



## Review Article

# Home Visits and Home-Based Care: A Necessary, Impractical, or Humanitarian Primary Care Service?

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### Abstract

Looking after patients at home may be considered to be more a feature of the past, but delivering quality home-based care may contribute to beneficent and cost effective overall healthcare. While regarding an elderly population of over sixties as more vulnerable, the added workload for primary care physicians is a consideration when using resources, allowing time, providing benefits, and seeking positive outcomes. New models of care studied confirm a perceived need for an extra level of patient-centred care. Nurse practitioners play a greater part compared with physicians, the latter more likely to sustain pressure from overwork. Burnout and loss of professional recognition and service can lead to dissatisfaction.

**Keywords:** Community-Based; Domiciliary Care; Elderly; Home-Based; Home Visit; House Calls; Palliative Care; Primary Care.

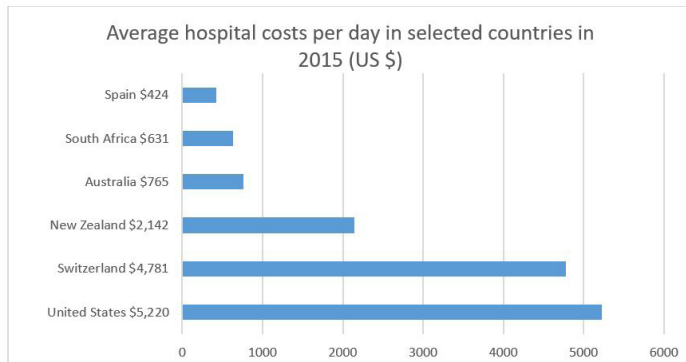
### Introduction

Studying elderly patient cohorts living in specific global populations recognizes domiciliary or home care. An extension of that area of work falls into primary care's hands with community hospitals, and patients' homes, receiving patients discharged from tertiary care, for convalescence, respite care, short stays, or fully discharged. Brown, et al. [1] suggested alternative forms of healthcare for the over sixties in one location, with the provision of multidisciplinary care in day hospitals. Managing patients with substance abuse withdrawal signs and associated symptoms needs specialized skills, as do some psychiatric patients with dementia or delirium. An underrated element is healthcare for patients who stay at home and need specific acute or progressive follow up, from wound dressings to palliative care when hospital services are not utilized. Providing home care in any capacity also has challenges. Theile, et al. [2] carried out a German population study and found home visits remained an integral part of medical care but were unconvinced of their benefit although such visits continued

undisputed. Financial recognition for service was an issue. There was conflict between motivation and obligation for completing home visits. Caring for patients in nursing homes are thought to be distressing for both carers and patients. Theile, et al. [2] continued with a survey to reveal physician comments on nursing homes being places of "resignation, incapacitation, sadness, anguish, despair, gruesome." Nursing home residents feel they "don't have a place elsewhere, are rejected, are living in forced circumstances, have lost their personality, are unhappy".

### Home Care

The point of home care fades if we forget objectivity. One could argue that home visits are inefficient and use up too much of a practitioner's clinical time. Conversely, one could see more patients presenting at a medical office or clinic in similar time. There is no precisely accurate idea of how much home visits cost, whereas hospital costs are regularly reported, and may raise consternation when the expenses are broken down. Hospital costs per day by country in 2015 ranged from US\$ 424 in Spain to \$5220 in the United States [3]. Home-based care or home visits cost a fraction in comparison (Figure 1).



**Figure 1:** Average hospital costs per day in selected countries in 2015 (US \$). Source: IHFP; HCCL.

It is recognized that more experienced practitioners, particularly male doctors, visit patient homes more frequently, and for longer than their junior counterparts. Three described types of home visit undertaken are “supportive,” “routine,” and “urgent.” The first option seems less popular, the next least challenged, and the last regarded as disruptive if not chaotic. Organization is the key factor, allowing for time, and prioritizing patient needs.

