The impetus for the development of Hospital in the Home (HITH) programs: A literature review

INTRODUCTION

The move to provide acute medical treatments in the home is seen as a desirable social option. The ability to provide such an alternative to hospitalisation has been made possible by the rapid development of scientific knowledge, the enhanced safety and portability of new “high-tech” equipment, and by the improved housing conditions of much of the developed world (KPMG, 1996). However, perhaps the most important element in the expansion of Hospital in the Home (HITH) programs is that governments with capitalistic agendas struggle to contain health care costs in the public sector (Arno, et al., 1994; McNeal, 2000). Home care is seen as a way of shifting costs and meeting consumer needs. The move into home care assumes a home environment

Received 24 January 2003 Accepted 4 April 2003

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that is conducive to care. This literature review explores the economic, political, ethical and social impetus behind the development of home health care programs.

THE SEARCH STRATEGY

A number of sources were used to search the literature concerning the political and ideological impetus for HITH programs. A number of databases were used and a variety of relevant search terms utilised (see Table 1). CINAHL and MEDLINE were searched using the time frames of 1982–2002 and 1996–2002 respectively. Proquest 5000 (Health and Medical) was consulted using the default timeframe of 1998–2003. As could be expected there was a great deal of duplication among these databases. There were very few papers found that explored the underlying impetus for HITH programs, however many articles touched on the financial benefits of home care programs, waiting lists, improved throughput and strategies to prevent the phenomenon known as bed-blocking. Consequently it was necessary to access a variety of other sources including books on the subject, reports and government documents. These were obtained through library catalogues, searching of pertinent web sites and manual searching of the bibliographies and reference lists of seminal articles.

TABLE 1 SEARCH STRATEGY

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Only material published in the English language was accessed. The search terms addressed the various nomenclature used to describe acute home care nursing including, hospital in/the/ at home, acute high-tech home care and home health care. Hospital at home and home health care proved to be the most useful terms for the search strategy. Nevertheless, each of these terms included many articles that were subsequently excluded as they dealt with institutional nursing homes rather than the patients’ own home. Seventy-four sources have been used in this review.

THE HOME AS AN ALTERNATIVE SITE FOR CARE

The first models of hospital in the home (HITH) or home health care commenced in Europe, however, this type of health care delivery model is now the fastest growing area of the United States’ health economy (Daniels, 1995). The growth of such programs is being driven by a combination of demographic, technological, economic and consumer trends (Jackson, 1998) and is moving to the stage where it is seen as an alternative to hospital care rather than a means of recovering from inpatient care (Arno et al., 1994). In part this is as a result of the doubts that have been raised as to whether hospitals are the best place to care for the sick (KPMG,
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Hospitals according to Gleeson (1997), are ‘... not places where people can realistically expect to recover or improve’ (p: 34). In contrast, home based care is purported to offer patients increased independence, reduced disruption of family life and more autonomy over their treatment (Arno et al., 1994; KPMG, 1996). Consequently, patients are being discharged from hospital earlier while still experiencing symptoms of their illness (Pousada, 1995).

THE ANTECEDENT OF MODERN HOME CARE PROGRAMS

Acute home-based care is of course not a new trend (KPMG, 1996). Although such models are seen as modern initiatives and the way of the future, they are in fact a return to pre-industrial times when care in the home was considered normal (Arno et al., 1994; KPMG, 1996). Prior to the industrial revolution most care was provided in the home or in the abbeys and convents of religious orders (F. Clarke, 1984). Physicians or barber surgeons tended to those who could afford it, which left those who were not wealthy or privileged, to be cared for by female family members or the wise women of the community.

However, with industrialisation came the emergence of what we now call hospitals. Giddens (1991) contends that hospitals were initially a response to the impact of poverty but that they provided the beginnings of the medical institutions we now know. Like Foucault (1977), Giddens argues that the development of the modern hospital was closely tied to the professionalisation of medicine. Hospitals became sites where medical expertise and new technologies could be fostered, and medical knowledge increased. Over time the medical profession gained increased power and influence due to the knowledge gained from access to the bodies of the sick in hospitals (Giddens, 1991). Hence, through much of the twentieth century, hospitals were associated with excellence in medical scientific practice (Latimer, 1999a) and were held in high regard by members of society.

