

# What do Victoria family physicians think about housecalls?

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## Abstract

**Objective** To determine the proportion of family physicians doing housecalls, the types of patients they think are appropriate to visit at home, whether physicians are satisfied with the number of housecalls they make, reasons family physicians list for not doing housecalls, and what they consider acceptable remuneration and travel time for housecalls.

**Design** A 12-question paper survey was formulated specifically for this study and piloted by 6 family physicians in British Columbia. It was then mailed with a cover letter to 250 physicians' offices and faxed back anonymously.

**Setting** Family physicians' private offices in Victoria, BC, between December 1 and 19, 2010.

**Participants** A total of 250 randomly selected family physicians from a list of 552 physicians practising in Victoria on the College of Physicians and Surgeons of British Columbia website.

**Main outcome measures** Proportion of physicians doing housecalls, reasons stated for not doing housecalls, and mean acceptable remuneration and travel time for a housecall.

**Results** A total of 73 surveys (29.2%) were returned, 5 of which were not fully completed but were included for the questions that were answered. Sixty-four physicians (87.7%) did at least 1 housecall in the past year, 23 (31.5%) did housecalls at least once a month, and 12 (16.4%) did them at least once a week. Of 71 respondents, 64 physicians (90.1%) listed lack of time as a barrier to performing housecalls, 37 (52.1%) listed unsatisfactory remuneration, and 35 (49.3%) listed lengthy travel times. Most physicians indicated that appropriate remuneration for a housecall was either \$142.21 (n=30, 42.9%) or \$108.41 (n=26, 37.1%). Thirty-seven physicians (52.9%) noted that 20 minutes was an acceptable maximum 1-way travel time for a housecall, while 29 (41.4%) listed 10 minutes.

**Conclusion** Several systemic factors, including lack of time, unsatisfactory remuneration, and large geographic catchment areas, make it difficult for urban family physicians to do housecalls.

### EDITOR'S KEY POINTS

- Our aging population coupled with our medical system's push toward moving health care out of hospitals and into the community under the supervision of family physicians will only increase our need for housecalls. This study aimed to look at what physicians cite as barriers to performing housecalls. Most physicians listed lack of time as a reason they do not do more housecalls.
- Surprisingly, less than a third of physicians were able to correctly select the current remuneration for a housecall.
- Medical Services Plan's wording around housecalls leaves it unclear whether physicians will be compensated for routine housecalls for follow-up, chronic disease management, and preventive health care.

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# Ce que les médecins de famille de Victoria pensent des visites à domicile

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## Résumé

**Objectif** Déterminer la proportion des médecins de famille qui font des visites à domicile, le type de patients qui, selon eux, devraient bénéficier de ces visites, si les médecins sont satisfaits du nombre de visites qu'ils font, les raisons pour lesquelles les médecins de famille se disent non disponibles pour faire des visites à domicile, et la rémunération ainsi que le temps de déplacement qu'ils jugent acceptables pour ces visites.

**Type d'étude** Un questionnaire comportant 12 questions et conçu spécifiquement pour cette étude a été testé auprès de 6 médecins de famille de Colombie-Britannique. Il a ensuite été posté avec une lettre d'explication à 250 bureaux de médecins pour ensuite être retourné par télécopieur de façon anonyme.

**Contexte** Bureaux privés de médecins de famille de Victoria, C.-B., entre le premier et le 19 décembre 2010.

**Participants** Un total de 250 médecins de famille choisis au hasard parmi une liste de 552 médecins pratiquant à Victoria et apparaissant sur le site Web du Collège des médecins et chirurgiens de Colombie-Britannique.

**Principaux paramètres à l'étude** Proportion des médecins qui font des visites à domicile, raisons invoquées pour ne pas en faire, et rémunération et temps de déplacement moyens jugés acceptables pour une visite à domicile.

