EXECUTIVE SUMMARY

FINDINGS FROM REGIONAL PRACTICE FOCUS GROUPS
CONDUCTED FOR THE INITIATIVE:

ESTABLISHING A NATIONAL FRAMEWORK FOR GERIATRIC HOME CARE EXCELLENCE

I. INTRODUCTION

Overview: This report presents findings from Regional Practice Focus Group (RPG) discussions with home health care clinicians, administrators, and academic experts in geriatrics. The focus group discussions were a part of the initiative, *Establishing a National Framework for Geriatric Home Care Excellence*, undertaken by the VNSNY Center for Home Care Policy and Research and funded by The John A. Hartford Foundation. Groups were designed to explore the view from the field, drawing on experiences and insights of professionals engaged in everyday practice of home health care as well as geriatric experts. These focus groups were carried out by Susan S. Hopper, PhD (Consultant), in collaboration with project team members Janice B. Foust, PhD, RN (Co-Investigator) and assistance from Dhara Naik, MPH (Research Analyst).

Methods: Qualitative methods[1], in particular, focus groups, were chosen because they encourage exploration of experiences, interaction among the participants as they answer questions, and presentation of different viewpoints. Computer-assisted telephone focus groups were chosen as a method to efficiently obtain information in a short time frame from a variety of professionals dispersed within three regions of the country. The Consultant prepared a moderator's guide using semi-structured questions that was suitable for a 90-minute group. She conducted the three groups during early March 2008.

Participants were recruited to represent a mix of professionals engaged in home health care including agency administrators; specialists/therapists such as occupational therapists; home health care physicians; clinical nurse specialists; and academic experts with an interest in geriatrics and/or home health care. A total of 30 professionals participated in three groups (See Attachment A: Participant List). They were also recruited from three regions of the country (East, Central, and West) with an effort to incorporate communities of various sizes including rural representatives in each group. By mixing participants from different states and communities within each region we also hoped to bring local perspectives to this project, not otherwise available. An analysis of the transcripts was conducted to identify themes and patterns (i.e. points of convergence and divergence), frequency of mention of topics, and identification of illustrative quotes.

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[1] Sofaer S, Firminger K. Patient Perceptions of the Quality of Health Services. *Annual Review of Public Health.* 2005;26:513–59.

A table was developed that lists helpful programs and resources identified by participants (See Attachment B: Programs and Tools that Contribute to Geriatric Home Care Excellence).

II. POSITIVE ASPECTS OF HOME CARE – THE GOOD NEWS

We intentionally began discussions with a focus on the positive aspects of home health care. Our goals were to understand what motivates people to practice in this difficult area as well as their views of what is working well for older adults, as both will provide the foundation for moving forward with geriatric home health care. Across regional groups, participants highlighted many of the "pockets of success" in geriatric home health care while simultaneously underscoring the existing inadequacies in strategies and infrastructure, (funding and resources, e.g. workforce) needed to systematically generate success in the care of older adults.

- **What are the most rewarding aspects of providing geriatric home care?** These include (1) supporting autonomy, choice, and safe functioning of older adults at home; (2) practicing more comprehensive and individualized care (including incorporating a multi-disciplinary approach); and (3) opportunities to teach and contribute to the field of geriatric home health care.
- **What is working well for geriatric patients in home care?** These include (1) home health care is viewed by others as an essential part of healthcare (e.g., greater integration of home health care providers in the care continuum; the referral process; and patients accepting home health care services because it is affordable); (2) core approaches to care (e.g. comprehensiveness of the initial assessment; multi-disciplinary approach; and "the client and loved ones as the central focus"); and (3) other up-and-coming strategies that are promising but not widespread (e.g. promoting care coordination; increasing attention to "helping people be able to do more for themselves"; use of specialty staff to address high-risk patient needs; front loading visits to prevent re-hospitalization; use of 'patient oriented' assessment tools to capture the patients' experience of function and symptoms; better wound care management; and use of telehealth).
- **What programs and resources are making a difference at the local, state and national level?** These include (1) examples of State programs that "support people in their homes rather than institutions", many of which are Medicaid funded; (2) federal/CMS demonstration programs (e.g., use of physicians in the home and telehealth); and (3) regional/local direct service programs (e.g., transition programs that coordinate care for older adults as they move across different providers or types of care; community—academic partnerships to enhance care and coordination; pharmacy-physician coordination; and home safety initiatives); (4) physician home visiting services; (5) training to advance clinicians' knowledge and expertise in geriatrics (e.g., The John A. Hartford Foundation initiatives; federally funded Geriatric Education Centers; and other individual academic endeavors); (6) other initiatives and websites that offer guidelines and support for best practices relevant to geriatric home health care;

and (7) support from oversight and accrediting organizations (e.g. Quality Improvement Organizations and some state agencies) to implement best practices.

