In the mid-1980s, when persons with AIDS first began to survive bouts of *pneumocystis carinii* pneumonia with the help of intravenous antibiotics, home infusion team nurses with the Visiting Nurse Association of Los Angeles (VNA-LA) began observing unusual behaviors in patients.

One field nurse remembers going into a patient’s home to find that he had ripped open a line of sutures and pulled out his porta-catheter, a tube surgically inserted into a central blood vessel to provide medication. He then presented her with a basin full of blood, saying, with no emotional expression, “I want to die.”

Another nurse recalls visiting a patient who was bedbound with wasting syndrome: “Here was this man who would never get out of bed again, would probably die within a few weeks, on SSI [Supplemental Security Income], and he just ordered a brand new, custom-made luxury car on the phone. He charged it! The crazy thing was the dealership actually delivered it to him!”

At the same time, field staff reported spending an extraordinary amount of time during the visits providing supportive counseling to their patients and to caregivers who presented with symptoms of depression, anxiety, or other emotional reactions to their situations. Because the
majority of the patients were, in fact, homebound, they were unable to go to a psychiatrist’s or psychotherapist’s office or clinic.

It wasn’t until the late 1980s that literature began to report the incidence and prevalence of psychiatric disorders in this population. First anecdotal, then more empirical literature began to describe the signs and symptoms of an AIDS-related dementia, or AIDS Dementia Complex (ADC) (see chapter 9 for additional information).

As more people with AIDS began to be treated at home rather than in acute-care hospitals, the VNA-LA field staff continued to notice and report difficulties in working with patients with ADC or other psychiatric symptoms. Many patients could not be responsible for their medication regimens because of the cognitive deficits associated with ADC. Others displayed dramatic personality changes that frightened their caregivers. Neuropathic pain, motor difficulties, and behavior management also required more in-home support than the IV (intravenous) field nurses could provide during their regular visits. In addition, because the disease process of HIV/AIDS is unstable and unpredictable, patients exhibiting these and other psychiatric problems posed a greater risk of more frequent hospital admissions and emergency room visits and were generally greater utilizers of health care resources (Hellinger, Fleishman, & Hsia, 1994).

In the late 1980s, there were few known programs available to provide the neuropsychiatric support required by these patients in their homes. Furthermore, no literature completely described the needs or possible treatments for homebound persons with neuropsychiatric difficulties. For patients unable to go to a clinician’s office for psychotherapy, neuropsychiatric care, and psychotropic medication evaluation, treatment in the patient’s home appeared to be the most viable option for effective care.

Our Clinical Work

In 1991 the VNA-LA, in partnership with the National AIDS Fund, received Ryan White C.A.R.E. Act Title II Special Projects of National Significance funding from the Health Resources and Services Administration. The VNA-LA developed and implemented a three-year pilot program that would become a model for integrating in-home mental health and psychiatric care with primary medical care and that would be replicated in Detroit, Michigan, Cleveland, Ohio, and Washington, D.C. The objectives of our AIDS Psychiatric Homecare Program were threefold:
1. To maintain the patient at home and to reduce the risk for acute care or psychiatric hospitalization
2. To ameliorate, control, and manage neurological and psychiatric symptoms
3. To optimize the patient's quality of life

The first objective differentiates an in-home mental health care model from more traditional models of care. Homecare is often more effective in identifying and intervening in situations that might, if ignored, later require costlier care.

An interim evaluation of our effectiveness indicates that our project is "quite successful in easing patients' social and cognitive problems and in maintaining a satisfactory quality of life, despite deteriorating physical conditions" (National AIDS Fund, 1994, 15).

Several aspects of our program are noteworthy.

Interdisciplinary Model

Most home health care psychiatric programs have been driven by Medicare or Medicaid reimbursement, but states have differed on which disciplines' services would be reimbursed. We believe that persons with AIDS, given their complex problems, required a multidisciplinary team with systematized interventions. Our program team now includes registered nurses and medical social workers with psychiatric training, a psychiatric social worker, a consulting psychiatrist, and a clinical pharmacist.

The team's registered nurses are responsible for education and management of medication issues, including teaching both patients and caregivers about the use, dosage, side effects, and schedule of each medication. Because many patients with neuropsychiatric problems cannot remember to take their medications, the psychiatric nurses develop a patient-friendly regimen to ensure that patients administer their medications properly and regularly.

