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72 – Revisiting "Home Visits: Your Practice on the Road"

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Home visits have been a central part of medical practice and were once a standard of practice (1). The number of home visits made by physicians has consistently declined, being today less than 1% of all patient-physician encounters, with the average doctor conducting fewer than one house call per week in the United States (2). In most European countries, home visits are increasingly becoming an exception and common reasons cited for this decline are inadequate compensation, the time required, limitations of technological support and poor physician training and exposure in this area.

Today there are 174 million people aged 65 years or older, in Europe and North America. A further increase of about 93 million people is expected within the next 20 years; a fact that illustrates the acceleration of an ageing population (3) and that a considerable number of persons will live home-bound, reinforcing the need for home visits.

This reality requires a thoughtful definition of the rationale for home visits in order to improve efficiency of care and optimization of physician's time and community resources, as the effective use of home care services has become a core competency for family physicians (1).

Home visits: who and how?

The major types of home visits reflecting patient-related situations viewed as a priority by the general practitioner (1):

- patient assessment: polypharmacy, comorbidity, immobility, social isolation, frailty, suspected neglect;
- illness management: emergency, acute and/or chronic conditions;
- dying patients: palliative/terminal care, grief support;
- post hospitalization follow-up;
- and preventive house visits.

A cross sectional study (4) which meant to evaluate which older people benefit most from a comprehensive geriatric assessment, concluded that general practitioners should, at least, target older people with ≥ two chronic conditions, using ≥ five medications, being female of an older age, living alone and less educated.

An effective home visit implies developing a systematic approach that includes advanced planning, minimal interference with daily practice, establishing the reason and type of home visit, gathering the necessary equipment and establishing a formal hour for the visit.

The INHOMESSS mnemonic (1) still reflects the components of a holistic house call and helps the physician remember some items to consider in a possible check-list:

Impairments/ Immobility, Nutrition, Home environment, Other people, Medication, Examination, Safety, Spiritual health and Services. In the majority of house visits only specific elements will be addressed, allowing the conciliation between patient needs and the physician´s agenda.

The equipment recommended for a house call should include: map, mobile phone, physical exam instruments and documentation as dictated by the patient and type of home visit. The technological evolution has made computers easily portable and internet connection widespread. This previously considered "optional medical equipment" has become fundamental for daily practice, allowing accurate record-keeping and access of important patient information and clinical tools for evidence-based decision making.

Overcoming barriers

Scheduling visits in geographic clusters and choosing a specific day/hour for home visits allows time optimization. The restricted diagnostic options available in the domestic setting are being overcome by the use of easily accessible technology, as the ever-expanding contents of the modern-day "black bag", which can include everything from a Blackberry to portable IV medications, keeps evolving. Concern about personal safety is reduced if the physician knows the community, makes daytime visits, carries a mobile phone or is accompanied by other health professionals.

The establishment of a "home visits curriculum" should be considered during medical training. The use of role models as well as mandatory and longitudinal clinical time provision of home visits and residential care will produce both challenges and opportunities. This will allow family physicians to become more confident when providing home care.

What does the evidence tell us today?

The number of home visits is continuously declining while the primary target group, older people with multimorbidity, is growing. These contradictory findings are sustained by several studies published in the last two decades, which have analysed the number of home visits from either quantitative surveys or practice data (5).

Since 2000, five English language systematic reviews have been published with conflicting results. Some reported that home visits and primary care programmes did not affect mortality, physical and psychosocial function, health status or health care use and costs; others concluded that these programmes reduced mortality, admissions to long-term care facilities and functional decline (6). Home visits were not consistently associated with differences in mortality or independent living; investigations of heterogeneity did not identify any programmes that were associated with consistent benefits, although the poor reporting of intervention components and delivery, did not allow for the possibility that some programmes may be effective (7).

Looking to the future

Quality of primary health care must be maintained while improving the quality of home visits. This modernisation implies designing effective and scalable programmes, developing education and training skills of general practitioners and their vocational trainees, investing in research and in continuous evaluation of the implemented programmes (5,6). Learning and adapting from specifically designed home-based primary care programmes can considerably affect patient, caregiver and systems outcomes; high-quality evidence from the Veterans Affairs System in the United States shows that these programmes can substantially reduce emergency department visits, hospitalizations, and long-term care admissions (8). Making theses outcomes reproducible would be critical to maintain the quality of life and function of the elderly and home-bound population, as well as to allow the sustainability of the health care system worldwide.

Take home messages

- The ageing population make home visits increasingly necessary and their rebirth must be seen as an essential part of a community integrated care programme.
- There are suggested economic benefits by eliminating unnecessary emergency room visits and by ensuring adequate health care for housebound elderly, although these presumed advantages must be critically addressed by further research.
- The challenge concerning home visits is making them cost and time effective, attractive, unthreatening and

rewarding for family doctors.

- Continual medical education and resident training programmes are fundamental for providing physicians with the attitudes, knowledge and skills to conduct home visits effectively.
- Home visits may provide benefits to patients and physicians, with their potential to re-establish a more intimate doctor-patient relationship. The opportunity of taking care of patients in their own home allows the perception of their living environment, support system and overall safety which gives the family doctor an insight that cannot be gleaned from office or hospital visits.

Original abstract

http://www.woncaeurope.org/content/926-po-home-visits-your-practice-road

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