Mobile Medical Care Units

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To cite this Article Kelley-Gillespie, Nancy(2005) 'Mobile Medical Care Units', Journal of Health & Social Policy, 20: 2, 33—47

To link to this Article DOI: 10.1300/J045v20n02_03

URL: http://dx.doi.org/10.1300/J045v20n02_03

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Mobile Medical Care Units:
An Innovative Use of Medicare Funding

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ABSTRACT. Medicare is an underutilized payment source for home-delivered health care services for homebound elderly. An innovative service provision for home health care, Mobile Medical Care Units (MMCU), is presented. MMCU consist of a multidisciplinary team of health care professionals who are responsible for following the health care needs of their elderly patients on a continuous long-term basis across settings. This comprehensive care has significant impacts on homebound elderly and the health care industry. MMCU have the potential to be covered more inclusively by primary or supplemental health insurance plans, including Medicare, Medicaid, and HMOs, or by special funding from state aging departments. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Home health care, frail, homebound elderly, Mobile Medical Care Unit

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The new millennium brings with it new demographic trends. The proportion of the population who are elderly is significantly increasing. At the turn of the 20th century, the number of people aged 65 and over made up only 4% of the population of this country. Now, at the turn of the 21st century, this age group makes up nearly 13% of the population. It is estimated that by the year 2030, more than 20% of the population of this country will be elderly (Cestari & Currier, 2001; Hooyman & Kiyak, 1999; Ozawa, 1999; Wright, 1999; US Census Bureau, 2000). Questions of how this group of people will be supported, who will provide for them, and what services will be available will be pressing in the next decades (Brink, 1997; Bury & Holme, 1990; Eng, Pedulla, Eleazer, McCann, & Fox, 1997; Kane, 2001; Winston, 1974). This article presents an innovative service provision for home health care, Mobile Medical Care Units (MMCU), that can be paid for through Medicare and/or other supplemental insurance plans. Current services available to the elderly, barriers to receiving these services, and projected needs and gaps in services are identified. MMCU may be an effective way to address the health care needs of the elderly who are frail and homebound.

Approximately 95% of people aged 65 and older live in the community; however, the rate of institutional long-term care (e.g., nursing home) use increases with age and disabling, chronic conditions (Hooyman & Kiyak, 1999). Residing in the community is often the desired choice of elderly people who prefer to “age in place” or live out the rest of their lives in the comfort of their own homes. It is generally considered preferable to nursing home or other institutional settings because of individualized attention and presumed better quality of care, as well as the familiarity of the environment and maximized independence (Barusch, 1991; Bell, 1973; Hughes & Guihan, 1990; Kane, 2001; Luckinger, 1994; Rabiner, Arcury, Howard, & Copeland, 1997; Brickner, Janeski, Rich, Duque, Starita, LaRocco, Flannery, & Werlin, 1976; Winston, 1974). Promoting the idea of keeping people at home rather than in a nursing home or institution, despite disability or finances, is based on the values of promoting the integrity, respect, dignity, and worth of a person (George, 1998; Kane & Kane, 2001; National Association of Social Workers, 1996). However, this preference often times contrasts with general practice; there seems to be a bias toward institutionalization, regardless of the inappropriateness of the placement (Barusch, 1991; Bell, 1973; Brink, 1997; Kane, 2001; Kane & Kane, 2001; Markson, Levitz, & Gognalons-Caillard, 1973; Rabiner et al., 1997). Because of current demographic trends and preferences of the elderly, there is a compel-
ling need to provide home-delivered supportive services to help the frail and homebound elderly resist the drift toward institutionalization (Bell, 1973; Braun & Rose, 1989; Brink, 1997; Cestari & Currier, 2001; Hughes & Guihan, 1990; Kane, 2001; Kane & Kane, 2001; Markson et al., 1973; Rabiner et al., 1997).

