The Home Visit: An Important Assessment Tool for Understanding the Family in Health Care

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ABSTRACT

This article presents descriptive data on the type of information gained through direct family observation from a total of 31 home visits made by family medicine residents. Of special note is the degree to which at least rudimentary concepts of family systems thinking found their way into the treatment plans developed for patients by residents at the conclusion of the home visit.

I. INTRODUCTION

A well-documented research and clinical literature exists establishing an important relationship between illness incidence, prognosis, and outcome, and various dimensions of family dynamics and function[1]. In fact, the efficacy of medical intervention is often influenced by the complex context of variables which comprise the patient's home situation. However, many physicians do not have an opportunity to adequately gather information about family structure and functioning within the confines of a traditional office visit, where the entire family is seldom seen.

The home visit presents itself as a potentially viable alternative for family assessment, and most educators in primary care medicine agree on the value of home visits for both physicians and patients[2]. Yet home visits are difficult to implement in the already overcrowded schedules of most physicians. And their value, in terms of providing worthwhile information to the physician about patient and family, while undisputed, has not been sufficiently documented.[3,4]

The home visit provides an opportunity for the physician to perform a psychosocial assessment of the family unit[5]. Most primary care physicians learn about the importance of the family in understanding a disease process, but do not always have the opportunity to use this understanding in an applied setting. With this in mind, this study addresses a broad but important question: What are physicians-in-training in a family practice residency program able to learn about their patient's family during a home visit.

II. METHOD

During a one-year period, 31 home visit reports (or 86.0% of the total possible) were completed by residents in their second and third years of a family practice residency program. Prior to the home visit, all residents completed a seminar focusing on expectations and requirements of the home visit.[6] The seminar included discussion of resident resistance and anxiety regarding home visits; family systems theory, and the impact of illness on the family; and observational and interview skills to assess psychosocial dimensions of the family. The seminar also identified the following categories as representing a range of situations in which the patient's health status could be significantly influenced by the family environment:

1) Preventive home visits (young mothers with their first babies);
2) Families with a family member identified as having problems (an elderly person making demands of family's resources - time, emotions, finances);
3) Patients with problems not well managed (the noncompliant patient and/or family);
4) Pre-terminal/terminal patient and their families;
5) Patients from other cultures; and
6) Patient whose problems are complex and confusing (those individuals whose problems or the manifestations of such problems prevent the resident from understanding the patient's issues or providing quality care for that person).

Residents completed a required report following the home visit. From this report, we were interested in determining the resident's ability to: 1) Understand the purpose of the visit, and the criteria used to select a particular family. 2) Identify family members and

their relationships to each other. 3) Characterize the financial/employment situation of he family. 4) Arrange/carry out a family conference with all members of the family, rather than with the patient only. 5) Describe the physical surroundings and environment of the patient and family. 6) Evaluate family interactions, relationships and roles. 7) Describe the impact of the current illness on the family unit. 8) Identify particular strengths and weaknesses in the family. 9) Incorporate information from the home visit into an ongoing treatment plan for the patient/family. 10) Include observations from the home visit on a family problem list.

A coding scheme for summarizing the data obtained from the home visit reports was developed by the first author. This coding scheme scored resident observations of the family system into specific categories such as family interactions, family relationships, family roles, and family strengths and weaknesses. Reports were scored Yes/No on dimensions of verbal and nonverbal communication within the family[7]; leadership style in family decision-making; traditional vs. egalitarian role patterns within the family[8]; structural family therapy concepts[9,10] of triangulation, enmeshment-disengagement, independence-dependence, the pivotal role of the marital dyad, and potentially pathological configurations of the parent-child relationship. A student on a research elective was trained in the use of the coding scheme and coded all 31 questionaries. Ten questionnaries were also selceted at random to be coded by the first author, with an overall reliability coefficient of .92.

III. RESULTS

PURPOSE OF VISIT: Ten residents simply expressed a general interest in evaluating the living conditions and observing the home situation of the patient. An additional 7 combined evaluation of the home situation with either a well-baby check or a prenatal

visit. Fourteen residents, in addition to a general desire to evaluate the home situation, had a special concern about their patient (e.g., alcoholism, teenage pregnancy, chronic health problem, etc.) (See figure 1).

WHY FAMILY SELECTED: The largest number of residents (7) selected the family because they were familiar with the patient and other family members. It appeared that these residents had already developed a relationship with their patients and wished to pursue it in greater depth. The next largest number of residents (6) chose either problem patients, or patients with a specific psychological/behavioral problem. Four residents chose multiple problem families, with a long list of both medical and psychological difficulties. Three residents each selected their family because a) the family constellation had changed, b) the patient had difficulty getting to the clinic, or e) the family needed emotional support. Two residents were concerned about the social isolation of their parents. No pre-terminal or terminal patients were selected for home visits (See figure 2).

DESCRIPTION OF FAMILIES: Thirty of the 31 families selected had Spanish surnames, and 11 of the interviewers were conducted in Spanish. The majority of families (12) selected were either young families with children under the age of 3 or young couples (often expecting their first child) who were still living with their family of origin. Six of the home visits were paid to single individuals. The remaining visits were paid to families with children in the age range 3-12 (6), families with adolescents (4), and middle-aged couples with an aged parent living at home (3). Four of the families selected were single parent families with the majority being two-parent families. A total of 36 women were included in the sample, with a mean age of 44.1 years (N=19).

Twenty households had children, with a mean age of 2.6 years.

In 21 cases (67.7% of the visits) all members of the family were present at the home visit. Where a family member was absent, in 4 cases this was a child, in 3 cases a male spouse and a child were missing.

CURRENT FAMILY HEALTH PROBLEMS: In six cases, residents listed no current health problems (these included prenatal visits, well-baby checks, and visits prompted by a primarily psycho-social concern). In 11 of the families, only the patient was identified as having a medical problem. In 8 cases, the patient plus 1 family member were identified as having a health problem, and in 6 situations, the patient and more than one family member were discovered to have health problems (See figure 3).

DESCRIPTION OF THE HOME; Most of the families had a low socioeconomic status. Twenty-one families lived in 1-2 bedroom apartments, while 10 had homes with 3 or more bedrooms. Twenty-five residents described these homes as neat and clean, with only one resident commenting on the cluttered, dirty appearance of the residence. Nine residents mentioned the furnishings of the home as being adequate, while three residents throught the furnishings were inadequate. Of the 8 residents who evaluated sleeping arrangements, 4 described situations in which all members of the family slept in the same room, while 4 commented that appropriate separation of the generations had been achieved in terms of sleeping arrangements. Six residents commented on the crowded nature of the accomodations.

