Work in progress

Integrating physicians' services in the home

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ABSTRACT

OBJECTIVE While increasing acuity levels and the concomitant complexity of service demand that physicians be involved in in-home care, conflicting evidence and opinions do not show how this can best be achieved.

DESIGN A phenomenologic research design was used to obtain insights into the challenges and opportunities of integrating physicians' services into the usual in-home services in London, Ont.

SETTING Home care in London, Ont.

PARTICIPANTS Twelve participants included three patients, two family caregivers, two family physicians, the program's nurse practitioner, two case managers, and two community nurses.

METHOD In-depth interviews with a maximally varied purposeful sample of patients, caregivers, and providers were analyzed using immersion and crystallization techniques.

MAIN FINDINGS Findings revealed the potential for enhanced continuity of care and interdisciplinary team functioning. Having a nurse practitioner, interdisciplinary team-building exercises and meetings, regular face-to-face contact among all providers, support for family caregivers, and 24-hour coverage for physicians were found to be essential for success.

CONCLUSION Integration of services takes time, money, and sustained commitment, particularly when undertaken in geographically isolated communities. Informed choice and a fair remuneration system remain important considerations for family physicians.

RÉSUMÉ

OBJECTIF Malgré une sensibilisation accrue à la nécessité de la participation des médecins dans les soins à domicile et en dépit de la complexité concomitante des exigences du service, les données et les opinions sont divergentes à savoir comment réaliser cet objectif de manière optimale.

CONCEPTION Une conception de recherche phénoménologique a servi à mieux comprendre les défis et les possibilités d'intégrer les services de médecins dans les services courants de soins à domicile à London, en Ontario.

CONTEXTE Les services de soins à domicile à London, en Ontario.

PARTICIPANTS Les 12 participants incluaient trois patients, deux dispensateurs de soins de leur famille, deux médecins de famille, l'infirmière de première ligne du programme, deux gestionnaires de cas et deux infirmières communautaires.

MÉTHODOLOGIE Des entrevues en profondeur, auprès d'un échantillon intentionnellement diversifié au maximum de patients, de dispensateurs de soins et de professionnels, ont été analysées à l'aide de techniques d'immersion et de cristallisation.

PRINCIPAUX RÉSULTATS Les constatations ont permis de cerner le potentiel d'améliorer la continuité des soins et le fonctionnement des équipes interdisciplinaires. Au nombre des éléments essentiels à la réussite figuraient la présence d'une infirmière de première ligne, des exercices et des rencontres de constitution d'équipes interdisciplinaires, des contacts réguliers en personne entre tous les intervenants, l'appui aux dispensateurs familiaux et l'accès aux services d'un médecin 24 heures par jour.

CONCLUSION L'intégration des services exige du temps, de l'argent et un engagement soutenu, surtout lorsqu'elle se produit dans des collectivités géographiquement isolées. Un choix éclairé et un régime de rémunération équitable demeurent des facteurs importants pour les médecins de famille

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As hospitals downsize and acute care shifts into the home, better integrated medical services have become a top priority.[1] Studies have suggested that in-home physician services offer costs,[2,3] patient satisfaction,[3-6] health outcomes,[7-11] and delivery of complex therapy[12-15] equal to or better than hospital care. But several investigations[3,11,16-21] have produced mixed results.[10,22] Hidden costs, caregiver stress,[23] indirect costs to patients,[24] and physical and financial burdens for physicians[25] have been identified.

Investigation to date has not described how physicians, their colleagues from other disciplines, informal caregivers, and patients themselves actually experience the process of integrating services. Conflicting evidence and opinions leave physicians with mixed messages.[20,23,25-28] How, then, can physician services best be integrated into home care?

To answer this question, a group of family physicians, in-home service providers, and researchers in London, Ont, developed a 2-year pilot program for Integrating Physician Services in the Home (IPSITH). Collaborating with the Community Care Access Centre (CCAC), the Ontario organization formed to allocate, arrange, and monitor all in-home services, IPSITH is a linked infrastructure for home medical care as an alternative to hospitalization.

This paper describes a qualitative investigation of the complexities and challenges of the start-up phase of IPSITH's operation and thereby suggests ways to refine approaches to IPSITH and similar initiatives in the future. The researchers asked: "How do participants integrating physician services in the home experience care in this service delivery model?" Answers to this question illuminate the challenges and opportunities family physicians confront as they work with other health care sectors to achieve better integrated service.