**CURRENT INTERVENTIONS/SERVICES**

Over the past several decades, many different kinds of services have sprouted up in order to help older people remain in the community. Services vary from housekeeping and shopping to home care and recreation/leisure activities, from home-delivered meals (e.g., Meals-On-Wheels) to transportation services, from counseling, therapy, and crisis intervention to telephone reassurances and friendly visitors, and from home health and case management to volunteer home repair/maintenance (Bell, 1973; Challis & Davies, 1986; Ellis, 1996; Hughes & Guihan, 1990; Kirwin & Kaye, 1993; Markson et al., 1973; Monk & Cox, 1991; Osterkamp & Chapin, 1995; Toseland, McCallion, Dawson, Gieryic, & Guilamo-Ramos, 1999; Winston, 1974). Service providers range in professional, nonprofessional, and volunteer capacities as well as in the levels of formal and informal care (Aldana & Fortus, 1992; Tennstedt, Chang, & Delgado, 1998; Winston, 1974).

**BARRIERS TO SERVICE**

Although these various services exist, there are many barriers for elders to receive them. The demand for services is greater than the supply; there just is not enough resources to go around. What services do exist are often uncoordinated, nonintegrated, and not comprehensive in nature. Frequently, services are fragmented, unorganized, and ever-changing. Also, there is usually a great deal of “red tape” to go through in order to receive services and meet eligibility requirements (Bebbington & Charnley, 1990; Hughes & Guihan, 1990; Markson et al., 1973; Minear & Crose, 1996; Nettings & Williams, 1989; Rosen & Persky, 1997). Public policy does not tend to support long-term community-based services (Braun & Rose, 1989; Brink, 1997; Hughes & Guihan, 1990; Kane, 2001; Kane & Kane, 2001; Monk, 1990; Rabiner et al., 1997; Rosen & Persky, 1997).
Minear and Crose (1996) pointed out five main themes regarding barriers to service: (1) emotional barriers, (2) economic barriers, (3) physical barriers, (4) knowledge barriers, and (5) communication barriers. Emotional barriers include things like a person’s pride, shame, and stubbornness. Older people often do not want to accept help from others or feel like they are a burden. They sometimes deny their deteriorating capacities or are painfully aware of them and feel embarrassed or frustrated. Also, many older people do not trust others and are fearful of scams or of losing their homes, independence, or privacy. Most older people fear entering a nursing home. Ageism, stigma, and stereotypes also preclude people from receiving services. Economic barriers include the high and sometimes hidden costs of services, low incomes and lack of financial supports of elders, and lack of meeting eligibility requirements (e.g., financial; physical; cognitive). Physical barriers include the lack of transportation, inconvenience, and lack of support. It includes physical illness, lack of strength, fatigue, disability, and mental health issues. It also includes physical limitations such as hearing and eyesight deficits and speech impairments. Many of these limitations may be degenerative conditions related to the aging process. Knowledge barriers revolve around knowing what services are available, who to contact, and eligibility requirements. It involves the lack of understanding of information processing, misleading information, and the lack of advocacy. Communication barriers include confusion, communication difficulties, overwhelming technology, and the lack of knowledge of details/specifcics. Often, receiving support services is a very complicated system in which to maneuver. Limited communication is sometimes a result of cultural, language, and/or ethnic/racial differences as well. These barriers make it difficult for older people to receive services that could potentially keep them living at home longer and as independently and comfortably as possible (Cestari & Currier, 2001; Hughes & Guihan, 1990; Markson et al., 1973; Minear & Crose, 1996; Netting & Williams, 1989; Rosen & Persky, 1997; Tennstedt et al., 1998; Toseland et al., 1999).

**FOCUS ON HEALTH CARE**

One aspect of community-based service delivery that is particularly needed is proper health care. Older people have more health care needs than any other age group (Hammerman, 1974; Hooyman & Kiyak, 1999; Monk, 1990). Community-dwelling elders are at high risk of further health declines and institutionalization because of their isolation (Reuben, Hirsch, Chernoff, Cheska, Drezner, Engelman, Frank, Schlesinger, & Siegler, 1993).
There is a growing need for home delivered health care to the homebound elderly in this country. It is estimated that for every patient in a nursing facility, there are three to four patients of equal debility residing in the community in need of assistance (Hooyman & Kiyak, 1999; Taler, 1998).

As the term implies, “homebound” means that these frail elders are not able to leave their homes, even to go to a doctor’s appointment (Scott, 2001; Taler, 1998). On average, homebound patients are seen by a doctor once every two years (Taler, 1998). What health care options do exist for older people are strongly geared toward crisis intervention or acute care. Few efforts focus on health screening assessments; most focus on strategies of diagnosis, treatment, and recovery (or death) for acute episodes rather than on a chronic, long-term care plan. The social and health aspects of prevention, rehabilitation, and maintenance services are neglected (Hammerman, 1974; Monk, 1990; Netting & Williams, 1989; Reuben et al., 1993).