EMPLOYMENT: Only 11 of the families had a least one employed member. Of these, 4 worked in either skilled or professional occupations, while the rest worked in unskilled positions/jobs. Those who were unemployed subsisted primarily on welfare, disability and social security.

OBSERVATIONS OF THE FAMILY SYSTEM: Since six patients were single and living alone, 25 actual family systems were visited (See figure 4).

The majority of family interactions commented upon (9) were described as "close, warm, supportive, loving". Five residents made observations regarding nonverbal interactions, and 7 residents described the quality of verbal communications. Only one resident observed any conflict in the family during the visit. Four of the family interactions were described primarily in terms of parental enmeshment/disengagement with children.

Relationships: Resident observations were coded as either vague (i.e., "close, supportive, loving") or referring specifically to one of the basic family system principles outlined in seminars. Twenty-one residents made observations on the specific nature of family systems, while only 4 used vague terms to describe relationships.

Roles: Eight residents commented on leadership style in the family system. Ten residents made observations regarding the traditional or egalitarian nature of family members' roles. The remaining 7 residents mentioned a variety of dimensions, including comments on stage of the life cycle[11], coping mechanisms, and isolation of family members.

Strengths and Weaknesses: The majority of residents (14) listed only strengths for their families. In terms of the nature of family strengths, 10 residents listed family cohesion; 6 mentioned a personal strength of the patient; 6 mentioned a good parent-child relationship; and 3 referred to the family's good support system (church, friends, extended family).

The weaknesses which residents observed were primarily poor marital relationship (5), poor parenting and poor parent/child relationship (5), and poor economic situation (2).

IMPACT OF ILLNESS ON FAMILY: As might be expected, the majority of residents (19) felt the patient's illness (or health status: i.e., pregnancy, psychosocial concerns) had had a negative impact on the family. Seven felt the illness had had a positive impact (usually in terms of the family's responding well to the stress), and 4 felt it had had both a positive and a negative impact.

INCORPORATION OF HOME VISIT INFORMATION INTO TREATMENT PLAN:

Comments on this question were evaluated on two dimensions: 1) Whether the treatment plan was exclusively medical or whether it incorporated a significant psychosocial component; 2) Whether the resident developed a concrete, specific plan as an outgrowth of the home visit, or simply said the information obtained would improve his/her overall understanding of the family. Only 5 residents listed exclusively medical directions for their treatment plans; the vast majority of residents (25) emphasized primarily psychosocial aspects of intervention. Residents were surprisingly clear as to what they intended to do as a result of the home visit. Only 11 residents described vague general implications of the visits. Nineteen residents developed concrete, specific plans for action from the home visit.

FAMILY PROBLEM LIST: Five residents mentioned only medical problems on their family problem lists. Five listed multiple problems in the family, but made no attempt to describe the interaction between these problems. Twelve residents, however, described problems which were family and systems-oriented. Interestingly, 7 residents cited financial problems as the only problem of the family, while a total of 12 residents mentioned finances on the family problem list.

DISCUSSION:

Overall, it appeared that residents did not have clearly defined objectives in initiating home visits. Thirty-two percent of the residents expressed only a vague goal to assess the home environment. The remaining residents were similarly vague, but appeared motivated by a specific concern, either a well-baby check/prenatal check or a specific patient problem. Almost a fourth of the residents selected families primarily because they were already familiar with them. This raises a question as to whether families who have initially positive relationships with their physicians are more likely to receive the extra attention of a home visit. On the other hand, a similar proportion was identified for the home visit because they were difficult patients who presented complex psychological and behavioral problems. Families with young children were somewhat more likely to receive home visits than families at other developmental stages.

Overall, the residents succeeded in making the home visits family-oriented. Predictably, mothers were never absent from these family conferences, with fathers and siblings being the primary absentees. This finding suggests a need for making special efforts to insure the presence of fathers, and to accommodate home visits to working hours whenever possible.

The residents also consistently made and recorded valuable and pertinent insights into family dynamics. This study gathered no validity data to determine the accuracy of resident observations. In terms of observisng interactions and identifying relationships within the family, however, it seems clear that residents tried to apply the basic principles of family analysis that they were taught. For example, one resident wrote, "Mother/daughter shared thoughts/feelings; husband/wife touched, kissed, talked openly." Another resident observed, "Mother mourning death of husband; son supporting mother, not expressing own feelings; Mother criticizing son as too much trouble; son's wife quiet, only interacted twice; Mom says she has no problems." Similarly, residents' observations about family relationships and strengths and weaknesses demonstrated family systems thinking. Eighty-four percent of the residents made observations which reflected this: For example, "Sisters are enmeshed, husband polarized against sisters' alliance", "Chronic strain in relationship between grown daughter and mother, mediated by older sister", "Patient dominating when sober, but shows helpless dependence when drinking; wife supports this pattern, submissive when dominant and supporting helplessness when drinking."

Residents also recognized relationships between the target illness and the family unit. typical comments follow: "Mother non-compliant with insulin, produces severe stress, anxiety for daughter; daughter's depression yields anger in the mother, contempt in her husband"; "Patient's sister's reecurrent tonsillitis stress for entire family"; "Family oriented around matriarch (patient) to keep her at home."

Of greatest interest was the surprising degree of input to treatment resulting from the home visit. We had expected residents to express their learning in vague terms, i.e., "Increased information about the family", as it was for about one-third of the residents.

However, almost two-thirds of the residents devised concrete plans as a result of the home visit: "On-the-spot parent conference to educate about the importance of interaction with a new baby"; "Enlist friend's help to encourage patient to seek medical attention earlier, to avoid hospitalization'; "Encourage husband and wife to attend night school together; meet with husband/wife to improve communication"; "Start identifying alternative sources of care for aged mother due to daughter's precarious health condition"; "Treat child for enuresis; discuss masturbation with parents; recruit father's participation inpregnancy; discuss contraception with parents." Furthermore, an overwhelming 83.3% of the residents incorporated psychosocial dimensions into their treatment plans, as opposed to outlining purelymedical suggestions.

Finally, when formulating their problem lists, almost half of the residents described problems with a system-oriented component. For example, "Son's poor health and marriage; mother's inability to cope with this situation"; "Dependent mother with multiple medical problems a burden on daughter with cervical arthritis, main source of support"; "Patient with severe COPD engaged in repetitive parent-adolescent conflict."