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METHOD

Patients are admitted to IPSITH for a stay expected not to exceed 2 weeks following an emergency room visit; early discharge from hospital; or an acute medical assessment in a doctor's office, patient's home, or hospital. Diagnoses include complex infectious illnesses or acute episodes of cardiac, renal, or pulmonary disease.[24]

The IPSITH team consists of CCAC staff and case managers, the project's nurse practitioner, and patients' family physicians. The program differs from the usual services by providing 24-hour physician coverage for in-home medical care, a primary care nurse practitioner with advanced clinical practice skills, greater physician involvement in interdisciplinary team care, and more in-home intravenous therapy and diagnostic testing.

Study design

To achieve a holistic interpretation through reflection on each part of the whole phenomenon[29,30] of integrating physician's services, the researchers selected hermeneutic phenomenology as the study design. The study was approved and conducted in accordance with the guidelines of the University of Western Ontario's Ethics Review Board. Purposeful sampling using maximum variation techniques[30] and sampling until theme saturation was reached[31] led to the involvement of 12 participants: three patients, two family caregivers, two family physicians, the program's nurse practitioner, two case managers, and two community nurses. Variation addressed role in the experience of care; involvement in care of patients of various ages, both sexes, various diagnoses, and diverse socioeconomic backgrounds; caregivers' sex and caregiving experience; and providers' years of experience and practice background.

Trained interviewers used a semistructured guide to conduct twelve 1-hour in-depth interviews to elicit information about the nature and extent of each participant's involvement and experience of care through IPSITH. All interviews were audiotaped and transcribed verbatim. Individual and team analysis using immersion and crystallization techniques[32] occurred concurrently with data collection and continued until themes and patterns emerged. Credibility was enhanced by tape-recording and verbatim transcription of interviews to ensure accuracy of the data, member-checking with study participants to ensure that themes and patterns made sense of the shared experience, and peer review by other professionals who had familiarity with IPSITH but had not participated in the study.[33]

FINDINGS

All participants were anglophone Canadians. Patients interviewed were all female, ranged in age from 38 to 77 years (|x| = 57 years), and included a retiree, a blue-collar worker, and a professional. All had family caregivers; all received case management and nursing services; one received additional occupational therapy. Family caregivers, one male and one female, both had post-secondary education and were employed full time, one in private enterprise, the other in skilled labour. Both had committed to providing care 24 hours a day.

Physician participants, one female and one male, averaged 41 years of age. One had practised for 2 years in an academic practice that served a broad population of more than 6300 patients (160 cases/physician daily); the other had practised for 12 years in a non-academic general practice that served 2500 patients (28 to 32 cases daily) and offered a range of family medical care. Before joining IPSITH, both physicians recommended in-home service for patients, had made occasional home visits, and had occasionally communicated with in-home nurses, but had not worked with a primary care nurse practitioner. The five other providers were all employed full time. Like most in-home providers, all were female. They ranged in age from 37 to 47 years (|x| = 43 years) and had 12 to 25 years of practice experience (|x| = 20.8 years), 3 to 17 of those years in the community (|x| = 8.8 years).

Together, this varied sample provided multiple perspectives on the shared experience of IPSITH. In total, members had participated in 18 different cases (**Table 1**) representing both sexes (male = 61.1%; female = 38.9%), and a range of ages and diagnoses, (pneumonia, dehydration, uncontrolled diabetes, acute renal colic, chronic obstructive pulmonary disease, and congestive heart failure). All had experienced frequent hospitalizations and emergency room visits, which resulted in patients' being sent home without problem resolution, sometimes because beds were unavailable.

Synthesized findings from participants' experiences portrayed opportunities and challenges associated with implementing IPSITH. While this initial phase clearly incorporated physicians, nurse practitioners, informal caregivers, and patients into a client care team, findings indicated that the IPSITH infrastructure had not yet been fully integrated. Physicians increased their communication with other in-home providers, but also communicated directly with the nurse practitioner, and indirectly through her, with case managers, nurses, patients, and their caregivers.

Table 1. Description of cases 1 to 18 from IPSITH program: Age, length of stay, and family physician visits.