However, while hospitals remain the dominant focus for health care delivery (Montalto & Dunt, 1993) the discourses that surround public hospitals have begun to change. Hospital care is now perceived as inconvenient and dangerous whilst home care is marketed as a desirable alternative. As an example, Caplan et al. (1999) assert that:

When treated at home, patients do not have to change their environment or routine, they are not exposed to nosocomial infection, and they do not need to adapt to the sociological culture of the hospital.

Whereas, patients were once encouraged to trust the hospital system implicitly they are now urged to transfer their trust back to the home which is idealised anew as a place of comfort and healing (Purkis, 2000). Patients are drawn to the notion of continuing their lives while avoiding the hazards of hospitalisation by receiving care such as intravenous antibiotic therapy at home (Breier, 1999).

Despite the rhetoric surrounding the benefits to patients of acute home based care, there is little doubt that the impetus for the drive to more community-based health care worldwide emanates from the need for at least cost containment if not cost reduction (Cooper, 1999; Daniels, 1995; Sheppard & Iliffe, 1996). Hospitals save money when patients are discharged earlier (Caplan, Board et al., 1999). Consequently, although patient satisfaction surveys have shown some positive outcomes from home care initiatives (Jester & Hicks, 2003; Santamaria & McKenzie, 2000), these programs are expanding despite very little systematic evidence that they provide a desirable alternative to in-patient treatment (Iliffe & Gould, 1995).
ESCALATING HEALTH CARE COSTS

The phenomenon of globalisation has had an impact on the economies of nation states worldwide (Andersson, Levin, Öberg, & Månsson, 2002). The business principles of competitiveness and rationalisation are now applied to the funding of most public services in an attempt to reducing escalating healthcare costs (Gleeson, 1997; McMurray, 1999; Pollock, 1997). Expenses are said to be on an upward spiral due to an aging population prone to chronic illnesses, and the increased availability and use of advanced medical technologies (Gleeson, 1997; Montalto, 1996a; Temmink, Francke, Hutten, van der Zee, & Abu-Saad, 2000). The public hospital system internationally has been struggling to meet the demand for acute inpatient care (Dwyer & Jackson, 2001). In Australia as elsewhere, this has resulted in high waiting lists for surgery and long waiting times for assessment of prospective patients (Patient Management Task Force, 2001).

Many countries are now targeting innovations that reduce health care costs (2000) and human resources professionals have identified home health care services as a key strategy in decreasing hospitalisation and contain costs (Jackson, 1998). Dwyer and Jackson (2001) reviewed the international literature in order to identify the most effective way to reduce demand on acute public hospital beds and cut costs. Alternatives to hospital admission such as, the transfer of patients directly to home from emergency departments and the increase of same day surgery emerged as useful strategies. These initiatives were recognised as effective in increasing ‘throughput’ and lowering costs. The review identified that the elderly in the population were held responsible for much of the ‘bed-blocking’ in public hospitals and that the provision of readily available low intensity care settings, including home care was the most effective strategy to reduce this perceived problem (Dwyer & Jackson, 2001).

ELDERS AS BED-BLOCKERS

The notion that elderly people may be acutely ill and in legitimate need of an acute hospital bed is largely ignored in the debate on bed-blocking. Older people are consistently discussed in ways that position them as chronically, rather than acutely ill (Latimer, 1999b) and their occupancy of acute care beds is seen as an impediment to the efficient administration of hospitals (Wilson, 2000). The shift to home is seen as unproblematic when compared to the efficiencies that can be gained. However (Hughes, Hodgson, Muller, Robinson, & McCorkle, 2000) conducted a content analysis of 3,280 statements that documented the teaching interventions performed by advanced practice nurses during 4-week episodes of home care. Their findings revealed that elderly post-surgical cancer patients require considerable information support during the transition from hospital to home. Despite this type of evidence Vass (2002) reports that the government in the United Kingdom is to provide a financial incentive to patients over 75 year old as an inducement to leave hospital and be cared for at home. While studies by (Andersson et al., 2002; Jester & Hicks, 2003) have indicated that care at home is cheaper compared to in-patient care the alterations in usual family life and customs that illness imposes are generally disregarded (Ruddick, 1995).

