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What Makes Home Care the Most Unique Practice Setting?

The first two chapters addressed some of the structural and other changes that are making "home" the preferred, and desired, setting for care. This chapter explores the practice setting itself, the setting of home as the place where care is being provided. The home environment brings with it some unique dynamics that must be fundamentally understood for success. In fact, it is important to note that the environment itself may change throughout the day when a clinician makes visits or fills a shift—all while caring for different patients and families in their various homes. Let's explore some of the reasons that make home care the most unique practice setting.

Generally, and outside the realm of home care, when we are invited into and go into someone's home, we already "know" them. They are comfortable inviting us inside, thus providing entry into their personal, and some would say sacred, space. But in home care, we are invited in as "strangers" when we first meet a new patient and family. This is an honor, and those in home care embrace and value this dynamic. In home care, we must honor and respect this home place and space.

I believe that the best home care is the opposite of care provided in the hospital or other inpatient settings. Let's explore why. Inpatient settings seek to provide generally high intensity and safe care to large groups of people or patients. With this model comes some intrinsic challenges. Of course, there must be mechanisms to provide care while housing, feeding, and otherwise caring for a large population in a building developed for that goal. For sheer economy-of-scale reasons, this includes some basic structures and processes that are standardized, so that patients tend to be treated generally the same—even with all the new focus on patient-centered care. There must be organized processes to get the work of the organization accomplished while still meeting patient needs. Examples include mealtimes, which must be generally at the same times, and patients wearing the same matching hospital gowns, as well as many others. These measures are all intended to provide safe care to a diverse population in one space at the convenience of the staff.

Home care can be viewed as the antithesis of this structure. Home care is the most unique practice setting because the nurse or other team member must fit into and function effectively in the patient space, and their most beloved place often times, rather than the patient fitting into the hospital or other setting. Think of it this way: When entering an inpatient setting, such as a hospital, patients must conform to that structure; conversely, when entering a patient's home/space, it is the visiting clinician or other team member who must adapt and be flexible. This seemingly simple fact changes the dynamic in many ways. Being in

and on the patient's turf makes it clear that we are guests in patient and family homes, and we must conduct ourselves differently as a result.

I believe and have seen that coming into the patient's home to provide care changes the typical patient–clinician construct and expectations in numerous ways. The following discussion addresses some of these ways and the implications for this unique and dynamic practice setting.

First, home care is truly where patients and clinicians are equal partners in care, care planning, and numerous components related to care, including goals, desired outcomes, and much, much more. For example, in healthcare we call to make an appointment at a physician's office, and the assumption is sometimes that we are not working full time and that we have to adjust our schedules or "fit into" the physician's office schedule. In home care, the exact opposite occurs. In fact, patients and families are called prior to scheduling the first visit or for any care; this courtesy and standard practice occurs whether for intermittent care visits, shifts, or other home care. In this way, home care behaviorally demonstrates respect for patient and family time. We truly are guests in another person's home!

With this understanding comes an incredible shift in power and responsibility.

Home care clinicians visit patients at the best of times and sometimes the worst times in their lives. The range across the lifespan includes everything from newborn assessment "wellness" visits to compassionate, supportive care at end of life and includes emotions from very happy to very sad. Home care clinicians are honored to witness and support people in the setting they value most—their homes.

Let's step back and think about this and how truly individualized the setting can be. Patients wear what they want (there are no hospital gowns), and they have no restrictions on visiting hours, the age of visitors, or the number of visitors. Meal planning, food choices, and eating times are up to the patient. I could cite many more examples of how patients choose to set up their own homes and schedules as well. Family, friends, and/or other caregivers are valued as the unit of care and as such are included in education and health coaching. In fact, they are viewed as very important members of the home care team, when permitted by the patient.

The mindset change—that we are guests in a patient's home—can be difficult for some clinicians or those new to home care. This special dynamic helps ensure that patients have input into all aspects of care, care delivery, and related decisions. In their home, patients truly have all the rights; they wear what they want, go to bed when they want, wake up when they want, have "pets" (some are animals that most would not think of as pets!), and eat whatever and whenever they want. With no imposed restrictions, home care is truly patient-centered care and all about unique lifestyles and choices.

