The College of Family Physicians of Canada
Le Collège des médecins de famille du Canada

The Role of the Family Physician in Home Care

A Discussion Paper

December 2000

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- **FAMILY MEDICINE IS A COMMUNITY-BASED DISCIPLINE**

THE ROLE OF THE FAMILY PHYSICIAN

IN HOME CARE

A DISCUSSION PAPER

December 2000

"We define family medicine in terms of relationships, and continuity of the patient-doctor relationship is one of our core values. How can we justify breaking our long-term relationships with patients whenever, in sickness or old age, they become housebound?"

Ian R. McWhinney, MD, FRCCP, FCFP, FRCP
"The Doctor, the Patient, and the House:
Returning to our Roots"
Fourth Annual Nicholas J. Piscano Lecture

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RECOMMENDATIONS

RECOMMENDATION 1

That the CFPC promote the vision that:

a. Home care be viewed as an integral part of family medicine emphasizing the value of continuity of care, where family physicians are encouraged to remain or become involved in the care of patients in the home.

b. The role of the family physician in home care be defined by medical necessity and patient need.

c. The family physician assume an active role in the home setting as a member of a multi-disciplinary team, and that mechanisms be developed nationally to facilitate the creation of such a team.

d. Family physicians organize themselves into group practices to ensure 24-hour coverage of the patient in the home.

RECOMMENDATION 2

That the CFPC continue to work on the development of models of care and define mechanisms to facilitate physician participation in the care of patients in the home. The mechanisms should ensure that:

a. Every family physician is informed promptly when his/her patient is discharged from hospital and admitted into home care.

b. Every family physician is provided with a medical assessment of patient status when admitted into home care, or that appropriate steps are taken to involve the family physician in medical assessment of the patient and assure appropriate use of her/his time and skills in the care of the patient.

RECOMMENDATION 3

That the CFPC further develop its relationship with the Canadian Home Care Association (CHCA) and other organizations in order to pursue research and program creation that would facilitate the family physician's participation in home care.

RECOMMENDATION 4

That the CFPC seek support from the Health Transition Fund and/or other sources to pursue research into mechanisms to facilitate physician involvement in home care.

RECOMMENDATION 5

That the CFPC encourage research on the impact of early hospital discharge on family physician resources and the quality of patient care.

RECOMMENDATION 6

That the CFPC advocate with governments:

a. To recognize the importance of the role of the family physician in home care as part of the multi-disciplinary team and support its development.

b. To provide financial incentives and flexible remuneration that will encourage the participation of all health professionals in providing comprehensive care of patients in the home (e.g. family physician remuneration including blended funding, telephone consultations, house calls and after-hours premiums, etc.).

RECOMMENDATION 7

That the CFPC advocate with the Royal College of Physicians and Surgeons of Canada to develop mechanisms that will facilitate communication between family physicians and specialist consultants when dealing with patient health status and admission into home care.

RECOMMENDATION 8

That the CFPC ensure that appropriate continuing medical education is available to family physicians to enhance their skills in caring for patients who require more acute care in the home.

RECOMMENDATION 9

That the CFPC ensure that all family practice residency programs provide increased exposure to care of patients in the home, and training in the requisite skills to provide more acute care in the home setting.

RECOMMENDATION 10

That the CFPC promote to all its publics the significance of home care as part of a continuum of care in the context of the establishment of a modern family practice.

1. Preamble

Home care is not new to Canada. What is new is the rapid shift of acute care to the home setting. Increasingly, complex medical interventions are being transferred out of the hospital into the home without adequate consideration of medical management of the patient. In many parts of the country, the family physician has been largely excluded from home care planning and implementation. This is unfortunate as family doctors provide a large proportion of health care services in the community and are an important potential resource to enhance the effectiveness of home care.[1]

Although family physicians are recognized as critical sources of referral and medical support for the home health industry, there has been a considerable lack of attention paid by governments (with some notable exceptions) and the home health industry on how to integrate physicians into the process. The role of the family physician in home care is an add-on in many jurisdictions with home care programs becoming more physician-friendly out of necessity. [2]

As the shift to acute, complex care in the home accelerates, what network solutions will be developed to integrate medical management and will they include the family physician? Will these solutions be guided by principles that are patient-centred and promote access, universality, continuity, and comprehensiveness of care? What role will the family physician play in home care and what is needed so that the family physician can participate in the various home care programs across the country?

It is recognized that to a large degree the role of the family physician in home care will be dictated by the needs of patients and the decisions that governments will make about the organization and funding of delivery along the continuum of care. But as Canada progresses to develop national home care program alternatives, it is important that family physicians work on behalf of their patients to help shape policy on the organization of new integrated delivery systems and network solutions that will optimize patient care.

This paper is a background document that sets the stage for longer-term examination by the CFPC of medical management in the home. Its purpose is to explore some of the many issues and options related to the role of the family physician and the growing need for medical management in the home. The paper is based on a literature search, interviews with physicians, and experiences in Canada and other jurisdictions, including Great Britain, New Zealand and the United States.

[1] Alberta Medical Association, Ad Hoc Committee on Home Care, May 1993
[2] CFPC, National Telephone Survey, August 1999.

