FINDINGS FROM REGIONAL PRACTICE FOCUS GROUPS

CONDUCTED FOR THE INITIATIVE:

ESTABLISHING A NATIONAL FRAMEWORK FOR GERIATRIC HOME CARE EXCELLENCE

REPORT SUBMITTED TO:

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I. INTRODUCTION

A. Overview

This report presents findings from Regional Practice Focus Groups conducted by the VNSNY Center for Home Care Policy and Research (CHCPR) with home health care clinicians and administrators and academic experts with an interest in geriatric home health care. This project was part of a broader initiative, *Establishing a National Framework for Geriatric Home Care Excellence*, which was 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. The intent of the focus groups was to obtain perspectives from various disciplines and geographic regions. Consultant Susan S. Hopper, PhD, carried out these focus groups and analysis in collaboration with Co-Investigator Janice B. Foust, PhD, RN, with assistance from Research Analyst, Dhara Naik, MPH.

B. Methods

Computer Assisted Telephone Focus Groups

Qualitative methods,[1] in particular focus groups, were chosen because they encourage exploration of different views and experiences, and interaction among the participants as they answer questions. Telephone focus groups were chosen as a method to efficiently obtain information in a short time frame from a variety of professionals in three regions across the country. This method also had the potential to decrease last minute drop out due to the burden of travel or changes in busy work schedules. By mixing participants from different states and communities within regions we also hoped to bring local and varied perspectives to this project. Computer-assisted telephone focus groups use technology that offered additional features to the moderator, such as the ability to view who is present on a computer screen, who is currently speaking, and to communicate privately via instant messaging with the operator regarding technical issues (e.g., background noise) and/or with members of the research team regarding substantive issues (e.g., adding a follow-up question).

1. Moderator's Guide

The Consultant prepared a moderator's guide using semi-structured questions that was suitable for a 90-minute group. Prior to use, the project team at the Center reviewed the guide as well as a preliminary list of issues relevant to home health care practice, policy

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

and research. The overarching goal was to gather information regarding day-to-day practice as well as local and regional programs, strategies, and challenges related to home health care for frail and very sick elderly people, i.e., geriatric home health care. The guide for discussions was organized into five broad sections:

- *Overview*. At the outset of the groups, the moderator introduced herself, the project, reviewed confidentiality issues, and the purpose and conduct of the group;
- *Introductions*. During the first part of the discussion, the moderator called on each participant to give his/her name, discipline, and primary work setting; participants were also asked for their views of the most personally difficult as well as most rewarding aspect of providing home health care.
- *The state of current practice in geriatric home care*. Participants were asked about what was working well; what are routine practices that benefit frail older patients being implemented by many, if not all agencies; and what are the most critical gaps in home health care.
- *What is making a difference: Innovative Programs and Tools*. Participants were asked for examples of what was making a difference in their region. They were asked to describe the program, their experience with it and how it was addressing a gap and improving care to older adults in their homes. In addition, participants were asked where agencies were getting support to implement best practices and high quality geriatric home health care.
- *Vision for the future.* In the final section, participants were asked for their vision for geriatric home health care in the future and what could make a difference in terms of improving it. They were first asked about potential strategies at the agency level; then the kinds of additional resources, whether tools, networks, or other, that could make the greatest differences; and finally, where the initiative should make connections with organizations engaged in innovations and implementing changes.

2. Conduct of the Focus Groups

The Consultant moderated the three focus groups, which were held during the first full week of March 2008. Along with confidentiality issues raised by the moderator in the overview section (see above), the moderator asked participants, who were not visible to one another, to mention their first names each time they spoke. They were also told that the discussion would be tape recorded and transcribed for the purpose of analysis. Participants were told that no quote would be attributed to a specific person but that their name would be included in a participant list. They were also informed that some members of the project team would be silent listeners. Listening in (but not audible to participants) were the members of the research team at the Center for Home Care Policy and Research and selected members of the project's National Advisory Council (to see full membership, go to http://www.champ-program.org/framework/) As silent listeners they sent suggestions to the moderator via instant messaging for follow up or

clarification. Participants were initially linked to the group via an operator, who remained available for technical assistance throughout the call. Transcripts were prepared from the recordings by the company providing technical assistance, which were sent to the team for analysis.