In summary, this descriptive study provided evidence supporting the contention that physicians can gather important information about the family during a home visit. for example, in almost half of the cases, physicians discovered health problems in other family members of which they were not previously aware. In terms of family dynamics, in general physicians were able to gather data on potentially important aspects of family functioning, such as communication skills, decision-making patterns, family rules, enmeshment/disengagement, family strengths and weaknesses. Research and clinical evidence suggest that these kinds of family factors can have an important influence on patient compliance, patient perception of illness and even presentation of symptoms. Physician sensitivity to family factors was indicated by the development of treatment

plans which addressed family problems or involved the family in patient treatment; and by patient problem lists describing family-oriented concerns. Overall, it appeared that the home visit provided physicians with an excellent opportunity to gather first-hand information about factors of family functioning related to their patient's health.

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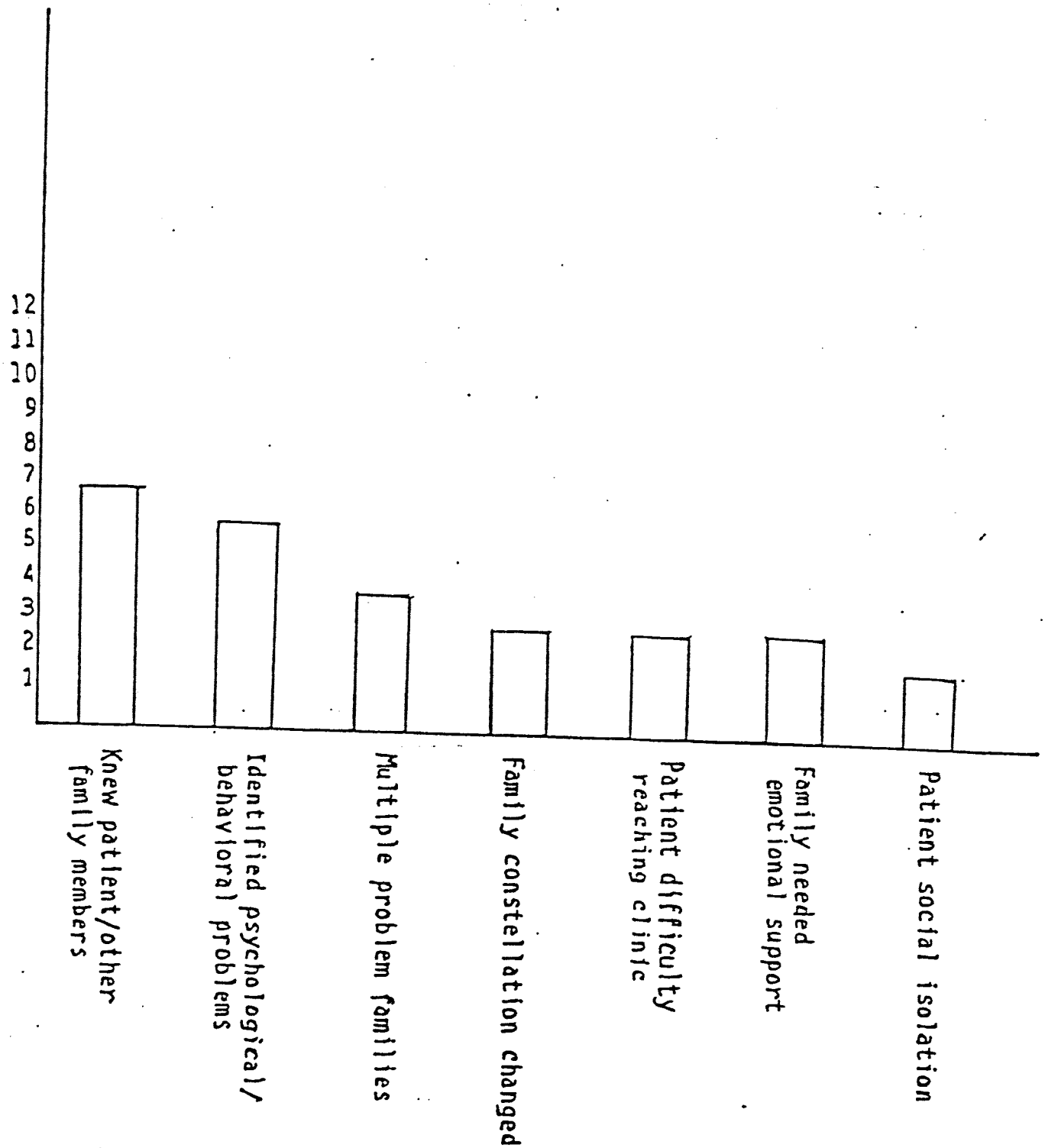

Figure 2.