2. Introduction

Defining the role of the family physician in home care is complex and multi-faceted. For some, home care is seen as an exciting new clinical frontier. For others, it is simply discussion of the impracticality of house calls. And for others, it is an affirmation of a long-standing tradition in family medicine.

Discussion of physician participation in home care goes to the very heart of the principles of family medicine; in particular, the challenge it presents to the patient-physician relationship as well as continuity and comprehensiveness of patient care. Physician failure to follow patients through the continuum of care from hospital to home is described by Bernstein in compelling terms as "moral abandonment" or an "abdication of responsibility".[3] McWhinney takes this concern even further suggesting that failure to participate will lead to an erosion of clinical skills and the confidence necessary to treat the patient in the home. [4]

Comprehensiveness of care is also challenged with home care programs nationally characterized by thin resources, differing levels of service delivery between provinces and within regions, and a general lack of recognition of the importance of the family physician in home care. [5]

While a compelling argument can be made for physician participation in home care based on the principles of family medicine, practical challenges to involvement such as time constraints, remuneration and the disorganization of delivery systems must be addressed before family physicians can assume an effective role in medical management in the home.

Adding to the complexity of role definition are the limitations of the research available especially in education, technology and the organization and quality of delivery. There is little research into patient outcomes, services provided, or cost effectiveness which could provide guidance on patient medical needs in the home setting. Canadian research into physician attitudes is also limited.

Further, much of the literature published on the subject is written from the perspective of the family physician analyzing physician participation and barriers to involvement. Home care in this context is often examined as an alternative mode of practice rather than as part of the continuum of patient care and the perspective of the patient is largely overlooked.

A basic premise of this paper is that the role of the family physician in home care must be defined by the needs of the patient. This view is supported by the 1998 CFPC Home Care Survey[6]. In that Survey, physicians expressed overwhelming support for both a patient-centred approach to service Delivery, ad to continuity of patient care.

[3] Bernstein, L.H., Grieco A.J., Dete, M.K., "Primary Care in Home", Philadelphia; 1987, p.10
[4] McWhinney, Fourth Annual Nicholas J. Piscano Lecture, "The Doctor, the Patient, and the Home: Returning to Our Roots", JABFP Nov.-Dec. 1997, Vol. 10, No.6, p.432
[5] CFPC Telephone Survey, IBID.
[6] Survey of Family Physicians On Home Care Services. College of Family Physicians of Canada, Mississauga, ON, 1998

3. Background

a. Home Care - A Growth Sector

Home care is the fastest growing sector of health care in Canada with a reported annual growth rate of 11 %. From 1990/91 to 1997/98, public spending on home care doubled from a low of $1 billion in 1990-91 (or 2.3 % of total health care spending) to $2.1 billion in 1997-98 (or 4.0 % of total spending). Spending varied by province from a low of 2.6 % in PEI to a high of 8.0 % in BC.

While a number of developments including advances in technology, less intrusive surgical techniques, new drugs, and changing attitudes toward institutionalization have driven the growth of home care, the primary driver behind the recent surge in public investment has been provincial government cost containment.

Statistics confirm that the downsizing of the hospital sector has been dramatic and ongoing. According to Health Canada, from 1989-1994, the number of hospital beds nationally per 100,000 population declined 14 % from 654 to 562.[7]

Hospital admissions are also falling. Inpatient discharges per 100,000 population declined from a peak of 16,802 people in 1973 to 11,165 in 1995-96.[8] The average length of stay is dropping. In 1997, the average was 7.3 days, compared to 7.6 days in 1995 and 11.5 days in 1990.[9] The result has been a significant increase in the number of people requiring care and support in the home. In 1994/95, for example, the number of people 65 and over receiving home care (335,200) exceeded the number of seniors living in institutions (185,600).[10]

Other factors driving the explosive growth in home care are consumer demand and changing public attitudes. A March 1996 survey of 4,000 Canadians by Ekos Research Associates found that 60 % of respondents wanted to see funding in health care shifted to the patient's home, but doubted that governments would commit the required resources. The research also showed that the transition to home care must be planned, managed and part of a comprehensive system of health care.[11] In 1997, the National Forum on Health released its final report naming home care one of three areas for action towards a more integrated system and called for the creation of a national home care plan.[12]

[7] Health Canada, National Health Expenditures in Canada 1975-1994
[8] Statistics Canada, 1998
[9] Canadian Institute for Health Information.
[10] Wilkins, K., Park, E., Home Care in Canada Health Reports, Summer 1998, Vol. 10, No.1
[11] Ekos Research Associates Inc. "Rethinking Government". Presentation to the National Conference on Home Care. Halifax 1998.
[12] National Forum on Health. Canada in Action: Building on the Legacy. The Final Report of the National Forum on Health. Ministry of Public Works and Government Services. Ottawa 1997

b. The Economics of Home Care

In Canada, there has been a tendency to see home care as a panacea for rising health care costs; the premise is that home care will provide better integrated and more compassionate care and that it is a lower cost alternative to hospital/institutional care.

Proving the cost-effectiveness of acute care in the home has been difficult and family physicians remain concerned that it off-loads public sector costs onto patients -- in effect, robbing Peter to pay Paul. In the CFPC Home Care Survey, 76 % of family physicians indicated that their patients are having to pay out-of-pocket for some health care services.