**Résultats** Un total de 73 questionnaires ont été retournés (29,2%) dont 5 non entièrement complétés, lesquels ont quand même été retenus pour les questions répondues. Soixante-quatre médecins (87,7%) avaient fait au moins une visite à domicile durant l'année précédente, 23 (31,5%) en avaient fait au moins 1 par mois et 12 (16,4%), au moins 1 par semaine. Sur 71 répondants, 64 médecins (90,1%) invoquaient le manque de temps comme raison de ne pas faire ces visites, 37 (52,1%) mentionnaient une rémunération insuffisante et 35 (49,3%), les déplacements trop longs. La plupart des médecins estimaient que la rémunération appropriée pour une visite à domicile était soit 142,21 \$ (n=30, 42,9%) ou 108,41 \$ (n=26, 37,1%). Trente-sept médecins (52,9%) étaient d'avis que l'aller simple d'une visite ne devrait pas dépasser 20 minutes alors que 29 autres (41,4%) suggéraient un maximum de 10 minutes.

**Conclusion** Plusieurs facteurs systémiques, incluant le manque de temps, une rémunération insuffisante et un grand territoire à desservir, font en sorte qu'il est difficile pour les médecins de famille urbains de faire des visites à domicile.

## POINTS DE REPÈRE DU RÉDACTEUR

- Compte tenu du vieillissement de la population et du fait que notre système de santé fait en sorte de déplacer les soins de santé des hôpitaux vers le milieu communautaire sous la supervision des médecins de famille, les visites à domicile seront de plus en plus nécessaires. Cette étude voulait connaître l'opinion des médecins sur les obstacles qui empêchent ces visites. La plupart des médecins mentionnaient le manque de temps comme raison de ne pas faire ces visites.
- De façon étonnante, moins d'un tiers des médecins étaient en mesure de choisir le montant actuel de rémunération pour une visite à domicile.
- Dans sa formulation concernant les visites à domicile, le Medical Services Plan ne précise pas clairement si le médecin sera payé pour un suivi routinier, pour le traitement d'un malade chronique et pour des soins de nature préventive.

Cet article a fait l'objet d'une révision par des pairs.  
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A century ago, housecalls were the way physicians delivered most of their medical care.<sup>1</sup> Today, only a small number of physicians regularly practise housecalls despite evidence that housecalls, when used appropriately, might benefit patients, physicians, and our medical system as a whole. The National Physician Survey reported that, in 2010, only 47.8% of British Columbia (BC) family physicians offered their patients housecalls and 0.9% described housecalls as a specific area of focus in their practices.<sup>2</sup>

A systematic review and meta-analysis showed that in the general elderly population, housecalls reduced mortality rates and admissions to long-term care.<sup>3</sup> A more recent systematic review and meta-regression analysis concluded that preventive home visits to geriatric patients, including a multidimensional assessment (medical, functional, and psychosocial) and extended follow-up, reduced the risk of admission to a nursing home, functional decline, and mortality.<sup>4</sup> Smaller studies have shown that housecalls lead to a decrease in the need for emergency department visits, hospital admissions, and institutionalization following discharge from hospital.<sup>5,6</sup>

Housecalls also benefit patients by removing the need to arrange transport, and they prevent physical discomfort and psychological distress associated with making a trip to the clinic.<sup>7</sup> Further, vulnerable patients avoid exposure to iatrogenic infections.

A housecall is a unique and powerful tool, as it allows physicians to gather information about their patients that might be impossible to elicit during office visits. From the state of a patient's home, one can quickly determine how a patient is coping and tending to his or her activities of daily living.<sup>8</sup> One can also assess a patient's mobility and safety within his or her environment.<sup>8</sup> Home supports and caregiver well-being can be explored.<sup>9</sup> Issues such as poor medication compliance, substance misuse, recent falls, and suspected abuse might become obvious after a home assessment.<sup>8,10</sup> Practical solutions to problems are also often more evident on housecalls, and coordination with other home-care services is improved.

