Home visits

An access to care issue for the 21st century

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abstract

OBJECTIVE To review trends and current practices in delivery of medical care at home.

QUALITY OF EVIDENCE A MEDLINE search from January 1989 to March 2000 yielded 65 articles. Most articles are descriptive; analytical studies are rare.

MAIN MESSAGE The number of home visits made by physicians has consistently declined in the last 30 years. The most common reasons cited are lack of efficiency, the time required, and poor reimbursement. Home visits, reserved mainly for frail elderly people and palliative patients, are seen as valuable for preventing unnecessary visits to emergency rooms and hospitalizations. Home visits are also useful for reducing caregivers' stress, monitoring chronic illnesses, and assessing need for institutionalization. Home visiting requires special skills; these must be taught to current trainees.

CONCLUSION With the shift to more community-based care, the demand for physicians to make home visits will increase. Physicians must be adequately prepared to deliver home care and be reimbursed appropriately.

résumé

OBJECTIF Examiner les tendances et les pratiques actuelles en matière de prestation de soins médicaux à domicile.

QUALITÉ DES DONNÉES Une recension effectuée dans MEDLINE de janvier 1989 à mars 2000 a cerné 65 articles. La majorité des articles sont de nature descriptive; les études analytiques sont rares.

PRINCIPAL MESSAGE Le nombre de visites à domicile effectuées par des médecins a fléchi considérablement au cours des 30 dernières années. Les justifications mentionnées le plus fréquemment sont le manque d'efficience, le temps requis et les remboursements médiocres. Les visites à domicile, réservées principalement aux personnes âgées fragiles aux patients en soins palliatifs, sont jugées valables pour empêcher des visites à l'urgence ou des hospitalisations inutiles. Les visites à domicile servent aussi à atténuer le stress chez les dispensateurs de soins, à surveiller les maladies chroniques et à évaluer la nécessité d'une institutionnalisation. Les visites à domicile exigent des habiletés particulières, qui doivent être enseignées aux stagiaires actuels.

CONCLUSION Compte tenu de la réorientation vers des soins plus centrés sur la communauté, la demande auprès des médecins d'effectuer des visites à domicile sera à la hausse. Les médecins doivent être préparés adéquatement à dispenser des soins à domicile et être rémunérés de manière appropriée.

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Housecalls are and will remain an integral part of medical care, particularly now that acute care services are being shifted to the community from the hospital. With more patients being managed in the community, physicians will be asked and must be prepared to provide care in homes, when appropriate. This article reviews aspects of delivering medical care in home settings.

Evidence

A MEDLINE search from January 1989 to March 2000, using the search terms housecalls, home visits, domiciliary visits, and home care services, yielded 65 articles. Unfortunately, most articles were descriptive; few were analytic. Housecalls seem to belong more to the art or folklore of medicine than to the science.

Rationale for housecalls

Despite a lack of rigorous scientific study, housecalls are still perceived to be a valuable medical service. They save (acutely or chronically) homebound patients, some of whom can be transported only by ambulance, the stress of going out to an office or emergency room. An analysis of a West Virginia rural practice estimated that 46% of home visits made emergency room visits unnecessary, and 9% made hospital admission unnecessary.[1] Home visits are necessary to monitor the care and medical status of patients being looked after at home. They can also be used to assess suspected abuse, recent falling, caregiver burden, and the need for institutionalization.[2] Home visits provide reassurance and support to caregivers, often an unrecognized benefit.[3] Finally, home visits following hospitalization have been shown to reduce subsequent institutionalization.[4]

Decline in number of housecalls

The proportion of housecalls has fallen from 40% of all patient-physician encounters in the 1950s to less than 1% today.[5] Nevertheless, 14% of American physicians report making housecalls[6]; numbers vary from region to region with rural physicians, older physicians, and physicians with geriatric training more likely to make housecalls.[5,7] In Canada, the experience is similar. In 1998-1999 in Alberta, there were only 41 000 home visits by 1600 physicians (out of 4752 practising physicians). This was an increase of 5000 housecalls from 1994-1995 and might reflect the shift to more care in the community. Family physicians made 98% of the visits.[8]