The Home Care Evaluation and Research Centre at the University of Toronto and other initiatives in several Canadian provinces have begun the process of evaluating the resources and the cost of home care. Some studies have clearly identified the huge discrepancy in resources across the country and within each province. Such initiatives need to be encouraged and funded appropriately.

Cost effectiveness studies are crucial and considerable work remains to be done. The Health Transition Fund has funded a number of studies on the cost effectiveness of home care. These studies will evaluate the extent to which home care is a cost effective substitute for long-term care and acute care facilities and under what conditions it is cost effective. The results will be a major influence on policy decisions about the balance between hospital and home care services and ultimately define the demands on family physicians to provide care for their patients.

c. Defining Home Care

First introduced in six of ten provinces and in the Northwest Territories in the 1970s, the provinces today all have their own home care programs. The picture that emerges nationally is fragmented and confusing. Programs have evolved separately and are at different levels of development so there is no consistency from province to province, or from region to region within provincial borders.[13] It is a measure of the calibre of the staff involved in these programs that, in spite of these challenges, they often manage to deliver care of very high quality.

Home care is not covered by the Canada Health Act and as such has not been guided by a national set of defining principles or quality standards. There is no definition of medically necessary services nor is home care insured in the same way as hospital or physician services. In fact, a form of two-tier home care is evolving as most provinces have introduced user fees for homemaking and home support services.

This makes defining home care challenging. There are a number of accepted definitions (see appendix I) which position home care as an option to institutional care and a bridge between hospitals and long-term care facilities. Home care serves a number of functions for acute,

[13] Portrait of Canada: An Overview of Public Home Care Programs. Background Information Prepared for the National Conference on Home Care. Canadian Home care Association in collaboration with l'Association des CLSC et des CHSLD du Quebec, 1998.

continuing, preventive and palliative care; each of these functions necessitates a different provider mix, level of care, and need for medical management in the home as follows:

- ***Acute Care:*** Facilitates early discharge or prevents admission to hospital or other costly facilities.
- ***Continuing Care / Long Term Care:*** Allows individuals to remain in their current environment in the community as long as possible.
- ***Preventive Care:*** Prevents occurrence of injuries, illnesses, chronic conditions and their resulting disabilities.
- ***Palliative Care:*** Offers total care to a person and caregiver(s) to improve quality of life. [14]

For the most part, home care is defined as offering two types of programs -- health and home support services -- to an individual in their place of residence. Health services comprise medical, nursing and rehabilitation services ordered on the patient's behalf by a physician. They include a variety of services such as chemotherapy, infusion therapy, physiotherapy, occupational therapy, social work, counselling, etc. Home support services include meal preparation, housekeeping, transportation, personal care, and other activities related to the activities of daily living (ADL).

In much of the home care literature from the United States, home care is described in terms of a basic set of tenets: a patient-centred focus, collaborative team management, self-care, continuity, comprehensiveness of care, and patient empowerment. While self-care and patient empowerment are key tenets of home care, they assume an acceptable level of patient stability in the home. In other words, home care is not seen as a substitute for appropriate acute hospital care and while patient independence is the goal, it must be within established standards of safe medical practice.[15]

Levels of Care

Level I	the patient is his or her own case manager
Level II	the patient needs the assistance of family members or significant others for planning/coordinating care
Level III	if problems are too complex for the family the patient-family-professional team must coordinate care
Level IV	a multi-disciplinary professional team is needed to assist the patient and family with a designated case manager or team

This is particularly important because most home care tends to be intermittent care with health care professionals rarely spending more than an hour per visit and visiting only two or three times a week.[16] The American Medical Association has established guidelines that recognize levels of care in the coordination of care/case management. The levels of care enlist an increasing level of caregiver and provider dependency as the patient's ability to function independently declines.

[14] New Brunswick Extra Mural Program, March 1998

[15] American Medical Association, Home Care Advisory Panel. Guidelines for the Medical Management of the Home Care Patient. Archives of Family Medicine 2(2); 194 -206, 1993, Feb.

[16] American Medical Association. Ibid.

d. Increasing Acuity

The role of the family physician in home care will be dictated to a large extent by the function it will serve within the continuum of patient care. Until recently, home care served primarily as a long-term care substitute -- a "support for independent living" role -- enabling individuals to delay institutionalization for as long as possible. Increasingly, home care is being used as an acute care substitute affecting shifts in the mix of patients being treated and in the mix of services being used in the home.[17] "What was once a menu of non-medical, personal and social support services now encompasses a growing list of increasingly complex medical interventions."[18]

Percentage of acute, long-term and other clients, 1996-97

Province/ Territory	Acute Care Clients	Long-Term Care Clients	Others	Total
British Columbia	56.4	34.5	N/A	90.9
Alberta	41.0	52.0	7.0	100.0
Saskatchewan	22.9	70.5	6.6	100.0
Quebec	21.1	63.7	15.2	100.0
New Brunswick	53.3	46.6	N/A	99.9
PEI	20.0	75.0	5.0	100.0
Yukon Territory	16.6	73.7	9.6	99.9
Canada	33.0	58.0	8.7	99.7

Source: Health Canada, June 1999

With the shift to acute care, the complexity of care need in the home is increasing, and with it, the need for an enhanced level of medical management. In the 1998 CFPC National Home Care Survey, members reported steady and significant increases in patient demand including an increase in the number of active medical treatments required by their patients such as IVs, feeding tubes, special medications, etc. [19]

Concern was expressed about the impact of the shift to home care on the health of patients. A majority (75 %) said that their patients were going home from hospital sicker and often in need of more complex medical care than in the past.