Most health care is provided to older people through emergency rooms, inpatient hospitalizations, and nursing homes (Fried, Wachtel, & Tinetti, 1998; Hammerman, 1974; Markson et al., 1973; Monk, 1990; Netting & Williams, 1989; Rosen & Persky, 1997). These health care practices are also reflected in the health care expenditures of such institutional settings compared to money spent on home-delivered health care services (Aldana & Fortus, 1992; Barusch, 1991; Brickner et al., 1976; Hughes & Guihan, 1990; Monk, 1990; Mora, 1992). If home health care is provided, it is usually time-limited and involves home visits that focus on acute illness episodes, hospital discharge follow-ups, investigational assessments, or terminal/dying patient visits (Unwin & Jerant, 1999). The few services that do or could provide ongoing in-home care, such as visiting nurses and physical therapists, are underutilized, not available to everyone, and not available on a long-term basis (Barusch, 1991; Monk, 1990). Transitional medical care programs have typically not been adopted because of the lack of Medicare reimbursement, the system’s focus on acute versus chronic care, and the organization of care into distinct settings (e.g., hospital; nursing home) without a safety net to connect them (Naylor, Brooten, Campbell, Maislin, McCauley, & Schwartz, 2004). Providing in-home health care services to frail, homebound elderly would help minimize institutionalization, ensure their remaining in the community, and be less costly.

Home health care, specifically, is one of the fastest growing segments of the health care industry (Aldana & Fortus, 1992; Mora, 1992; Taler, 1998). According to Mora (1992), home health care, in its broad-
est sense, refers to different home health services provided under a physician’s direction and plan of care of the homebound patient. These services can be skilled, intermittent, or part-time. Aldana and Fortus (1992) define home health care as the provision of services and equipment to the patient in the home for the purpose of restoring and maintaining his or her maximum level of comfort, functioning, and health. Home care can be preventive, therapeutic, restorative, or supportive. Home care is viewed as an appropriate response to the needs of an aging population and an increasing number of homebound patients (Meyer & Gibbons, 1997). Because of its cost-effectiveness and the need for it in the community, home health care is attracting greater physician interest, support, and participation (Aldana & Fortus, 1992; Campion, 1997; Scott, 2001).

**INNOVATION: MOBILE MEDICAL CARE UNITS**

Successful maintenance of community living for the elderly is reliant on a comprehensive network of in-home service delivery systems that compliment and supplement each other. Different types of services are needed at different times by older people. As Bebbington and Charnley (1990) state,

> Community care is about the health as well as the social needs of the population. Health care, in its broadest sense, is an essential component of the range of services which may be needed to help people to continue to live in their own homes for as long as possible. (p. 410)

Integrated, coordinated services help to ensure that elders receive appropriate levels and continuity of care, especially in a complex and ever-changing health care system (Aldana & Fortus, 1992; Netting & Williams, 1989). This cooperation (rather than competition) is essential for the development of more services with greater availability to the elderly who reside at home (Hughes & Guihan, 1990).

One possible solution toward integrative health care is for health care professionals and hospitals to collaborate with each other to form Mobile Medical Care Units. Variations of MMCU can be found throughout the country, including Illinois, Texas, Florida, California, Delaware, Massachusetts, Pennsylvania, New Jersey, Maryland, and New York. These programs were developed on the idea that older patients feel
more comfortable and at ease in their own homes, and therefore, are able to concentrate all of their energy and attention on the process of healing (Miller, 2000; Scott, 2001). Providing in-home health care increases patient motivation and self-control, positively influencing recovery (Aldana & Fortus, 1992). The goal of the home health care is to make the patient and family as self-sufficient as possible in a cost-effective way (Aldana & Fortus, 1992; Naylor et al., 2004).