Why Family Selected

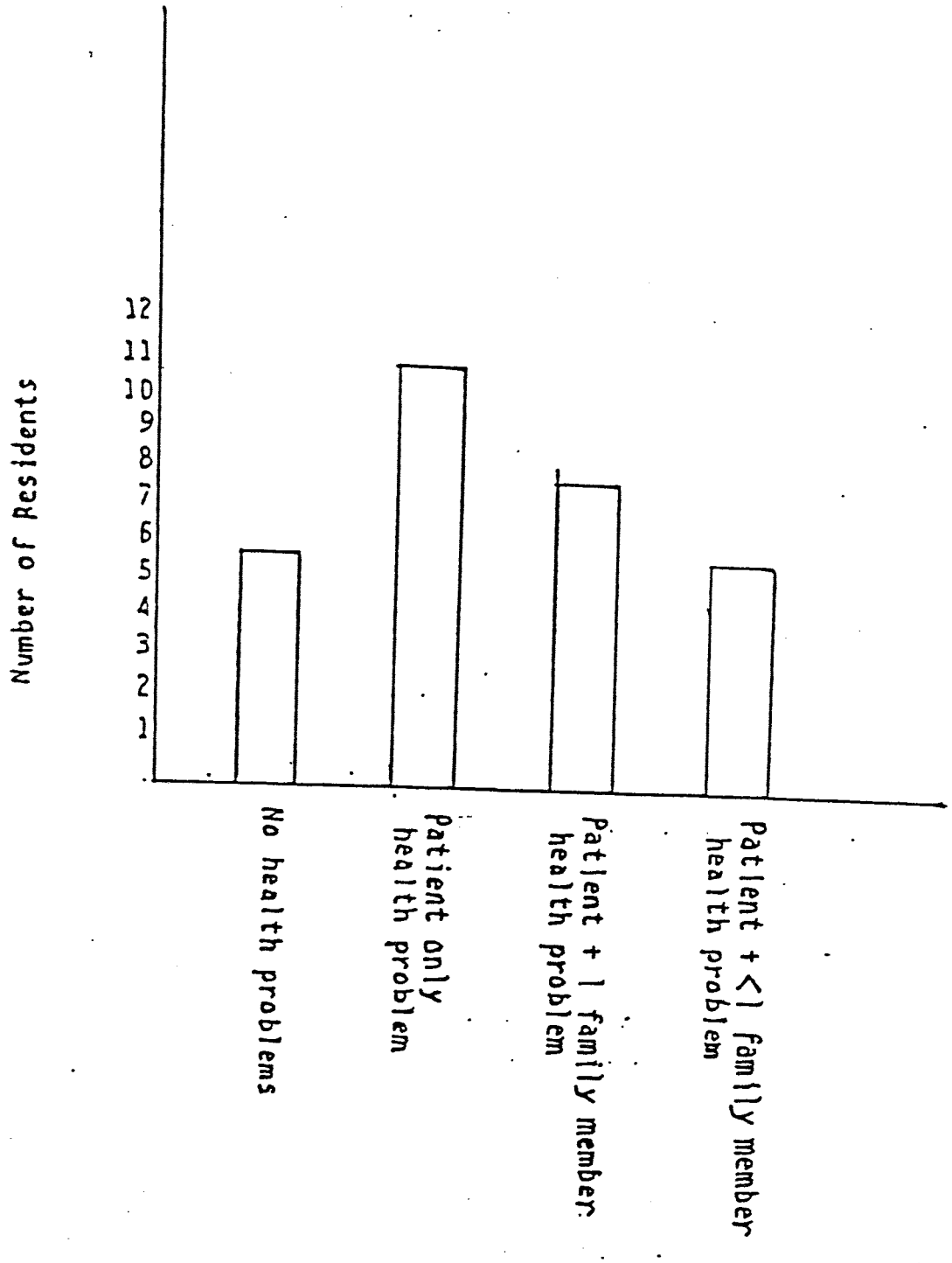

Figure 3

Current Family Health Problems

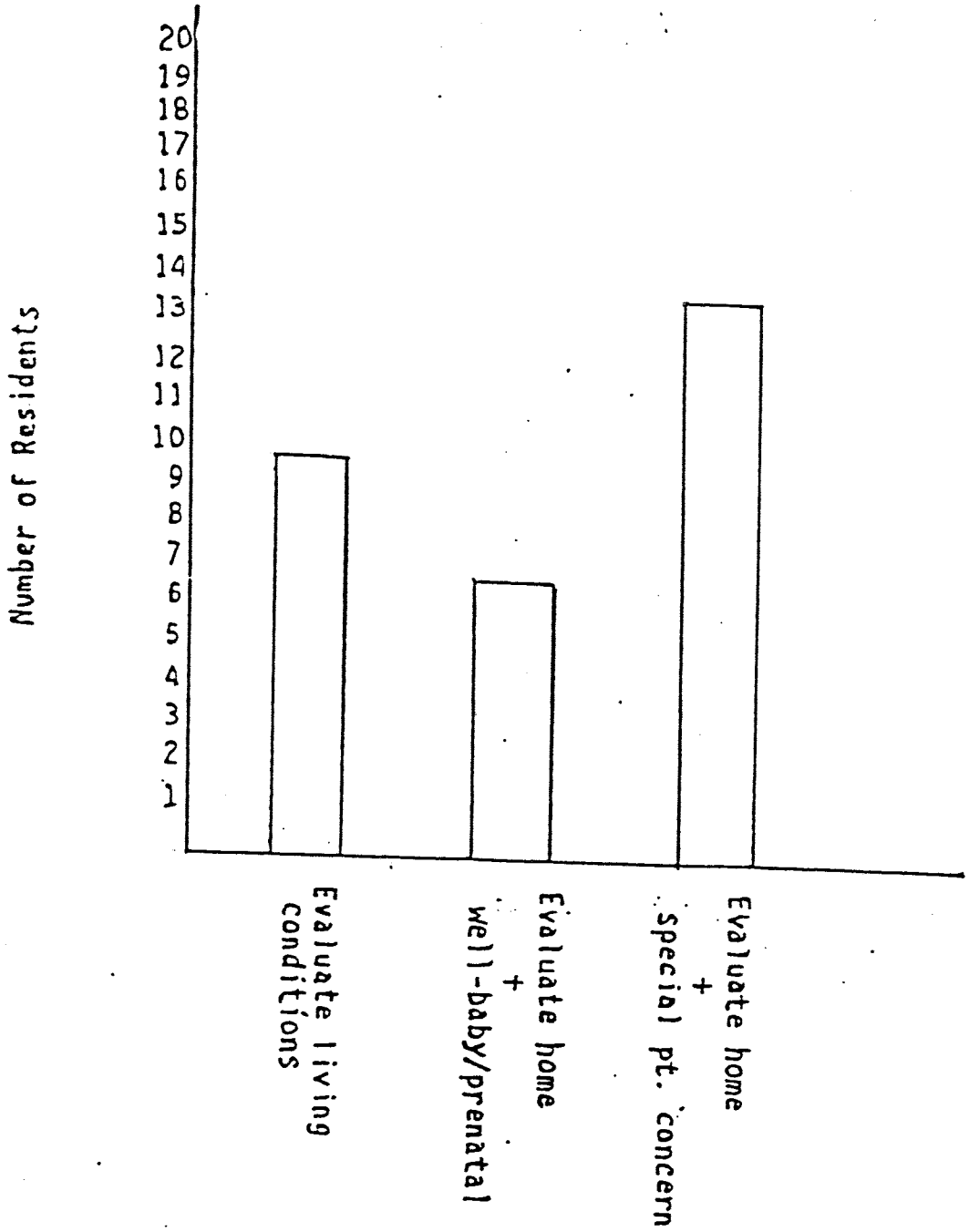
Number of Residents
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
Evaluate living conditions
Evaluate home + well-baby/prenatal
Evaluate home + Special pt. concern
Purpose of Home Visit

Figure 1.