III. GAPS IN CARE AND MOST DIFFICULT ASPECTS OF CARE

Participants identified specific gaps where a cascade of problems frequently led to significant deficits in geriatric home health care. Participants in each group described a number of gaps in care that are common to all areas, while some are particularly acute in rural areas, including:

- **Uncoordinated fragmented home health care.** This pervasive problem was seen as one of the major factors holding home health care back from being successful. Participants returned again and again to the multifactorial gaps in care affecting older adults (e.g. lack of comprehensive planning, clinicians' inadequate geriatric training, limited specialist involvement) that lead to ineffective or non-existent implementation of care, serious problems, and possibly hospitalization or institutionalization. They identified the following contributory factors: (1) poor integration of effective and reliable tools into practice; (2) lack of follow through after an assessment; (3) lack of analysis of underlying causes of preventable problems (particularly related to four key areas: medication management oversight; safety and functioning; nutrition support; and need for mental health and cognitive impairment support); (4) poor interdisciplinary planning, communication and implementation; (5) inadequate physician involvement; and (6) poor coordination across providers (e.g. home care agencies and hospitals), creating 'silos of care' (including information disconnects – "so people tell their stories over and over"; after the case is closed-patients are "right back where they were, Never-Never land"); and (7) lack of appropriate referrals to palliative care.
- **Lack of patient/family involvement in care planning and implementation.** Specific issues include (1) no caregivers; (2) lack of necessary time to teach and support patients and caregivers to learn how to self-manage.
- **Workforce issues--the sheer lack of numbers.** For some participants, this was the personally most difficult aspect of their own work and they also mentioned the contradiction inherent in planning for new programs without recognition about lack of a workforce, or high turnover rates. They discussed (1) direct care workers[2]—"competing with the casinos"; (2) lack of skilled professional staff, which has some agency directors saying they must 'beg, borrow, or steal'; and (3) lack of qualified physicians.
- **Lack of geriatric training for all disciplines and levels of care and lack of information sharing about best practices.** Specific areas included (1) inadequate training for direct care workers including those providing private duty care; (2) nursing schools with inadequate enrollment capacity in general and limited attention to geriatric home health care; (3) lack of interdisciplinary training; (4) inadequate collaboration between academia and the practice

[2] Focus group participants consistently used the term 'paraprofessionals' to refer to home health aides, home attendants and nursing assistants. We use 'direct care worker' in this document as this is the term used in other documents from the Framework Initiative.

communities; and (5) lack of opportunities among geriatric home health care providers to share information about implementation of best practices.

- **Limited guidance for quality improvement.** Participants discussed their mixed experiences working with The Joint Commission and other accrediting agencies and the loss of QIO support specifically for home health care.
- **Gaps in funding and policy associated with current practice gaps,** including (1) the emphasis on episodic rather than long-term coordinated care for chronically ill older adults; (2) interpretation of 'improvement' that is driven by funding rather than evidence; (3) no or highly limited reimbursement for certain clinical experts (e.g. social workers); (4) inadequate funding for community long-term care, such as Medicaid waiver programs, which are viewed as highly successful but so "under funded that most of the home health agencies can't afford to be part of it." They also provided details about specific gaps within those programs (e.g., lack of funding for basic personal support and home assistance; omission of preventative care in home health care; under-funding of supportive services such as meal programs and transportation; inadequate reimbursement for rural travel; and non-reimbursable equipment and/or service (e.g., telehealth). (5) Special issues for rural home health care (e.g. inadequate travel reimbursement, lack of medication alert systems and lack of geriatric trained physicians).

IV. SUMMARY AND RECOMMENDATIONS

The Regional Practice Focus Groups brought together representatives from diverse disciplines and work environments, yet there was much convergence of views related to current strengths and deficits in geriatric home health care. Participants provided numerous examples of what was currently working in the delivery of geriatric home health care, ranging from core practices, to emerging strategies and specific programs that provide exemplars of good geriatric home health care; and helpful national and regional training and resources directed at best practices. This "good news" forms an essential platform for future efforts to support high quality geriatric home health care. However, they also identified gaps in care and deficits in strategies that were consistent and significant across agencies, communities, and the three regions. The primary divergences were less related to discipline or region and more related to experience with rural and under populated areas, where as a matter of degree, staff shortages, imperiled agencies and other practical challenges were highlighted.