Members were also concerned about the quality of care being delivered; identifying problems with patient access to care reporting delays and waiting lists for home care (66 %) and inadequacy of service either in duration (54 %), frequency (64 %) or level of care available (59 %).

[17] Roundtable on March 16, 1998 with Health Policy Forum Editor S. Usher in Ottawa, Health Policy Forum, Vol.1, no 1. Montreal, QC, 1998
[18] Vital Signs, CFP, Vol. 44, Oct. 1998, p.2332.
[19] Survey of Family Physicians On Home Care Services. College of Family Physicians of Canada; Mississauga, ON., 1998.

Practical problems to physician involvement such as time constraints and remuneration were identified, yet 78 % indicated that they had increased their advocacy efforts on behalf of their patients to gain necessary home care services.

Perhaps the most significant finding of the survey was the reported isolation of family physicians from the home care process. Sixty per cent said that they are not informed when their patients are referred into home care and 49 % said that they are not consulted on their patients' care plans. Ninety-six per cent of those surveyed indicated that they would like to see a formal mechanism requiring hospitals and other providers to involve family physicians in the home care process reaffirming their overwhelming commitment to their role as patient advocates and continuity to care.

4. Service Delivery Models

Work on integrated delivery models in Canada is a work in progress. There are good examples of integration of services -- hospital, home care and medical -- across the country, but silo organization and silo thinking predominates in many jurisdictions making efforts to integrate services along the continuum of patient need difficult.

From the perspective of family practice, what is most notable is the separation or isolation of primary care from the hospital and home care sectors. As a result the family physician is rarely a member of the home care team. Physician non-involvement in home care is largely a systemic issue related to a number of factors including: the conceptual design of home care systems, competition with surgeons and specialists, and a failure to communicate.

a. Conceptual Design Of Home Care Systems

The Alberta Medical Association notes that home care programs are not medical models, but were designed originally as social models of care which downplay the input of medical professionals and the acute medical needs of the patient. "It is not uncommon for physicians to become involved only when a patient has been assessed by the home care assessor as requiring placement."[20] A telephone survey of family doctors conducted in 1999 confirmed that in many jurisdictions, physician involvement in home care is still an add-on when necessity dictates rather than an integrated component of the home care delivery system. [21]

[20] Alberta Medical Association, Ibid.
[21] CFPC Telephone Survey, Ibid.

Physicians often work as solo practitioners or in small groups, a factor that prevents easy integration. McWhinney[22] contends that the lack of organization of medical services in a cohesive structure outside of the hospital is a major obstacle to physician involvement. He adds that family practice needs some form of institutional structure to link community-based physicians with home care and hospital services.

b. Competition With Specialists And Surgeons

While considerable more research needs to be undertaken, it would appear that family physicians in some jurisdictions are competing with hospital-based physicians, usually specialists and surgeons, over the care of patients in home care. This is more of an urban issue where many physicians do not have hospital privileges and where hospital management systems have been put in place to promote early discharge of patients from hospital. In Newfoundland, for example, surgeons are responsible for post operative care in the home for 42 days following hospital discharge even though they do not make house calls. [23]

c. Lack Of Communication And Mechanisms

The lack of communication between hospitals, home care programs and family doctors is a significant barrier to physician involvement in home care as it often means that family doctors are left out of the process and are not notified when their patients are discharged from hospital or admitted into home care.

The physicians recommended a number of mechanisms and processes to facilitate their involvement and suggested that more attention be paid to the development of appropriate mechanisms such as the following:

- ✓ consistent and formalized discharge, referral, and admission processes
- ✓ automatic notification of patient discharge from hospital by phone, fax, letter or a standard form
- ✓ ongoing progress reports
- ✓ a monthly list of patient admissions to home care
- ✓ regulations that will not allow patient admission to home care unless the family doctor is notified
- ✓ providing the patient with an interim discharge summary to take to their family doctor

[22] McWhinney IR. Working Paper Series. Physician Services In The Home: Planning For The Integrated Home Care Of Acute And Complex Illness. Paper 95-1. London, ON: Centre for Studies in Family Medicine, 1995

[23] CFPC Telephone Survey. Ibid.