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Housecalls are now primarily reserved for elderly or palliative care patients.[7,9] Physicians give many reasons for the decline in housecalls saying they are an inefficient use of time, are often inconvenient, usually occur after office hours, and are underfunded.[5,7,10] Very little diagnostic support is available, and housecalls are not without risk of litigation.[5] Physicians who do make housecalls perceive the value of this service for certain patients and express satisfaction with the work.[1,9,10]

Typical housecall

The most common problems encountered on housecalls are cardiovascular, respiratory, and musculoskeletal.[3,11] A British study that reviewed 111 consecutive home visits found that, in 90% of visits, only history and physical examination were required; in 50% of visits, physicians left prescriptions; and in 30%, only reassurance was provided.[3] An American study had similar findings.[11]

Types of visits

Housecalls can be grouped into geriatric, emergency, and palliative visits.[1]

Geriatric visits. Geriatric visits fall into two categories: geriatric assessment and preventive health monitoring. Components of geriatric visits have been well documented; they include functional assessment, assessment of caregiver stress, nutritional assessment, identification of safety issues, medication review, and determination of service needs.[12] By identifying illness early and providing rehabilitation, this type of home care can reduce hospital admissions.[13]

Monitoring the health of chronically homebound patients most commonly includes patients with stroke, dementia, severe arthritis, and degenerative neurologic diseases. Such patients should be seen as frequently as you would see them in the office, and appropriate investigations should be ordered.

Emergency visits. Occasionally, patients are acutely ill at home, and physicians are asked to attend on an emergency basis (eg, an elderly patient with acute influenza). In other cases, clinical presentation is more vague, and physicians have to judge whether a patient is better assessed at home or in an emergency room. Patients who have fallen and cannot move or bear weight are better assessed in an emergency room.

Obtaining as much history as possible before visiting can be helpful. Many conditions can theoretically be managed at home. Home management of acute

illness depends on available nursing services, community resources, and family support. The advent of low molecular weight heparin has allowed safe management of venous thrombosis at home.[14,15] An Australian study[16] comparing acute home care with hospital care for the elderly found no differences in mortality, falls, incontinence, urinary retention, phlebitis, or pressure sores. Medical conditions treated were infections requiring intravenous antibiotics, deep vein thrombosis, minor cerebrovascular accidents, and mild congestive heart failure. When deciding to treat patients at home, physicians must use their judgment and be prepared to admit patients to acute care if warranted.

Palliative visits. It is common for patients to ask to die at home and for their physicians to provide palliative care. Before agreeing to such requests, physicians should consider whether they or their colleagues are prepared and are available to handle problems that arise in the home. They must be familiar with pain and symptom control in palliative settings and familiar with and prepared to deal with the common emotional problems that arise. Anticipating the common types of crises (eg, acute dyspnea, persistent vomiting, impaction, bleeding, delirium, combative behaviour) that occur in palliative care and having strategies to deal with them are essential. A patient dies only once, and families can remember a bad death experience for a long time.[17,18]

Tips on logistics

Physicians often set a geographic (15 km) or driving time (15 minutes) limit for housecalls.[1,11] A call usually takes 20 to 50 minutes.[1] I have found the following practical tips useful.

On arrival, tell the family or patient how long the visit will be and ask them to deal with the most pressing issues first. Ask to see their lists, if they have prepared them. This will help avoid reaching the end of the visit only to find that the main issues have not been addressed.

Patients should be examined as they would be in your office or in the hospital, in privacy, usually in a bedroom on a bed, appropriately undressed and with proper lighting. If you think you will require an assistant for the examination, ask a home care nurse to meet you at the home. Most physical examinations can be performed at home (even pelvic examinations, the essential elements of which are an assistant, the proper-sized speculum, and a powerful light source). The standard of care is an adequate and complete examination, despite the limitations of the environment.[19] If a patient cannot be adequately assessed at home, he or she should be moved to an appropriate setting.

