Caring for patients at home

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One of my goals in my year as President is to use this space to highlight some of the great work family physicians do across Canada. Last month I wrote about members of our research community. This month I focus on some of the family physician leaders who have developed interprofessional home-based primary care services.

In 2013, Stall et al wrote a 2-part article on the value of home-based primary care for older homebound patients.[1,2] They described "modern home-based primary care models that provide comprehensive ongoing primary care in the home and specifically target patients with complex chronic disease who are poorly served by office-based care." They said this kind of care is often provided by physician-led interprofessional teams including allied health professionals. Stall et al described several home-based primary care models, but most of the published research has been done in Europe and the United States. Two of the few Canadian programs, referenced in the article, were the Primary Integrated Interdisciplinary Elder Care at Home (PIIECH) intervention in Victoria, BC, and the House Calls program in Toronto, Ont.

Home-based primary care is an underappreciated and undersupported part of our health care system. When I read about these pioneer programs, I wanted to learn more.

The PIIECH program was started by Dr Ted Rosenberg. In 2003, Dr Rosenberg was doing geriatrics consultations when there were health care funding cuts. In response, he wanted to establish an interprofessional team that could provide assessment and continuity for homebound elders. When his request for funding was rejected, he was undeterred. He persisted, providing much of the funding himself. He went on to establish a team that now includes 2 nurses, a rehabilitation aide, a part-time physiotherapist, and 2 part-time family physicians in addition to himself. When we talked, they were caring for 280 elderly patients in their homes. The physicians bill fee-for-service, while the patients pay for non-insured allied health services. It has been a wonderfully successful program, allowing elderly patients to stay in their homes longer and spend less time in hospital. After enrolling with the program, patients used the emergency department 20% less often, and there was a 40% reduction in acute care use.[3]

I found a similarly successful model on a recent trip to Toronto, where I visited Dr Nowaczynski's House Calls team. Dr Nowaczynski started providing home visits during family medicine residency because of a strong role model. He found the work compelling and continued to provide home visits after he graduated in 1992. Like Dr Rosenberg, his passion for home-based care was inflamed by health care cuts. In 1998, Dr Nowaczynski, with the explicit consent of his patients, started to photograph and document the circumstances of their lives. This led to a 3-page article in *The Globe and Mail*.[4] Dr Nowaczynski expressed how his patients could be better supported by an interprofessional team. Three not-for-profit community agencies volunteered part-time human resources in the form of a nurse, a social worker, and an occupational therapist 2 days a week. Secure funding for a stable team was not obtained until 2009. The team now consists of 6 family physicians with a mix of full- and part-time commitments. Half the physicians bill fee-for-service, while the others are alternatively funded. There are 2 nurse practitioners, 3 occupational therapists, 2 social workers, 2 team coordinators, and a part-time physiotherapist on the team. They told me they provide services to approximately 600 to 800 patients a year in a catchment area of more than 1 million residents.

Similar to the PIIECH program, House Calls patients are less likely to use hospitals and have very high levels of satisfaction. Many of these patients would go without service or be institutionalized if it were not for this program.

My interest in home visits led me to Dr Jay Slater and his Home ViVE program in Vancouver, BC, and Dr Thuy-Nga (Tia) Pham and her South East Toronto Family Health Team—2 more examples of interprofessional home-based primary care for homebound patients. It is remarkable to me that all 4 programs would not exist if not for the initiative of these physician leaders. All were established in direct response to community need. Not only did these physicians aim to serve this marginalized population, they also pursued funding for interprofessional teams to better meet the many needs of these patients.

We do not know how many Canadians are homebound. I do know these programs need strict criteria for whom they can serve or they would be inundated. By their nature, homebound patients do not advocate for themselves very loudly and can be invisible if we are not looking. I am grateful to these physician leaders who identified a need and have worked so successfully to fill it. Despite the wonderful efforts of these teams, many homebound Canadians go without primary care and are waiting for more of us to hear the call and experience the rewards serving this deserving population.

Cet article se trouve aussi en français à la **page 150.**

References

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