**GERIATRICS HOME VISIT REFLECTION**

The most recent home visit with Dr. K was an eye opening opportunity and one that was in stark contrast to the first home visit I took in the FMC month. That first home visit was to the public housing units near OTR where we visited a patient in her late 30’s who was essentially homebound, had poor health literacy, was living in a bedbug infested apartment and spent most days just lying on her couch because her mobility was such an issue. For this patient, just getting up to Christ required 3 buses and was an all day affair. What was most apparent was a lack of social supports for her to rely in the management of her chronic conditions.

In contrast, this most recent visit was to an elderly woman with diabetes showed me how the geriatric population can flourish when they are supported by a multitude of the social determinants of health. She has three children who all support her: the son with house maintenance, a daughter with groceries and all other errands, and the daughter I met who coordinates all her medical care, pays her bills, and is her daily social contact.

Additionally, one of the daughters owns her own home-health aide company and is a nurse so she can be a healthcare advocate and guardian for her mother at all times. Needless to say, while the chart review of the patient led me to believe that her chronic medical conditions and age would lead to a bleak living situation, I was so pleased to see this elderly patient flourishing given her supports. While I certainly cannot write a prescription for a loving and supportive family for my patients, this visit afforded me insight into how my elderly patients who lack such supports may fare.

One thing that will change my practice from this visit is constantly thinking about how to simplify the medication regimen. This patient endorsed some memory issues and even had a poor score on MOCA during exam, yet she was able to adhere to her simple insulin regimen of 45 units BID. I should never make the assumption that a patient can handle complicated dosages at varied times (ex: ISS) so I will either simplify medication regimens as possible or truly take the time to perform teach back to ensure the patient

understands given instructions. For this patient, Dr. Klienschmidt has developed a simple and understandable diabetic regimen that maintains patient autonomy and buy-in.

Additionally, this visit afforded me my first opportunity to perform a MOCA exam. In doing this however, I felt somehow intrusive to the patient and her world; I am a stranger invited into her home and here I was administering a test which test mental functioning and has implications on the future of patient decision making and autonomy. I did my best to frame the test as a tool that would help us assess baseline mental function and then we could ensure medication regimens were easily understandable. However, in an effort to downplay the accusatory nature of the exam, I kept using dismissive phrases like “Oh, it’s just a silly little test.”

In a feedback session after the visit, Dr. K wisely cautioned against this as we do not want other family members or the patient to think we are just wasting their time when in fact it truly is an important assessment. I shouldn’t have fretted though, because my patient received the test well and did not take offense when I explained that it was a tool. Thus, I am glad I am more comfortable administering this test and have honed some techniques that will help me navigate a potentially offensive interaction with my geriatric patients.

In summary, this stood in stark contrast to a previous experience where I was able to see how a committed family supporting the social determinants of health for an elderly patient allows for good health. Additionally, I have learned the importance of viewing medicine through the eyes of the elderly who may have cognitive decline and thus the need to make healthcare and medication regimens more understandable and accessible.

**Geriatric Home Visit Reflection**

Having done three home visits so far with different patients, I have been surprised at how different each interaction has gone. True to form, this past visit to see an elderly patient in Christ Hospital’s neighborhood was an entirely new experience for me.

I was warned that our 90 year old patient is a bit eccentric and although she has dementia, gets along quite well in her home with the support of her son on the ground floor. In the prerounding for the visit, I was prepared to discuss her hypertension management and the need for her to obtain followup labs on a workup for multiple myeloma, however Dr. K soon realized there were broader and perhaps more difficult social issues to discuss.

Upon arriving, we met the Duke energy worker in her basement assessing a gas leak. Our patient had her gas shut off over a month ago and has been without hot water and the ability to cook on her stove. She had finally got a gas/pipe worker to perform the repairs and paid $900 in cash, but the Duke energy man said the repairs were faulty and he would be unable to turn the gas back on. In addition to this, we discovered the toilet was not flushing and there were mouse droppings over her bed, the kitchen counters, and her cooking areas.

While addressing these living situation issues would be a lot for anyone, I was admired by her fiercely independent attitude toward fixing the problems herself. Our patient has refused help from her son and the Council on Aging and has tried to manage her funds and coordinate repairmen. However, as an advocate for this patient, I was concerned about her lack of insight into the cleanliness of her home and if she could truly manage these services to make her home safe and livable again.

Through speaking with the Council on Aging, I learned that a case has been opened by the Department of Elderly Protective Services who will determine if our patient needs to be removed from her home and placed in nursing care. Knowing that forced removal is a real possibility, Dr. K and I tried to convince our patient to let her son be helpful and care for her in her old age. Unfortunately, she seemed to lack the insight that in order to maintain her independence and remain in her home, she must give up some independence.

This visit was certainly challenging, but I saw the power of home visits and how a physician can use their status to be a true patient advocate and build consensus among parties. Dr. K carefully coordinated with our patient’s son and we prepared her for the discussion that she will need to let other’s help her manage her home.

Without a home visit, a physician would never have the context and visual environment of a patient, which are arguably the most prescient concerns and impact on our patient’s wellbeing currently. As I move forward in my career, I would like to continue home visits in a patient just like this where meeting people in their own environment and working closely with families can ensure patient safety.

I was definitely surprised by my home visit today. I admittedly have not seen this particular patient too many times I believe due to him not only having difficulty getting to the office, but also the fact that he was in the nursing home for most of the first half of the year. The last time I had him visit in June, he was not taking insulin, he had some skin breakdown and based on his story, it sounded like he did not have a lot of support at home.

