



## Going Home: The Next Forefront for Oncology Programs

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# Going Home: The Next Forefront for Oncology Programs

by Joy Stair, M.S., B.S.N.

**O**ncology programs have consistently been leaders in implementing interdisciplinary care models that focus on patient and family needs across a continuum of care that extends from diagnosis to treatment to hospice care. Home care, however, is one element of cancer care that has traditionally been excluded from these models. Although home care has always been provided for those patients needing it, seldom, if ever, has it been formally incorporated into oncology service lines. Lack of integrated home health services constitutes a major gap in the cancer care continuum.

The pressures of today's financial and patient-focused environment are causing hospital administrators to reconsider the role of home care services in oncology. A number of forces are driving the home care issue:

- Today most integrated health delivery systems are seeking to add or strengthen the community-based services essential to a full product line. These services include all variants of home care, hospice,

home IV, adult day care, and assisted living.<sup>1</sup>

- Increases in managed care's share of the marketplace and capitated payment models require alignment of services across the health care continuum.

- The Congressional Budget Office (CBO) recently released a report that examines the growth in Medicare spending for postacute care services along with policy options to slow the rate of growth in this area. The report places special emphasis on how payments for postacute care services might be "bundled." Under the CBO's approach, hospitals would be paid a single prospective payment for both inpatient care and some amount of postacute care services—typically, all services provided within sixty days of hospital discharge.<sup>2</sup>

- Shortened hospital lengths of stay are moving patients with increasingly complex care needs into the home, which has required home care agencies to develop nursing "specialists" in a variety of areas rather than continuing the "generalist" focus of the past.<sup>3</sup>

- A disease management model is increasingly being accepted as the health care delivery design that most effectively addresses today's needs. In this model the appropriate level of care is delivered in the appropriate setting by providers with appropriate skill levels. As disease management is defined and

implemented, it requires formal links among health care providers in all settings.

## THE HOME CARE PERSPECTIVE

Home health care is one of the last bastions of a fee-for-service business. President Clinton's budget proposal for fiscal year 1998 includes \$15.5 billion in five-year home care cuts. Although the budget plan does not include any proposal to bundle home care with other provider payments at this time, it does include the establishment of a prospective payment system.

Historically the over-65 Medicare population has comprised 80 percent of the home care patient population. The government's proposed restructuring of the Medicare program will mean more beneficiaries joining health maintenance organizations. During the past two years, the number of Medicare beneficiaries moving into managed care plans has increased dramatically in some states. The Health Care Financing Administration aims to have as many as one-third of the 38 million Medicare beneficiaries enrolled in some form of managed care plan. Thus, there will be the incentive for home care agencies to better coordinate care with acute care facilities, physician offices, and other referral sources.

Home care providers have generally functioned by assigning nursing teams to specific geograph-

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ic territories within their service areas to limit travel time for staff members. However, with the increasing complexity of patient needs, specialty teams are becoming more common today.<sup>4</sup> Home health agencies are developing specialty care-giver teams for high-volume, high-risk populations such as patients with cancer. Furthermore, many agencies are redesigning their core processes of care delivery with a move to an interdisciplinary care team model, which includes nurses, social workers, physical therapists, and home health aides, rather than the separation of care givers by discipline. These changes, which support affiliation and collaboration among settings, are more in line with the interdisciplinary care delivery models of oncology product lines.

### **THE ONCOLOGY PROGRAM PERSPECTIVE**

Over the past three to five years, oncology programs have focused their cost-containment efforts on moving care from the inpatient to the outpatient setting. Administration of chemotherapy is a prime example of oncology's relocation of one of its major services. Shortened lengths of stay for mastectomy also highlight the move away from the acute care setting. With an increased emphasis on outpatient services, however, minimal attention has been given to home care's role.