The social worker offers psychotherapy and assistance with community resources. The pharmacist reviews the patient's medications for side effects, complications, and interactions and makes the appropriate recommendations to the primary medical doctor. The psychiatrist frequently makes home visits to evaluate for the use of psychotropic medications and for differential diagnoses. Both the pharmacist and the psychiatrist offer continuing education to the field staff about the ever-changing arena of HIV.
Home-Based Services

Because most of our patients have only limited ability to leave their places of residence for such activities as medical appointments, all program services are performed in the residence, whether it be a home, shelter, hospice, or other facility.

A key advantage of our model is that the field clinician actually witnesses the patient and his or her support systems functioning in the home. Many problems that impair a patient’s functioning or activities of daily living are not immediately evident in a clinic or physician’s office. In addition, regular supportive home visits often reveal crises such as inadequate home safety, caregiver inadequacy, substance abuse, and suicidality, which might not be presented to the patient’s primary medical care provider or to a mental health provider in another setting.

Seeing Caregivers as Clients

A fundamental element of our care is the understanding that the “client” includes not only the patient but also the significant other, family, friends, and other formal or informal caregivers, including paid attendants. Because the patient’s whole environment affects quality of life, all of it becomes an integral part of the treatment plan.

Often the team will work with the patient and his or her support system to define and develop treatment goals and a plan that will work in the patient’s home. In one case, we worked with a thirty-six-year-old black woman living in a twelve-step residential facility for HIV-positive women and their children. She had been diagnosed with depression with psychotic features, and she had a history of alcohol and abuse of other substances. The facility’s management felt that her HIV treatment should preclude her taking mood-altering drugs. Although the consulting psychiatrist had prescribed an antidepressant and an antipsychotic medication to manage her symptoms, the program managers required education to assure them that the therapeutic use of these medications did not interfere with the client’s sober living goals. The psychiatric nurse and the social worker conferred with the facility’s management and were able to work out a plan in which the client would take her medicine, which would be administered by the house mother. The plan was successful. Our client completed the drug treatment program, her depression resolved, and the psychotic features were eliminated.
Comprehensive Assessment

The cornerstone of effective home-based mental health treatment is a comprehensive assessment to guide the care plan. Our assessment includes psychiatric and medical information; a description of the support system, including social service agencies involved in care; an evaluation of the patient’s ability to perform activities of daily living, called “ADLs”; an understanding of all medications and the patient’s ability to manage the regimen; and a description of the home, with special attention to physical safety issues.

In addition, we use a uniform assessment tool designed to assess specific areas of neuropsychiatric functioning and stages of ADC. The Neuropsychiatric AIDS Rating Scale (NARS) (Boccellari & Dilley, 1992) has subscales to rate cognitive, behavioral, and motor domains relating to the patient’s orientation, memory, behavior, ability to problem-solve, and perform ADLs. The clinician rates the patient on the subscales, using information obtained during the home visit.

The NARS’s advantages are its simplicity in staging the illness process, its usefulness in anticipating the need for ancillary support services like attendant care and hospice, and its service as a “common language” tool for team members to describe the patient’s level of functioning and impairment.

While quality of life is, perhaps, subjective, having the patient assess quality of life can open up areas for the therapeutic process. In our experience, some of the factors that contribute to decreased quality of life include poor management of pain and symptoms such as diarrhea, depression and anxiety, and concern over finances. Once these issues are identified, appropriate interventions are initiated, and an improvement in the patient’s perception of quality of life should result.

The assessment leads to development of a problem list that targets specific needs. A regular review of the problem list is helpful in monitoring progress toward goals and in maintaining the focus of the treatment plan.

Reinforcement of Existing Support Systems

Since most patients can be maintained at home with adequate support (Hellinger, Fleishman, & Hsia, 1994; Reitmeijer, Davidson, Foster, & Cohn, 1993), all of the team’s interventions are designed to reinforce the patient’s existing support systems.
We may introduce the patient to ancillary community resources as a critical beginning both to ensure that basic needs are met for housing, food, and finances and to "jump start" the therapeutic rapport through immediate, active, anxiety-reducing interventions.

**Psychotherapy**

Psychotherapy and counseling, both for the patient and caregivers, typically focus on adjustment to the illness process and dealing with the multiplicity of losses: past, present, and anticipated.

**Education**

Education regarding the illness process, especially when dealing with ADC, helps patients and caregivers understand the limitations of the illness, retain a sense of control, relieve real and imagined fears, and anticipate their future needs.