VARIABLE (UNIT OF MEASUREMENT)	N	MEAN	STANDARD DEVIATION	RANGE
IPSITH PATIENTS				
Age (years)	18	70.56	15.64	38-92
Length of stay (days)	18	8	4.42	2-17
Family physician visits (no. of visits)	18	2.39	1.46	0-5
COMPARISON PATIENTS				
Family physician visits (no. of visits)	17*	0.12	0.33	0-1

**Cases 1 to 18 have only 17 comparisons, as one IPSITH case was not yet matched.*

Communication from in-home care professionals to physicians was initiated somewhat more frequently than was characteristic before IPSITH began, and with somewhat greater ease. But in-home professionals still were reluctant to initiate communication with physicians. The nurse practitioner, therefore, acted as liaison, preserving distance between physicians and other service providers. As the following themes reveal, participants' experiences in filling their respective roles revealed several potential refinements for IPSITH.

Achieving mission clarity

All provider participants identified a need to continue to work together to sort out which patients required IPSITH over and above the usual in-home services or, alternatively, to make physician involvement a part of all in-home care. As one suggested:

> In an ideal world, everybody would not question why this is an IPSITH case, [would not] question the acuteness [of each case], and [would] not question the physician's decisions to admit [patients to IPSITH]....

Role confusion and overlap

As might be expected when many players initially come together to achieve a common goal, sorting out who should be doing what, when, and where, was a challenge. Referrals to home care normally came to the intake case manager. With IPSITH, physicians alternatively or additionally contacted the project's nurse practitioner for assessments, diagnostic procedures, and other tasks requiring advanced skills. Physicians also more routinely visited their patients at home, adding their assessments, just as if patients had been in hospital. Physician practices varied, however,

and other team members consequently experienced role confusion, role overlap, and duplicated efforts in admission, assessment, and care. As one said: "That initial 'who does what' and defining roles and redefining roles makes for a lot of confusion…."

Designating appropriate tasks for each professional to perform in IPSITH was important because physicians were uncertain about care providers' competence. One provider readily grasped this problem:

> Most nurses have good clinical assessment skills, and they can call the physician, but the communication has been difficult. The physicians have all these [homecare] nurses [to work with], and they have no idea who [the in-home nurses] are…. Their level of confidence in them is minimal.

Unlike hospitals, geographically and physically remote communities did not readily allow providers to become acquainted and develop into a cohesive integrated team.

Communication and coordination challenges

Communication tended to be top-down, originating from the physician, either directly or through the nurse practitioner. While case managers and in-home nurses described increasing comfort in initiating communication with physicians, only the nurse practitioner, patients, and caregivers were at ease in contacting physicians directly. All providers identified the need for more face-to-face communication. As one said, "It would be wonderful if… we all were able to meet face-to-face and [physicians] understood our role so we were able to communicate much better." But as one physician noted, "[Communication and coordination] was actually somewhat difficult in that it did mean for me a few more housecalls and phone contacts with people."

Funding issues

Overall, providers recognized that in-home care of patients who otherwise would have been admitted to hospital created extra service costs for the CCAC: "They take more visits, they take more equipment, there is a cost factor to this…. We need the funding in the community if we are going to look after really 'high needs' clients."

Inequity in coverage of supplies was noted: "Oxygen is not covered; [dimenhydrinate] (Gravol) injections are not covered…. If [the patients] were sitting in the hospital, these would be free to them…." Inequitable remuneration for all community providers as compared with colleagues in hospitals was seen as a major barrier to more permanent implementation of IPSITH. Physicians expressed concern about the long-term indirect and direct costs of their involvement: "It is just a little bit more of my time. I have to get in the car and go there…. I need to cover my costs so that I would make the same amount of money as I would [in the office] because I don't want [in-home visits] to tack onto the end of my day."

Unique outcomes

Patients. Patients described care through IPSITH as a positive emotional experience, one that seemed to lead to more rapid recovery.

> What was good… was the friendliness and the kindness, the caring of the people who were here for us…. You've got to get feeling better faster because you've got that care, that concern…. I think if I had been in the hospital, I probably might have been sicker a few more days. When you're at home your surroundings are your own…. You've got people around you who care…. I got to know these people, and we all kind of worked together.

A provider confirmed the positive gains of this alternative to emergency services.

> In the past we had tons of patients with cellulitis… seen in the emergency department and sent home on antibiotics. They would be told they needed to return the next morning to be reassessed;… they usually had to be there before 7:00 AM…. It was a huge ordeal. They would have to be at the hospital, wait, receive their antibiotics, and then they would come home. We [in-home nurses] would give their IV antibiotics. Then they would be reassessed… in the emergency department.

Physicians noted other advantages, including direct access to convenient, free, in-home diagnostic services, but also observed that not all diagnostic services could be readily implemented in this setting. They expressed concern about raising public expectations and creating inequities.