For those procedures with shortened lengths of stay or services that have been moved from an inpatient to an outpatient setting, two questions must be asked:

1. Is home care formally included in whatever protocols or care maps that are developed? Most often, inpatient care maps or critical pathways address the care that must be

## **Home Care at a Glance**

Home care in the United States continues to be a diverse and rapidly growing service industry. More than 18,500 providers deliver home care services to some 7 million individuals. Annual expenditures for home care were expected to exceed \$36 billion in 1996, according to 1995 Congressional Budget Office projections. Estimated home care expenditures were estimated to grow at an average of 13 percent per year for the period 1996 to 2005. However, CBO's estimate of home care spending omits hospital-based home care agencies.

According to HCFA's Center for Information Systems, in 1995 hospital-based agencies com-

prised 27.1 percent of all certified home care agencies. In 1995 close to 2,500 hospitals had facility-based home care agencies serving Medicare patients. Medicare remains the largest single payer for home care services.

About 6 percent of all home health care patients receiving services had a first-listed diagnosis of neoplasms (ICD-9-CM codes 140-239), according to a 1994 survey by the National Center for Health Statistics. The same survey showed that close to 26.6 percent showed a first-listed diagnosis of diseases of the circulatory system (ICD-9-CM codes 390-459).

accomplished on a day-by-day basis during hospitalization, but the care map ends at discharge. Care maps often include a referral for home care but do not delineate the responsibilities of the home care provider, which would clearly demonstrate the coordination of services and avoid duplication. For example, the patient education required for a new colostomy patient could be defined as to what needs to be accomplished during the inpatient stay and those education components that can be initiated at home.

2. Are there services or procedures that can be moved from the outpatient setting to the home? For years many home care companies have provided in-home chemotherapy services. Many agencies primarily serve residents living in rural areas who would incur hardship to travel to an outpatient setting. For exam-

ple, Memorial Hospital of Salem County Home Health and Hospice in Pennsville, N.J., delivers care in a rural county where miles of winding two-lane roads connect one neighbor to the next. The agency maintained that its cancer patient population would be much better served if patients could receive chemotherapy in the home and subsequently developed an oncology specialty team to include chemotherapy-certified nurses.<sup>5</sup> In today's economic environment, this model, with its one-on-one nursing care, is not necessarily the most cost effective. However, the model does illustrate a common oncology service that has successfully been moved from the outpatient setting to the home.

Additionally, the development of sophisticated home infusion therapy services has facilitated the move to home for such actions as

placement of PICC lines or mid-line catheters, formerly accomplished in outpatient radiology departments. Having highly trained nurses place lines rather than radiologists contributes to cost savings. In addition to placing lines in patients at home, the IV infusion nurses at St. Joseph Mercy also travel to the hospital to place a line in a patient being prepared for discharge. This system provides an opportunity for the patient and nurse to meet and for the nurse to begin the required teaching.

#### **WORKING TOGETHER...NEXT STEPS**

In positioning for the future, oncology programs should consider the following actions:

- Identify home care agencies with which to affiliate. This choice is obvious if the hospital owns a home care agency or has a formal affiliation with one. If not, identify those agencies commonly used and initiate discussions regarding their approach to oncology patients, such as availability of specialists.
- Incorporate the home care component into any care map, protocol, or critical pathway developed. For example, clearly delineate what is to be accomplished at home to avoid duplication of patient education efforts. Include home care agencies in this process—you might be surprised to discover the scope of services and resources available.
- Since most agencies now provide twenty-four-hour, seven-days-a-week service, identify those patients who can be moved home earlier if the care plan includes an evening visit by a home care nurse or home health aide. For example, patients at St. Joseph Mercy undergoing laparoscopic cholecystectomy have historically required a twenty-four-hour stay. With home

care incorporated into the protocol, discharge can be facilitated after eight to nine hours. A home care nurse visits later that evening to evaluate the patient's condition and address any concerns.

- Include a home care agency representative at oncology multidisciplinary team meetings. This representative can provide information related to community services and resources and help the team position for the future.
- As programs develop risk-sharing models for managed care or carve-out business, include home care as a service delivery site in the continuum.

When integrated into oncology service lines, home care services have the potential to improve quality of care and increase patient satisfaction. Partnering with home care services demonstrates an institution's commitment to providing quality care across the continuum. ■

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## **Variations on a Theme**

by Anne Hackman, R.N., M.P.A.