An illustrative case: The parents of a thirty-year-old Latino patient were angry and frustrated because, they said, their daughter was always lying and trying to manipulate them. "In the hospital, she kept saying that the nurses wouldn't feed her. I'd get mad and yell at the nurses. They told me that they gave her dinner, but she wouldn't eat it. I don't know why she's lying so much. She just wants to start trouble." Our project social worker assessed cognitive symptoms of a moderate stage of ADC causing severe impairment of short-term memory—an inability to store new information. She educated the parents about the signs and symptoms of ADC as well as counseled them to assist with their frustration. On the next home visit, the patient's mother told the social worker: "Now it makes sense . . . what she does. If the nurses in the hospital would have explained it to me, I would have felt better."

**Crisis Anticipation**

There is no place to better identify a crisis than in the patient's residence. Early assessment and intervention are the best tools for averting crises, which can include anything that might jeopardize the objectives of the program, such as inability to maintain the patient at home, risk of hospitalization, and/or the exacerbation of acute psychiatric symptoms. Changes in the caregiver's ability to continue providing care, patient suicidality or substance abuse, neglect, inadequate care provision, and
safety risks are just a few of the potential crises that can develop in the home. These issues need to be assessed during each home visit and the appropriate intervention implemented.

Moreover, working in the patient's home permits immediate access to crises that often cannot wait for the next scheduled clinic appointment.

A forty-three-year-old man with AIDS was referred by his physician for evaluation and treatment of "paranoia." The team assessed moderate AIDS Dementia Complex, bipolar disorder, and severe schizoid personality disorder. Because of the patient's psychiatric condition, he could tolerate only the team's psychiatric nurse and social worker. No home health nurse could visit to manage his physical needs. After some weeks passed in which the patient either did not return team phone calls for visits or refused visits, the psychiatric nurse "stopped by" unannounced, finding the patient gasping for air and with extremely low blood pressure, able to say only, "Don't send me to the hospital." After consulting with the physician, she was able to secure liquid oxygen and agreement from the infusion team to administer intravenous antibiotics in the patient's home. Our team members increased visits for a while to assist the patient in coping with another home health worker in his home and to maintain his care at home.

**Barriers to In-Home Care**

Some of the barriers to in-home mental health care are:

- Lack of knowledge of the effectiveness of this type of program and its critical role in the continuum of care. Our program has demonstrated the critical role of psychiatric homecare in integrating comprehensive services for people with AIDS. There continue to be few published data to document the beneficial effects of this model of care, but we are in the process of documenting the benefits of our program. This underscores the need for good evaluation and publication of findings (see chapters 17 and 18).

- Limitations on financial support for in-home care. The current managed care environment challenges providers' continued ability to respond to the growing need for psychiatric homecare services. Most Medicaid programs provide only very limited coverage for in-home mental health care. Private insurance carriers
offer even fewer benefits. The challenge in the next decade will be to demonstrate empirically the cost-effectiveness of home-based mental health care in preventing acute-care hospitalizations.

- The tradition of office-based psychiatry and psychotherapy. Home delivery of mental health care introduces a new concept of practice. As a new clinical resource for HIV/AIDS care, there does not yet exist the wealth of "how-to" information available, for example, on working within a changing frame, fees, transfers, countertransferences, that is available for other modalities.

- Lack of government support. Because traditional providers lobby for governmental funds for their practices, governmental agencies are less likely to fund novel approaches to care provision.

**Tools for Clinical Practice**

After five years of providing mental health services to persons with AIDS (PWAs) in their homes, we've learned a few lessons. What follows are some of the more salient features of the work that differentiate psychiatric homecare from more traditional office or clinic models of mental health care.

