Home Visits in Geropsychiatry Fellowship Training

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Purpose: The psychiatric home visit is an effective intervention for elderly patients who otherwise would not receive mental health services. Home visits also have potential to be useful for training. Here, the current practice of home visits in geropsychiatry fellowship programs is examined.

Design and Methods: The directors of 55 current geropsychiatry fellowships in the United States were sent a 13-item questionnaire regarding the use of home visits for training. Results: Of the 51% of programs responding, 57% provide a formal home-visit experience for fellows. Respondents commented favorably regarding the educational value of home visits, but raised concerns about funding this time-intensive clinical activity.

Implications: Training programs in geropsychiatry can benefit from the inclusion of home-visit programs. A description of a recently established home-visit program illustrates the feasibility of such an enterprise when developed as a collaboration between a teaching hospital and an appropriate community agency. This arrangement provides training for fellows and allows the agency to provide broad mental health services.

Key Words: Community psychiatry, Elderly people, Homebound

A growing literature has demonstrated the clinical efficacy of home-based geropsychiatric evaluation and treatment. The utility of this form of intensive community outreach has been demonstrated in a variety of settings. These include an urban public housing project (Brown & Lieff, 1982; Roca, Storer, Robbins, Tlasek, & Rabins, 1990), a suburban county (DeRenzo et al., 1991), a residential home for the aged (Sherr & Goffi, 1977), and the catchment areas of large psychiatric hospitals (Sherr, Eskridge, & Lewis, 1976; Stolee, Kessler, & Le Clair, 1996). Home-visit programs designed to address specific populations such as frail elders with depression (Bangerjee, Sharmash, Macdonald, & Mann, 1996) and inner city elderly adults with dementia (Edwards et al., 1999) have also been shown to increase access and improve quality of care. In general these programs have aimed to reduce the need for psychiatric hospitalization and to enable seniors to remain in the community (Reifler et al., 1982; Sherr et al., 1976; Stolee et al., 1996).

Programs described in the literature typically involve a multidisciplinary team often associated with outpatient clinics, educational programs, and other services designed for elderly people (DeRenzo et al., 1991; Stolee et al., 1996). In Great Britain, where there is a long tradition of home visits by medical specialists or consultants, home services involving multidisciplinary teams have been compared with visits by individual physicians, and both have been shown to be effective (Collighan, Macdonald, Herzberg, Philpot, & Lindesay, 1993; Orrell & Katona, 1998).

The home would appear to be an excellent locus for geropsychiatric education. Home visits allow trainees to see elderly patients, many of whom would not attend ambulatory facilities, in their living environment. The available literature regarding the training opportunities afforded by psychiatric house calls is limited to program descriptions emphasizing the value of acquainting students with the challenges confronting the mentally ill in the community (Kadner & Brandt, 1991; Reifler, 1986). Nonetheless, trainee participation in senior outreach services is a program requirement for geropsychiatry fellowships, according to the American College of Graduate Medical Education (1994), and has been recommended for general psychiatry residents (Kennedy et al., 1999; Marin et al., 1988).
This article describes the results of a survey we con-
ducted looking at the use of home visits for train-
ing in geropsychiatry fellowships. We also provide a
program description that includes the perspective of
the social service agency that refers homebound pa-
tients as well as the psychiatric team that performs
the home visits.

Methods

We obtained the names and addresses of geropsy-
chiatry fellowship directors from Fellowship and Res-
idency Electronic Interactive Database Access Online
and from the newsletter of the American Association
of Geriatric Psychiatry. We developed a 13-item ques-
tionnaire to obtain information about home-visit pro-
grams. Individual items were aimed at obtaining data
such as number of annual home visits, sources of re-
ferral, frequency of follow-up, financing, and reasons
for discontinuing home-visit programs. The survey
included a section for comments. The questionnaire
was distributed through regular mail to 55 site direc-
tors in the United States. In cases in which e-mail ad-
dresses were available, we also sent the questionnaire
in a format enabling an electronic response. We mailed
a second set of questionnaires to programs that did
not answer us to improve the response rate.

Results

We received 28 completed questionnaires from the
55 programs surveyed (51% response rate). Five re-
sponses arrived by e-mail with the remainder coming
by regular mail. Fellowships ranged in size from one
to seven fellows per year with the modal number of
fellows being two. Sixteen fellowships (57%) re-
ported a currently existing formal home-visit pro-
gram. Participating fellowships performed between 6
and 200 home visits in the 1998–1999 academic year. The median number of visits for active pro-
grams was 25. One program director reported that
fellows had home-visit opportunities through a Vet-
ers Administration (VA) hospital rotation but did not
consider this to be a formal program. Two addi-
tional programs had ended an established program
within the last 5 years. In one case the referring
agency ended its relationship with the fellowship,
and in the other case the program was terminated be-
cause of a combination of inadequate funding and
excessive time commitment for the fellows.

