be provided and specifies the frequency and duration of each. Locator 10 is the medication profile, which should be reviewed for accuracy.

Home health agencies generally write orders for 9 weeks of services for documentation convenience. The physician may rely on communication with the home health agency to determine when discharge is appropriate based on the patient’s progress, or the physician may set a specific time frame to begin and end services.

The home health agency prepares the HCFA 485 form, but the physician must review and sign it before the claim is submitted. Most states also have regulations specifying the time frame in which the physician must sign the orders.

Physician’s signature is critical. Lack of a physician’s signature is one of the 10 most common reasons home health agencies are denied payment. This common problem likely exists because until recently, physicians have not been reimbursed for the time this takes. However, effective January 1, 2001, HCFA implemented a system of codes, called the HCFA Common Procedure Coding System (HCPCS) codes. These are used to bill for physicians’ services when they review and sign home health plans of care for certification and recertification.

Billing Medicare for care-plan oversight

At present, physicians can bill Medicare for care-plan oversight—review and reevaluation of the home health orders, laboratory or other tests, communication with health care providers, and other information is used to develop or change the care plan. However, they can do so only if specific CPT (Current Procedural Terminology) codes are used and particular criteria are met. The physician must

have seen the patient within 6 months, and time spent must be greater than 30 minutes per patient per month. This time includes time spent talking with home care staff or pharmacists but not with the patient or family, reviewing laboratory work, coordinating care with others, or meeting with home care staff to review the care plan.

The physician must maintain documentation of this time; documentation cannot be provided by the home health agency. Care plan oversight is billed under Medicare Part B and includes a 20% copayment to the patient.

■ COMMON REASONS FOR DENIAL OF HOME HEALTH SERVICES BENEFITS

Single visits. One-time visits for any of the services described above and services provided indefinitely without a clear end point are likely to be denied. A single visit to evaluate shortness of breath or dysuria would not meet Medicare Home Health Services criteria, nor would a one-time visit to give gamma-globulin.

Medicare defines a single physical therapy visit for evaluation and instruction as “intermittent,” but a single nursing visit is not considered intermittent and therefore is not reimbursable unless the patient is rehospitalized, dies, or enrolls in a hospice program.

Gradually progressive disability. A second common reason for denial is when therapy is started for a patient who has only a stable or very gradually progressive disability. Although not explicit in the regulations, most Medicare intermediaries model their decisions on inpatient rehabilitation. They are most likely to reimburse for an acute event and a definite period of recovery.

■ MEDICAID WAIVER PROGRAMS

Some states have Medicaid programs that fund personal care support for patients who would otherwise qualify for nursing home care. These programs are overseen by registered nurses and are often called “Medicaid waiver” programs. Waiting lists tend to be long, and little or no skilled care is available, as the registered nurse generally visits only every 60 days.

Lack of a physician’s signature is a top reason for denying payment



■ HOSPICE CARE

Medicare Part A, which reimburses hospitals and home health services, also reimburses for hospice care. But there are key differences between hospice and home health services in patient selection, services provided, and the benefits under Medicare reimbursement.

Patient must be terminally ill

Patients are eligible for the Medicare hospice benefit if they are eligible for Medicare Part A, choose in writing to enroll in hospice, and have a terminal illness as defined above.

The attending physician and the hospice medical director must certify that the patient is terminally ill, ie, has a disease to which he or she will likely succumb in 6 months or less if the disease runs its normal course. Cancer is the most common diagnosis for which patients qualify as terminally ill, but dementia, stroke, heart disease, and various neurological disorders can also be predicted to be terminal. Hospice providers can give the physician a clinical worksheet to assist in determining if the patient has reached the terminal phase. The patient is not required to be homebound.

What if the patient lives longer than 6 months?

In choosing hospice care, the patient agrees to favor palliative care instead of curative treatment. If the patient survives longer than expected, the hospice benefit may be continued indefinitely as long as the physician certifies that life expectancy is less than 6 months.

Some hospices are now reluctant to provide care to patients who have outlived the 6-month expectancy because charges of fraud and abuse have been made against some hospices that provided care for longer intervals. This tension remains unresolved.

In 1999, the mean length of hospice enrollment was 48 days. However, the median length of service was only 29 days—ie, 50% of patients survived less than 29 days.²

Reimbursement issues

Hospice patients sign over their Medicare Part A benefit to the hospice program. Any services related to the terminal diagnosis are

directed by and become the financial responsibility of the hospice. The hospice program, in turn, receives a per diem payment from Medicare to cover hospice services, durable medical equipment, and medications related to the hospice plan of care.