The following sections provide information about these differences from both the nurse/clinician perspective and from the patient/family perspective, supporting what makes home the most unique practice setting from each perspective. Each of these topics is explored in detail from both perspectives—first the clinician's and then the patient/family's:

- Physicians and orders
- Patient assessment and/or initial visit
- Care environment
- Care or case management environment
- Communications and care coordination

- Home care team
- Planning ahead and problem-solving

Physicians and Orders: The Clinician's Perspective

Just as in the hospital setting, home care is not usually provided without oversight for that care. Depending on the program and payer, there are usually verbal or signed physician orders. In home care, these orders may be called the plan of care (what used to be called the CMS Form 485, referring to the government form number), interim orders, verbal orders, or telephone orders. This is the form or data elements required by Medicare and Medicaid. Other programs and payers may also use this form and information. What forms are called depends on the organization, their policies, and related requirements. Patients are usually "certified" or "recertified" on a regularly recurring basis/timeline, and it is the physician who does this certifying. Because of this, the plan of care is sometimes called the certification form. It is important to note that Medicare and Medicaid are medical insurance programs, and, as such, they have medical necessity parameters that must be met for eligibility, coverage, and payment. This information is more fully addressed in Chapter 6, "The Fundamentals: The Interface of Law, Regulation, and Quality."

The best home care is a team effort, and the physician can be seen as the quarterback of the team. The physician signs the plan of care/certification and, therefore, certifies and clarifies such items as the patient's ordered medications, functional limitations, activities permitted, allergies, safety measures, the patient's nutritional requirements, durable or medical equipment, needed supplies, and more. The required plan of care also comprises such data elements as specific goals of care for the patient, the specific care to be provided, the services/disciplines to be providing that care, and the frequency and duration of those services. In addition, for Medicare, and in some states Medicaid, home care, physicians must

have a face-to-face encounter with their patients to ensure the need or continuing need for home care services. Readers are encouraged to stay apprised of changing requirements.

Physicians and Orders: The Patient/Family Perspective

The case manager manages the complexity of many moving parts that occur with providing care to patients at home. There can be changes to medications, services, and any other of the elements of care. One example of a change of service is when the patient goes to the physician's office and the physician tells the family caregiver and patient that the patient is ready for therapy services. In this example, the family member calls the home care nurse to say this is what the doctor said at the office visit. The nurse would then confirm the information, obtain an order as it is a change to the physician-ordered plan of care, and make a referral to home care therapy for the initiation of services. Family and other "lay" caregivers are valued members of the care team and are instrumental in helping patients meet goals and in assisting nurses and other interprofessional clinicians and team members in care coordination and communications.

Patient Assessment and/or Initial Visit: The Clinician's Perspective

The first visit is a lengthy and comprehensive one. This is particularly true if the patient's insurance is Medicare or Medicaid. Because of the environment of care—the home—components of an effective comprehensive assessment are related to that unique and personalized environment. Those components include elements of the home space itself, including assessing factors related to home safety, and also a detailed history and physical assessment. A standardized data collection tool called the OASIS (**O**utcome and **AS**sessment **I**nformation **S**et) is used to gather data

that is a part of a quality improvement process as the government seeks to improve care and related processes. This tool is undergoing change, and, like other Medicare or government reimbursed programs, will continue to be modified as needed.

It is important to note that the OASIS and its data collection is just a part of what is considered a "comprehensive" assessment. These visits range from 1.5 hours to 2 hours (or more) and can be provided only by a registered nurse or therapist because of the assessment and other components. These assessment visits may also require hands-on care. In other words, the patient is initially assessed to be sure they meet the organization's admission criteria per their policy, as well as the qualifying or other requirements for insurers such as Medicare, Medicaid, and others. Patients may also need physician-ordered care on that first visit, such as, for example, a wound assessment, teaching and training related to the wound and infection control, and related education and hands-on care of that wound, per the specific physician orders.