SHIFTING HEALTH CARE COSTS

It is not difficult to see why the disruptions to home life are disregarded in the move towards increased use of HITH programs. Increasing efficiency is linked to outcomes, accountability, throughput, and identifying blocks in the public hospital system because health care has become a resource to be managed (Krizova & Simek, 2002; Rees & Rodley, 1995). According to Giddens (1991), capitalistic concerns represent the fundamental driving force behind modern institutions and aim to shape individual consumption. Pollock (1997) asserts that the principles
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CJV; eco~onic rationalism operating in the health care system insist upon faster turnover, decreased length of stay and increased use of the private sector. This approach he claims, places costs directly onto individuals but depresses standards and quality of care. Similarly Avis (1999) claims, that there is a move in health care management to shift the emphasis of resource distribution from the needs of the collective to one of individual responsibility. Andersson et al., (2002) found that there is a redistribution of costs away from health care providers in home rehabilitation, whilst Arno & Levine (1999) point out the often unacknowledged economic value of unpaid caregivers in the community.

The funding of public hospitals is in many countries, tied to the number of bed days and throughput (Patient Management Task Force, 2001). Although considerable savings and efficiencies have already been made in the hospital system with the increase in technology that allows for less invasive procedures, shorter stays and requires less nursing input it seems that still more savings are required (Purkis, 2000). Evidence has been offered (Jackson, 1998; Temmink et al., 2000)(Jones et al., 1999; Sheppard & Iliffe, 1996) that points to the efficiencies that are possible for hospitals if home care substitutions are increased. Accordingly, alternative health care delivery models that facilitate substitution for hospitalisation are encouraged and rewarded (Hensher, Fulop, Coast, & Jefferys, 1999).

ALIGNING ECONOMIC INTERESTS TO CONSUMER CHOICE

Although patient preference is offered as a motivating force behind the growth of acute home care programs (Hensher et al., 1999) there is a strong economic and political advantage for institutions to have people resume responsibility for their own care. In addition, managerial objectives are strengthened by the consumerist movement that encourages patients to articulate their needs and expectations (Lupton, 1996; Pollock, 1997; Pousada, 1995). According to Clayton (1994) more and more care will be delivered at home as the health care system moves from a non-competitive medical model to a customer focussed one. The call for consumer focussed health care legitimises activities that lead to cuts in public spending and shifts responsibility from the public sector to the individual (Avis, 1999).

Latiner (1999b) and Pollock (1997) point out that the financial objective of speeding up throughput by transferring patients to their homes, has been skilfully represented as in the best interests of customers/patients who are said to demand their right to alternatives to hospital care. Governments have succeeded in creating a need for home care as a commodity. By doing so they have harnessed their capitalist agendas to individual wants and needs ensuring that the satisfaction of these becomes basic to the system (Giddens, 1991). Accordingly Jackson (1998) asserts most people prefer to remain in their homes, surrounded by their families, possessions and pet.

There have been several arguments that champion patient choice and customer focus (Clayton, 1995; Hensher et al., 1999). Heller, et al. (1999) assert that today's patients are educated consumers who demand more power in their relationship with health professionals. Although Clayton (1994) describes home care as driven by a customer focus with people experience more autonomy and independence leading to a quicker recovery, unfortunately she does not present evidence to support these claims. Rather, she acknowledges that 'the stress and strain on the health care system is challenging Clinicians and Administrators to search for alternative ways of providing acute services' (p:8).