- "That isn't what the home health nurse said to do!"
- "My doctor told me to take my antiemetics regularly, but the home health nurse said to take them only when I became nauseated. What am I supposed to do?"
- "When I was in the hospital, I was on a special diet. Now that I am home, the nurse says to eat whatever I want."

To respond to such comments from patients—and to better position their institution in the managed care market—planners at St. Marys Health Center decided to design their own inpatient-based home health service.

The driving force behind development of an "inpatient-based" home health agency at St. Marys Health Center in Jefferson City, Mo., was the lack of continuity as patients moved from hospital to home care. Patients reported inconsistencies between the teaching and care techniques learned in the hospital and physician office and the care provided by home health staff—despite documented plans of care and numerous verbal reports between the hospital and home health staff. Especially troubling was the conflicting advice patients received about the management of nausea or vomiting and the nutrition and bowel regimens.

At the same time, in early 1994, the cancer service at St. Marys was experiencing tremendous growth in volume and acuity of patients. Cancer treatment

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# Structuring an *Inpatient-Based Home Health Agency*

was becoming more complex with the addition of new drug therapies and interventions such as hepatic arterial ports and intraperitoneal chemotherapy. Inpatient stays were becoming shorter, and increasingly chemotherapy regimens were offered outside the hospital.

The changes in chemotherapy administration and the reports of inconsistencies necessitated that nursing home care be provided by experienced oncology nurses familiar with the appropriate medications and interventions. St. Marys Health Center therefore developed its program to ensure that inpatient oncology nurses also provide care to patients in their homes.

The St. Marys Health Center is a 167-bed nonprofit hospital located in a community of approximately 33,000 in central Missouri. The service area includes nine rural counties with a combined population of more than 200,000 people employed primarily in farming and light industry businesses. The state's two metropolitan cities are at least two hours away from this community. Numerous home health agencies serve this extensive population; however, at the inception of the St. Marys program no agencies specialized in the care of cancer patients at home.

## GETTING STARTED

In early 1994 the directors of both the cancer service and the hospital home health agency met to discuss the concept of establishing an inpatient-based home health agency—one that would stand out from the rest by preserving continuity of care between the hospital and home whenever possible. A literature search revealed that no documented precedent existed for such a program at that time; therefore, criteria and standards had to be developed without benefit of experience. Planners agreed

to the following criteria:

- The number of nurses to be cross-trained would initially be limited to three.
- Each nurse would complete the same orientation process as the other home health nurses: a) three consecutive days of intensive introduction to regulations, infection control processes, and paperwork requirements; b) joint home visits with the present home health staff to complete opening three new cases, four to five routine visits, and a supervisory visit; c) insertive on home IV therapy equipment; and d) solo home visits, including documentation of three new cases and four routine visits.
- Each nurse would rotate to weekend and on-call coverage for cancer patients only.
- Each nurse would attend weekly case conferences to discuss patients within the home health agency.
- Each nurse would participate in chart audits and performance improvement activities for home health.

The cancer nurses would operate under the license of the hospital's home health agency; however, they would continue to report to the director of cancer services, who develops their schedules and assignments based on the caseload of home health patients.

## SCHEDULING STAFF

Cross-utilization of nurses from the inpatient unit to home health dictates that schedules include rotation to both areas on a regular basis. An assignment system was initially developed using a combination of four- and twelve-hour shifts. The home health nurse began a shift at 7:00 a.m., worked four hours on the inpatient unit, and was relieved at 11:00 a.m. by a twelve-hour nurse. This schedule allowed each home health nurse four hours per assigned day to complete home visits.

Initially the home health case-

load was small and varied weekly depending on the timing of routine chemotherapy procedures. This scheduling system worked well for a small caseload and for completing visits close to the health center; however, the following problems did evolve:

- Four hours was insufficient time to complete visits more than thirty miles from the health center, unless only one or two visits were scheduled.
- The nurses found it difficult to complete work efficiently on the inpatient unit in only four hours before reporting off to the 11:00 a.m. nurse.
- Because other nurses were working eight- and twelve-hour shifts, change-of-shift reports occurred nearly every four hours on the inpatient unit—an inefficient use of nurses' time.