3. Recruitment

In recruiting participants, we aimed to get diversity in (a) discipline; (b) region (see below); (c) role, and (d) urban/rural representation. Participants were purposively recruited so that each group represented a mix of professionals (i.e. disciplines) engaged in home care including agency administrators (each of whom also had clinical training); specialists/therapists; home care physicians; clinical nurse specialists; and academic experts with an interest in home health care. Focus groups were organized around three separate regions of the country (East, Central, and West.) Participants were recruited in several ways. The project staff issued a public call for nominations in the early fall of 2007; staff conducted various outreach activities (e.g. a reception at the annual National Association for Home Care and Hospice (NAHC) conference; presentations to interest groups at Gerontological Society of America's annual research conference; and professional newsletter announcements). In early 2008, key informants were contacted for recommendations in areas where few or no professionals were represented. Invitations were e-mailed and in some cases, follow up e-mails and telephone calls were made. The goal was to recruit between 7 and 11 individuals for an ultimate size of 6 to 10, considered a typical focus group size [2] in order to encourage time for responses and discussion. While a few people were unable to participate due to prior commitments, all who agreed to participate in the discussions did so, with no dropouts.

4. Participants' Profile

A total of 30 professionals participated in the three focus groups (in groups of 9, 11, and 10). [See Attachment A. List of Participants]. Each group reflected diverse disciplines, roles, and community size. Across groups, participants included administrators of not-for-profit home health care agencies (who were also clinically trained); home health clinical specialists/consultants to agencies (e.g. occupational therapists, consulting pharmacists); a geriatric care manager; physicians with a home health care practice based at universities, private group practice or a vertically integrated system; and academic researchers with an interest in geriatric home health care.

5. Analysis and Report

First, the Consultant and the Co-Investigator on the project read each transcript in its entirety. Key topics were identified with illustrative quotes. Three analytic meetings were held by the authors to identify themes and patterns (i.e., points of convergence and divergence) within each group and across groups. The Consultant and Co-Investigator

[2] Morgan, D.l. and Scannell, A.U. 1998. Planning Focus Groups. Sage Publications: Thousand Oaks.

undertook further analyses to identify the frequency of similar views and capture the diversity of comments. They also identified illustrative quotes to authentically represent the views of participants. The questions in the guide (including specific probes) were used as the basis for sorting, analysis and reporting of findings. In addition, using a framework provided by the Consultant and Co-Investigator, the Research Analyst created a table for attachment (see Attachment B.Programs and Tools that Contribute to Geriatric Home Care Excellence) to this report that lists helpful programs and resources mentioned by participants. For accuracy, the Research Analyst retrieved program details and contact information from selected participants and Internet searches.

II. POSITIVE (GOOD NEWS) ASPECTS OF HOME CARE

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

A. <u>What are the most rewarding aspects of providing geriatric home care?</u>

At the outset of the discussion, participants were asked about the personally most rewarding aspect of their involvement in caring for older adults receiving home health care. Responses were consistent across regional groups and disciplines and grouped into several themes: opportunities to (1) support patient autonomy and functioning; (2) practice more comprehensive patient care; and (3) teach and contribute to the emerging field of geriatric home health care. In detail:

1. Support patient autonomy and functioning.

Not surprisingly, the most commonly and immediately mentioned rewards entailed helping older adults stay in their homes…"their own environment" and "out of a facility." They spoke of "promoting aging in place…we don't fix and cure, [we] provide wellness and quality of life." To do so, the participants simultaneously talked about promoting older adults' autonomy, choice, function and preventing harm to them. The importance and roles of informal caregivers were woven into the discussions in ways that underscored their importance and centrality to providing geriatric home health care.

- ***Support autonomy and choice.*** One participant said the biggest reward was "helping patients to achieve their goals"; and stay at home "safely" and maintain "maximum level of functioning." The participant continued, "I think it's helping people stay where they want to be at the last phase of life." Another who valued,

"allowing people to stay where they want to stay," echoed this view. Still another spoke of "having the honor of supporting people in their own homes and make decisions, particularly when they are best informed decisions." One spoke about "giving the family new skills and the patient new skills" so that they are able to "stay in their same living environment;" another referred to "supporting the families and significant others of our …elder clients so those informal supporters can do what they want to do to help their loved ones stay at home." A social worker described the rewards of "helping people who have mostly fallen into the cracks, make choices that can improve the quality of their lives, or give them access to resources they would not otherwise have."