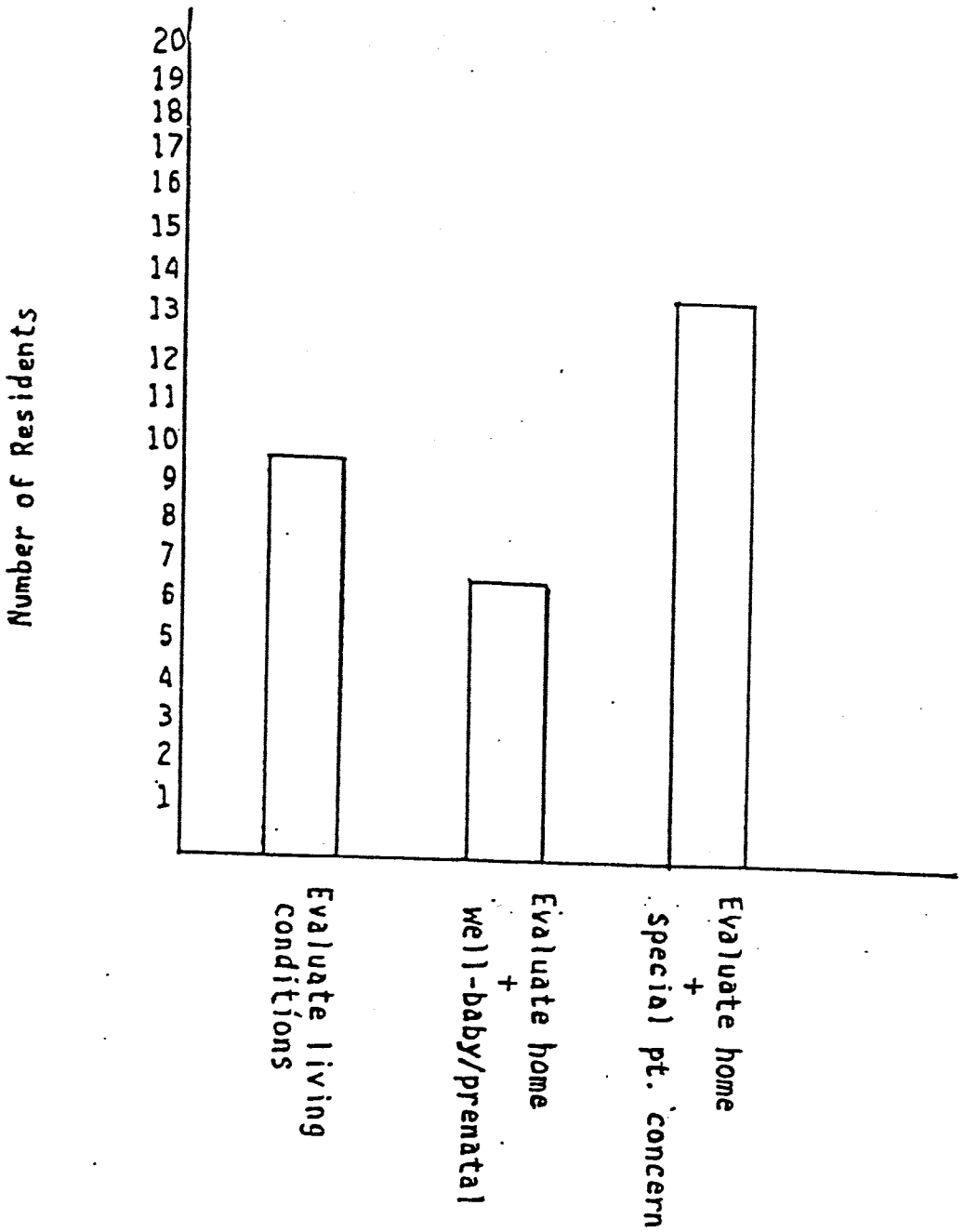

Figure 1.

Purpose of Home Visit

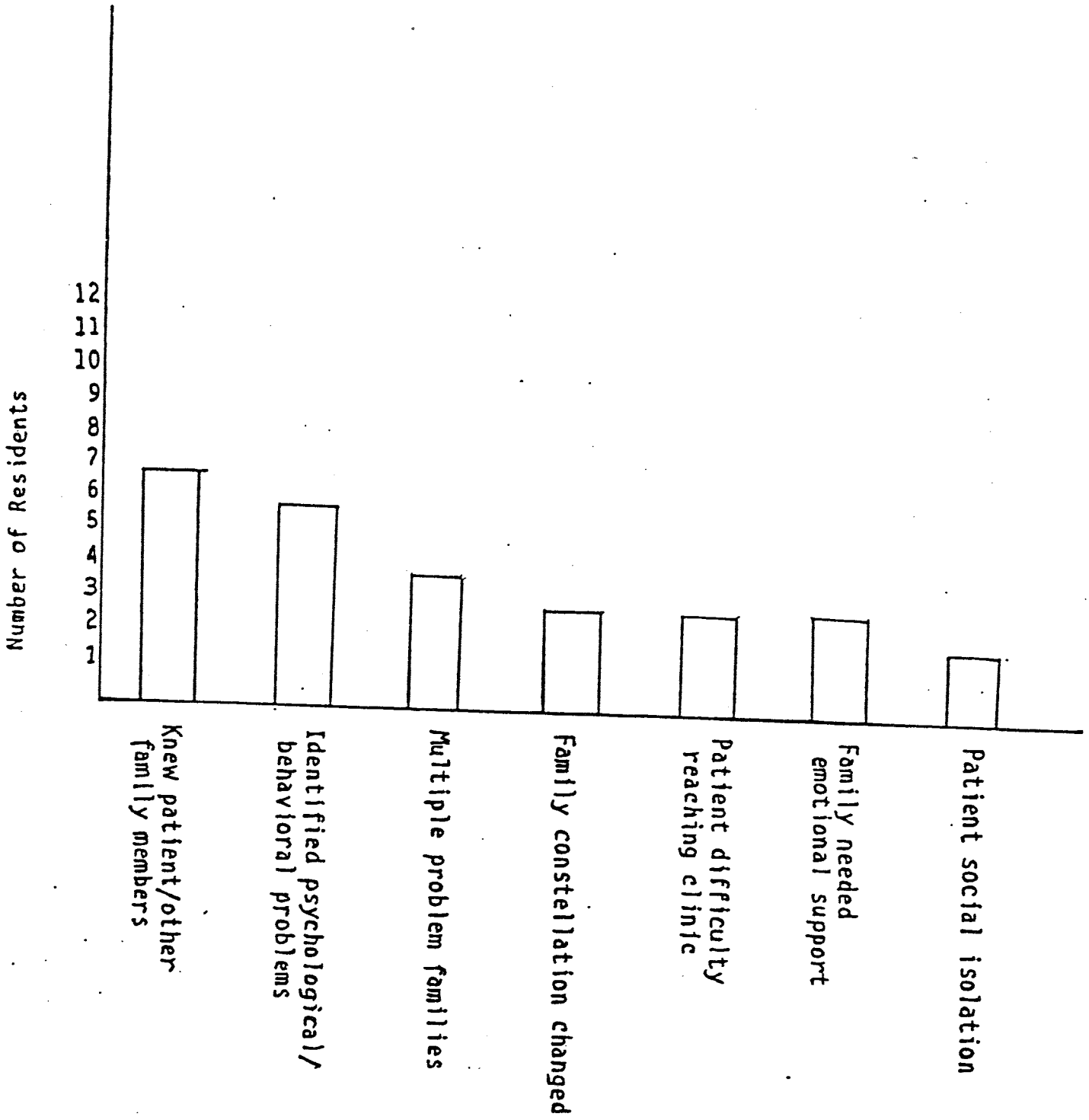

Figure 2.