- ✓ a province-wide home care medical director to promote a medical perspective as well as continuous quality improvement with the development of practice protocols
- ✓ joint hospital-home care governance to bring all the parties together under one umbrella
- ✓ permanent home care coordinator(s) in the hospital setting[24]

5. Models of Care

More organized models of care are essential for the treatment of patients with more acute and complex conditions in the home setting. They are called acute care substitution models and are patient-centred, collaborative models that rely on a team approach to manage care and integrate medical, home care and hospital services.

a. Usual Model of Care

The usual model for medical management of the home care patient, however, is the family physician "supervising from afar" with the ongoing monitoring responsibility in the home delegated by the physician to the registered nurse.[25] In this model, the nurse becomes the liaison, team leader and coordinator in addition to performing regular nursing activities. Key to the success of this model is communication with the family physician and the use of mechanisms such as formalized discharge, referral and admission processes as well as the care plan which outlines the plan of treatment and expected outcomes.

b. Diversion Programs

These are home care programs designed to prevent avoidable hospital admission and readmission through crisis intervention and by monitoring early patient discharge. They involve integrated teams of professionals from different disciplines working out of health units or hospitals. Examples include the Quick Response Programs in Victoria B.C. and Halifax N.S. and consulting palliative care teams such as the one in London, Ont.

In this model, family physicians are always informed when their patients are referred into care. In fact, it appears to be a requirement that a designated family physician must accept medical responsibility for the patient or the patient is not admitted into home care. Other requirements include:

- medical stability compatible with treatment at home

[24] CFPC Telephone survey. Ibid.
[25] American Medical Association. Home Care Advisory Panel. Ibid.

- adequate resources for treatment at home

- a safe environment for the patient and the professional caregiver[26]

The consulting team for palliative care appears to be a variation of the quick response model. This is a hospital-based specialized team of experts used to provide care in the home to palliative patients. It builds on the existing patient-physician relationship by providing community physicians, nurses and family caregivers important back-up support, advice and on-call capability. It functions as a consulting service, but can also take over total care at the family physician's request.

c. The Hospital in the Home

The idea of the hospital in the home originated in New Zealand in the 1960s. Essentially, there are two versions of this model; hospital-based and community-based. These models go by a number of different names usually using the word hospital since those who receive care would traditionally have received it in a hospital setting.

Hospital-based models are outreach initiatives of acute care hospitals where the hospital runs its own home care agency as a department of the hospital. The obvious advantage of this type of model is the integration of hospital and home care services which enhances discharge planning, continuity of patient records, and the availability of hospital staff for care. However, linkages with community-based physicians who had previously had long-term relationships with these patients are unclear.

Community-based models provide hospital-at-home services through a series of partnerships and a collaborative team effort. Patients in this model are admitted, treated, and discharged by their own family doctor who becomes the attending physician.

Patients can either be admitted from the hospital, or directly from the community without going into hospital. Physicians who wish to use hospital-in-the-home services or resources must apply for privileges. Admissions are made from the community by physicians to a unit coordinator by telephone or from the hospital by a liaison nurse and must be formalized by the physician completing and mailing in an admission form.

Staff monitoring the patient in the home keep physicians informed of the patients' progress through a number of mechanisms, including team communication forms, telephone calls and occasional conferences. Joint house calls are encouraged if a home visit is deemed necessary. In Canada, the best example of the hospital in home model is the New Brunswick Extra-Mural Program (formerly Hospital). Experiments of this type are being conducted in several areas of the country and deserve close monitoring.

[26] Medical News. Medical Information for Members of the Medical Society of Nova Scotia. Vol. III - No. III. Feb. 1998.

6. Issues

The following highlights a few of the issues related to physician involvement in home care. Some of the issues represent identified barriers to practice; others raise questions about physician attitudes and the practicalities of home care practice.

a. Time Constraints and Competing Priorities

For overworked family physicians, home care represents yet another demand on their already limited time availability. According to the CFPC Janus Survey, physicians work an average of 50.3 hours a week, and undertake a further 26 hours a week in on-call activities. The addition of acutely-ill home care patients can add as much as 2.5 hours per week per patient to the physician's workload as complex acute care cases in the home are estimated to require as much as 10 hours per month per case of physician time.[27]

Time pressure was also flagged in the 1998 CFPC Home Care Survey by 57 % of respondents as the most significant barrier to carrying out clinical and administrative activities related to home care.

Complicating physician participation is the unpredictability of home care that makes balancing practice in an ambulatory setting with office practice difficult. "When home care visits can be planned, they work out well. Where it breaks down is when it's unplanned, because the doctor is busy with a clinic full of patients and all of a sudden a palliative care patient needs immediate help."[28]

The challenge for many physicians is how to balance the competing priorities of office, hospital and home care. The collaborative nature of home care offers time-pressured physicians a solution. For many, the introduction of organized home care delivery has relieved a considerable burden from the shoulders of the family physician who in the past had to do everything when arranging home care for their patients including the administrative coordination. Now family doctors can focus on the medical aspects of care and use the organized home care system in their area to monitor the patient in the home and assume much of the labour intensive coordination and administrative aspects of care.[29]

Effective management of home care also calls for physicians to look at the organization of their own practices. Group practice can help physicians tackle many of the problems involved with balancing patient priorities. Working with a group/team of physicians, the family physician can share patient care by deputizing known professionals with access to patient charts and records to ensure 24-hour coverage, rapid response and information continuity.

[27] 1997 National Family Physician Survey; The Janus Project: Family Physicians Meeting the Needs of Tomorrow's Society.
[28] Rothkopf, M.M. Physicians Role in Home Care. Doctoring in a Hospital without Walls, 1997.
[29] CFPC Telephone Survey. Ibid.