- ***Assisting with functioning and preventing harm***. A related reward was being able to support a particular aspect of functioning (typically one that reflected the professionals' own area of expertise), such as "helping them get on or off their own furniture"; "provide them with food…as part of their life that they enjoy." For a consulting pharmacist, the most personally rewarding aspect was to "decrease their medications by working with physicians or preventing them from having a fall" while inferring a more positive outcome of avoiding hospitalization.

2. Practice more comprehensive patient care.

The participants shared many examples of how they capitalize on information and opportunities uniquely available to them in the home. Specific advantages included:

- ***Individualizing care by "seeing the complete picture".*** "The best part of the job" said an agency director is that "it is total nursing." Nurses can "individualize their care; help with instruction, disease management." A physician commented that "You can spend the time you need to take care of patients with high-acuity medical problems which is difficult in an office setting." Many agreed that an advantage of providing care to older adults in their homes was "seeing the complete picture." One participant described, "Our ability to go into a client setting and actually see first hand what is really going on to be able to help them." Another stated, "We can go medicine by medicine through the bag or the medicine cabinet and be very clear about such details that often remain unknown and invisible in the office"; and evaluating whether or not the home is the best setting for the person.
- ***Participating in and seeing the benefits of multi-disciplinary practice***. One nurse referred to the satisfaction of being able to help her patients "with all of the various disciplines." Throughout discussions, participants underscored their belief in the benefits of multidisciplinary care to address complex needs of older adults. Therefore, this issue is addressed at various points in this report.
- ***Getting quick feedback about what works***. Several participants noted professional rewards of witnessing an intervention working because they are in the home and actually see what happens – or not. "What is most gratifying to me personally as a clinical social worker…the gratification is almost immediate.

Usually [with] an intervention in a home, you know immediately if it is going to work and you also almost immediately see the benefit, so at a kind of selfish level, this is one of the best benefits." A consulting pharmacist observed that "resolving a significant adverse effect of a medication…can have a significant improvement in overall functional status of the individual."

3. Teach and contribute to the emerging field of geriatric home care.

- ***Teaching other professionals.*** This was discussed as an interest/commitment from within and across professional disciplines. Several physicians and nurses mentioned examples of how they are showing "home health care as a way of taking care of older persons who are at risk" as well as "cultivating nurses and other clinicians [to] focus on…evidence based practice…we can do things to keep [patients] out of hospitals."
- ***Supporting geriatric home health care as an important nursing specialty.*** One participant noted a more recent reward related to involvement "at the State level and my many years in this field...I am helping evolve home health care into a nursing specialty." Another participant, looking toward the future, stressed a growing trend of nursing positions outside the acute care arena, citing a nursing home care leader as saying, "so many more of the nursing jobs within the next 10 years are going to be outside the hospital."

B. <u>What is working well for geriatric patients in home care?</u>

Early in the discussion, participants were asked to describe what is currently working well in home health care, including routine or "hard wired" practices being used by many, if not most agencies. Participants mentioned features related to the visibility as well as availability of home health care, core approaches, and some newer elements that were becoming common. Interestingly, some of the same strategies viewed as working (e.g., initial assessment, collaborations, and referrals) were also described later as gaps, and important targets for improvement. The areas that are working well include:

1. Home care viewed as an essential part of healthcare:

- ***Greater integration of home care providers in the care continuum.*** An administrator described the recognition by "colleagues in acute care of the benefits of home health care and making those referrals." Another administrator observed that "referral sources are more aware of home health… and what we do, access to care is better than it has been and also our ability to shorten hospital stays and handle the more high-tech patients in the home." Another described "having home care providers at the table and part of discharge planning discussions with acute hospitals, with rehab, or long term care facilities." Some participants specifically mentioned bridge programs that "many home care

providers have set up transitioning from home care to hospice care to support quality of life and quality of care."