The case manager (or admitting clinician) at these visits is also the admission expert, the expert clinician providing skilled hands-on care, the explainer of insurance benefits, and much more. The best part of orientation, an important step to becoming a competent and effective home care nurse, is to accompany and listen to experienced home care nurses ask questions, listen quietly, reflect on gathered information, and generally begin the care planning process.

Of course, safety and other concerns, such as dangerous pets or hoarding, may also be identified on the first visit or encounter. Notify your manager of these findings or concerns. For more information, Chapter 5, "The Environment of Care: The Home and Community Interface," addresses community and personal safety concerns and Chapter 7, "The Home Visit: The Important Unit of Care," illustrates an initial visit with a case study about Mr. Hinckley.

I have had nurses ask, "How did you get so much information from this one patient in that period of time?" The answer is we must truly observe and "hear" and not assume or rush the answers. Otherwise, we only get a piece of the picture, and the picture is always more complex than a list of data items to complete. I try to think of it as 1) content and 2) intent. The latter is harder to discern, but sometimes it makes all the difference in meeting the patient's prioritized care goals. We just have to be open to seeing and hearing it. These initial visits are quite lengthy and comprehensive and are addressed in more depth in Chapter 7, "The Home Visit: The Important Unit of Care."

Patient Assessment and/or Initial Visit: The Patient/Family Perspective

The first visit and/or admission visit with the completed documentation requirements is a lengthy process. Often, patients have been discharged from hospitals or rehabilitation centers, so these visits may be very tiring for patients and families. Because of patient fatigue or other reasons, sometimes not all of the data is collected and assessed on that first home visit, particularly when the patient has complex assessment findings with associated critical thinking or clinical reasoning and then related hands-on care needs.

Often, calls are made from the patient's home to confirm orders with the physician, such as which wound care products are to be used or a medication found in the home needing clarification for the medication regimen and reconciliation process. From customer service and patient-centered care perspectives, always tell the patient the projected length of time of the visit and, of course, the time of expected arrival for the visit. Patients and their families should also be notified when the nurse or other scheduled clinician is running late and the new projected time for arrival.

Care Environment: The Clinician's Perspective

Organizations providing care at home have specific policies related to admissions. It is recommended that readers review these policies prior to assessment visits. It is for this reason that "assessment visits" are called just that—not admission visits. Not all assessed patients become admitted patients. Patients who do not meet the organization's admission criteria or where there are safety or other concerns should be discussed with the supervisor. For those who are new to home care, this review of the agency's policies and procedures should be a fundamental part of a comprehensive orientation and onboarding information.

The patient's home and environment are key to effectively meeting the goals on the developed plan of care. For example, suppose the patient is on a complex medication regimen, some part of which requires that the medication be refrigerated. What does the nurse do when the patient does not have a refrigerator? Similarly, for patients requiring infusions when there's not a cool place for storage as required by the medication or fluid policy, what does the nurse do? When the patient does not have a phone and is on some complex technology, what is the procedure to follow? These and other questions must be discussed with your supervisor to have a holistic understanding of the policy and the intent of the organization related to safe care and acceptance of patients onto service.

The Care Environment: The Patient/Family Perspective

Patients should not simply be told that they do not meet admission criteria. Otherwise, the hospital, physician, or other referring entity would not have thought of home care in the first place. These patients usually do have some problem necessitating some kind of intervention. Usually

these patients still need some level of care, even if it's not appropriate for this particular organization. This is where a local knowledge of community resources and linkages is very important.

Patients should be referred to other services if the referring organization cannot adequately care for them and meet their needs or admit them per the organization's admission criteria. Organizations should also keep track of these patients/families who are referred but not admitted for care, and why. This data can be reviewed, analyzed, and trended. This data may be a part of the agency's quality assurance and performance improvement (QAPI) process. It may help in identifying the need for new services or specialty clinicians, such as WOCNs (wound, ostomy, and continence nurses) or infusion-certified nurses.