The Janus Survey reported that 44.6 % of physicians already work in a group practice with the average size of practice 5.4 family doctors. Family Practice Networks (FPN) as described in the CFPC position paper *Primary Care and Family Medicine in Canada: A Prescription for Renewal* [30] will be best equipped to take on new challenges, including for family doctors who prefer to work in solo practice on a daily basis.

b. Remuneration

The economics of modern medical practice present a formidable barrier to physician participation in home care that is often associated with financial loss because of how it is remunerated. In many provinces, family physicians are only remunerated for house calls. All too often, they are not remunerated for most home care services including telephone calls, case conferences, consultations and administrative paper work. Recently, some provinces have begun to recognize this problem and provided additional remuneration for some of these services or piloted alternative modes of remuneration for family doctors involved in home care. Such initiatives should be encouraged and monitored.

In the 1998 CFPC Home Care Survey, 45 % of family doctors identified compensation as a factor limiting their involvement in clinical (45 %) and administrative (47 %) services related to carrying out home care.

U.S. research also indicates strong physician dissatisfaction with reimbursement; 88 % of physicians surveyed were dissatisfied with the remuneration and 50 % said that they would make more home visits if reimbursement improved. Reimbursement, however, would have to double in order to make home visits financially feasible.[31]

Remuneration is one of the core problems with integrating the physician into home care. Since physicians are not paid for their different responsibilities in home care, there is a perception among physicians that government does not place value on or understand the importance of the family physician in home care. The lack of remuneration in this context is seen as a deliberate disincentive to discourage physicians from participating as the remuneration system clearly favours office practice.[32]

[30] The College of Family Physicians of Canada. Primary Care and Family Medicine in Canada: A Prescription for Renewal. Mississauga, October 2000.
[31] Keenan, J.M. National Survey of Home Visits Practice and Attitudes of Family Physicians and Internists. 1992
[32] CFPC Telephone Survey. Ibid.

c. Physician Concern about Standards of Care

For physicians trained in evidence-based medicine, the lack of patient outcome research in home care is an important issue undermining physician confidence in the quality of home care. To provide beneficial care in any setting along the continuum of care, doctors need information about outcomes so that they can draw on best practices and evaluate patient progress relative to normative data. Even though home care programs have been operational for over 20 years, there has been little data collection or analysis of outcomes or even how service need is determined.

Physician confidence in the quality of home care overall is not strong. There is concern that availability of home care services is determined by supply rather than patient need and that care is being rationed. A case in point is the user fees for home support services present in many provincial home care programs.

In the CFPC home care survey, reservations were expressed about the availability and adequacy of non-physician services in the home to meet their patients' needs; 66 % reported delays or waiting lists for services and many felt that services were being rationed in terms of duration (54 %), frequency (64 %) and level of care (59 %).

Some physicians see the home as a place where they cannot provide the best care because they are not backed up by the office supports of staff and the latest diagnostic technology. Further the bulk of home care is provided to the over 65 population where co-morbidity is common and more complex clinical care is required.

In the 1990 U.S. physician survey by Keenan and Boling into physician home visiting practices, 76 % of family physicians who did not make house calls expressed concern about their ability to provide "the usual level of quality care" and 40 % of those who did make house calls saw drawbacks to providing care in the home.[33]

Strong evidence suggests that physician concerns about quality of acute patient care in the home have some validity. The Hospital to Home Study conducted in 1994 showed that four of nine patients followed were re-admitted with medical complications. Some of the problems identified were fragmentation of services, family doctors not informed of discharge, and limited hours for accessing home care. Further studies as noted by McWhinney illustrate that re-admissions are common, typically occur within 30 days of discharge, and are usually for problems that arose during the previous hospitalization (but that they are preventable and can be reduced with in-home monitoring). [34]

[33] Keenan and Boling. Ibid.
[34] McWhinney. Ibid.

d. Physician Attitudes Towards House Calls

It is generally agreed that house call frequency has declined significantly over the past four decades. Prior to World War II, house calls were part of the main stream of medical practice. However, in the 1950s, 60s, and 70s, they began to decline as medical treatments became more intrusive and technologically tied to the hospital or the office. [35]

PHYSICIANS MAKING HOUSE CALLS	
Overall	56%
Solo practice	62%
Group practice	64%
Rural family physicians	73%
Small towns	62%
Inner city	48%
Urban	51%
Suburban	60%

Source: Janus Survey (1998)

While caring for the patient in the home is generally seen as uneconomic and time-consuming, many physicians still consider the house call to be an important component of medical practice. In the Janus Survey, 60 % of family physicians reported that they did house calls. For many physicians, house calls appear to be a planned activity scheduled weekly in addition to emergency visits to the home with 2.5 hours the average amount of time per week spent on this type of activity.[36]

U.S. research shows similar findings; 65 % of family physicians reported in the 1992 National Survey of Home Visiting Practices that they make house calls (67 % rural, 45 % urban), but it appears to be more of a discretionary activity. The U.S. survey also shows that 75 % of physicians consider house calls to be important for selected patients. Physicians not making house calls were most likely to report being too busy and more likely to regard calls as unnecessary if a visiting nurse of other provider is readily available.