- *The patient's home is his or her castle. Its walls protect secrets.*

  A forty-five-year-old Latino male with AIDS was referred for evaluation and psychosocial treatment of ADC, depression, and anxiety. He lived with his wife of twenty-five years and their four children: two sons, ages twenty-three and twenty-one, and two daughters, seventeen and nine. Although the wife was present during each of the interviews, she was mostly silent. The older daughter assumed all responsibility for managing her father's needs, including changing diapers and bathing. During the course of treatment, the patient's wife explosively admitted that her husband had been sexually molesting the elder daughter since she was ten. When the local reporting agency was notified, both patient and daughter denied the allegations, and the workers were unable to intervene. Immediately after the patient died, the team's social worker needed to involuntarily hospitalize the daughter in a psychiatric facility for treatment of acute psychotic depression.
In another case, a twenty-nine-year-old single male was referred for evaluation of early signs and symptoms of ADC. He was living with his parents. Fearful of sharing with them his AIDS diagnosis as well as his homosexuality, he had said he had a brain tumor. He shared with us his fears of abandonment and rejection should he divulge his sexual orientation and diagnosis. His parents accepted his false diagnosis and provided excellent care for him at home, assisting with infusions and personal care. Because it was necessary to educate the parents about universal precautions, which requires barriers when handling blood and body fluids, the patient needed to address his fears of anticipated loss and rejection by his parents in order for the team to educate them to safety issues. Through counseling, the team provided the support necessary for the patient to share his diagnosis and lifestyle with his parents for the first time. The team was then available to provide the necessary support to the parents to assist them in dealing with these issues.

Secrets abound in homes. It is important that the clinician deeply respect the patient’s and the caregiver’s needs for privacy. Only those secrets that clearly pose a threat to the treatment, the patient and/or others need to be addressed and worked through—delicately.

- To be . . . or not to be? If suicide’s the question, what’s the answer?

John, a single, fifty-eight-year-old with AIDS, was referred for community resources to assist with homemaking, meals, and other functions. He presented as an upbeat, intelligent, positive-thinking man. He was pleasant to be around, conversational, flattering, with a hearty sense of humor. Because of the patient’s apparent positive outlook on life, a complete mental status evaluation was never done at intake.

The visits were enjoyable, with the patient complimenting the worker on his excellent skills at helping people, sharing laughs, and making certain the patient followed through with the referrals. On the fifth visit, our project staff member noted that the patient had been quieter than on prior visits. After a long silence, the patient quietly asked: “Do you know the California policy on assisted suicide?” He had been thinking about suicide for more than a year. He had a stockpile of unused morphine and sleeping pills stored up “just in case.”
Suicidal ideation is no alien thought to people with AIDS (Dilley, Ochitill, Perl, & Volberding, 1985; Dilley, Shelp, & Batki, 1986; Marzuk, Tierney, & Tardiff, 1988). It may, however, be one of the most easily overlooked symptoms. The social worker working with John had been “fooled,” along with his physicians, into believing that the patient was doing well.

The therapeutic rapport between patient and worker in the home provides, perhaps, a better opportunity to assess and intervene with suicidal patients than do meetings in the clinic. This may be due to the transference that the patient feels toward the homecare worker. As noted earlier, the boundaries get blurred in the home: There may not be any starched white lab coats, and the setting is often far from sterile. It is, again, the patient’s home, offering him or her safety and comfort. The patient has already allowed the worker in the door and has control over the situation; the rapport seems to develop rapidly, making it easier for the patient to reveal his or her “secrets.” Uncovering consequent suicidal plans and often the intended means flows easily after assessment of suicidal ideation.

1. The risk of suicide must be assessed during each home visit.

Because of the volatile nature of the disease itself, persons with AIDS are often confronted with unexpected and unwelcome news of another infection or change in prognosis, which challenges their ability to cope. The clinician’s regular visits provide the opportunity to assess the nature of the risk and to intervene appropriately and in a timely manner to reduce the risk of suicide.

There is presently much debate on the issue of “rational suicide”—when the patient makes a well-informed, conscious decision to end his or her life (see Kain, 1996; Motto, 1994). This kind of decision should not be confused with the patient’s wish to limit or discontinue aggressive therapies in favor of palliative care only. Our responsibility as clinicians with people considering suicide is to assist them in clarifying their wishes, desires, and needs. For most of our patients considering this option, the authors uncovered the patients’ need to regain some control, the wish not to have pain and discomfort, and the desire to live and die with dignity.

2. The medical model emphasizes “medication compliance.” Our profes-
One of the more frequent comments cited by physicians referring someone to our project is “The patient is not compliant with medications.” This usually means that, for whatever reasons, the patient is not taking his or her medications as ordered and as scheduled, if at all. The issue is a complex one.