As the caseload of home health patients continued to grow, schedules were adjusted to provide a balance between the specified number of entire shifts worked in the inpatient unit and the assigned days for home health visits. This schedule is still in practice today.

The on-call and weekend coverage requirements were also minimal at first due to the small caseload and the already existing process that encouraged patients to call the inpatient unit for questions or emergencies at any time. As the caseload grew beyond fifteen patients, the demands of on-call and weekend coverage increased. Today nurses are regularly scheduled on weekends with additional days off during the week, and on-call coverage is rotated one week at a time.

## ASSURING CONTINUITY OF CARE

Once the basic structure was effectively operational, the inpatient-based home health program was expanded to capitalize on the

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cross-utilization of staff. First, all patient education tools were standardized between the inpatient and home health services, which allowed for a continuous record of patient education from hospital to home. Second, care pathways and nursing protocols were also standardized for both the inpatient and home health areas to assure the same level of care was provided. The home care pathway, which operates as an extension of the core pathways, enables nursing staff to anticipate home care options earlier in the treatment process. Third, home health nurses were asked to attend the twice-weekly multidisciplinary cancer treatment planning meetings to discuss the home health patients with the inpatient group. Thus, the entire treatment team was kept apprised of the progress and status of home health patients.

This information sharing led to the participation of other disciplines in home care. The social worker for the inpatient unit now works with the home health agency to provide services to cancer patients at home. The cancer counselor is able to maintain relationships with patients from hospital to home, and the cancer pharmacist frequently follows up patient questions regarding medications and treatment regimens after discharge.

The extensive paperwork requirements for home health were problematic at first. However, stocking extra forms, such as those required for Medicare and Department of Health regulations, on the inpatient unit has allowed nurses to catch up on documentation while at the health center; each nurse keeps a supply of forms in his or her car to complete as needed. Interoffice mail is offered as an alternative to submitting paperwork directly to the home health office.

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#### **BENEFITS**

Benefits of the home care program continue to be realized daily. The impact of developing care pathways and teaching protocols across the continuum of care has facilitated earlier discharge from the hospital as well as improvement in patient compliance with treatment regimens. This improved compliance is credited to a better understanding on the part of patients and families in following discharge instructions and medication guidelines, and has resulted in a decrease in patient readmissions to the hospital for complications developed at home.

Perhaps the most dramatic and immediate benefit of the program has been elimination of the previous confusion between inpatient and home care instructions. Patients express relief that the cancer home health nurse now knows and understands their individual care requirements. The fact that the patient gets to know the nurse before a home visit has

become a critical factor for many patients in their decision whether or not to accept home care. Patients are grateful to learn that a particular nurse, whom they already know by name from the inpatient unit, will be the one seeing them at home. This familiarity and comfort have helped facilitate earlier discharge from the hospital and decreased the amount of time spent in communication between the hospital and home health agency.

Nurses have expressed satisfaction with the opportunity and challenge of caring for cancer patients in a more independent setting. They view making home visits as a relief from the intensity of inpatient care and enjoy the time at home with patients to provide more teaching and psychosocial support. Nurses report developing stronger relationships with patients and their families who are seen at home. As one nurse observed, "When patients are in the hospital, they act like a patient—they do what we expect them to do. When we see patients in their own homes, we are their guest. We see them in a whole different way—how they are with their families, how they live, what physical needs they have, their support systems—it's totally different!"

The program has continued to grow as more referrals are received within the health center and from other physicians treating cancer patients. Nurses are regularly added to the staff to meet these growing needs. As nurses become more experienced in delivering home care, their skills have improved in providing such additional, high-tech interventions as arterial port infusions and intraperitoneal chemotherapy at home.

The goal of continuity remains intact. As one patient added, "It's just great—I have my nurse, and she knows what I need!" ■