Should the patient need a short stay in an acute care unit for symptom management, the hospice program arranges and pays for it. Some hospices have residential facilities, but most provide home care. Many hospices have contracts to provide hospice care to residents of long-term care and assisted-living facilities.

The focus of hospice care

While home health care focuses on treatment and teaching to attain cure or long-term management of health needs, hospice care is directed at managing symptoms, providing comfort, and helping the patient and family deal with life issues, plan for death, and maintain quality of life while dying. Hospice care also includes practical things such as working through memories and plans, helping to finish family business, and planning the funeral.

Hospice nurses work closely with the pharmacist and physician to determine drug combinations and dosages that will control pain and other symptoms, leaving the patient alert and interactive. Therapists, social workers, home health aides, community volunteers, pastoral counselors, and bereavement counselors are also part of the hospice care team. Social workers and spiritual counselors work with the patient and family in advance of the patient's death. Bereavement care continues for the family for 13 months after the patient's death.

The pattern in which services and resources are used differs greatly between hospice care and home health care. Whereas in home health care more services are provided at the beginning of care and are tapered down as discharge approaches, in hospice care the patient is relatively stable at the start. Services might not all begin at once and tend to increase slowly in number and intensity as the patient's needs increase.

Each hospice is required to have a medical director whose salary, if he or she is not a volunteer, comes from the hospice program's budget. A physician who enrolls a patient in hos-

In hospice care, use of services expands according to need

pice generally remains the physician of record, and continues to bill Medicare Part B for care provided. More information about hospice programs is available on the National Hospice and Palliative Care website (www.nhpco.org), an excellent resource for physicians, patients, and families.

■ HIGH-ACUITY HOME CARE: THE 'HOME HOSPITAL'

Although not part of any Medicare-reimbursable program, high-acuity home care has great potential. As technology continues to develop, an increasing variety of diagnostic and therapeutic interventions can be performed in the home. A logical culmination of this is the "home hospital," a situation in which a hospital-level illness is cared for in the home.

Evidence of effectiveness

In a trial conducted at our institution, patients were eligible for home hospital care if they were age 65 or older, were insured by Medicare, lived within a defined catchment area, required hospitalization for community-acquired pneumonia, cellulitis, or exacerbation of chronic heart failure or chronic obstructive airway disease, and met other criteria described elsewhere.³ Hospital-level care in the home included intravenous medications, antibiotics, and nebulizers, with twice-daily nursing visits and daily physician visits. The intervention was cost-effective with no difference in mortality compared with patients who also met the eligibility requirements but were cared for in the hospital.

The obvious attraction of this strategy is that it avoids the many well-documented risks of admitting frail, elderly patients to the hospital.⁴ A randomized clinical trial in Australia demonstrated significant reductions in confusion and bowel and urinary complications in the group treated at home.⁵

Home-hospital programs were successfully implemented in the United Kingdom⁶ and Israel,⁷ and multi-site demonstration programs are being developed in the United States.⁸

Rich et al⁸ reported that patients who received a nurse-directed, multidisciplinary in-home intervention after surviving a hospital-

ization for congestive heart failure had a higher quality of life, incurred lower costs, and had a lower rate of readmission, a lower mortality rate, and a longer time to first readmission compared with patients who did not receive the intervention. Kornowski et al⁹ reported similar results. Deep-vein thrombosis can now be treated almost entirely at home with the use of low-molecular-weight heparin.¹⁰

These types of programs will certainly be commercialized, and reimbursement schemes will have a great effect on how they develop.¹¹

■ THE LOST ART OF HOUSE CALLS

Physician house calls were once commonplace but have been declining for decades. In 1993, less than 1 Medicare dollar in \$5,000 was spent on physician home visits (Medicare does reimburse for house calls). In one report,¹² fewer than 1% of older patients received house calls, and these were more often made by older generalists in solo practice in the Northeast.

Example of a house call program

Our institution has integrated a house call program into our internal medicine residency program and geriatric fellowship program. Residents provide continuity of care to a panel of patients as they do in an ambulatory outpatient clinic. Fellows do a 2-month rotation in the house call program and may elect to remain the primary care physician for certain patients throughout their fellowship.