MMCU essentially brings back the practice of the physician house call. Physician house calls had been declining in this country since the 1940’s due to new advances in hospital-based medical technology, which resulted in a shift toward inpatient treatment or institutional care (Aldana & Fortus, 1992; Mora, 1992; Unwin & Jerant, 1999). The house calls practice is designed to provide medical services similar to those patients would receive if they were able to come to a doctor’s office. In some instances, it is possible for house calls to replace hospital care (Fried et al., 1998). In a well-organized program, virtually any service available in a hospital room can be provided in a patient’s home (Cestari & Currier, 2001; Taler, 1998). Modern technology, including advanced telecommunication systems, have made it possible to adapt medical care to be portable, simple, and reliable, which makes physician home visits more practical and helpful (Aldana & Fortus, 1992; Berg, 1997; Taler, 1998; Unwin & Jerant, 1999).

In essence, these MMCU consist of a team of physicians (including interns and residents), nurses, nurse practitioners, physician assistants, psychiatrists, technicians, and social workers who have expertise in gerontology and understand the medical needs of older adults and their caregivers. This team goes out to the homes of the frail, homebound elderly on a routine, scheduled basis (e.g., regular and follow-up check-ups) and on an as-needed basis (e.g., emergency situations; changes in status or condition). Efforts to use a multidisciplinary team approach to health care services provided in the home have significant impacts on the homebound elderly as well as the health care industry.

**Services**

MMCU may get referrals from doctors, hospitals, home health agencies, home care agencies, families, friends, neighbors, guardians, case management units, or flyers and other distributed written and online materials (Cestari & Currier, 2001; Fried et al., 1998; Sullivan, 2000; Miller, 2000).

When an older person receives services from a MMCU, a primary care physician is assigned from the group who leads the other team
members and the plan of care. The team is affiliated with a specific hospital where services are performed and hospitalizations take place if necessary. Therefore, there is a bounded catchment area that generally coincides with hospital jurisdictions (Aldana & Fortus, 1992; Fried et al., 1998; Taler, 1998). Not all hospitals have a MMCU; some jurisdictions overlap; other places have gaps in service areas. These catchment areas help to curb costs by minimizing travel times of the MMCU team, increasing the number of older people that can be seen, and reducing time away from private practice sites of the physicians (Fried et al., 1998; Scott, 2001; Taler, 1998; Unwin & Jerant, 1999).

The initial visit by the MMCU involves a medical/health history, psychosocial history, physical exam, assessment of motor skills, and a cognitive screening if necessary. Other visits continue to address the complete picture of the patient’s situation and needs (Aldana & Fortus, 1992; Fried et al., 1998; Naylor et al., 2004; Scott, 2001). Unwin and Jerant (1999) describe a home visit checklist that has been developed for the use of physicians and medical teams that make house calls. This checklist involves the assessment of the following areas:

- immobility (e.g., ability to transfer; ability to move from one location to another; ability to maintain upkeep of home)
- nutrition (e.g., amount and type of food in house; ability to shop and prepare meals; hydration)
- home environment (e.g., stairs; space; cleanliness/organization; pets)
- other people (e.g., family support; caregivers)
- medications (e.g., side effects; ability to self-administer; accessibility)
- examination (e.g., physical; psychological; cognitive)
- safety (e.g., fall hazards; need for grab bars; neighborhood)
- spiritual health (e.g., outlook; religious affiliations; attitude; beliefs)
- services (e.g., convenience; availability; access)

These guidelines address such areas as activities of daily living (e.g., bathing; dressing; toileting; feeding) and instrumental activities of daily living (e.g., shopping; cooking; cleaning; managing finances). They address such things as neighborhood safety/vulnerability issues as well as in-home safety hazards (e.g., throw-rugs; power cords; lighting; improperly working appliances; stairs). These home visit guidelines help
medical teams properly and comprehensively assess the whole person in their environment (Scott, 2001; Unwin & Jerant, 1999).

Visits are done on a regular basis (e.g., quarterly; bi-monthly) and the team is available on a 24-hour basis between visits to address concerns regarding changes in status, medication side effects, accidents (e.g., falls), and the like. Support, advice, or instructions may be offered over the phone, which minimizes unnecessary trips to the emergency room as well as unnecessary house calls (Fried et al., 1998; Miller, 2000; Sullivan, 2000; Scott, 2001; Taler, 1998; Unwin & Jerant, 1999).

