Building a Dream: Creating an Oncology Day/ Evening Hospital

Fletcher, K.
Painter, V.

Abstract

The demand for inpatient beds has reached and often exceeds capacity producing waiting lists for cancer care. There is a need to explore alternative approaches to oncology treatment. The Oncology Day/Evening Hospital (ODEH), originally envisioned in 1995 as a joint project between an ambulatory cancer centre and a large teaching hospital, is an important cancer treatment initiative offering extended hours of ambulatory oncology treatment on days, evenings, weekends and statutory holidays. A review of current inpatient treatment modalities revealed that many patients receiving inpatient therapy could be safely and effectively managed in the ambulatory setting if treatment regimens were modified and if ambulatory hours of operation were extended.

Healthcare improvements expected were: appropriate movement of inpatient activity to the ambulatory setting; more opportunities for patient choice in treatment time thereby allowing for maintenance of normal living; better quality of life for patients through prevention of hospitalization; decrease in treatment waiting times; consolidation of patients into an ambulatory oncology treatment setting as opposed to utilization of adult medicine units; and more rational inpatient bed utilization with reduction of admissions and intra-treatment transfers.

This article describes our experience in building a dream, the challenges and lessons learned in implementing a better way to deliver oncology care in an environment of rapid change and staff shortages.

The Need

Over the last decade there has been a radical change in the political climate in which health care resides. Prior to the 1990's, governments were much more open to funding budget shortfalls, deficit spending and large capital projects. It is difficult to identify the exact stimulus for the change from this climate to our current experience but some factors might be the recession and high inflation of the 1980's, the explosion of expensive technological care and the trend towards deficit reduction. All of these factors created an atmosphere of social reform and cost-containment, which has had a powerful effect on health service in Manitoba. All providers were challenged with identifying patient care that could be shifted safely and cost effectively to outpatient settings.

Beginning in the early 1990's and in keeping with the current political philosophy, acute inpatient care beds were closed in large numbers. Ultimately, the greatest cost savings occur when entire units close. Concurrently, rational combinations of regrouped patients should occur and experienced staff need to move with the patients. The reconfiguring of patient groups has not always occurred rationally; some reconfiguring has occurred based on patient numbers and not on related clinical activity. Experienced staff have not always moved with their patients. This type of reconfiguring of patient groups and staff occurred at our partner hospital. It was also identified that current services for oncology patients were provided in too many areas in the hospital making it difficult to develop knowledgeable and experienced oncology nurses. A team of administrators at the hospital and at our cancer centre agreed that a unique setting could be created to support movement of a considerable amount of inpatient activity to the ambulatory setting and the consolidation of existing ambulatory services into a focused program.

Building the Dream

Understanding the population to be served is key to the success of any project. The first step in understanding the population and the first step in this project was a comprehensive assessment of the numbers and types of inpatient cancer cases and the related lengths of stay. A further analysis was made as to which of these cases could receive outpatient therapy if an extended hour treatment facility existed. From the data gathered, it was clear that we had a potential population that was sizable enough to warrant the creation of this treatment venue. As well, we conducted a cross-country survey of the hours of operation of cancer treatment service delivery to explore what others were doing and if there might be a template that could be followed. At the time of data collection, we were unable to find any extended hour ambulatory settings in operation, although many respondents reported that they were contemplating this type of expansion.

Once the patient population had been determined, a review of the services that would be required by such a new unit took place. All stakeholders including Nursing, Medicine, Pharmacy, Health Records, Materials Handling and Housekeeping participated. The initial proposal stated the intent of the project, the need for the services, the patient population to be served, and how this cost containment

balanced with the maintenance, if not the improvement, of cancer care services could be achieved.

Seven proposals were written and submitted for funding between 1995 and 1999. The differences among the seven proposals were few; each proposal had a different emphasis to best fit the political climate of the day. Two key events took place between 1995 and 1999 in Manitoba. First, in 1998, health services in Winnipeg were regionalized and second, a change in government occurred in the fall of 1999. The final proposal fit the newly elected government's mandate to "End Hallway Medicine". Also, it called for a phased in approach to the implementation, which reduced the budget from the original proposal and made it more palatable for the government to fund. ODEH was the perfect project to reduce use of inpatient beds.