Why Family Selected

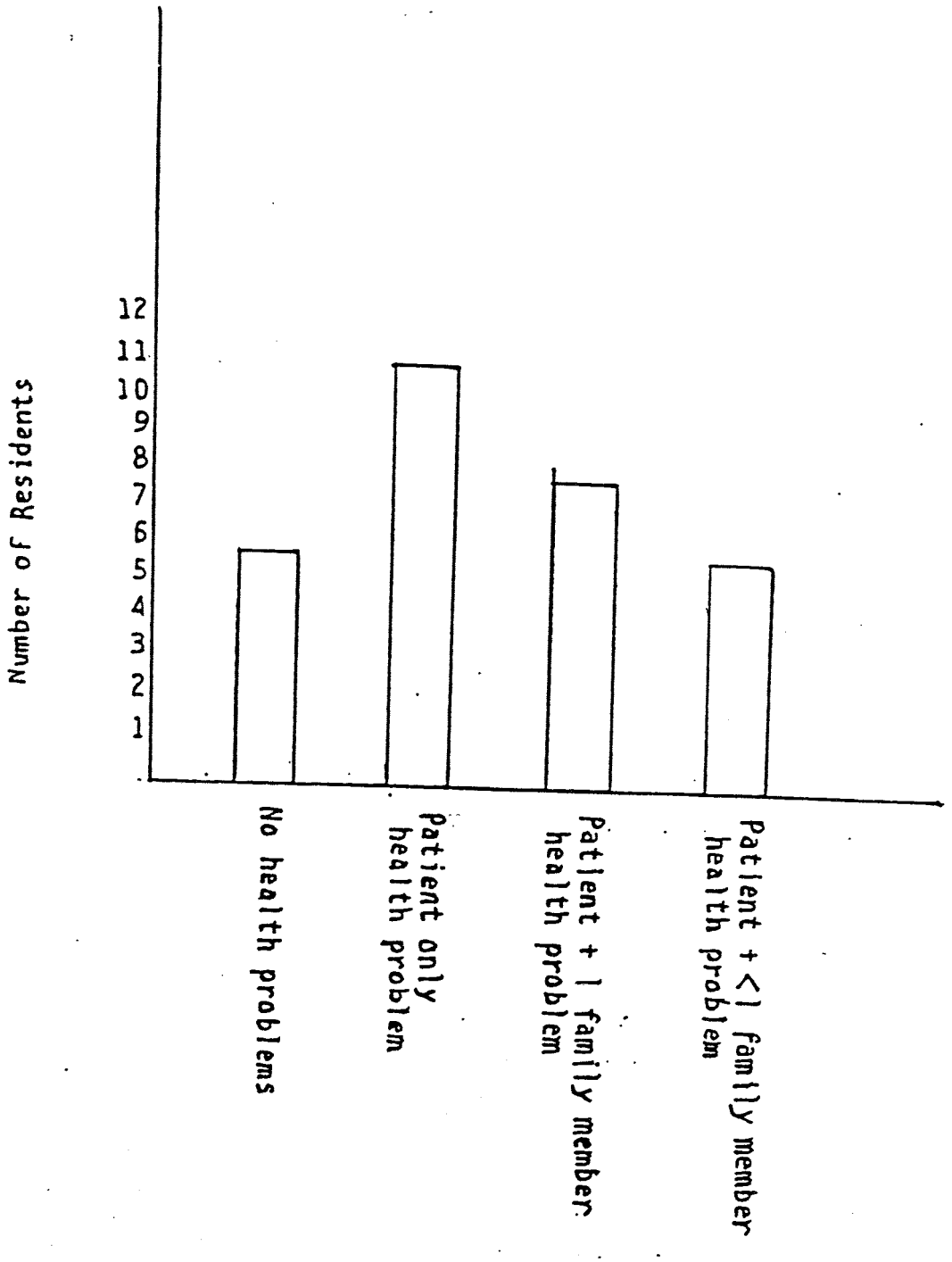

Figure 3

Current Family Health Problems

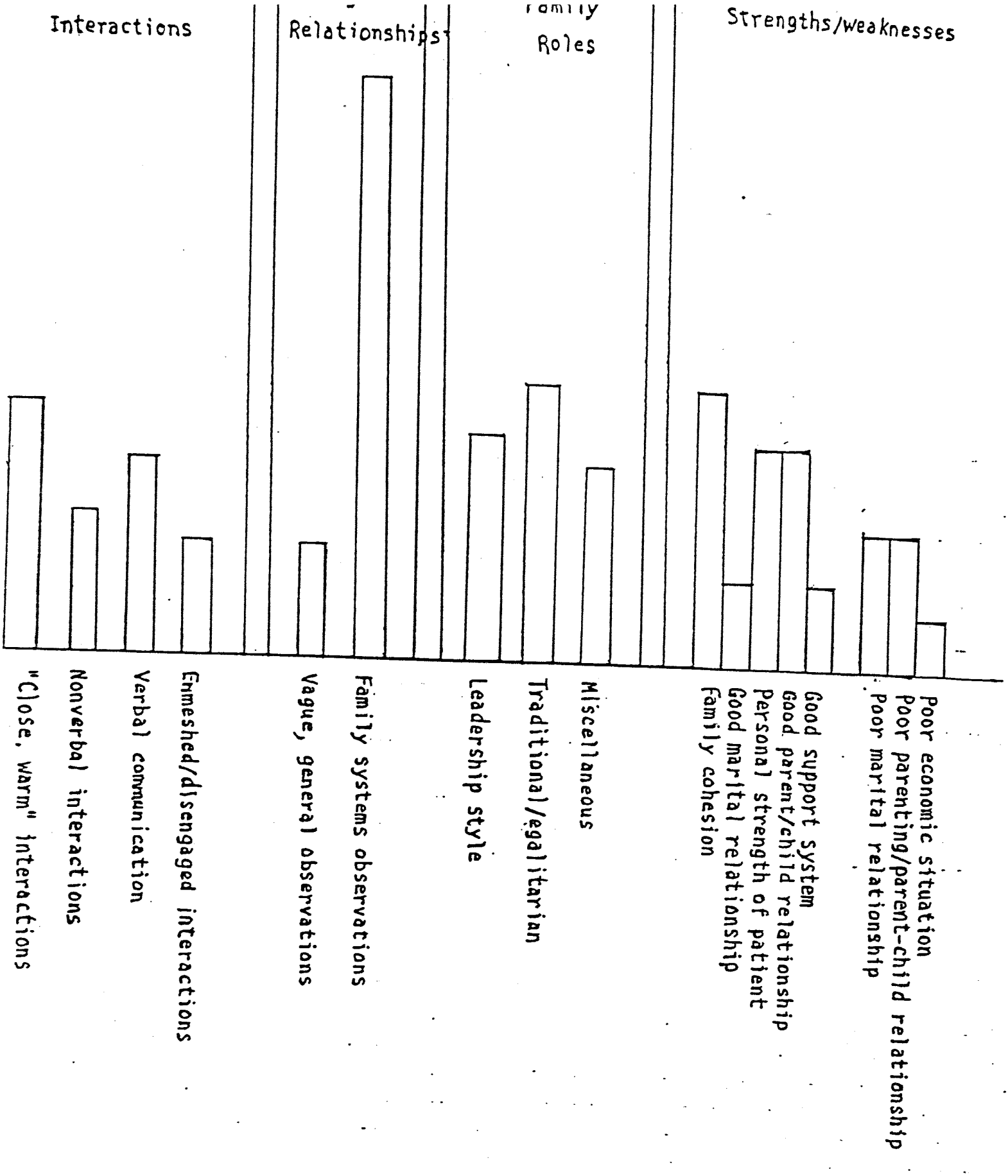

Figure 4

Observations of the Family System

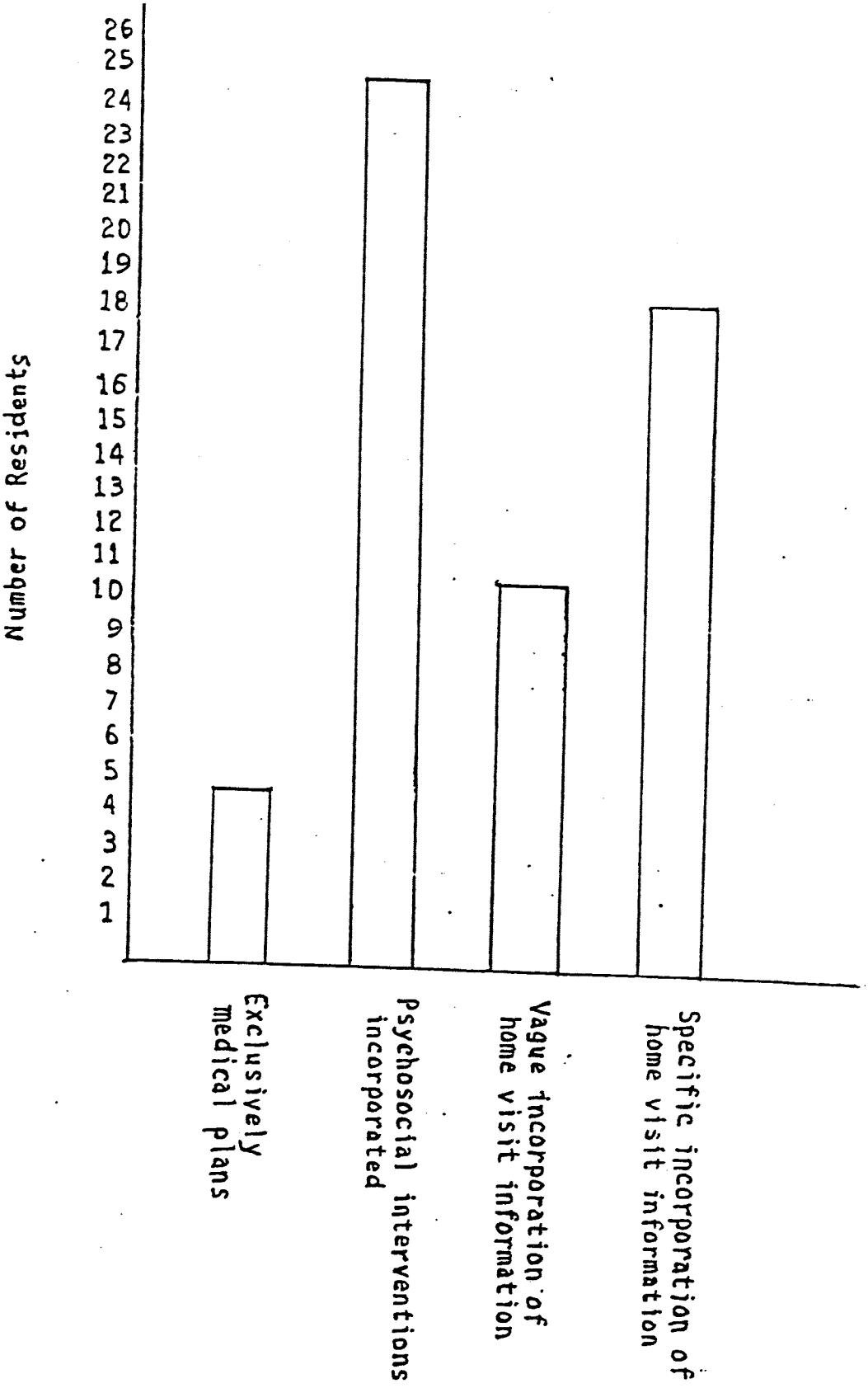

Figure. 5

Treatment Plan

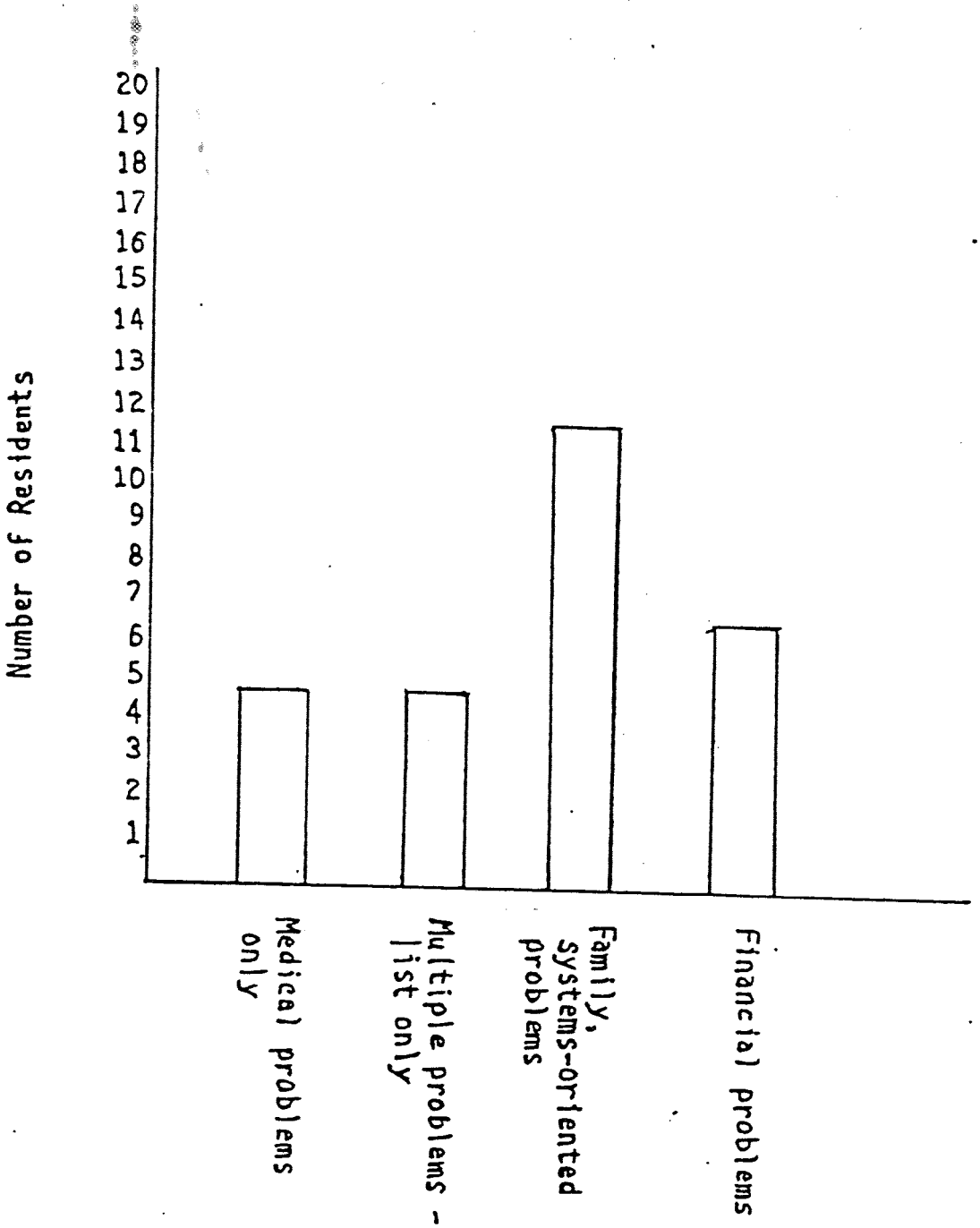

Figure 6

Family Problem List

GENERAL GUIDELINES FOR HOME VISITS

1. The initiator of the home visit shall make his/her role expectations clear re: teacher-translator-learner relationship.

2. The initiator and/or the visitation team shall define the educational and service goals for the;

   A. Resident

   B. Patient

   C. Comm. Health Worker or social worker.

3. The initiator of the home visit shall coordinate or cause to coordinate (relegate) the home visitation effort.

DRAFT - ONLY - FOR FACULTY DISCUSSION AND FEEDBACK.

HOME VISIT, FAMILY STUDY AND GENOGRAM

GOALS:

To experience a home visit and to learn about the importance of the family in health care.

OBJECTIVES:

At the completion of this experience, the resident will be able:

1. To arrange and complete a home visit.
2. To complete a Home Study Report.
3. To do a Genogram.

REQUIRED ACTIVITY:

The resident is required to make one home visit within the first eight weeks of training; and complete the following:

1. Home study report
2. Genogram
3. Evaluation of this experience

NOTES:

1. Visit may be made during or in place of the regularly scheduled Behavioral Science session.
2. Faculty must accompany resident on visit.
3. Choose a patient with an on-going problem which would benefit from continuity of care (i.e., diabetes, high blood pressure, prenatal, family planning.)

HOME VISIT PROGRAM 5/7/81

1. Required of all residents on family medicine in-patinet service. Rotation is not considered complete unless home visit requirement has been fulfilled.

2. Ann Hardy will coordinate CCOC residents.

3. Kay will coordinate Building 9A residents.

4. Home visit form must be filled out, co-signed, and returned to Dr. Shapiro. Note: in-patient chart also required-summary only.

5. 1st year residents: on-site supervision required. Possible supervisors- Lujan, Martinez, Shapiro, Rhoda Lyn, Lenahan, physician faculty.

6. 2nd and 3rd year residents: supervision at discretion of supervisor, but resident must consult with supervisor <u>before</u> making home visit.

8. Referrals from visiting nurse associations to be elicited.

Patient Name: _____

REQUIRED HOME VISIT REPORT

Chart Number: _____

What was the purpose of this home visit? _____

_____

Why did you choose this particular family? _____

Who is in this family?

Name	Age	Sex	Relationship	Occupation	Education

Who was present during the home visit? _____

_____

In what language was the home visit conducted? _____

Give a brief description of the home (mention type of residence ie., apartment, house, hotel; approximate size; orderliness and cleanliness; amount of furniture; any potential health hazards; also note any peculiar sleeping arrangements).

_____

_____

_____

What did you observe about the interactions of the family members present? (include both verbal and nonverbal information)

What did you learn about the relationships between family members?

Review roles of various family members and describe below. Include "leadership", spiritual/religious leadership, communication problems, security of the family unit, styles of coping of various members, family origins, social involvement of each member.

What is the economic situation of this family? (note maternal/paternal employment, other sources of income).

Note any current (chronic or acute) health problems in this family:

Family Member	Nature of Health Problem

Describe impact on family of above illness, with special attention to management problems

Note any particular strengths and/or weaknesses of this family which emerged from this home visit.

How do you intend to incorporate information obtained from this home visit in the ongoing health-care of this family?

Family Problem List:

Signature of Resident _____ Date _____

Signature of Supervisor _____