House calls give unique insights

The response of residents, fellows, and attending physicians has been very positive. They enjoy this unique perspective into a patient's life and find the experience both challenging and educational.

When asked what they found unique to house calls, physicians in our program often reported safety issues in the home or neighborhood, compliance, and family dynamics. One physician who watched a 90-year-old blind woman precariously climb a very narrow, winding set of steps described the experience as "absolutely terrifying." In another home visit, the source of a homebound patient's chronic cough was explained by the fact that

Hospital-level illnesses are being cared for in the home



she lived with four smokers in an unventilated home.

A family's unwavering refusal to accept a do-not-resuscitate order for a frail, ill, elderly woman became immediately understandable to the physician who visited one patient's home: the living room had been transformed into a "mini-ICU," and the adult daughter had made her mother's care the central focus of her life.

Home safety evaluation is largely a matter of common sense, focused by seeing the elderly in their own environments. We believe that cleanliness is a cultural matter that should be ignored, unless lack of it is a diagnostic clue, an aesthetic barrier for the care givers, or a medical risk.

Physicians on home visits relearn lost skills

Although ancillary services can be brought in, the physician takes responsibility for routine care, including routine laboratory studies and phlebotomy—an unusual skill for most residents in training today. Patients with defined skilled needs qualify for home health nursing visits.

Most of our patients do not have a skilled need, so the doctor works without the assistance of nurses and phlebotomists, relearning forgotten skills.

How the house call program works

A program coordinator and a receptionist field calls from patients and families and screen patients for admission into the house call program, depending on homebound status and geographic location. An attending physician serves as the director.

Appointments are scheduled as in ambulatory clinics. Patients are scheduled by geographic location so that driving time is limited. Visits are scheduled in the mornings if possible. Urgent visits are scheduled when feasible.

Weekly meetings are held with the fellow, attending physician, a dedicated group of nurses from our affiliated home health agency, therapists, and social workers to discuss those patients in the program who are at that time open to skilled nursing. The meeting thus allows physicians, nurses, and other care

providers to discuss in person the course of these very ill and vulnerable patients.

As with outpatient visits, the attending physician of record must be present and provide appropriate documentation to bill Medicare for visits provided by residents or first-year fellows. Most second-year fellows complete appropriate paperwork and are able to bill for their visits.

Goodbye black bag

Residents and fellows carry their house call paraphernalia in fishing tackle boxes, for safety reasons discussed below. Contents include gloves, glucometer, sphygmomanometer, otoscope, "small sharps" container, lidocaine, injectable steroid solution, thermometer, alcohol prep solution, cotton-tipped applicators, gauze, fecal occult blood test cards and developer, sublingual nitroglycerin, and venipuncture equipment including collecting tubes, various sizes of syringes, needles, and butterfly tubing sets, and culture broth.

Are house calls worthwhile?

Do house calls improve patient care, apart from the obvious convenience factor? Is reimbursement adequate to justify the physician's time?

Some health services research shows that physician house-call-based home care is effective. A meta-analysis showed that home-based assessments improve the likelihood that elderly patients will remain at home.¹³ For individual physicians who do not work within a particular program, few data are available about the utility of home visits. An appreciation of the people, environment, and systems on which these patients depend and a deeper and better doctor-patient relationship are commonly reported, but have not been studied—and perhaps cannot be. Several trials of medication compliance have shown that what physicians think patients are taking and what patients actually take, as confirmed by a home visit, are widely discrepant.^{14,15} With few exceptions, research on home care has been fundamentally limited by variable definitions of who should receive services (the "targeting" problem), the precise nature of the intervention, and the outcome measures.

Health services research on the cost of

**Patients
assessed at
home are likely
to remain at
home**



home care is further limited because care of the frail elderly is so intrinsically expensive, neglect is so inexpensive, and most of the work is already done by nonprofessional care givers. Review of these data is beyond the scope of this paper. At least in urban areas, programs of physician house calls have been reported to be financially successful.

Personal safety issues in making house calls

Personal safety is a serious concern for professionals making house calls, and there are certainly associated risks. But it is important to recognize that seeing patients in the clinic or the hospital is not risk-free, nor is getting to work. In the absence of data, we offer the following recommendations based on our experience:

- Schedule visits in the morning; we believe morning visits are safer than later in the day
- Don't wear your white coat or carry your doctor bag; these might attract the atten-

tion of potential aggressors (hence our decision, after thoughtful discussion, to use fishing tackle boxes)

- Alert the patient or care givers when you are leaving for the visit
- If a situation feels unsafe, don't take chances—just keep driving.