It is interesting to note, however, that in this study, 21.2 home visits per year by a physician was deemed to be a minimum criteria to judge whether home visits comprised a substantial proportion of overall practice.[37]

Much has been written about physician attitudes towards house calls and the reasons for its decline in practice. There are many reasons and complicating factors such as safety and increased personal risk. The assessment of caregiver risk should be a key part of the home care environmental assessment process during which potential risks and dangers should be assessed and intervention strategies identified.

Physician willingness or lack of willingness to make home visits could prove a barrier to providing complex acute care and palliative care in the home. For example, in 1987, the Metropolitan Toronto

[35] Hepburn, K.W., Keenan J.M. The Role Of The Family Physician In Home Care. Harris M.D. Handbook Of The Home Health Care Administration, 2nd Edition, Gaitersberg.
[36] CFPC Telephone Survey. Ibid.
[37] Keenan and Boling. Ibid.

Home Care Program identified difficulties in finding family physicians willing to make home visits as one of the problems with providing palliative care in the home.[38]

Physician attitudes toward home visits, however, are not synonymous with their attitudes toward home care and continuity of patient care. In the recent telephone survey, family physicians went to great lengths to distinguish between the two. House calls are seen as only an episodic intervention while home care is seen as an extension of traditional practice.[39]

PHYSICIAN ATTITUDES TO HOUSE CALLS

PHYSICIAN ATTITUDE	MAKING HOUSE CALLS	NOT MAKING HOUSE CALLS
House calls are important for selected patients	93%	69%
Too busy with office or hospital practice to make house calls	47%	80%
With readily available visiting RNs and RNAs most home visits by MD are unnecessary	48%	70%

Source: 1992 U.S. National Survey of Home Visiting Practices

Physicians continue to express their commitment to continuity of care. In the 1998 CFPC Home Care Survey, physicians overwhelmingly expressed their interest in following their patient from hospital discharge into home care; 96 % indicated that they would like to see a formal mechanism requiring hospitals and other providers to inform them when their patient is referred to home care.

7. The Role of the Family Physician in Home Care

In Canada, integration of the family physician in home care has clearly not been a systemic priority and the physician's role in home care is largely defined by practical necessity. With notable exceptions such as the New Brunswick Extra-Mural Program, participation is ad hoc, reactive and motivated by physician commitment to ensure that patients receive appropriate care across the continuum of care settings.

The literature on the physician role in home care outlines two extremes of physician involvement. At one extreme is total involvement where home care evolves into a sub-specialty of family medicine with the family physician assuming the role of a home care specialist. At the other extreme is physician non-involvement where the nurse practitioner working with a hospital-based specialist replaces the family physician in the home care setting. For physicians committed to continuity of care, neither of these present viable options.

[38] Coombs M.E. Planning the Possibilities: Community-Based Palliative Care In Metropolitan Toronto. Journal of Palliative Care; 2/2 pgs 35-40, 1987

[39] CFPC Telephone Survey. Ibid.

Home care is shared care and the integration of physician services seems to work best in collaborative team arrangements such as consultative teams or in total care models such as the hospital-in-the-home. In the ideal, medical care in the home is a collaborative effort with caregiving responsibilities shared by an interdisciplinary team in which the patient and family play an important role. The team may include hospital discharge planners, community/case management agencies, home health staff, homemakers and physicians. As part of the interdisciplinary team, the physician would have defined responsibilities for planning and monitoring care, with the majority of care provided by others. The physician would rely on other members of the team to stay informed about the effectiveness of the treatment plan and changes in the patient's condition that might necessitate modifications to the care plan or a home visit.

There are divergent views on physician attitudes toward home care. In a recent survey, family doctors were very supportive of the role of the family physician in home care strongly endorsing it as an extension of the traditional role of the family physician.[40] The 1998 CFPC National Survey on Home Care indicated that family physicians have already assumed multiple roles.

According to the survey, physicians feel that they can play an important role in patient advocacy, participate on multidisciplinary teams with other health care providers, supervise medical care and personally deliver some medical services in the home for their patients.[41] On the other hand, Hepburn and Keenan in the "Role of the Family Physician in Home Care" suggest that, at least in the United States, "a whole generation of family physicians have been trained whose knowledge, skills and attitudes about home care are out of sync" and they rarely have exposure to home care practice.[42]

The role of the family physician in home care is often confused with house calls. Physicians make a clear distinction between the two with home care defined as diagnosis, treatment, and ongoing monitoring of the patient in the home. House calls are seen as a subset of home care -- as an episodic care intervention or aid to practice.[43]

The American Medical Association in their "Guidelines for the Medical Management of the Home Care Patients" has defined the role of the family physician in terms of functional tasks. These relate to the development and oversight of a treatment plan which may be carried out by the patient alone or with the support of family and professional caregivers and include:[44]

- ✓ management of medical problems
- ✓ identification of home-care needs of the patient

[40] CFPC Telephone Survey. Ibid.
[41] Gutkin, C. Vital Signs. Ibid.
[42] Hepburn and Keenan. Ibid.
[43] CFPC Telephone Survey. Ibid.
[44] Guidelines for the Medical Management of the Home Care Patient. American Home Care Advisory Panel, Arch Fam Med. 1993; 2:194-206