Surveys have shown that most family physicians still value housecalls, as they believe that when used selectively they can improve patient care and satisfaction.<sup>11,12</sup> Further, most family physicians who do housecalls regularly report the joy and satisfaction they get from this aspect of medical practice.<sup>13</sup>

Although several studies have speculated about why physicians do not make housecalls, and multiple American studies have asked physicians this exact question, no recent study has directly asked Canadian family physicians what barriers prevent them from doing more housecalls.<sup>11-13</sup> For the BC government to consider making changes that will encourage family physicians to

do more housecalls, we must know exactly what reasons physicians currently cite for not doing them. This study will address this question, and will specifically attempt to ascertain what physicians expect in terms of remuneration and travel time limits for housecalls.

## METHODS

Of the 552 family physicians listed by the College of Physicians and Surgeons of BC as practising in Victoria, BC (accessed online on November 15, 2010), 250 were randomly selected. There were no specific inclusion or exclusion criteria. A questionnaire was formulated specifically for this study and was piloted by 6 family physicians in BC. Feedback obtained from the pilot study was used to revise the survey.

On December 1, 2010, each of the 250 selected physicians was mailed a survey package including a cover letter describing the study and the survey itself. Physicians were asked to return their completed surveys anonymously by fax before December 20, 2010. The survey had 12 questions and took less than 10 minutes to complete. The survey instrument is available on request.

The target was a sample size of 100 completed questionnaires (40% return rate on 250 surveys) to achieve a margin of error of 10% for proportions at a 95% confidence level. Univariate analysis consisted of frequency tables for all items. Bivariate analysis was conducted using  $\chi^2$  tests of independence for 2 categorical variables. Statistical significance was set at  $P < .05$  (2-tailed).

The University of British Columbia's Research Ethics Committee granted approval of this study.

## RESULTS

Seventy-three (29.2%) of the 250 surveys sent out were returned. Of these, 5 were not fully completed but were included for the questions that were answered.

Of the physicians who responded, 64 (87.7%) stated they had done at least 1 housecall in the past year. Twenty-three physicians (31.5%) did housecalls at least once a month and 12 (16.4%) did them at least once a week. Physicians were arbitrarily divided into 2 groups: those who graduated from medical school before 1990 and those who graduated from medical school in 1990 or later. The 49 physicians (67.1%) who graduated from medical school before 1990 were no more or less likely to have done at least 1 housecall in the past year than the 24 physicians (32.9%) who graduated in 1990 or later ( $n=42$ , 85.7% vs  $n=22$ , 91.7%;  $\chi^2=0.53$ ,  $P=.47$ ). However, 11 (22.4%) physicians who trained before 1990 did housecalls at least once a week compared with only 1 (4.2%) physician who trained in 1990 or later

( $\chi^2=3.92, P=.048$ ). **Table 1** summarizes the frequencies with which family physicians did housecalls. **Table 2** outlines the types of patients physicians visited at home and who they listed as appropriate to visit at home.

When asked how satisfied they were with the number of housecalls they currently did, 10 physicians (14.5%) wished they did more housecalls, 50 (72.5%) stated they did the right number of housecalls, and 9 (13.0%) would have preferred to do fewer housecalls. Factors stated as barriers to performing housecalls are listed in **Table 3**. One physician added that the need to justify a housecall to the Medical Services Plan (MSP) limited his or her housecall practice, and 3 physicians noted that housecalls were rarely required in their practices.

Physicians were quizzed on their knowledge of current MSP remuneration for housecalls. Given 4 options, 7 physicians (9.9%) responded that the fee was \$35.55, 42 (59.2%) responded that it was \$73.72, 22 (31.0%) correctly responded that it was \$108.41 (now \$108.95), and none responded that it was \$142.21.<sup>14</sup> When given the same 4 options and asked to indicate what the remuneration for housecalls should be, most physicians indicated that the appropriate fee was either \$108.41 (n=26, 37.1%) or \$142.21 (n=30, 42.9%). No

physician considered \$35.55 to be enough, and 5 (7.1%) replied that \$73.72 was appropriate. Three physicians (4.3%) stated that the remuneration should be more than \$142.21, with values of \$150 to \$200 listed. A further 6 physicians (8.6%) answered that housecalls should be compensated based on an hourly rate, with \$160 to \$200 per hour listed by 1 of the 6 physicians. Those physicians who underestimated the current fee for a housecall were no more likely to have listed remuneration as a barrier to conducting housecalls ( $\chi^2=0.57, P=.45$ ).