On one hand, harmful incidents are rare in the thousands of house calls that are made annually. On the other hand, a questionnaire survey of home health agency nurses revealed that a surprising number carry guns in their cars while working.¹⁶

Financial feasibility

Whether house calls are financially feasible for the primary care internist depends mainly on how payers view them. In capitated systems, they are likely to be seen as advantageous, particularly when high-acuity home services can substitute for emergency room visits and hospitalization.

REFERENCES

1. Mikos C, Koch L. The legal considerations surrounding OASIS (Outcome Assessment and Information Set) reporting requirements. *Caring* 1999; 18:20–23.
2. www.nhpco.org. National Hospice and Palliative Care Organization. Vol. 2000, 2000.
3. Leff B, Burton L, Bynum J, et al. Prospective evaluation of clinical criteria to select older persons with acute medical illness for care in a hypothetical home hospital. *J Am Geriatr Soc* 1997; 45:1066–1073.
4. Leff B, Burton L, Guido S, Greenough W, Steinwachs D, Burton J. Home hospital program: A pilot study. *J Am Geriatr Soc* 1999; 47:697–702.
5. Caplan G, Ward J, Brennan N, et al. Hospital in the home: a randomised controlled trial. *Med J Aust* 1999; 170:156–160.
6. Shepperd S, Iliffe S. Hospital at home: An uncertain future. *BMJ* 1996; 312:923–924.
7. Stessman J, Ginsberg G, Hammerman-Rozenberg R, et al. Decreased hospital utilization by older adults attributable to a home hospitalization program. *J Am Geriatr Soc* 1996; 44:591–598.
8. Rich M, Beckham V, Wittenberg C, et al. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *N Engl J Med* 1995; 333:1190–1195.
9. Kornowski R, Zeeli D, Averbuch M, et al. Intensive home-care surveillance prevents hospitalization and improves morbidity rates among elderly patients with severe congestive heart failure. *Am Heart J* 1995; 129:762–766.
10. Levine M, Gent M, Hirsch J, et al. A comparison of low-molecular-weight heparin administered in the hospital for proximal deep-vein thrombosis. *N Engl J Med* 1996; 334:677–681.
11. Burton J. The house call: An important service for the frail elderly. *J Am Geriatr Soc* 1985; 33:291–293.
12. Meyer G, Gibbons R. House calls to the elderly—a vanishing practice among physicians. *N Engl J Med* 1997; 337:1815–1820.
13. Stuck A, Siu A, Wieland G, et al. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet* 1993; 342:1032–1036.
14. Anderson D, Prunty N, Partridge M, et al. Does anyone know what medication the patient should be taking? *Int J Geriatr Psychiatry* 1994; 9:573.
15. Stewart S, Pearson S. Uncovering a multitude of sins: medication management in the home post acute hospitalisation among the chronically ill. *Aust NZ J Med* 1999; 29:220–227.
16. Kendra M, Weiker A, Simon S, Grant A, Shullick D. Safety concerns affecting delivery of home health care. *Public Health Nurs* 1996; 13:83–89.
17. Shaughnessy P, Kramer A. The increased needs of patients in nursing homes and patients receiving home health care. *N Engl J Med* 1990; 322:21–27.
18. Welch H, Wennberg D, Welch W. The use of Medicare home health care services. *N Engl J Med* 1996; 335:324–329.
19. Munson M. Characteristics of elderly home health care users: Data from the 1996 National Home and Hospice Care Survey. *Advance Data*. Vol. 1999. U.S. Department of Health and Human Services; Centers for Disease Control and Prevention, 1999.
20. Brickner P, Teresita S, Kaufman A, et al. The homebound aged: a medically unreached group. *Ann Intern Med* 1975; 82:1–6.
21. Gurley R, Lum N, Sande M, Lo B, Katz M. Persons found in their homes helpless or dead. *N Engl J Med* 1996; 334:1710–1716.

ADDRESS: Thomas E. Finucane, MD, Division of Geriatric Medicine and Gerontology, Johns Hopkins Bayview Medical Center, 5505 Hopkins Bayview Circle; Baltimore, MD 21224; e-mail tfinucan@jhmi.edu.

Hospice patients are not required to be homebound