The Challenges and Lessons Learned

With the advent of the new Winnipeg Hospital Authority in 1998, we thought we had written the final proposal; the project made it into the Authority's glossy brochure that went to every household in the Winnipeg region. However, no funding was received and one more proposal was required.

Lesson Learned:

Keep focused on the dream. Patients report that they want to receive cancer care in an outpatient setting whenever possible (Miaskowski, 1993). We knew that ODEH would provide an opportunity for better treatment options for oncology patients and kept our focus on the patient. Day hospital improves quality of life for patients who need frequent treatment (Clark, 1986; Summers, Dawe, & Stewart, 2000). Mor et al. (1988) found that day hospital care for oncology patients equals inpatient care in medical, psychological, and social terms, and that it is significantly less costly. Also, we found it is important to listen, be open, and be prepared to alter the route to achieve the vision. We were ready to take whatever opportunity came our way and prepared to adapt the project to meet the focus of the funding agency.

Our next challenge was time. The imperative was to implement immediately. There was a November 3rd announcement with an expected start date of December 1st. In this time frame, it was expected that we would implement the program, essentially moving from a proposed implementation phase of years to an implementation phase of weeks. Nurses and support staff had to be hired. Coordination with the hospital's Pharmacy, Lab, Housekeeping, Security, and Emergency Support and Response services had to occur. We also needed to coordinate with our internal team services: Medical Records, Hematology Lab, Psychosocial Oncology and the Oncologists regarding their on-call support. This required many meetings in a short period of time. Because many of the stakeholders had not been involved since the original proposal, it was a challenge to deal with resistance and move the project along to meet the government's expectations.

Lesson Learned:

It took us three months to implement the ODEH. It was necessary to take this time as there were two facilities involved, each with a host of departments involved in the implementation. Staff had to be hired and orientated. Also, in the course of the ongoing proposal submission, the ODEH changed from a joint project between the hospital and this agency, to a project that would be managed by the agency. The hospital services were crucial to support the program, therefore it was important to maintain our relationship and continue to work collaboratively. The time frame for implementation, even at three months, was very tight, since other work in both organizations needed to continue as usual. As a result, not as much time as was needed was taken to involve all stakeholders in the process, creating some tension in the process.

The third challenge was resources. We were facing in Manitoba – as was the challenge right across the country – a nurse shortage. In addition, most of the nurses in Manitoba had signed a new collective agreement that allowed nurses to take seniority, vacation and benefits to another facility without penalty. This mobility agreement did not include this agency (we are a provincial, not regional, agency), so we were challenged to recruit nurses in an environment of shortage and one that did not allow them to bring their benefits with them. Many experienced nurses declined positions because of this.

Lesson Learned:

This challenge was more a reality of working in a unionized environment than something we could change. We have supported the nurses in their quest to become part of the mobility agreement but have not been successful to date. We also had union issues around not having a shift-scheduling clause in the collective agreement. Our assumptions were not always the same assumptions that the members of the collective bargaining unit were making. We had to come to an understanding of common contract interpretation as well as make a commitment to developing letters of understanding to address this gap in the contract. In addition, we have been challenged to hire nurses without oncology experience. We have attempted to meet this challenge by developing an oncology curriculum for orientation that will help the nurses develop expertise in oncology.

Change is never easy and dealing with the change imperative was one of our main challenges. We were moving from a Monday to Friday, days only schedule to one that would involve evening and weekend shifts. We had anticipated that there would be resistance and difficulties with this transition so meetings were held to listen to concerns, to debate, and to get input into the process. The bottom line, however, was that the project was going ahead, and quickly – it was an expectation of the Minister of Health. Since the transition was more difficult for some of the nurses than anticipated, the team spent considerable time during this period listening to individual concerns in addition to the general meetings. The nurses acknowledged the ODEH would be a positive change for patients; their resistance related to the personal changes they would have to make by working evenings, weekends and holidays. A small group in the organization would bear this burden of improved patient care.