Should a patient not meet admission policies for whatever reason, talk with your supervisor for direction. Usually someone at the organization communicates back to the referral source to relay the information found on the home visit, which includes the reason that the patient is not appropriate for the organization. Patients are often referred from an inpatient setting, and of course, the hospital may have no information on how the patient truly lives and what their daily health and lifestyle "looks like" on a daily basis in their unique home environment.

Care or Case Management Environment: The Clinician's Perspective

Patient care and patient care assignments in home care may be organized along specialty lines, geographic or catchment areas, and/or a combination of factors. For example, your organization might provide specialized infusion services and employ certified infusion nurses, or

provide skilled wound care with nurses certified as wound, ostomy, and continence nurses (WOCNs). Whatever model your organization uses, there is usually a care or case manager, what may also be called a primary nurse, assigned to that patient and family. This provides the patient and family with one person who knows them, their history, and their unique needs.

One of the most important roles of the case manager is to be an advocate for your patient and your patient's needs. As population health truly becomes integrated into healthcare in the United States, I believe home care will be at the forefront of these changes. Readers are referred to the section entitled "Skillful Caring for Patients in Poor Socioeconomic Conditions" in Chapter 1.

In home care, the clinician sees the unique needs of these patients and, with ongoing assessment and analysis, tries to intervene where possible with whatever tools or interventions may best help a certain patient and family meet their goals. With experience, home care—nurses using well-honed critical thinking, assessment, communication, sometimes thinking "out of the box," and other skills gained over time working in home care—can have a huge impact on people's lives. This is especially true once a relationship is initiated, nurtured, and sustained.

As is true in all relationships, you have an opportunity at every home care interaction, visit, and phone call to either improve that relationship or not. Positive and constructive negotiations can occur. I have found that patients and families are usually open to new ideas when things have not "worked" or they are tired of feeling "sick and tired." The home care nurse can have a great and positive impact because of these communications and interactions and this earned trust.

Care or Case Management Environment: The Patient/Family Perspective

Having one nurse or case manager to contact when a question arises helps patients and families get their questions answered and needs met. In this way, they have one person to call and develop an ongoing therapeutic relationship with over time. When patients are asked what is important, they note this ability to have someone who knows them and have someone call them back promptly is important and are contributors to quality from a customer service and patient/family experience perspective.

Communications and Care Coordination: The Clinician's Perspective

Communications and care coordination go hand-in-hand and are key to helping patients achieve goals. Of course, these are very different in home care than in the inpatient setting, where everyone is in the same building and can more easily meet to talk about a patient or have face-to-face care coordination meetings. Though there may be face-to-face meetings in home care related to care coordination, often numerous and multiple phone calls to different team members are what keep everyone apprised of what is happening with a patient. Electronic medical or health records (EMR or EHR) and information systems have helped greatly in this quest to literally have everyone on the same page about what is happening with the patient and family.

Communications and Care Coordination: The Patient/Family Perspective

Phone calls from the nurse or other team members between visits can be effective ways to update them on what is happening with patients and families. Sometimes the family picks one "point" person for communications. This person or representative may be the primary caregiver or not. This is just one example of how the family can participate in care coordination and communications. These communications are key to safely maintaining patients at home and to keeping the nurse apprised of any changes, such as a re-hospitalization, a new or worsening symptom, or a new need emerging.

These communications may help prevent the need for a higher level of care, such as an emergency department visit. They also help empower patients to understand the nurse's information when they have a question. In this way patients have their questions answered and can continue on their health journey with the right information, and an understanding of that information. Encouraging patients and family members to call when they observe a change in a patient's status helps the team stay informed. Some examples might include an increased weight; a change in the patient's clinical condition, such as a fever; or other information.