- ***The referral process.*** According to another administrator, the referral process is "pretty well integrated and works pretty well in just the access to care and getting the patients into the system." An administrator commented that particularly in urban areas, agencies are viewed as "being able to get people back into their homes with home health care in place fairly quickly."
- ***Acceptance by patients of post-hospitalization home health care because it is covered by Medicare.*** Of the current "intermittent" (post-hospitalization) skilled home health model, an agency director observed that "it is still working well to have 100% Medicare coverage for services because that allows the patient to feel like they can accept it, so you can provide nursing therapies, social work, home health aides." That use of multiple disciplines, plus "high frequency care" (front-loading of home health visits) allows staff to "get a good, good start" on addressing the patient's problems, even if there are multiple chronic illnesses present.

2. Routine approaches:

More specific components of routine practice used by most if not all agencies

- ***The initial assessment.*** One home care physician viewed the initial nursing assessment as particularly helpful because it addresses "areas that maybe I had missed at the time of my visits." Another echoed "the fact that there are structures in place for comprehensive assessments. I am a little bit concerned about what we do with those assessments, but I think there are good and thorough structures in place for assessment."
- ***Multi-disciplinary approach.*** Although one administrator viewed nursing care (in general) as "one of the strengths of home health right now," most participants focused on interdisciplinary (some referred to multi-disciplinary) care as strength of home health care and necessary to the best geriatric care. It was described as a "more effective approach no matter what the plan of care is." Another administrator viewed the strength of the assessment coming from multi-disciplinary input and family, e.g., "an individually tailored assessment that does not have to be done by a particular discipline. I think it's best when there are contributions from a number of different disciplines." Another spoke about "the interdisciplinary aspects of home care and how important [it is] in working with frail and elderly." However, this person followed this comment with addressing how much time her large agency spends on education of multidisciplinary groups about what each discipline can do. Another person put it succinctly, interdisciplinary collaboration "works well… when it happens," referring to some of the challenges discussed later in this report. Of note, it was often participants trained in one discipline that commented about the value, but often the neglect of including other disciplines in the plan of care.

- ***"The client and loved ones as the central focus*** of the decision making wherever possible, can lead to the development of a comprehensive plan of care in the home, in the community" noted a nurse. Others spoke about education of the "primary contact" (either the patient or a family member) and the importance of "keeping that person up to date… as changes occur." One person viewed this engagement as being key to keeping the patient "in the home or out of the hospital." A geriatric social worker urged "making sure the patient and caregiver are involved in making decisions about a plan of care" including balancing formal and informal support and preferences regarding choice of an agency consistent with their culture. A physician highlighted "the way the close relatives of the patients stepped up to the plate to take care of them…There are so many of them and they do their job so well."

3. Other up-and-coming strategies:

Other strategies described by agencies that are not routine but promising

- ***Promoting care coordination.*** A few participants described efforts to bridge existing "information disconnects" and coordinate care. An agency director commented, "I'm also excited about efforts like the impending initiation of a geriatric resource nurse within my own home health agency, which will begin with a two day training seminar through [the local academic hospital and clinics] led by our geriatric CNS. I'm hoping to generate some networking connections that may contribute to the evolution of home health nursing into a specialty and also allow us to pilot evolving geriatric practice standards, and potentially measure some outcomes with a benchmarking group." Others described fee-for-service, professional care management services to "maximize the use [of] our nursing resources using social work and social service personnel in that care management function" which has "reduced the fragmentation and enhanced care coordination." For clinicians working within vertically integrated systems, there are functional and structural incentives to coordinate outpatient, inpatient, and home health care services. For example, a physician described how electronic access to an integrated record facilitated better and timelier care coordination that kept older adult members in adult group homes and out of the hospital. Similarly, there are several transitional care programs mentioned later in this report that promote coordination of care and delivery of services that are beneficial to older adults. Also mentioned were local partnerships, including a university led program using a "coalition of nonprofit agencies" that works closely with the Center on Aging to create ties with the "medical community." The program has been "making inroads in this area in terms of coordination of services across disciplines."
- ***Increasing attention to "helping people be able to do more for themselves."*** Educating family caregivers is a core approach in home health care, which is increasingly important for frail elders. Interestingly, although use of the term

"self-management" was rare, the concept of helping older adults and their caregivers to maintain a safe and therapeutic plan of care was a prominent theme raised by participants throughout each of the regional practice focus groups.