The MMCU team arranges for all levels of care and has on-site access to a wide range of diagnostic and analysis equipment. For example, the following diagnostic and treatment services can be provided at the elderly patient’s home: medication prescriptions, portable x-rays, medical supplies and equipment, prosthetics, EKGs, blood draws, lab work, injections (e.g., vitamin B shots; flu vaccines; pneumonia vaccines), wound care, IV treatments, antibiotic therapy, parenteral nutrition, and mental health monitoring. Ancillary services are also arranged including: pharmacy deliveries, podiatry care, dental care, ophtalmology care, cardiology care, audiology services, physical therapy, occupational therapy, and speech therapy. The medical team also provides assistance with arranging home care services, home health aids, visiting nurses, and hospice. Education and training to family members and/or caregivers for special caregiving needs of older individuals (e.g., feeding tubes; oxygen treatment; lifting/transferring techniques) is also provided by the MMCU (Cestari & Currier, 2001; Fried et al., 1998; Miller, 2000; Sullivan, 2000; Taler, 1998). With this coordination of home health care services, it is possible to treat the following such conditions at home rather than in a hospital or other institutional setting: hypertension, congestive heart failure, obstructive pulmonary disease, diabetes, asthma, osteoarthritis, cerebral vascular disease, urinary tract infection, cellulitis, depression, bronchitis, and pneumonia (Fried et al., 1998; Meyer & Gibbons, 1997; Unwin & Jerant, 1999).

If hospitalization is necessary, the team makes the arrangements and maintains the patient under its care at the hospital and upon discharge. In the event that a patient cannot be transferred to the preferred hospital, such as in an emergency situation where the ambulance must be directed to the closest hospital or is diverted to another hospital, the MMCU team physician would make every effort to confer with the attending physician regarding care and discharge plans (Fried et al., 1998; Miller, 2000; Sullivan, 2000).
Visiting elderly patients in the home allows for the MMCU team of health care professionals to assess both important medical and nonmedical aspects of care. Assessing social support structure, functional status, home environment, and safety of the homebound elderly are equally important as medical conditions to the success of the home and health care plans (Aldana & Fortus, 1992; Berg, 1997; Scott, 2001; Unwin & Jerant, 1999). According to Berg (1997), the quality of care also increases when physicians are able to directly observe a patient’s home, lifestyle, and diet. Providing these comprehensive services affords better, more integrated community care (Aldana & Fortus, 1992; Scott, 2001; Unwin & Jerant, 1999).

**Impacts**

Several positive impacts of MMCU on the frail, homebound elderly have been identified (Aldana and Fortus, 1992; Campion, 1997; Unwin & Jerant, 1999):

- inconvenience, discomfort, and trauma of the homebound patient is minimized
- medical and nonmedical factors are able to be assessed
- physician-patient relationship is improved with better communication, increased compassion and understanding, and greater commitment and empathy
- one-on-one attention allows for a more personal/individualized and humane care plan, including the identification of short-term and long-term goals
- physicians take on an active role of educator and adviser
- physicians are better able to view care needs, including new, acute, or emergency medical problems from multiple perspectives provided by an interdisciplinary team approach
- support and reassurance is provided to family members and/or caregivers who may feel stressed and ill-prepared for their responsibilities
- communication with family and/or caregivers is improved; quality of care is better assessed and monitored
- feelings of isolation may be reduced
- reduces multiple physician care and incompatible medication prescriptions
- a better determination of risk for mistreatment or abuse is possible
The impact of the utilization of MMCU offers homebound elderly individual’s an opportunity to get their health care needs met safely in the comfort of their own homes, which affords them privacy and personal dignity as well as minimizing emotional distress. Increasing the use of Medicare reimbursement opportunities and other potential health insurance coverage for MMCU would reduce the financial hardship of in-home health care for frail, homebound elderly individuals. Additionally, having a consistent, primary contact person within the MMCU team ensures advocacy of the elderly patient and allows for more communication between health care providers, elderly patients, and family members/caregivers, thus reducing confusion, misinformation, and frustration.