Most physicians (n=37, 52.9%) indicated that 20 minutes was an acceptable maximum 1-way travel time for a housecall. Twenty-nine (41.4%) listed 10 minutes as the maximum acceptable 1-way travel time, and 4 (5.7%) were prepared to travel for 30 minutes.

## DISCUSSION

A large proportion (87.7%) of Victoria family physicians did at least 1 housecall in the past year, but a far smaller proportion did them regularly. This is surprising

**Table 1. Physicians who reported doing housecalls at each frequency: N = 73.**

FREQUENCY	PHYSICIANS, N (%)
More than once a week	6 (8.2)
Once a week	6 (8.2)
Once a month	11 (15.1)
Several times a year	22 (30.1)
Rarely	24 (32.9)
Never	4 (5.5)

**Table 3. Physicians who listed each factor as preventing them from doing more housecalls: N = 71.**

FACTOR	PHYSICIANS, N (%)
Lack of time	64 (90.1)
Remuneration	37 (52.1)
Travel distances	35 (49.3)
Lack of equipment or technical support	14 (19.7)
Concern for personal safety	11 (15.5)
Concern for medical liability	6 (8.5)
Feeling unprepared or untrained	1 (1.4)

**Table 2. Physicians who reported providing housecalls to each patient population in the past year and physicians who believed housecalls should be provided for each patient population**

PATIENT POPULATION	PHYSICIANS WHO REPORTED VISITING SUCH PATIENTS IN THE PAST YEAR (N = 64), N (%)	PHYSICIANS WHO BELIEVED SUCH PATIENTS SHOULD RECEIVE HOUSECALLS (N = 72), N (%)
Frail elderly patients	57 (89.1)	70 (97.2)
Palliative patients	48 (75.0)	70 (97.2)
Patients with disabilities	26 (40.6)	49 (68.1)
Patients recently discharged from hospital	14 (21.9)	33 (45.8)
Patients for whom death needs to be pronounced	12 (18.8)	31 (43.1)
Patients with psychiatric illnesses or behavioural problems	10 (15.6)	24 (33.3)
Postpartum patients or their newborn infants	2 (3.1)	14 (19.4)
Patients who pay for the service privately	2 (3.1)	12 (16.7)
Any patient who requests a housecall	NA	4 (5.6)

NA—not applicable.

considering Victoria's substantial geriatric population and physicians' overwhelming consensus that frail elderly patients and palliative patients are appropriate candidates for housecalls.

Not surprising were physicians' reasons for not doing more housecalls. An overwhelming 90% listed lack of time as a factor, and about half listed unsatisfactory remuneration and travel distances as factors. Additional comments left by physicians echoed this. Physicians reported that by the time they finished seeing patients in the office, managing patients in hospital, and attending to paperwork, they no longer had the time, energy, or desire to do housecalls.

There is obviously no simple way to reduce the demands on physicians' time. Perhaps those physicians with experience doing housecalls could be recruited to give other physicians instruction on how to efficiently incorporate housecalls into their practices. Exposing medical students and residents to housecalls would allow them to observe first-hand how to effectively organize one's practice to incorporate housecalls. Working alongside nurses and other allied health care professionals is one time-saving strategy. A team approach to housecalls allows physicians to delegate certain time-consuming tasks, such as patient follow-up after a medication adjustment or liaising with home-care supports. With good training and communication, this can be done effectively and safely. However, until the MSP compensates physicians for such services by proxy, few will be able to finance their team members' salaries. Also, physicians might be more inclined to do housecalls if they were compensated for their time on an hourly rate.