Home Care Team: The Clinician's Perspective

Home care historically has used an interdisciplinary or interprofessional team approach. Here is an explanation of the differences between these terms:

> *"Interdisciplinary means that two or more disciplines work or learn together to solve a problem or gather information. Interprofessional describes the relationship*

> *between various disciplines as they purposely interact to work and learn together to achieve a common goal." (St. Joseph's Care Group, n.d., para. 1)*

Although the term *interprofessional* is relatively new, the team approach has been the essence of home care and hospice since its inception. All work in home care and home care operations gets done through the team. This includes the important clerical and administrative team members, leaders in the organization, and peer nurses or clinicians; the work all gets done through the team. This is even more important in home care since one cannot always "see" the patient or "run down the hall" when there is a question. In the hospital setting, someone is coming in for the next shift to relieve the earlier shift; in home care, the entire team may be on that next shift. In other words, there are not those institutional supports to rely on, or they cannot be relied upon in the same way. This is particularly true for "intermittent" patients or patients receiving "visits." In private duty or 24-hour care at home, there may in fact be another shift coming in.

The home care team may include the physician; the nurse; therapists, including physical and occupational therapists; and speech language pathologists. There may also be a home health aide; a dietitian or nutritionist; and, of course, the physician who is involved in the patient care. In the case of more complex patients, a number of physicians who are authorized to write orders for patients to safely meet their unique specialty care needs.

The patient's home care team revolves around the patient and information, continually communicated to or handed over to other team members, particularly when different services are involved, such as in a more complex patient's care. For this reason, many organizations leave a calendar for the patient to know which service is coming in, the team member's name, on what day/date, and projected time for arrival.

With this calendar, patient visits are coordinated and not scheduled all on the same day or afternoon. It's truly patient-centered care, and the visits are staggered and planned appropriately by the team to meet patient needs. This also may help with better decision-making since decisions are then based on the most relevant and up-to-date information. The best home care is based on extensive and up-to-date fact finding. Then the detailed information is collected, processed, analyzed, acted upon, documented, and shared among team members.

Home Care Team: The Patient/Family Perspective

A simple calendar in the home helps with planning and scheduling for patients and families. In this way, patients can try not to get overtired or exhausted with many services on one day. In addition, families need to plan their days. Calling when one is running late is a must! Having someone come into the home, particularly on a regular basis, is like having someone invade your personal space. Think about just wanting to sleep in some mornings or enjoying a quiet cup of coffee alone, but being unable to do that since the nurse comes at 7:00 a.m. to care for an adult with complex care needs. Or think of wanting to have some private time with your spouse, but having a child with 24-hour-care needs necessitating shifts of nurses coming in at all hours.

Privacy is very important and, therefore, sticking to a schedule and respecting the home, the things in the home, the space, and family time is paramount to quality of life for families. Having the experience of first finding caregivers and then having people who start out literally as "strangers" coming in to your personal space can be a jarring and exhausting experience. Families may also be unnerved by the nurse needing to provide intimate and personal care on that very first encounter or visit.

From personal experience, whenever possible, consider what it would feel like for you to have people in your home while also trying to work, raise children, maintain a household, and do all of your day-to-day activities. Be empathetic and act accordingly.

Planning Ahead and Problem-Solving: The Clinician's Perspective

Home as the patient care environment is as variable as the people and populations served in the organization's geographic or catchment area. In some places, this can be a few ZIP codes, which can include a few large counties. In rural areas, it may be many miles of counties and sometimes stretch across state lines. It all depends on licensure, state laws, and other requirements. Keep this in mind, because your environment is not like the hospital where you can run down the hall if a forgotten supply is needed or a urinary catheter is dropped. In the home, you generally have no back up onsite. The nurse or other clinician must function independently and autonomously; this can be a very good thing for some or very uncomfortable for others who are used to more structure. This is not to say it is good or bad. It just depends on the person and their experience.

In home care, one of the best ways to avoid problems is called the Noah's Ark philosophy: Always take two of any needed supply for visits. Similarly, this is also a good model for the nursing bag and its supply contents. (For a listing of general supplies needed for a nurse visit bag, see "Sample Visit Bag Contents" on page 173 in Chapter 7, "The Home Visit: The Important Unit of Care.") Being prepared also may necessitate communications with the hospital prior to patient discharge to ensure that the supplies needed for the visit are at the home or are sent home with the patient from the hospital, for example, specifically ordered wound care supplies, an extra tracheostomy tube, or whatever that patient must have in the home for quality and safety.