Caregivers. Caregivers appreciated the convenience of "in-home" as opposed to "in-hospital" care: "[Hospitalization] would have meant that I would have been at the hospital more than at home…."

A provider explained: "It was a support for the family. They had been going through… a terrible couple of months watching their loved one deteriorate, and nobody seemed to be listening. [With IPSITH in

place], you've got somebody not only listening, but moving mountains to get tests done."

One personal advantage specifically noted by a family caregiver was the sense of control afforded by the patient's receiving in-home care. She explained: "There would be more terror for me to have him in a hospital.… I did have some control over the situation. I was there when the dressing was being changed. I was there when the IV was being administered. I was on top of his pain."

Nevertheless, caregiver burden also took its toll: "[My husband] and I shut down everything—work, family, friends, our lives, basically—for 3 weeks to care for [the patient]; it created extraordinary stress,… emotionally and physically."

Professional providers. All professional providers seemed to appreciate their sense of control and improved continuity of care. A family physician said: "It [IPSITH] is continued responsibility or care for my own patients.… It is certainly the family doctor's model of care, all under one person, [who] knows them best."

A nurse commented: "You get to follow through on a situation more closely.… Being a nurse [in the home], I understand the whole picture. I understand the living conditions, their relationship with their significant other, the emotional ups and down,… and how much support they have.…"

But providers also had concerns about what institutionalization of IPSITH would mean for them. Would it increase their case loads, increase demands on their time, create parking and commuting problems, and necessitate arrangements for after-hours coverage? Physicians emphasized that all physicians must have the right to decide whether or not to provide in-home service. Adequate remuneration, nurse practitioner backup, a system of coverage for all clients (whether or not their physicians provided this service), increased access to diagnostic services in the home, and insured service coverage were identified as essential for permanently integrated physician services. As one physician noted:

> It is not attractive running out in the middle of the winter,… trying to get to the patient's home, trying to find the patient's home. If it is after hours or closer towards night time, if it is dark outside, you have safety concerns and it is very difficult to see the signs [patient's addresses]. There are some homes… that raise concerns about safety issues.

Other providers viewed physicians' provision of in-home visits to be a priority, one that they, too, said must be recognized by adequate remuneration. In their view, ideally, all physicians would be fully committed to providing this service and would make themselves fully accessible team members, with face-to-face team interaction. Greater nurse practitioner involvement and expanded in-home services, including diagnostic testing and informal caregiver relief, would be incorporated. From their perspective, greater respect for, understanding of, and remuneration for the in-home nurse's contribution would also be necessary.

DISCUSSION

Qualitative investigation does not elicit generalizable results, but focuses instead on the processes and issues of everyday experience that offer insights to others confronted with similar circumstances. The findings of this study suggest how family physicians and others might work together to achieve better integration of physician services. In particular, the findings suggest the importance of developing a shared vision of any new service delivery model; devoting time and resources to building a team across communities; attending to issues that challenge the principles of the Canada Health Act; and addressing the potential gains and losses of all who need to be involved.

Team building premised on a cocreated, commonly shared vision is essential to achieving these aims. While there has been limited research on team building in in-home care,[34] research in other settings has found team building to enhance patient outcomes,[35] organizational effectiveness,[36] provider job satisfaction,[37] and retention of nurses.[37,38] Nurturing a shared mission and goals is critical to clarifying for all "what's in it for them," thereby motivating people to make the new approach work.[39] Team-building exercises improve group function, collaboration, and communication, and reduce negative stereotypes of other disciplines,[40] thereby establishing functional norms.[41]

Refining interdisciplinary team function is particularly challenging in geographically isolated communities. While information systems and related technology facilitates communication and coordination, previous investigation[42] has documented the importance of personal acquaintance in building mutual trust and, in turn, effective teams. Thus, face-to-face contact and team-building workshops are particularly important "hidden" tasks. Shared experiential education also might help. The nurse practitioner in this pilot project helped overcome potential interdisciplinary barriers, but others recommend three or four monthly meetings initially, with quarterly meetings thereafter.[34]

