After collapsing at home, Mr X, a 75-year-old male, was rushed to accident and emergency, where he was diagnosed with congestive heart failure. He remained in hospital for five days and was commenced on triple therapy. On discharge, a follow-up appointment with his general practitioner (GP) was scheduled to monitor his condition. However, Mr X did not visit his GP and was re-admitted to the hospital three weeks later. When questioned why he did not attend his GP’s surgery, Mr X simply said: “I could not get out of bed”.

On a good day, Mr X has difficulty dressing, getting to the toilet on time, and negotiating the staircase in his home. During an exacerbation, he is fatigued and spends most of his time in bed. Leaving the house is an endeavour and usually requires the assistance of friends or family. Given his circumstances, the physicians considered long-term residential care or physician house calls as a means of delivering care to Mr X.

Although the case of Mr X is fictional, it is not unique. His condition mirrors the circumstances of many elderly citizens in Western society. Many elderly people suffer from debilitating conditions that can negatively impact activities of daily living or render the individual housebound. In 2007, approximately 42.1% and 45.2% of Irish males and females over the age of 65, respectively, were limited in activity due to health problems. Health morbidity limits the elderly person’s participation in social engagements and hinders their ability to reach medical offices regularly, leading to inadequate access to care and a lack of continuity of care. As the age of the population advances, the number of frail, chronically ill patients will increase. These patients may have difficulty attending their GP’s surgery due to distance, physical limitations or lack of social support. Such barriers can lead to the inadequate management of chronic illnesses and an increased rate of hospitalisation. Moreover, acute exacerbations require the use of costly healthcare resources. Effective healthcare management of the ageing Irish population is required to address specific needs of elderly patients, and to ensure that they do not get lost in the system.

One approach to ensure continuity of care for the elderly is the implementation of long-term residential facilities. However, this solution is costly and may compromise the individual’s independence. Electronic monitoring of patients in their home has also been proposed, but obstacles include patient privacy, technological malfunctioning and the potential for information overload. A modality of care that strives to eliminate this gap in the system without impinging on patient privacy or autonomy is the physician house call. Physician house calls are unique; barriers in the access to care are eliminated, and the GP can directly observe the patient in the context of his/her home environment, which is a particularly helpful feature in the care of older patients. This article considers the role of physician house calls in the context of the Irish healthcare system.

Physician house calls in Ireland

“The fundamental barrier to access results in fragmented, unco-ordinated care that can be detrimental to these frail, vulnerable older adults and result in high-cost acute care”. In recent years, physician house calls have become more common in the management of older adults in Western society who are unable to access care. In Ireland, physician house calls are provided by GPs and have long played a role in
medical care. House calls provide a ‘humanistic’ approach to medicine that allows the physician to observe the patient in the context of their physical and social environment. They are a unique modality of care that requires critical thinking, quick decision making, and risk assessment. As in general practice, there is a strong reliance by the physician on history taking, environmental cues and clinical acumen during a house call. The ability of the physician to extract important information will affect symptom management as well as the urgency of the next visit. For example, it may be prudent for the physician to take into consideration bedside cues, as well as additional environmental details such as looking into the fridge to gain awareness about their diet and to see if they are being properly nourished. The objective of the house call is based on the nature of the patient’s situation, but can be grouped into three categories: geriatric, emergency and palliative preventive. Geriatric visits primarily focus on prevention, monitoring the patient and risk factor modulation. The objective of emergency visits is to determine if hospital admission is necessary after or during an acute event. Lastly, palliative visits are centred on managing pain, emotional problems and crisis situations in palliative patients. Examples of common crises include acute dyspnœoa, bleeding and persistent vomiting.

When a GP visits an elderly patient at home, the physician assesses the patient’s health, revises treatment plans and makes recommendations and referrals, just as the GP would in his/her surgery. Dr Niall Maguire, a general practitioner in Co. Meath, views house calls “just like any other consultation. I use the SOAP approach to care, but have the additional value of assessing social factors, nutrition, warmth, hygiene, carer stress, coping, and compliance with medication”. During house calls, GPs may provide therapeutic, preventive, palliative and/or rehabilitative care. Similar to any other GP appointment, the patient’s physical and mental states are assessed using directed questions and examination. However, the GP is also able to liaise with the primary caregiver, who may provide insight into the patient’s general wellbeing and habits. Depending on the severity of the condition and the patient’s health, the GP may deem it necessary to monitor the patient with increasing frequency.

Physician house calls may also be offered to patients with acute illness, such as those recovering from falls. Chronic patients commonly suffer from congestive heart failure, hypertension, chronic obstructive pulmonary disease, dementia, urinary incontinence, diabetes, depression, osteoarthritis or terminal illness, and may require hospitalisation for acute exacerbations of illness. Physicians may offer house calls in such cases to manage the patient’s symptoms without adding the physical stress of relocation.