From personal experience, especially in some areas of the country, you would be hard-pressed to find an extra indwelling urinary catheter of a particular size or type. I've been in that position and had to drive to a hospital about an hour and a half away. One of the lessons learned here is from a practical perspective—always bring more than you think you might need, because if you don't have it with you, you will need it!

Planning Ahead and Problem-Solving: The Patient/Family Perspective

It can be frightening to a family and the patient when they have been waiting for the nurse visit since being discharged from the hospital and they realize the nurse did not bring what is needed for their care. The patient and family are usually already somewhat anxious after being discharged. They are only referred to home care because they have some specific medical problem necessitating the specialized skills of a home care organization and nurse. Many times they are very excited you are coming there and that you—the nurse—can answer the myriad questions that have arisen since pulling back into the driveway.

Always communicate with the patient/family before the visit to help ensure that what is needed will be brought and that you will be able to answer any questions that they are very concerned about asking. Things may have changed since discharge, and as a nurse, it is better to know earlier than later about these changes. Changes might include a new wound or a new symptom or finding that becomes a priority and makes your "planned" visit placed on the back burner or otherwise reprioritized appropriately. Communication is the key to avoiding preventable problems and to assist in effective problem solving when necessary.

Summary

This chapter provides an overview with some examples of why home care is so different from any other practice setting in healthcare. The specialty of home care demands additional skills. Not only is the nurse who conducts the assessment visit the admissions expert, she also acts as the expert clinician, listener for data collection and interpreter of its nuanced implication for the care plan, and patient and family "go-to" person for care once they are back in the community.

The nurse is also the care or case manager, the scheduler who considers numerous factors for the next visits(s), the clarifier for confusing or non-congruent orders with the physician(s), the coordinator of care with the team, and more. One of the most important roles the nurse plays in the home care environment is explaining the glossary of healthcare to people in understandable terms. The healthcare model has become so "medicalized" that common sense and terms are hard to find or understand. Home care nurses have a huge role to play in "flattening" the language of healthcare and making it truly understandable and accessible for all. They do that daily in patient living rooms or bedrooms!

The tables are truly turned in home care because of the power shift, and we must sometimes negotiate and care for patients with varying lifestyles, beliefs, houses and environments, relationships, values, and myriad other variables. From visiting the most economically disadvantaged to caring for those who are very well-to-do, home care is a diverse and exciting practice setting. Home care is a reflection of the community, and, as such, home care clinicians are often experts about their communities and geographic areas. In this way, they can know of, and offer to help with, community linkages and resources that may help patients and families find better health and care in their homes.

This overview leads to further discussion in the next chapter about the important skills and competencies needed should you wish to practice in the primary healthcare setting of the future—the patient's home.

Questions for Further Consideration and Discussion

1. List the main reasons why care provided in one's home is so different from that provided in an inpatient building.
2. Who are the members of the home care "team" and what are their roles?
3. Discuss the difference between the terms *interdisciplinary* and *interprofessional*.
4. Identify five factors that make the care environment of the home key to helping patients meet goals.
5. Brainstorm and list three reasons why electronic medical, health records, and information systems can assist in communications and care coordination in home care. Specifically, how are they helpful to nurses and other clinicians? How are they helpful to patients and families?

For Further Reading

- *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, by Patricia Benner
- Framework for Action on Interprofessional Education & Collaborative Practice from the World Health Organization: http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf

- Core Competencies for Interprofessional Collaborative Practice (Report of an Expert Panel): http://www.aacn.nche.edu/education-resources/ipecreport.pdf
- *Handbook of Home Health Standards: Quality, Documentation, and Reimbursement,* by Tina M. Marrelli at http://marrelli.com/, Mosby, 2012, 5th Edition

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