Brickner et al. (1976) claimed that the home delivery of a full range of health-related services provided by such mobile medical teams emphasizes the continuity of the relationship between health care providers and patients. Continuity is a major ingredient in the quality of care of medical services. Providing continuity of care to and from all settings (e.g., institution; home; or community) is essential to the development of well-designed interventions at home that may prevent falls, reduce disability, and delay nursing home admissions (Campion, 1997; Unwin & Jerant, 1999). This joint working relationship between hospitals, health care workers, and the community improves the welfare of frail, homebound elders, reduces organizational fragmentation, and makes it easier for older people to continue to reside in the community (Bebbington & Charnley, 1990; Cestari & Currier, 2001).

**Medicare: An Underutilized Payment Source**

MMCU services are billed to Medicare Part B as basic pay-for-fee services and are also chargeable to supplemental insurance plans. HMOs and Medicaid have the potential to provide coverage for such services, as do other primary and supplemental insurance plans. To make it easier for the patients, the MMCU members process all paperwork necessary for reimbursement. Appropriate collaboration with sponsoring hospitals and/or community organizations will help to obtain vans (or other sources of transportation) to be used for the home visits either through donations or special purchases (Aldana & Fortus, 1992; Miller, 2000; Sullivan, 2000).

Scott (2001) reported that the number of house calls billed to Medicare has remained at about 1.5 million annually since the early 1990s. The costs of routine in-home medical care provided to high risk older adults saved taxpayers an average of 37.6%, or $4,845 per patient, over a one
year period of time because of fewer hospital readmissions, total hospital stays, and overall inpatient hospital costs (Naylor et al., 2004).

**CONCLUSION**

As the number of elderly people increases, their needs must be carefully addressed via public policies and services. People are living longer with long-term health conditions and experiencing fragmented care and multiple transitions from hospital to home that affect their quality of life and consume substantial health care resources (Cestari & Currier, 2001; Naylor et al., 2004). Supporting people who reside in the community poses special challenges for service providers. A wide range of services have been developed to assist people in their own homes. However, more and new resources are needed in order to effectively maintain frail, homebound elders and meet the demands of their medical care. MMCU are one way of providing in-home health care. Utilizing partnerships with hospitals and health care professionals, this option minimizes barriers to services and promotes effective health care delivery to frail, homebound elders who would otherwise go without proper medical treatment. It also helps to successfully maintain people in the community for as long as possible.

Training medical students to make house calls and educating them of the values of house calls to homebound elderly patients will serve to promote the practice of home health care by physicians (Meyer & Gibbons, 1997; Scott, 2001; Taler, 1998; Unwin & Jerant, 1999). Efforts to incorporate home care curricula in medical schools and geriatric training programs are being made across the country that focus on the economics of house calls as well as the personal techniques (Aldana & Fortus, 1992; Berg, 1997; Scott, 2001; Taler, 1998). In addition to fostering more significant research and academia interests in this practice, Aldana and Fortus (1992) highlighted several benefits to medical students. Such an educational experience (1) forces the medical student to balance the technical and scientific aspects of medicine with the humanistic aspects of care; (2) stimulates the prioritization of differential diagnosis with careful and orderly selection of diagnostic tests; (3) familiarizes the novice physician with the variety of noninstitutional resources and community support systems available to patients; (4) encourages the medical student to analyze the interaction of the patient with his or her social support structure and environment, and also to evaluate his or her functional status; and
sensitizes the resident to the cost and the potential discomfort of a
diagnostic evaluation. Providing on-going education in the adminis-
trative and clinical aspects of home care will encourage the develop-
ment of preferred home-centered health care alternatives for frail
older people that are more cost-effective and efficient (Taler, 1998).

Expanding funding sources for home-delivered health care services
will be an issue for future policies. The hope would be to have these
health care resources covered more inclusively by primary or supplemen-
tal health insurance plans, including Medicare and Medicaid, HMOs, and
other supplemental insurance plans such as, AARP and Blue Cross/Blue
Shield or by special funding from state aging offices/departments. The
American Association of Home Care Physicians are currently working
with the Health Care Financing Administration to negotiate payment for
travel time and equal coverage for visits to individual homes (Scott,
2001). As Taler (1998) states, “only with continuing support of federal,
state, and private insurance will the knowledge gained from [the experi-
ences of MMCU] lead to the development of a comprehensive spectrum
of services in a seamless system of care” (p. 247). Filling the gap between
the demand for services and the supply of resources is imperative to the
next generations of elderly people in this country.

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