Surprisingly, less than a third of physicians selected the correct remuneration for a housecall. Therefore, it might be beneficial to offer physicians reminders about remuneration for housecalls. More than 40% of physicians are happy with the current remuneration; however, more than half answered that pay for a housecall should be closer to \$150.

Travel distances was the third most noted barrier to performing housecalls. To overcome this, physicians in group practices could divide up their home-bound patients based on the neighbourhood in which each physician resides so that housecalls could be done on the way to and from work.

A few physicians mentioned that a further barrier to doing housecalls was the government's requirement that they justify why a patient requires a housecall. One physician stated that his or her annual office profile created feelings of guilt about spending so much of the taxpayers' money on housecalls, as he or she was providing far more housecalls than the average physician. What a physician's office profile does not capture is how many of his or her patients make visits to the emergency

department or require admission to hospital, as well as the cost of these services to our health care system.

The BC Medical Services Commission makes the following 2 statements:

A house call is considered necessary and may be billed only when the patient cannot practically attend a physician's office due to a significant medical or physical disability or debility and the patient's complaint indicates a serious or potentially serious medical problem that requires a medical practitioner's attendance in order to determine appropriate management.<sup>14</sup>

A house call may be initiated by the patient, the patient's advocate, or by the physician when planned proactive care is determined to be medically necessary to manage the patient's condition.<sup>14</sup>

The first statement implies that housecalls should only be used for emergent or urgent concerns. However, the second statement grants physicians some liberty to use their own judgment in scheduling housecalls. The ambiguity of these statements leaves it unclear whether physicians will be compensated for routine visits for follow-up, chronic disease management, and preventive health care. Essentially, all care offered to mobile patients who visit their family physicians in clinics should be offered to home-bound patients in their homes, and this should be made explicit in a new and clear directive to physicians from the MSP.

This study did not attempt to comment on the cost advantages of seeing patients in their homes. To date, no Canadian study has looked at whether housecalls are cost and resource effective. Recent studies from northern Europe examining housecalls to frail elderly patients have reported mixed results.<sup>15,16</sup> Ultimately, we need more physicians doing housecalls to determine any associated net financial loss or gain.

With our medical system's push toward moving health care out of hospitals and into the community under the supervision of family physicians, our need for housecalls will only increase.<sup>7</sup> Our aging population amplifies this need and technologic advances make housecalls feasible.<sup>7</sup> Further, the public will likely start demanding physicians make more housecalls. Popular media is catching on with descriptions of family physicians across the country successfully starting up practices based largely on housecalls.<sup>17-19</sup> Some physicians are also advocating for more housecalls through literary and artistic means, including Dr John Sloan and his book *A Bitter Pill*,<sup>20</sup> and Dr Mark Nowaczynski in the documentary *House Calls*.<sup>21</sup>


## Limitations

This study is not without limitations. The first is that of selection bias. Owing to the low rate of surveys returned,



one could speculate that respondents tended to be physicians who value and conduct housecalls. This would account for some of the difference in the proportion of physicians who reported doing housecalls compared with the proportion found in the 2010 National Physician Survey. Second, owing to recall bias, it is difficult to assess whether physicians were accurate when reporting the number of housecalls they did. Another limitation is that mostly closed-ended questions were used in the questionnaire. This was necessary to standardize and analyze the data; however, closed-ended questions limit respondents' answers to the listed options. Further, because the survey was self-administered, any ambiguity in the survey questions might have affected the results.

## Conclusion

Several systemic factors make it difficult for urban family physicians to do housecalls; the most important factors are unsatisfactory remuneration, pressures on time, and large geographic catchment areas. Hopefully the information collected from this study will start discussions that influence changes to BC's MSP policies and fees, to continuing medical education courses, to medical training, and to our health care system as a whole. 

**Dr Hammett** is a family physician in Victoria, BC, whose practice focuses on geriatric primary care.

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### Competing interests

None declared

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