It is clear that many patients appreciate the ability to choose an alternative to hospital admission and feel more in control when in their own home (Jackson, 1998). For some,
such as cancer patients, the choice of home care can facilitate a better quality of life (Arno et al., 1994; Pfister, 1995). However, Pousada (1995: 108) suggests that the dialogue around increased patient choice is at best illusionary. He points out the irony embedded in the move to acute homecare services,

... this trend towards patient autonomy and a more “kindly”, less institutional approach to medical care has coincided with the financial realities of prospective payment systems...

MANAGERIAL INTERESTS
Although initially slow to embrace the shift to home care, health administrators in both acute hospitals and government health departments have recognised the potential benefits of transferring patients home earlier (Cooper, 1999). The financial advantage to be gained from reduced hotel costs such as, cleaning and food preparation have provided a strong incentive for home care initiatives to be undertaken. Advances in medical technology, improved housing, and the emphasis on primary care have assisted this plan and resulted in care in the home being seen as an appropriate way of providing safe, cheap health care (Cooper, 1999; Jackson, 1998; KPMG, 1996). Therefore, these programs have been welcomed as a means of reducing costs by reducing length of stay and of delivering comparable care at similar or lower cost than an equivalent admission to an acute hospital (Board, Brennan, & Caplan, 2000; Caielawrence, Peploski, & Russell, 1995; Hensher et al., 1999; Jones et al., 1999; Maclntyre, Ruth, & Ansari, 2002; Sheppard & Iliffe, 1996).

THE REALITY OF ACUTE HOME CARE AND FINANCIAL BENEFITS
The use of the word equivalent is problematic in most of the studies that have investigated comparative costs. There is a need to look at how patients are chosen when such comparisons are made (Padigilone, 2002; Temmink et al., 2000). While there is some evidence that bed days can be reduced (Daly, 2000; Obeid, 1996) there is no evidence that home care program can assist the health care system to become more efficient without jeopardising patient outcomes (Angus, Auer, Cloutier, & Albert, 1995). Claims of less costly health delivery are not always explained. When reporting improved fiscal management, data rarely explicate that patients at home come from a low risk category, and are chosen because they are not likely to experience complications (Vinay, Haas, Shanahan, & Cameron, 2001). In these circumstances it is highly likely that costs will be lower. Conversely, hospital costs are more likely to be high because patients who are sicker require a longer stay and are therefore more resource intensive (Arno et al., 1994).

Consequently, while studies continue to be couched in positive language there is hesitancy about the assertions made with regard to possible economies. A political environment, which rewards those who shift patients into the home, is reflected in the language employed to report outcomes from home care programs. Statements such as at ‘cost-effective for certain acutely ill older persons’ (Leff et al., 1999: 1) and ‘appears’ to be beneficial (Grayson, 1998: 262) make-up a discourse of generality which is common in the discussion of cost savings in acute home care. Even those who report no significant differences (Hensher et al., 1999; Sheppard, Harwood, Gray, Vessey, & Morgan, 1998) usually soften this finding with a discussion of the positive anecdotal evidence available. This commitment to presenting the positive side of the transfer of patients to acute home care programs assists the programs to be reproduced and ensures their viability. Overall, however, it is a matter for contention whether costs are reduced or merely shifted (Andersson et al., 2002; Board et al., 2000; Daniels, 1995; Rice, 1998).
SHIFTING COSTS
Despite the cost containment focus of the debate around home care it is unclear whether there are any actual benefits for all patients and carers as well as any financial benefit to the community (Cooper, 1999). Cost containment structures and initiatives tempt those responsible for discharge planning to benefit the hospital at the expense of the unsuspecting family (Arras, 1995). When a patient is cared for in the home there are inevitable shifts in the burden of financial responsibility (Rice, 1998). Families and friends contribute time to the care process, perhaps to the extent of altering or cancelling work commitments. The savings celebrated by the hospital in terms of food provision and laundry services, are resumed by the unpaid family members or caregivers (Arras & Neveloff Dubler, 1995; A. Clarke, 1997; Daniels, 1995). Home care can place a strain not only on the caregivers' financial capacities but also on their physical and emotional selves.