I wonder how much of his issues stemmed from the troubles he had described regarding the experience he had at the nursing home. In any case, when I visited the patient at home today he seemed to be doing very well. I was surprised to be greeted by two family members (even though they did not participate in the visit), as well as surprised to be entering a simple, yet nearly spotless apartment. The patient had almost everything he needed. And in spite of being immobile and incontinent, he had the support of family to change, bathe and move him when he needed.

It makes me wonder how accurate my assessments of patients are in the office. We only see them a snapshot in time, probably dressed their best and in an artificial environment when they come to our office. I feel like I have pretty good instincts and I had imagined this patient to have great difficulty at home. This is one time, I am quite happy to be wrong and see the support and great set up he had at his house.

Maybe most striking is how candid the patient was with us regarding his feelings. He has always been pretty stoic and fact-oriented in the office as opposed to feeling-oriented, but definitely shared some emotions with us today that I had not heard from him yet. The hard facts are that the patient is quadriplegic, low income and uneducated. In my narrow mind this sounds utterly devastating, but somehow this patient is able to articulate how lucky of a person he is in spite of his struggles. He really did not seem to be just saying that either; I think he really feels like a lucky person. It is in a way very similar to some of the global health experiences I have had where the patients really don’t have anything but are so thankful and happy. As physicians we hope to be educators to our patients, but sometimes our patients can be great teachers to us.

Before going to see Mrs. D, I tried to imagine what it would be like to have medical professionals come to visit my own home. If they happened to visit during a busy inpatient month, they might find piles of laundry, an empty refrigerator, and piles of belongings that don’t seem to be quite tidy. Thinking about this, the idea of somebody coming to my home and making judgements about me seemed to be a bit terrifying. I wondered if our home visit patients thought about these things too. I wondered if they knew how this would be a “double-edged sword” as Dr. Schlaudecker puts it.

Upon meeting Mrs. D, I quickly found out that yes, some patients do understand just how significant it is for a medical professional to come into your home. While initially she seemed pleasant enough but a bit quiet, she quickly denied us any access to information that might condemn her – her pill box, her granddaughter, and even her physical exam. To be honest, I didn’t blame her. We were in her territory. Patients always have the right to refuse to give us information but the power differential in the doctor’s office makes it difficult for them to feel entitled to that right. In her own home, Mrs. D felt perfectly fine telling us exactly how much or how little we were allowed to know about her.

Later on I was told about the perceived poor safety of Mrs. D’s neighborhood. While I don’t know the specific crime statistics there, I’ve found that you can get a general sense for these things just by driving around the block. The tree outside her front door had clothing scattered in the limbs – a sign of disgruntled neighbors and a landlord who doesn’t care too much about appearances. There were plenty of working-age adults hanging around the entry of the building – a sign that they don’t have typical middle-class 9-to-5 jobs. The neighboring buildings were in bad need of paint and new windows – a sign of the general lack of wellbeing in this community.

While all these signs may point towards a social determinant of health – lower economic status – it also shows that my “judgement” was in full swing before I ever met Mrs. D herself. And I imagine she’s a pretty smart woman who has a good idea of what others think of her living situation. All of this could contribute to her resistance that day. Or it could have just been a bad day for her. I’m not sure how to fix the differences I see between her and myself.

I could tell her that I grew up in Price Hill, that I drive a car that has over 200,000 miles on it, or that most of patients live and work in the same types of neighborhoods she does. But that would be arrogant of me to try and play up our similarities to win her over. Ignoring our differences doesn’t do any good either. And while I can help connect her with various social services to assist her with things that may come up – safety issues, utility assistance, home health, etc, it doesn’t change the grand scheme of things. I think in the long run just being able to connect with her as a fellow human being will be the thing to help her feel a bit more comfortable inviting strangers into her home. That will take repeated visits and more exploration into her goals of care. Trust takes time.

Going on my first local home visit made me realize just how much we can miss seeing patients only in an office setting within a 15-20 minute appointment or in the hospital setting while managing an acute illness. In this particular case, we were seeing a patient who is elderly, with limited mobility, living independently (although with some help), and having several chronic medical conditions, including one that affects her memory. This particular patient is fortunate enough to have family members who can come check on her frequently, along with home health aides coming 5 days a week. However, even with this level of care, which most of our patients don’t have, we were able to catch some important things that had been missed.

The patient’s daughter and primary caregiver didn’t realize that a change was made to one of her medications. Luckily, this change was not life threatening, but it made me consider the common situation of a patient with severe heart failure. This could very easily have been a patient with heart failure who had an increase in her Lasix dose while being hospitalized for an exacerbation. If the patient in this circumstance had been sent home without realizing the medication change, this would very likely have led to readmission shortly down the road. Looking back at our patient, the daughter was also unaware of one of the patient’s daily controller inhalers.

This was very important because this could have been the difference between COPD that can be managed at home vs an exacerbation that would likely require readmission in the near future. If patients’ families and caregivers have difficulty remembering all of the patient’s medications and medication changes, how can we expect an elderly individual living on their own to keep track of these things? It seems that even when we put the time into making sure that our patients are squared away for discharge, there are still so many unsettling aspects of sending someone home who is still in the recovery process.

Even when we, as physicians, spend the time making our discharge instructions in a larger print, bold font, and simple language, these instructions are still buried within the mound of papers the patient receives on discharge. The home visit today made me realize just how eye opening and informative home visits can be for physicians. It also demonstrated how they can be clarifying for patients who have been sent home with confusing instructions or medication changes. However, I just feel unsettled and a little overwhelmed knowing the circumstances under which we’re sending our patients home.