- ✓ establishment/approval of a plan of treatment with identification of both short- and long-term goals
- ✓ evaluation of new, acute or emergent medical problems based on information supplied by other team members
- ✓ provision for continuity of care to and from all settings (institution, home and community)
- ✓ communication with the patient and other team members
- ✓ participation, as needed, in home-care/family conferences
- ✓ reassessments of care plan and outcomes of care
- ✓ evaluation of quality of care
- ✓ documentation in appropriate medical records; and
- ✓ provision of 24-hour on-call coverage by a physician

When asked to describe their role in home care, family physicians show a surprising degree of consensus. Home care is seen as an extension of their traditional role; it continues to evolve to include the physician as part of an integrated team of providers. On this team, the physician's responsibility is focused on medical care. The historic role of "gatekeeper" to all community-based services has become an outdated concept displaced by a more collaborative role. In this role, the family doctor is the coordinator of medical care, director of medical care or medical consultant.

Medical consultant is seen by many as the best descriptor of the physician role in home care. It is a role similar to the relationship that currently exists between the specialist consultant and the family doctor. For others who want a more hands-on, clinical role providing care in the home, medical consultant is too limiting. This was seen to be important as many felt that the skills of nurses and family physicians are complementary and both are necessary to provide medical care or treatments.[45]

8. Conclusion

As home care continues to take on increasingly complex medical management, the pressure for physician involvement will continue to grow to meet the needs of patients. Clearly, it is in the best interest of patients that physicians become more proactive and begin to advocate with governments

[45] CFPC Telephone Survey. Ibid.

and home care programs for family physician involvement in home care. The goal must be to ensure that patients do not fall through the gaps in the system as they move from hospital to the home. Family physicians want to avoid the situation in which the first notification of a patient admission into home care is a distress call to visit the patient in the home because something is wrong.

Barriers to physician involvement such as remuneration and administrative workload need to be addressed. It is both an issue of fairness and common sense to suggest that all partners in home care be paid appropriately for managing patients in the home setting.

The most significant barrier, however, to physician participation has been the disorganization of the systems across Canada that have often failed to integrate the community-based family physician. Family physicians are not informed when their patients are referred into home care and they are often not consulted on their patient's care plans. Some excellent examples of home care programs in Canada demonstrate that involving family physicians from the onset is a key to the success of a whole program.

Original research needs to be undertaken into the types of mechanisms that would most effectively integrate the family physician with the care team. It was almost unanimous among respondents to the CFPC Home Care Survey that they would like to see a formal mechanism requiring hospitals and other health care professionals to notify a patient's family physician when home care is initiated.

The challenges posed by home care to physician practice patterns underscore the need for physicians committed to home care practice to rethink how their practice is organized and to move to more collaborative management structures such as family practice networks (FPN). By working together in groups, family physicians can more readily meet the needs of home care patients providing 24-hour, 7-day a week coverage, deputizing known professionals, providing continuous access to patient records and managing time demands.

Physicians will also have to begin to examine their attitudes toward home care if they are to meet future challenges. It has been suggested that for family physicians, home care could represent an exciting new clinical frontier, but can family medicine meet the challenge? As an accrediting body, the CFPC has a key role to play shaping the attitudes of young physicians by ensuring that home care is identified as a training priority and that family medicine residency programs promote physician involvement in care in the home. Whether or not home care is a new frontier, if family physicians are committed to meeting the needs of their patients and to fulfilling the principles of family medicine, this is a challenge that will be met.

APPENDIX 1

DEFINITIONS OF HOME CARE

The Canadian Home Care Association

The Canadian Home Care Association is the largest provider association in Canada and defines home care in terms of services and providers:

"Required health care services as essential health and/or personal support services, delivered in one's place of residence to a person/client, who, without such services, would require placement in a costlier nursing home or hospital setting or would not be able to remain safely at home.

These services may include one or more of the following: nursing, physiotherapy, occupational therapy, social work, nutritional and dietetic, speech therapy, respiratory therapy, home support and case management services."

Health Canada

"Home care describes a range of services which enable people, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying or substituting for long-term care or acute care alternatives. Home care may be delivered under numerous organizational structures and funding and payment mechanisms. It may address needs specifically associated with a medical diagnosis (e.g. diabetes therapy) and/or may provide support for daily living activities (e.g bathing, cleaning, food preparation). Home care may range from services for people with minor health problems and disabilities, to those who are acutely ill and require intensive and sophisticated services and equipment. There are no upper or lower limits on the age at which home care may be required, although, as in other segments of the health system, utilization tends to increase with age.

Home care operates within the broader context of efforts to improve the health and well-being of Canadians. Evidence suggests that when home care is provided as part of a system of integrated services delivery, combined with case management and entry through a single assessment point, it may contribute to appropriate and cost-effective care."

New Brunswick

"Home health care includes services provided to clients of all ages within the context of their daily lives (e.g. home, work, school/other community settings) for the purpose of promoting, maintaining or restoring health. Services assist clients to achieve, maintain health, well-being and personal independence through the process of assessment, case coordination and/or intervention. In addition, services are provided to individuals with progressive, life threatening illness to improve quality of life and provide relief from pain and other distressing symptoms. A variety of providers and the client function as a team and use innovative way to provide quality home health care."

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