Lesson Learned:

Resistance is a natural phenomenon. We know from the literature (Lewin, 1951; New & Couillard, 1981; Coeling & Simms, 1993) that change creates anxiety and a variety of reactions that may result in resistance to change. This resistance was the most difficult challenge in implementing ODEH. Lewin (1951) emphasizes the importance of constant attention to resistance, of demonstrating the need for the change, supporting the change with updates on progress and promotion of independence, and integrating the change so it becomes normal behavior. We also knew gradual change is easier for people (Ward & Moran, 1984), therefore, we would have preferred more time to make this transition. Nurses were encouraged to express their concerns. They were involved in development of the new rotation. We understood that resistance is stronger when individuals perceive their personal costs caused by the change are greater than their personal benefits. However, we found that prolonged resistance by a few individuals can contaminate the larger group. In retrospect, challenging the resistant staff to take next steps sooner rather than later might have been helpful to the larger group.

Progress and Next Steps

Phase I was implemented in March 2000, Phase II in November 2000. Phase I involved extending hours of operation until 2200 hours weekday evenings and the addition of eight hours daily on weekends and statutory holidays. Phase II added seven treatment spaces and successfully moved inpatient gynecological cancer treatment to the outpatient setting. As hoped, we have successfully decreased treatment waiting times and reduced admissions to hospital and intra-treatment transfers (see Figure 1). Patients report anecdotally they are highly satisfied with the lack of disruption to their work and home life and that the atmosphere in ODEH is more relaxed. Weekly reports are submitted to the Minister of Health with an update on the treatment space utilization and the categorization of treatments. This information is shared with staff as they have indicated it is helpful for them to see the positive impact their program is having. There has been a steady increase to full capacity as well as clear indication that inpatient beds are being freed. We had originally seen ODEH as primarily for chemotherapy activity, but have found that up to half of the activity is supportive therapy: hydration; blood component therapy; and anti-infective therapy. Patients are supported effectively post treatment in the ambulatory environment.

ODEH is a better way to deliver oncology care. It is the intention to develop a Patient Satisfaction Survey to confirm the anecdotal feedback we have received from patients and

Figure 1

EVALUATION FRAMEWORK

	Before ODEH	ODEH
1) Oncology beds available per day	Ø	4 - 6
2) Oncology patients waiting for treatment per day	≅ 4[1]	Ø[2]
3) Patients transferred at end of shift to inpatient bed per day[3]	1[1]	Ø

1) Based on retroactive data of 24-month period.
2) Occasionally an oncology patient is listed; recent experience indicates these patients are out of facility transfers in.
3) For completion of lengthy regimen, blood product infusion, supportive therapy and/or treatment of side effects.

families. The recent closure of seven BMT inpatient beds challenges us to increase outpatient Blood and Marrow Transplant activity. The safety of this transfer is supported in several reports (Meisenberg, Miller, McMilland, & Piro, 1995; Gluck & Rochers, 1997; Summers et al., 2000). We are currently planning an ambulatory pump program to support the increase in 24-hour infusional therapy in gastro-intestinal cancer treatment and the associated stem cell transplant regimens. The team has created a strong foundation for ambulatory cancer care. It is now our dream that in the near future, it will be possible for patients with cancer to have their entire treatment experience, from early diagnosis through palliation, in the ambulatory setting.

Authors

Karen Fletcher, RN, BN, CON(C), is the Director of Nursing, CancerCare Manitoba, Winnipeg, Manitoba.

Vivian Painter, RN, MN, CONC(C), is the Senior Director of Patient Services, CancerCare Manitoba and the Nursing Director of the Winnipeg Regional Health Authority, Oncology Program Team, Winnipeg, Manitoba.

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