As study participants noted, both the direct and indirect costs of integrating physician services in the

home merit careful consideration, with due attention to the consequences[43] for fulfilling Canada's commitment to health care for all. In particular, the overall potential of technology to permit in-home testing and treatment raises a cautionary note. Quantitative investigation already has documented shortcomings of the in-home sector in achieving accessibility, equitability, and universality.[44] Before Canadian family physicians fully commit to mobilizing and providing in-home diagnostic services, they could want more evidence on the costs and consequences, to be determined by the end-of-project evaluation of IPSITH within the next year. As well, while some research suggests that remuneration does not ultimately sway physician participation,[45] the findings of this study confirm other evidence indicating that financial compensation, on-call coverage, night and weekend coverage, peer support, organization of work time and workload,[27,46-48] travel time, parking, and geographic dispersion of patients all must be satisfactorily resolved. Although findings of a recent survey in Quebec[27] suggest that these demands are not onerous, alternative payment systems and informing physicians about the actual demands of in-home service could help.

Nursing service changes must also be weighed. The findings of this study suggest that nurse practitioners are essential to effective integration of physician services into in-home care, but role clarification and role fit with that of other providers need to be addressed.

Findings also suggest physicians attempting to better integrate their in-home services need to consider more respite and other strategies to offset caregiver burden and optimize caregivers' contributions. As it is difficult to estimate the costs of caregivers' involvement, more research and innovative primary care policy are needed.

Congruent with the findings of some[48] but not all[49] other research, patients identified comfort, convenience, and safety as important outcomes. While others[48] have found that patients often are not involved in site-of-care decisions, participants in this study stressed the importance of patient choice. Family physicians play a key role in identifying patient preferences.[49]

Conclusion

This phenomenologic investigation of the shared experience of integrating physician services into home service delivery provides insights into the challenges and opportunities that confront family physicians interested in pursuing similar activities. Findings reveal the opportunity to refine continuity of care and interdisciplinary teamwork, and suggest the importance of budgeting time and resources for team building within the community; involving nurse practitioners; and attending to potential gains and losses for patients, their caregivers, and physicians. Integrating physician services into home care is feasible, but constitutes a work in progress, requiring time, energy, and commitment from all involved.

Editor's key points

- This pilot project was designed to better integrate family physicians into home care services.
- The most important new element was addition of a nurse practitioner who acted as an intermediary between busy family physicians and patients, families, and community caregivers.
- Considerable time was spent at the start of the project to clarify goals and develop a sense of teamwork.
- Patients and families appreciated care in the home; community caregivers felt more positive about integrated services, and family physicians had a better sense of knowledge and control of their patients in the community.

Points de repère du rédacteur

- Ce projet expérimental était conçu pour mieux intégrer les médecins de famille aux soins à domicile.
- Le nouvel élément le plus important se situait dans l'ajout d'une infirmière de première ligne agissant à titre d'intermédiaire entre les médecins de famille occupés et les patients, les familles et les dispensateurs de soins communautaires.
- On a consacré beaucoup de temps au début du projet à préciser les objectifs et à développer un esprit de travail en équipe.
- Les patients et les familles ont apprécié les soins dispensés à domicile; les dispensateurs de soins communautaires se sont dits plus favorables à l'endroit des services intégrés, et les médecins de famille avaient le sentiment de mieux connaître leurs patients et de pouvoir mieux contrôler leurs soins dans la communauté.

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Contributions of authors

Dr McWilliam *designed and implemented the qualitative component of this study; conducted some interviews; participated in individual and team analysis; and drafted the original and all revised versions of the manuscript.* **Dr Stewart** *was co–Principal Investigator of the study within which this qualitative component was organized; participated in planning meetings for this component; discussed preliminary findings and clarification of themes; and reviewed drafts of the paper.* **Dr Sangster** *was co–Principal Investigator of the study within which this qualitative component was organized; participated in planning and managing the project; discussed preliminary findings and clarification of themes; and reviewed and edited the drafts.* **Dr Cohen** *was Medical Coordinator of this project; participated in planning meetings, developing the project, and coordinating the multidisciplinary management of the research team; participated actively as a family physician by organizing meetings and creating relationships with decision makers in the region; and reviewed the manuscript.* **Ms Mitchell** *acted as nurse practitioner of the IPSITH Project; participated in planning meetings for this component; discussed preliminary findings; and gave suggestions about content and shared references, and reviewed drafts of the paper.* **Ms Sutherland** *assisted in developing the semistructured interview guide; conducted some interviews; participated in team analysis of interview data; and provided feedback on preliminary drafts of manuscripts.* **Ms Ryan** *provided quantitative data analysis from survey collection and construction of tables and provided background material on use of home care.*

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Competing interests

None declared

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