In addition, participants had a striking appreciation of infrastructures needed to propel best practices into home health care that address the unique needs of older adults. Groups were also eloquent in dissecting the specific gaps associated with practice implications. In addition, these participants were astutely aware of the direct connection between policy and funding decisions affecting practice. For example, all groups mentioned preventing re-hospitalizations as a goal coinciding with professional, personal and policy values of providing the best care in a more cost-effective way that supports older adults in their home. Participants also highlighted essential changes at the policy and financing level that were necessary for high quality geriatric home health care to be achieved.

Of note, participants across regional groups shared similar views about the most personally rewarding components of geriatric home health. These fell into three thematic areas: (1) Supporting autonomy, choice and safe functioning of older adults at home; (2) Practicing more comprehensive and individualized care (including participating in multi-disciplinary care); and (3) Pursuing opportunities to teach and contribute to the field of geriatric home health care. These thematic areas were evoked by diverse disciplines and reappeared throughout discussions as important areas for high quality geriatric home health care.

Moreover, throughout the discussions participants continued to emphasize the importance of collaboration and of multidisciplinary efforts as a key to successfully addressing complex problems common to geriatric care. At the same time, participants acknowledged frustration regarding the frequent failure to implement a multidisciplinary, collaborative approach to home health care.

There was strong interest expressed among the diverse members of the Regional Practice Focus Groups in becoming involved in a network to connect clinicians, administrators and researchers and support the infusion of best practices into geriatric home health care. These findings suggest specific opportunities to address the gaps identified by participants through future quality improvement activities. Recommendations and selected strategies derived from the Regional Practice Focus Groups include to:

1. Coordinate care within the agency and with physicians:

- Integrate assessment tools relevant to older adults living at home.
- Establish mechanisms to follow through on issues and track progress.
- Embed multi-disciplinary care as a core practice.
    - Build understanding of potential contributions of various specialists to geriatric home health care
    - Make appropriate referrals to specialists (Occupational and Physical Therapy, and Social Work)
    - Create incentives and strategies to support a multi-disciplinary approach to care for geriatric patients
- Engage physician support, targeting those active in home health care.
- Educate and actively involve patients and/or family caregivers to better ensure follow through during and after professional interventions.

2. Analyze underlying causes of potentially preventable problems.

- Target four areas where problems commonly occur:
    - medication management;
    - safety and functioning;
    - nutrition support; and
    - mental health support including addressing cognitive impairment.

- Analyze causes of problems in the context of the home setting and patient habits: See the whole picture in order to individualize care.
- Act on multi-disciplinary input into plan of care.

3. Overcome fragmented care at the community level:

- Implement bridge programs that include palliative care for high-risk patients recently discharged from the hospital.
- Generate mechanisms to share and track information across settings.
- Identify local and regional alliance and incentives to build bridges between silos of care.

4. Create opportunities to stay connected with geriatric home care providers and experts outside their agency:

- Create a network to connect clinicians, administrators and researchers and support the infusion of best practices into geriatric home health care.
- Identify key stakeholders of a network such as: professional organizations involved with home health care and/or geriatrics, professional and quality improvement organizations, state agencies as well as academic institutions.

5. Educate and build knowledge of geriatric home care best practices across disciplines and providers:

- Generate geriatric education opportunities targeting unique aspects of home health care and multi-disciplinary skill building through collaborations with agencies, providers, academic institutions, professional organizations, and other regional and national resources.
- Integrate best practices in geriatric home health care into continuing education offerings.
- Provide multi-disciplinary education and training to identify and address underlying causes of preventable problems in older adults.

6. Revise policies related to meeting the needs of older adults in home care:

- Provide opportunities for leaders in geriatric home health care to meet with regional and national healthcare leaders regarding manpower, reimbursement, and training needs.
- Link with professional and state based groups (e.g. the American Association of Home Care Physicians) to educate policymakers regarding needed changes in home health care policies and reimbursement.

In conclusion, the Regional Practice Focus Groups provide valuable insight into the current state of providing home health care to older adults and their caregivers. Their perspectives are a valuable source of evidence to inform the Initiative, *Establishing a National Framework for Geriatric Home Care Excellence.* Collectively, these "voices

from the field" illustrate the many rewards, challenges, opportunities and commitment to elevate the quality of geriatric home health care practice. It is hoped that these findings will contribute ideas and strategies grounded in daily practice to help shape priorities and recommendations designed to advance a national agenda of excellence in geriatric home health care.