Telephone before visiting to ensure being let into the house. A map and the telephone number are helpful if the neighbourhood is unfamiliar. Organize patients' housecalls with other activities if possible to make the most efficient use of their time. Have a list of telephone numbers prepared: a pharmacist who will deliver 24 hours; home care nurses or intake workers; home laboratory, oxygen, and intravenous services; and the coroner. A blank death certificate can be useful.

Equipment

Physicians should bring only the bare essentials to home visits. The most common equipment is a blood pressure cuff, stethoscope, penlight, tongue depressor, prescription pad, and patient's chart.[3,11] Physicians seldom carry medication; in most cases, medication is not required. In one study,[3] physicians administered medication during the visit in fewer than 10% of visits, and in fewer than 5% of visits was it parenteral. Physicians should consider, however, the type of problems they might encounter and the type of medication, if any, that might be needed.[20] An efficient housecall involves planning; a good history can alert you to additional equipment or medication that might be useful.

Communication

An essential component of managing patients at home is communication with home care nurses, pharmacists, other health care providers, and families. These parties must feel they can contact physicians promptly and easily if they have clinical concerns. In addition, it is important to spell out the management plan so other team members can actively participate. Written instructions can supplement the plan. Home care at its best is team care. If you are in a call group, involve on-call physicians in the management plan; otherwise patients could easily end up in emergency rooms.

Future

While housecalls have declined, they are still an important service that family physicians provide. The shift to care in the community and primary health care reform will increase the demand for physicians to provide this service. The challenge will not be whether to make housecalls but whether physicians

can work as members of integrated teams caring for patients at home.[21]

The advent of the electronic age might assist physicians in reaching into homes. At present, telemedicine systems are being developed to allow physicians to examine patients with video technology and to receive vital sign measurements (blood pressure, heart rate).[22] Telemedicine will aid physicians in screening and monitoring patients but will not replace actual visits and physicians' human touch.

Continuing medical education and resident training programs are important for providing physicians with the attitudes, knowledge, and skills required for housecalls.[23,24] Experience and role modeling will help trainees feel confident doing home visits. Inadequate reimbursement is a deterrent to providing home care; this must be addressed at the political level if we are to continue to provide this service to patients.

There are many unanswered questions about home care. What is the optimal frequency of visits? What is the best way to monitor and treat the more common cardiovascular and respiratory illnesses? Which medical conditions treated at home will have the same outcomes as those treated in hospital? How are families affected by the shift to home care? More research is required to answer these questions.

Conclusion

Housecalls are a valuable service to frail and housebound patients. With the aging of the population, demand for home care will increase. Physicians need to prepare themselves with the appropriate attitudes, skills, and knowledge to provide care in patients' homes.

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Key points

- Despite a decline in the frequency of housecalls, they remain an important part of family medicine, especially with the greater emphasis on care in the community.
- Home visits are usually for geriatric assessment, evaluation of homebound seniors, or palliative care.
- Some practical tips: on arrival, discuss the time available to deal with the most important issues; phone ahead to ensure someone is home and to find out whether special equipment is needed; carry relevant telephone numbers; bring a blank death certificate; be aware that medications are rarely required; and communicate well with community nurses and other caregivers.

Points de repère

- En dépit de la fréquence à la baisse des visites à domicile, elles demeurent une composante importante de la médecine familiale, particulièrement en raison de l'insistance grandissante sur les soins dans la communauté.
- Les visites à domicile visent surtout l'évaluation gériatrique, l'évaluation des personnes âgées confinées chez elles ou les soins palliatifs.
- Voici quelques conseils pratiques: dès l'arrivée, discuter du temps disponible pour pouvoir aborder les questions les plus importantes; téléphoner au préalable pour s'assurer qu'il y a quelqu'un à la maison et vérifier si du matériel spécial est requis; apporter avec soi les numéros de téléphone pertinents; apporter un formulaire de certificat de décès; être au courant que des médicaments sont rarement nécessaires; et bien communiquer avec les infirmières communautaires et les autres dispensateurs de soins.

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