An important element of many home care programmes is the provision of various health services through a referral process to ensure proper medical and social support. In Ireland, house calls are managed solely by the GP, who arranges referrals only when deemed appropriate. Other models of home care take a more team-based approach. An example of a successful multidisciplinary home care programme is ‘House Calls’ in Toronto, Canada, a not-for-profit organisation funded by the Canadian Government. The House Calls team consists of two physicians, a nurse practitioner, an occupational therapist (OT), a social worker, a programme manager and an intake worker. The House Calls team collectively decides whether the applicant requires their services. The nurse practitioner or the GP is first to assess the patient, followed by the social worker and OT, who address a variety of issues. The social worker may organise a meal delivery service for the patient or address family issues that the patient may have, while the OT would ensure that lifestyle modifications are made to make daily living easier for the patient. For example, the OT may oversee the installation of a ramp in the home of a wheelchair-bound patient. Follow-up appointments are scheduled by all members individually, but group meetings with several team members may be organised when appropriate. Such a multidisciplinary approach to home care ensures that all the patient’s needs are addressed from a medical and social standpoint.

Advantages of physician house calls
Physician house calls present many advantages to the chronically ill. With this modality of care, individuals who are frail, limited in mobility and/or cognitively impaired are not forgotten or lost in the system. House calls allow the GP to better manage the patient and reduce the incidence of hospitalisation in this patient group. and continuous care can reduce disability and functional decline, all of which reduce healthcare costs.

One study in Denmark found that post-discharge physician follow-up at home resulted in a 23% relative re-admission risk reduction within six months for elderly patients with a high re-admission risk. Furthermore, Ramos et al. found that house visits reduce the rate of hospitalisation and institutionalisation. Although more involved economic evaluation is required, it is believed that house calls can eliminate unnecessary medical expenditures.

In addition, there are psychosocial advantages to the house call. Physician house calls allow the patient to remain in the comfort of his/her own home while receiving treatment, and encourage positive ageing through the preservation of daily routines and social supports. Furthermore, patients with significant morbidity may find that the house call allows them to continue to exercise their autonomy, when alternative care options include long-term residential care facilities.

House calls also positively impact the patient-physician relationship. The physician is more likely to engage in thorough patient education, teaching the individual and their caregivers about self-care and the importance of compliance to medication regimens. Moreover, house calls invite the GP into the patient’s home, and the physician is given important insight into the patient’s personal circumstances. Facades that may be maintained at the GP’s surgery may be more difficult to conceal in the patient’s home.

Other previously demonstrated advantages of the house call include improvements in the patient’s physical function, prevention of disability and higher patient satisfaction. Furthermore, physicians are also able to acquire collateral histories from family members, friends and/or caregivers to obtain a more complete picture of the patient’s lifestyle. Interdisciplinary approaches to care may also be accommodated in the home setting, which reduces re-admission rates and healthcare costs, and increases patient satisfaction. Ultimately, home visits facilitate a holistic, patient-centred approach to care.
Barriers to house calls

As Western society ages, it is important to establish effective modalities to cater to the population's healthcare needs. Since 2002, the number of residents over 65 years in Ireland has increased by 8%, and this demographic will rise from 11% to 15% over the next ten years. Although positive ageing at home strategies exist, resources are currently being directed towards nursing home care. While only 7% of individuals older than 64 years reside in nursing homes, they consume approximately 60% of the budget for the care of the elderly. The allocation of funds is not the only financial issue that hinders the provision of physician house call services. Low physician compensation rates for home visits may discourage general practitioners from offering house call services or may limit the number of home visits provided. On average, a GP is provided with an annual capitated rate of €90-120 per senior citizen; this rate is intended to cover an unrestricted number of physician house calls during that year. If the patient is to be seen at home, the physician must in exchange forego seeing multiple patients in his/her surgery; this results in loss of compensation for the physician, and evokes arguments of judicious allocation of resources from a population perspective. Other extra costs for house calls include transportation, and parking fees are also imposed on the GP. Currently, there are no Irish guidelines that set out indications for house calls, and they are provided at the GP’s discretion. In his practice, Dr Niall Maguire selects patients for house calls based on their functional status and a needs-based negotiation with the patient or relatives of the patient. However, Dr Maguire sometimes volunteers his services in the form of a house call if it best suits the situation, especially when the patient is frail, quite elderly or disabled. Dr Maguire finds home visits to be “very rewarding clinically, but there is a fine line between being good and feeling overburdened.”

Conclusion

Physician house calls are a unique modality of care directed towards the frail and chronically ill elderly who are otherwise unable to access care. Home visits are a re-emerging form of healthcare delivery with the aim to minimise re-hospitalisations and support positive ageing at home strategies. The United Kingdom, Denmark and Australia have established national policies, while various localities in the United States, Canada and Europe have piloted preventive house calls projects, some of which have shown a reduction in unnecessary emergency room visits and hospitalisations. Inevitably, as individuals age, disability and morbidity increases. It is becoming increasingly important to find cost-effective solutions to quality care as the costs of healthcare continue to rise. Although house calls offer many benefits and may be rewarding experiences for both the physician and patient, low financial compensation and the time-consuming nature of the visit may deter physicians from providing this type of care in Ireland. Without the provision of house calls, an unmet need for geriatric care evolves. Further economic evaluation is required to determine if house calls are a financially sound solution. In considering house calls, a multidisciplinary approach to physician home visits in Ireland should also be explored, as this modality may deliver more comprehensive and efficient care.

References