Additional survey results of the 16 active house-
call programs are shown in Table 1. A majority of
programs (63%) have operated for at least 3 years.
The most common referral sources included social
service agencies (listed by 44% of programs), VA
services (19%), and geriatric medicine departments
(19%). The vast majority of programs saw patients
both with and without dementia (94%).

Home visits involved a high degree of collabora-
tion between geropsychiatry fellows and other disci-
plines. Clinicians accompanying fellows most fre-
quently included social workers or social work students
(81%), nurses or nursing students (44%), attending
psychiatrists (44%), and nonpsychiatric physicians
(38%).

The most common sources providing funding for the
programs were the VA (38%), graduate medical educa-
tion resources (19%), and grants specified for home vis-
ts (19%). Four programs (25%) indicated that visits
were unfunded and did not generate revenue.

Of training directors with active home-visit pro-
grams who made comments, seven of seven (100%) in-
dicated that this activity is a valuable component of
geriatric fellowship training. Comments included,
“Fun, instructive, and a valued community service.
Gives fellows an appreciation for the importance of
the community agency that refers homebound pa-
tients as well as the psychiatric team that performs
the home visits.” Two training directors raised the concern
that their fellows resented the amount of time neces-
sary for travel.

Table 1. Characteristics of 16 Home-Visit Programs

<table>
<thead>
<tr>
<th>Program characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;3 years</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>&gt;3 years</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>Indication for Home Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predominantly crisis intervention</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Predominantly home-bound patients</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>Both of the above</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Source of Referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social service agency</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Veterans Administration</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Visiting nurse</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Community mental health center</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Patient Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conditions other than dementia</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Both of the above</td>
<td>15</td>
<td>94</td>
</tr>
<tr>
<td>Frequency of Follow-up Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;50% of cases</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>&gt;50% of cases</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Participating Clinicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social workers/students</td>
<td>13</td>
<td>81</td>
</tr>
<tr>
<td>Attending psychiatrist</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Nurses/nursing students</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Nonpsychiatric physicians</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Psychiatrist residents</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Funding Sources (for two or more programs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Administration</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Graduate medical education</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Grants</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>State funds</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Billed as off-site clinic visit</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Unfunded</td>
<td>4</td>
<td>25</td>
</tr>
</tbody>
</table>
Several training directors did express frustration about funding for home visits. One program director commented that “Home visits are only possible because of grant support. Medicare billing would not cover the enormous time commitment (two to three hours per visit, including transportation, case coordination, phone calls, family informant interviews, documentation, and collaboration with pharmacy services, etc.).”

A number of training directors stated that the collaboration with other health professionals, such as visiting nurses and social workers, is worthwhile. One respondent whose fellowship does not conduct home visits stated, “We need to foster opportunities for fellows to work with visiting nurses in a collaborative way, in caring for these patients. I would rather put our resources into finding ways to facilitate this collaborative effort, rather than placing the emphasis on home visits, which are not real world clinical activities.”

Program Description

The Jewish Association for Services for the Aged (JASA), a comprehensive social service agency, received its state license for a satellite mental health program for geriatric clients in Manhattan in 1998. Ninety percent of the Manhattan clients are homebound. Although New York State Certification allows reimbursement for social work and psychiatric treatment, there is no funding for a psychiatrist on-site visit. Thus, the satellite needed to create an efficient, low-cost way to provide psychiatric services to homebound patients.

The satellite clinic was formed, in part, to help the agency fund the counseling services it had been providing for years. Originally, program support had come through foundation grants, but as these financial resources have been stretched among more and more organizations, the agency has had to find new ways to stabilize ongoing programs. By gaining state certification for mental health services, JASA can receive sufficient reimbursement from Medicaid and Medicare to remain viable.

After months of contacting professional psychiatric associations, individuals in private practice, and hospitals with geriatric psychiatric units, a contract was reached between Beth Israel Medical Center and JASA. Beth Israel’s geriatric psychiatric division agreed to have fellows perform home visits, accompanied by an experienced geriatric psychiatrist. This arrangement meets the state’s mandate for the JASA clinic to use a licensed psychiatrist, while offering the geropsychiatry fellows an opportunity to gain experience in home assessment. The advantages for the agency mental health clinic include flexibility of scheduling, on-site team meetings with the psychiatric fellow, a strengthened connection with a teaching hospital, and an additional referral source.

The program has the psychiatrist and psychiatric fellow averaging one to two home visits per week. The social worker conducts an initial evaluation with the client, and the psychiatrists visit independently, unless the presence of the social worker during their interview is deemed necessary. Beforehand, the social worker sends the client’s psychosocial assessments to the fellow and supervisor.

From the point of view of JASA, the psychiatric input serves several functions. The social worker’s DSM–IV diagnosis is validated or modified, as appropriate, and the psychiatric team documents a comprehensive mental-status exam. The psychiatrists’ knowledge of the client also provides a baseline for reevaluation, should the social worker observe deterioration in the client’s behavior. An advantage of working with psychiatric fellows is affordability for the agency. JASA pays the psychiatric team a consultation fee including reimbursement for travel time, supervision, and report preparation, but the fee is kept reasonable. The geropsychiatry fellowship gains a unique training opportunity that generates sufficient revenue to justify the time and effort of the physicians.