Santamaria et al. (2000) conducted a series of structured interviews to investigate the effects on of health and lifestyle experienced by carers in HITH programs. The participants were consulted regarding their information needs and the psychological processes they went through. They reported sleep disturbance, stress and financial implications and 60% reported reduced health status themselves. Similarly Montalto (1996b) conducted telephone interviews with patients and carers following their discharge from a hospital at home program, the results of this descriptive survey revealed that patients and carers preferred home care to traditional hospital care. The patients in this study were however, still reliant on the hospital for ongoing care and treatment so the potential for bias in these results was high.

The expectation that caregivers can and will manage equipment and technical care can be a burden that results in loss of sleep and reduced health status. However, (Santamaria et al., 2000) counter that most carers find the sacrifice required is acceptable given the short-term nature of the acute episode at home. Certainly, Jester and Hicks (2003) found that the majority of carers respond positively when asked about their experience of home care. What is not acceptable to some though, is the disruption to their private lives made possible by the opening of their home to the scrutiny of sometimes judgmental health professionals (Bloor & McIntosh, 1990; Cooper, 1999).

MEDICAL AND NURSING INTERESTS
Latimer (1999a) points out that issues of cost saving, and efficient management of resources were once confined to hospital administrators, more recently however, reducing bed days and increasing throughput have become the objective of not only administrators, but of doctors and nurses alike. She further argues that doctors have been co-opted into realigning their interests with those of management. They are now responsible for rapidly moving patients through the system and are accountable to managers for their performance in this regard. According to Laughlin (1996), administrators no longer provide money for professional work to occur, rather they now define professional activities linking output measures to input resources.

Similarly, nurses have become engaged in a gate-keeping role, becoming channels for both medical and managerial objectives (Latimer, 1999a). As an example, whereas once triage in an emergency department (ED) was the entrée to further hospital treatment, it has become a barrier through which it is difficult for patients to pass. Doctors with nurses advice now identify those patients who can go straight to home care programs for treatment without having to set foot beyond the ED. The patient is considered to be have been admitted yet they do not take up a bed, or require the associated hotel
services. Brierley and King (1998: 40) claim that:

Emergency departments, as gatekeepers to acute hospital services, can play a strategic role in implementing bed management strategies and home based care.

However, Creasey (1997) argues that this type of initiative leads to patients being prescribed expensive intravenous antibiotics for conditions that may well have responded to oral treatment. Nevertheless, the transfer of patients from ED to a home care program is an increasingly popular choice for doctors who are no longer 'benevolent guardians' (Pousada, 1995: 107) but are agents of a political program.

THE SOCIA L ISSUES OF HOME CARE

Little attention seems to have been given in the literature to the social dilemmas which are likely to occur as a result of the blurring of the lines between hospital and home. Currently, the admission to hospital provides permission for the sick person to suspend all normal roles and responsibilities (Arras & Neveloff Dubler, 1995). Men, women, wives, mothers, husbands, fathers and children are released from their normal role obligations. In return they give up the power embedded in their social role to hospital staff. The surrender of their right to exercise such power can provide cause for both relief and concern. Lupton (1997), asserts that there are benefits for the patient in allowing themselves to be dependent upon health professionals but this does not necessarily equate to a surrender of power.

Nevertheless, care at home shifts the balance in the relationship between patients and health professionals. According to Ruddick (1995) patients at home may still be expected to function in their usual role by family members but are at the same time expected to deal with their illness and the treatments required for it. There is little scope in our society for the pessimistic or grumpy patient who is lucky enough to be cared for at home and so discomfort is sometimes concealed or minimised (Ruddick, 1995). Consequently, acute, care interventions at home, may lead to the loss of the sense of the home as a source of comfort that promotes healing (Gardiner, 2000). Home is clearly a therapeutic environment for many, but there are some who are concerned that the 'gaze of medicine' which dominates the hospital setting is likely to follow the patient home (Cox & Cox, 2000; Liaschenko, 1994). The medical ethicist Arras (1995) suggests that the use of complex technology in the home amounts to over-medicalisation, and an extension of medical control into the once private setting eroding its intimacy, privacy and freedom.