## Use of Nursing and Allied Health Support

The vocational and professional care that can be provided by physicians to patients at home, impossible without specialist nursing support and input from other carers including pharmacists, social workers, volunteers, advocates, and family relatives, are professionally fulfilling. Not all physicians seek such additional tasks. Pereles [4], had a more optimistic slant after reviewing sixty-five descriptive and non-analytical articles from a Medline search between 1989 and 2000, stating that home visits would need to increase with more community-based care. Remuneration remains an issue. The United Kingdom’s National Health Service has a patient panel reimbursement structure on a per annum basis. Canada has a fee for service structure, with differential rates for out of hours visits. Yao, et al. [5] describes the role of Nurse Practitioners (NPs) for house calls in the United States. In 2013, NPs provided 22% of home visits and covered 30% larger geographical areas than medical practitioners.

## Spectrum of Care

Post-operative patients, post-delivery mothers, chronically debilitated, disabled, mentally ill, or those in need of palliative care, have different issues. At home, they retain control of their environment, see people they know, feel stabilized by familiar objects and surroundings. More important, it is patient-centeredness that enables families to be involved by a physician when a patient returns home from hospital admission or falls ill at home. End of life issues generate innate emotion within a family setting. Some patients wish to die at home, from old age or terminal illness. The latter’s timeline is less predictable, and home visits are both supportive and completed as required rather than being regarded as

routine. Tanuseputro, et al. [6] assessed the impact of home visits by palliative care physicians and family physicians, both showing a corresponding reduction in the odds ratio of 47% and 59% of hospital deaths.

## Relish or Loathe

Anyone trained for home visits either relishes the opportunity of meeting their patients with families or loathes it as a disruptive burden. Deciding on a domiciliary visit is at the behest of the physician of care. For the former, many have continued to gain professional satisfaction. They may not give up their current care habits, regardless of the semblance of time spent, and can continue to take training family medicine residents with them to home-based visits, where determinants of health are self-evident as Pham, et al. discuss. [7]. For the latter, providing healthcare at home is a chore, not an eye-opener. Dining, bedroom and bathroom arrangements need consideration. Social, nursing, pharmaceutical, occupational healthcare, mobility issues by using a walking frame, or wheelchairs, or staircase chairlifts at home, elicit new hurdles. Norman, et al. [8] completed an observational study of home-based care from six practice sites. Best primary care practices were derived to tend to seniors with multiple pathologies, to enable more efficient and comprehensive care. McGregor et al. [9] studied the difference between home-based integrated and usual primary care and found that the former was superior for health outcomes.

## Experiential Learning

The experience and learning on site are apparent for doctors to sense at once, as well as generating compassion, serving to set a level of care and expertise that stimulates their doctoring aspirations. Office visits for minor ailments or procedures like injections are not challenging, and many physicians can become disheartened by the “same old, same old” repeaters. The constant pressure imposed by full waiting rooms spark the flame of tedium with anxiety. Many physicians may suffer unnecessary stress and burnout from lack of professional satisfaction, overwork, ensued in a medium to long-term period. Drybre, et al. [10] using a screening tool, the Physician’s Well-Bing Index (PWBI), estimated that 24.8% of physicians planned to leave their current post, with 26.8% intending to reduce their working hours.

Every patient consultation is intrinsic, if not critical to a degree, regardless of where and when conducted. The hidden curriculum is that home visits provide time-outs from the office, availing physicians with respite too, with no interruptions, a visual change, no extra walk-ins, and a chance to be away from phone calls, and the ever-present demands to complete the EMR.

One cannot counter visits for repeat prescriptions with holistic care, and continuity of care, for a dying person, to gain income. Planning, time-management, trained professional office staff, guidelines for practice, and effective doctor-patient communication, all are essential.

The response when a patient or a family member expresses gratitude after weeks or even months of home-based care is unique

and justifies the time spent in trying to achieve a satisfactory outcome. A simple compliment makes one feel valued, without expectation of reward or accolade. One should be able to say that all the rigorous medical school and postgraduate training was worthwhile, and that delivery of care and not financial gain is more important. Payments should not be an issue that clouds clinical judgment.

## Conclusion

Home visits may be declining for a targeted elderly population and seen by many as being impractical for primary care. Discouraging this aspect of care may result in a loss of traditional clinical experience, unmet demographic needs, and increased or expedited referrals to emergency departments or for hospital admissions, with anticipated volume overload. Both secondary and tertiary facilities are costly and less personal services. While home visits cannot be regarded as essential, recalling McWhinney's words [11] serves to remind physicians and nurse practitioners of their responsibility, and competencies, while retaining "compassion and empathy for those most in need", in a lifelong commitment of humanitarian service.

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