A thirty-three-year-old male accountant, living with his significant other of six years, was referred for evaluation and treatment of depression. During the initial assessment, the nurse logged nineteen different medications. While he initially presented with blunted affect and slightly depressed mood, his symptoms did not meet the criteria for a depressive disorder. He stated, “I take my medicine, but it’s so confusing.” On further evaluation, the patient was assessed with early-stage ADC. The nurse helped to organize a weekly medication planner and educated the patient and his caregiver about dosing schedules. In addition, the pharmacist discovered that the interactions of some of his medications could be contributing to his depressed mood. The patient became “med compliant,” and his physician reevaluated his regimen for side effects and interactions.

Often, the patient will make a conscious decision to discontinue some or all medications. Because such decisions have critical repercussions, it is the clinician’s role to provide the support needed for the patient to make an educated, informed choice. Our professional values make us advocates for every person’s right to self-determination. Decisions against further medical treatment should thus be made with full knowledge and understanding of the ramifications of this choice, including their impact on prognosis and quality of life, and not as a result of hopelessness stemming from depression, suicidal ideation, or other psychiatric symptoms.

A thirty-two-year-old single male with AIDS was referred by his physician for treatment of depression and “noncompliance with medical regimen.” The patient was first diagnosed with AIDS five years ago. Last year, he built himself a new home. After his latest bout with pneumocystis pneumonia, his mother came to stay with him from the East Coast to assist with his care. During her stay, her son became progressively weaker and more
depressed. The associated feelings of hopelessness, coupled with
the weakness, impaired the patient's desire to take his many
prophylactic medications. He agreed to antidepressant therapy
with adjunctive supportive psychotherapy with the goal of relieving
his depression. After about a month, the symptoms of depres-
sion had abated, but weakness, nausea, vomiting, and diarrhea
persisted. He had done some research into the medications he
was taking and realized that some of them were contributing to
these physical symptoms. He told the social worker, "I don't
want to die, but I don't want to live this way either. I feel like it's
time to choose between all of these meds and some quality in my
life. I don't know what to do. I feel like I'm taking them for my
mom." We explored options with the patient, his physician, and
his mother, including the immediate and the long-term effects of
discontinuing all but pain and antinausea medications. The pa-
tient opted for control. He chose to take only "comfort" — or
palliative — medications, hoping that with the weeks or months
he had left, he could feel well enough to accomplish what he
wanted to. The team helped the patient's mother understand and
support her son's difficult decision.

- **Home treatment raises new transference and countertransference issues regarding maintaining professional boundaries.**

  In a clinician's office setting, the boundaries between client
and therapist are fairly well defined by the furniture, decor, and
seating and by the traditional medical model in which the patient
actually goes to the healer's office. In home mental health care,
the clinician is the guest of the patient and his or her caregiver
and family. The home is the seat from which the patient controls
his or her world. It is designed for the patient's comfort and
maintained in accordance with the person's own individuality,
tastes, and chosen lifestyle. It is the patient's home, and the
patient ultimately maintains control over its comings and goings.

  Because it is easy for professional boundaries to get blurred in
the patient's home, frequent self- and supervisory reminders that
the visit is more than a social call are required to maintain
therapeutic integrity, especially when working with patients and
their families over a long period of time. The patient may feel
that he or she was developed a good friend, sibling, or parent
figure in the clinician. The family or caregiver may feel the same
way or may develop a more negative transference because of the perceived intimacy between the patient and the worker. While it is often unproductive to engage in an in-depth analytic exploration of the patient’s or caregiver’s transference in this setting, it is important to recognize it and to help them to interpret the underlying need behind their feelings. Nurturance, safety, security, a decreased sense of isolation, association, and self-esteem and self-value are common needs associated with positive transferences. Negative transferences need to be confronted and resolved quickly in order to protect the integrity of the treatment. Interpreting the transference then becomes a clinical tool where appropriate interventions can be made on the basis of the patient’s need.

The clinician’s countertransference falls into two categories: those issues we bring with us that are based on our own personal and professional life experiences, including our deepest needs, biases, and prejudices, and the empathy we experience as clinical containers for the patient’s and caregiver’s emotions (Cohen, 1952/1988; Ferenczi & Rank, 1923/1988; Orr, 1954/1988; Racker, 1957/1988; Reik, 1949/1988). Both need to be carefully monitored and checked by the individual with clinical and team supervision.