CARER BURDEN

Institutional motives are not always clear to patients and their families when the offer of care at home is broached. The voluntary nature of an alternative care model such as HITH is integral to the discourse of choice and individualism. In reality many that accept have little idea of what such a preference entails. Carers may underestimate the commitment required and misjudge the pressures involved in caring for a sick relative (Carr, 1995).

The unpaid burden of the care does not fall evenly on family members but rests mostly with the female members. Indeed, male patients with a carer have been found to require fewer visits from the nursing staff because their wife/female carer took on the role (Ballard & McNamara, 1983). The assumption that women will accept this added responsibility is described by Arras (1995: 8) as:

... parasitic on widespread but socially unjust roles for women caretakers. The traditional image of the 'home as castle' reflects a male point of view; its appeal derives in large measure from the unstated premise that
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someone else [Authors’ emphasis] will be doing the cooking, cleaning and caregiving.

The option of refusing to become the carer for a family member is fraught with feelings of guilt that are not likely to be dispelled by an institutional structure motivated by self interest. In any event it is not uncommon for carers to be left ignorant of the decision to transfer the patient home. Montalto (1996b) states that the carer needs to agree to be available but acknowledges that they are not assessed as to their suitability or asked whether they are willing. Currently, consent is only obtained from the patient (Santamaria & McKenzie, 2000). Consequently, carers have little choice but to agree to become caregivers. It is difficult for a parent to refuse to take a child home, or for a daughter to reject a parent’s care, particularly when it is evident that hospital staff believe the patient would be better off at home (Arras & Neveloff Dubler, 1995).

THE ETHICS OF HOME CARE

Health professionals are generally perceived as committed to the ethical care and cure of the ill, including patient welfare and questions of equity and justice. Increasingly however, the debates related to these concerns reveal a shift in the focus of the medical and nursing discourse surrounding acute home care to one that supports managerial objectives (Latimer, 1999b). This approach is couched in ways that appeals to a person’s natural desire to be cared for in familiar rather than institutional surroundings and by positioning home care as “a more caring approach to the sick and disabled” (Pousada, 1995: 108).

The discussion surrounding the burden on the home and carer supposes that these resources are readily available to all. Grande (2002) point out that recipients of hospital in the home services for palliative care tend to be younger and come from more affluent areas that those who remain in hospital. Rose (1989) acknowledges that there is a less heralded argument that surrounds society’s failure to deal with those who have no home and/or no carer. While health for all is the common mantra of governments there are those who are disenfranchised when alternative health care models are offered. The ideal of a home, which is conducive to recovery and healing, fits best with a middle class conception of the family home. Staley (1999) provides criteria against which assessment of patient suitability can be made. Homes with too few rooms, too many occupants, poor sanitation and without resources such as the telephone are perhaps rightly, not considered suitable for the conduct of hospital care at home. Therefore, those whose homes do not fit the stereotype are barred from home care options (Ruddick, 1995). Issues of justice and equity such as these require careful consideration before resources are redistributed away from hospitals. Darr (2000) presents another view on the equity issue when he argues that hospitals in the United States have a responsibility to conserve their resources for in-patient acute services rather than becoming distracted by community care programs such as home care.

CONCLUSION

In this review we have explored some different ways of examining the alternatives to hospitalisation that HITH or acute home care programs offer. Instead of uncritically reproducing the literature that lauds this venture, we have set out to examine the evidence base for some of these claims and to identify competing claims. In this process we have demonstrated that although there are many advantages for some patients including comfortable surroundings and familiar diet there are also other reasons why home care is being touted as the best option.

Hospital administrators encourage their proliferation as cheap, safe forms of patient care that relieves the strain on the resources of acute care hospitals. Clearly however their implemen-


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