- ***Use of specialty staff to address high-risk patient needs.*** Participants referred to specialists in wound care, respiratory care, cardiac care, nutrition, safety, and medications. At one agency the use of specialists has helped to avoid the use of the emergency department and "has really increased the quality of our service delivery."
- ***Front loading visits*** to prevent re-hospitalization. That is, providing visits several days in a row "to stabilize…get a handle on the med management, the coordination phone call, and bringing in the team" was also mentioned. For example, social work, occupational and physical therapy are brought in "within the first week."
- ***Use of 'patient oriented' assessment tools.*** The participants described the benefit of using tools to capture the patients' experience of function and symptoms – rather than a biological "systems" approach typically used by clinicians (see Attachment B.Programs and Tools that Contribute to Geriatric Home Care Excellence).
- ***Better wound care management.*** A nurse felt that "wound VACs [Vacuum Assisted Closure dressings] are making a huge difference in the ability to manage pretty nasty wounds in the home." Another noted that communication between referrers and her agency's wound care management nurse was strong because they had developed a lot of "cross talk" about it.
- ***Use of tele-health***. Several of the participants mentioned the use of tele-health as a promising approach to care (although no definition or description was obtained) generating "outcomes that have been phenomenal" said one. Two specific advantages of tele-health included being able to "cover a wider area with both its hospice and home health care program" for one rural agency and improving staff's ability to care for "patients that need a little bit closer managing." One participant emphasized that staff were "novices" and they "had a lot of training to do with staff before we are more proficient [with the tele-health]."

C. What programs and resources are making a difference at the local, state and national level?

Each regional practice focus group was asked to identify specific programs with which they have been involved that provide innovative and/or effective geriatric home health care, regardless of funding source. Interestingly, when presented with a broad question, the participants immediately expanded the discussion of geriatric home health care beyond episodic post-acute care to include a myriad of home and community based services – especially long term care populations. Details of specific programs and resources can be found in Attachment B: Programs and Tools that Contribute to Geriatric Home Care Excellence. Among the categories mentioned were:

1. State programs:

Specific state programs were cited because they "support people in their homes rather than institutions" and "provide a variety of services including help with meals, nursing care, and other home health…supports." Noting the recently approved inclusion of social work services paid for by Medicaid, a participant suggested that some states are starting to "think beyond traditional Medicaid coverage for home health care." For example, three state programs were mentioned in more detail. The Connecticut Home Care Program employs care management using interdisciplinary teams of nurses and social workers to reduce fragmentation whereas Utah's Medicaid Aging program and New Choice Waiver, pose an "alternative to nursing home placement for people with chronic illness." Similarly, the Oregon Project Independence allows "folks to stay in their homes and out of nursing homes" and provides homemaking services and personal care.

2. Federal: CMS demonstration programs:

A number of participants had been involved in such projects and viewed them as more effective than conventional home health care. One physician described a demonstration project that took care of the "sickest two percent of the Medicare population and one of the successes was having physicians go to the home." Patients had access to physicians' cell phones "24/7" and "we would go out 24 hours a day and try to prevent hospitalization and catch the CHF or COPD exacerbation earlier." Participants also mentioned CMS grants to state Medicaid programs to expand use of telemedicine.

3. Regional/local direct service programs:

Participants mentioned positive experiences with a range of effective regional programs that might provide useful models elsewhere (See Attachment B. Programs and Tools that Contribute to Geriatric Home Care Excellence). Examples include:

- ***Transition programs that coordinate care for older adults as they move across different providers or types of care.*** Transition programs were mentioned as a new approach to care for seriously ill individuals. They frequently incorporated palliative care, which was addressed repeatedly during discussions. Specific programs mentioned include the transitions program at the Medical Center of Central Georgia that integrates an interdisciplinary team, house calls, and palliative care and serves a low-income and predominantly African-American county. A participant observed "I see the bridge programs that many home care providers have set up transitioning from home care to hospice care as working well to support quality of life and quality of care for older adults." Also mentioned was *Transitional Care at Virginia Commonwealth Hospital* that utilizes hospital based nurse practitioners to provide short term intensive case management for discharged high-risk patients, including home visits, providing the "medical oversight that's often missing during that unstable period." The

program was described as similar to "Mary Naylor's initiative at the University of Pennsylvania."