Whereas the geropsychiatry program has three fellows per year, the fellowship director and JASA have determined that a 4-month rotation would be inadequate for the development of an effective working relationship between the fellow and the agency. Six-month rotations allow two of the fellows to have an in-depth experience (the third fellow has an alternate community-based clinical rotation). Currently, the supervising psychiatrist accompanies new fellows to their first team meeting to assist with orientation. The supervising psychiatrist also provides continuity of care for the few clients who require home-based psychiatric treatment on an ongoing basis.

Communication between the fellows and social workers occurs primarily on the phone and at monthly team meetings. The fellow, the social workers, and the agency’s district director attend the team meetings. First, the fellow presents the client’s history and mental status, then the social worker discusses the treatment plan. A client’s case cannot be opened until a physician has signed the treatment plan. Three social work screening visits and one psychiatric evaluation are allowed prior to the client being admitted to the JASA program for ongoing home-based psychotherapy. Because the psychiatric report must be filed within 30 days of the initial referral to JASA, the psychiatric team needs to visit the patient and document their findings promptly.

For the fellows, the program offers a true consultative experience. In virtually all cases the fellow confers with the patient’s primary care physician as well as with the JASA social worker. When psychiatric medicine is recommended (e.g., antidepressants, antipsychotics, cholinesterase inhibitors), the primary physician is asked to write the prescription if feasible. This procedure ensures the coordination of psychiatric and medical care and often obviates the need for follow-up psychiatric home visits. Regardless, the fellow remains available for subsequent phone consultation, and patients are revisited should circumstances warrant.
The most common referral presentation is an elderly woman with depression and anxiety following a stressful event such as spousal loss or medical illness. Psychosis, cognitive impairment, and substance abuse are seen less frequently. Patients most often require home-based services because of disabling medical conditions or reluctance to seek psychiatric attention. Many patients admitted to the program have responded to the combination of standard antidepressants along with psychotherapy provided by JASA social workers. Patients who might benefit from antidepressants but decline medication are generally offered a trial of psychotherapy alone followed by a psychiatric reevaluation.

The ongoing interaction between the agency and hospital team allows for periodic adjustments to improve efficiency. More importantly, the collaborative approach allows the program to offer a range of mental health treatments to a homebound population that might otherwise be underserved.

Discussion

To our knowledge, this is the first investigation of the actual practice of home visits in psychiatric training. The decision to focus on geriatric psychiatry fellowship programs reflects the interest of the investigators. Home visits appear to be particularly relevant in advanced geropsychiatry training, as many seniors are unable or unwilling to use traditional outpatient psychiatric services.

Interpretation of the data produced by our questionnaire of fellowships is limited by a response rate of just over 50%. Given the possibility that fellowships lacking home-visit programs might be less likely to answer the survey, it is possible that the actual percentage of fellowships participating in this activity is lower than the 57% that we found.

The comments section of the survey indicated that most directors believe in the training value of home visits. In particular, house calls enable the fellow to assess the limitations and strengths of the patients’ living environment, to observe their ability to function in their apartment, and to detect any specific dangers needing immediate attention. Additionally, we found that home-visit programs can be sustainable, that the patient population is diagnostically diverse, and that the visits do provide an opportunity for interdisciplinary collaboration. The most apparent drawbacks revealed by the survey include the lack of adequate reimbursement for services and the amount of time required.

Our program has mitigated these problems by teaming with a referral agency that can reimburse us for time spent in travel, supervision, and report preparation. In return, we offer a vital service to the agency by providing timely clinical reports that accurately document the medical necessity of mental health care provided by the agency social workers.

Perhaps most important is that geriatric home visits introduce trainees to a form of community psychiatry that has the potential to improve the overall mental health of elderly adults. Rabins and colleagues (2000), in the Journal of the American Medical Association (JAMA), have recently demonstrated that an outreach program to identify and treat the psychiatrically ill in senior public housing is more effective than “usual care” in reducing psychiatric symptoms in persons with psychiatric morbidity. They found that educating building staff in case-finding helped to identify community elders in need of mental health services. Further, providing clinical services in the home resulted in better treatment adherence. An editorial in the same issue of JAMA (Katz & Coyne, 2000) argued for reforming the Medicare program to make interventions, such as this outreach program, more widely available. It stated,

The public health model suggests the importance of modifying current public policy to support bringing care for mental disorders out of the mental health care system and encouraging its integration with housing, long-term care, and medical care systems. (p. 2845)

We urge that program directors continue to look for ways to include home visits as part of geropsychiatry fellowship training. This educational vehicle should be extended to include residents and medical students when possible. Additionally, geriatric educators should encourage the political action committees of their professional societies to lobby for adequate reimbursement for home visitation services through Medicare, Medicaid, and supplemental insurance.

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