Working with persons who have life-threatening or terminal illnesses, who are facing the ultimate loss, may kick up many of our own feelings about loss, life, and death. Doing clinical work in an office setting, in some ways, protects us from the intensity of witnessing the whole life of the patient. In homecare, everything about the patient’s life, lifestyle, and illness process is right there to see in abundant detail, replete with the direct effects of the illness on the patient’s daily life. It is therefore easy to be not only overwhelmed but also overextended. Setting firm professional limits on working hours, frequency, time, and duration of visits, and times available for phone consultation and recognizing the boundaries of our own discipline are valuable tools in maintaining an effective “therapeutic closeness,” if not distance. Anytime we consider working outside these established limits, we should examine the reasons and be aware of the risks to ourselves and to the relationship.

Paying close attention to our personal reactions to the patient’s body, surroundings, smells, and neediness is a good place to
begin. Each member of the team needs constantly to examine areas of intense curiosity to determine whether the patient’s needs or the team member’s are being met. The key to maintaining healthy personal and professional boundaries in psychiatric homecare is to manage a well-balanced life of work, rest, and leisure, including the generous use of a network for social support.

- **Clinical work in the field can be isolating and overwhelming.**

  Psychiatric homecare requires the field clinician to make several home visits each day. Usually, the social worker or the nurse travels alone, although joint visits are sometimes indicated and helpful to coordinate and maintain the care plan. This aspect of the work can leave the clinician feeling alone and isolated from peers. These feelings are especially evident during the initial home visits, during which the clinician may assess a seemingly overwhelming mountain of problems and needs. A frequent sentiment mirroring these feelings is, “There are so many problems, I can’t seem to find a place to start.”

  Because these feelings are so common, clinicians need to have an available connection to peers and colleagues who understand the work and can assist them with prioritizing the patient’s needs and focusing the treatment goals. The interdisciplinary team approach is an invaluable resource to manage the sense of isolation as well as to maintain quality care. Staying within the clinical realm of our respective disciplines and referring to other team members for more specialized evaluation and intervention is critical in both managing feelings of being overwhelmed and maximizing good patient care. Regularly scheduled team conferences and the frequent use of informal consultations provide built-in support. Another important resource is the use of clinical supervision and peer support, whether formally scheduled or obtained through informal, but regular contacts.

- **Homecare mental health providers face dogs, gangs, unsafe neighborhoods, weapons, darkness, and other threats.**

  There are times when field clinicians may long to work a fifty-minute hour session in an office setting. In the microcosm of a clinical office, safety and security are pretty much assured by the layout of the space, accessible doors, comfort-controlled temperatures, pleasant lighting, possibly panic or alarm buttons, and
privacy. Working in the field, uncertainty abounds. We never know what situations we’re going to confront until we get to the patient’s home.

On a recent visit, one social worker was bitten by the patient’s seemingly docile dog. The threats of gang violence in “unsafe” neighborhoods is always a concern. People hanging out in the streets are curious about the increased presence of doctors, nurses, and other clinicians. Many of our field staff have been approached by people hoping to score drugs or money.

In unsafe neighborhoods, it is not unusual for patients and their caregivers to have guns or other weapons used for self-protection. It is important to assess the presence of any potentially violent weapons and their perceived purpose during the initial evaluation visit. An appropriate time for this is usually during the assessment of the patient’s psychiatric history and suicidality.

Staff safety must be a priority. No clinician should be forced into a situation where he or she does not feel safe. In areas where safety is at risk, the policy about after-dark visits should be stated clearly with the patient during the initial assessment visit. The field staff should feel comfortable in asking the patient and the caregiver to accommodate safety concerns by placing pets in another room, putting away unconscealed weapons, or even having someone meet workers at the curb when they arrive. Most patients want and desperately need the in-home services and are usually more than willing to work with the homecare staff.

**Conclusion**

Fifteen years after the first case was reported, AIDS has become a fact of life that will continue to challenge patients, caregivers, and health care professionals well beyond the year 2001. As our understanding of the disease and its psychosocial effects advances, we must develop treatment options that are innovative, cost-effective, and directly responsive to the needs of our patients. These options must include service provision in the patient’s home. Care that maximizes quality of life can be accomplished by comprehensive, patient-centered services. And, sometimes, as Dorothy Gayle of Kansas said, “There’s no place like home” to provide these services.
REFERENCES

The project described was supported by grant number BRH970015-03-3 from the Health Resources and Services Administration. The contents of this chapter are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

The authors are listed in alphabetical order and each contributed equally in the preparation, research, and writing of this chapter.

The authors acknowledge with appreciation the support of Elaine Brown for her assistance with the preparation and editing of this work.