- ***Community—academic partnerships to enhance care and coordination.*** Programs mentioned include *Neighbors Helping Neighbors* at the University of Utah's College of Social Work described as using social work interns supported by volunteers to provide care coordination, enabling older adults to remain in their home. The program offers a "somewhat unique model" that is "not bound by eligibility requirements" and focuses on "people that are not eligible for other types of services because they make just a little bit too much money." The School of Social Work also coordinates a local coalition that provides training seminars and other services. "We are making a lot of inroads in terms of the coordination of services across disciplines." Similarly, the *Carelink Program*, operated by the University of Connecticut School of Nursing, utilizes senior nursing students supervised by community health faculty to monitor patients at home.
- ***Pharmacy-physician coordination*** An Eastern region program works with an innovative local pharmacist who voluntarily provides individualized blister packs for patients of a university based physician home visiting program. The pharmacist delivers and reports to the team if medications have not been used. Such efforts by local pharmacies could potentially fill a major gap in medication management, as noted by participants (see later comments). However, there is little information available about the scope and range of such programs elsewhere.
- ***Home safety initiatives***. A multi-dimensional North Carolina falls prevention and home safety program (*SPICE for Life*) is supported by the Area Agency on Aging and can be used by home care agencies.

4. Physician home visiting services:

A growing resource and partner for home care agencies nationwide are physician home visiting programs. Participants offered examples from their own experiences with services based at medical centers, integrated systems, and community/private practices. Teams often include nurse practitioners and social workers. One physician noted that the American Academy of Home Care Physicians (AAHCP) is supporting legislation for *The Independence at Home Act* [introduced in Congress in September 2008] that offers incentives to physicians and nurse practitioners to provide home care. The AAHCP also offers a listserv open to home care nurses to discuss challenging care issues.

5. Training to advance clinicians' knowledge and expertise in geriatrics:

A recurring theme was the need for increased training for all disciplines in geriatrics. Resources cited include national and local programs as well as web-based information. Participants praised such efforts as physician, nursing, social work, and other geriatric training initiatives of The John A. Hartford Foundation; state/regional Geriatric Education Centers which offer multi-disciplinary continuing education; and a

certification initiative of the Practice Advisory Board of the University of Washington's School of Nursing.

6. Other initiatives and websites that offer guidelines and support for best practices in geriatric home care:

Participants mentioned a number of helpful resources they had used. For example, the *Home Health Quality Improvement* website, a component of a joint CMS and QIO home health care focused quality improvement initiative. Agency participants said the initiative helped with "forums, ideas…" and that the website has useful tools to assist with geriatric care. Challenges of caring for home care patients with dementia were mentioned by a number of participants. In this context, the dementia management training and guidelines from the California Alzheimer's Association was mentioned as "a practical management approach encompassing medical, pharmacological, and psychosocial interventions based on evidence from the literature and expert consensus..." Another useful program mentioned was Medication Management Improvement System, whose website, *Home Meds*, can be accessed for guidelines and tools (including a simple risk screen to identify patients receiving problematic medications or combinations) and best practices for medication management. Also recommended was the website of the National Research Center on Nutrition, Physical Activity, and Aging at Florida International University, for its compilation of tools and other publications to assist nutrition consultants and home care agencies.

7. Oversight and accrediting organizations supporting best practices:

Quality Improvement Organizations were mentioned by participants in all groups as helpful to improving care. With regard to home health care in particular, participants had positive views of the recently concluded nationally based CMS/QIO initiative *Reducing Acute Care Hospitalizations* (ReACH) that offered tools and strategies to reduce hospitalization. One participant referred to her state's "wonderful QIO…that has given us education and started projects and allowed us to set goals. We are down to 13 percent re-hospitalization, which is very good." One noted that "Although the initiative was to reduce hospitalization, it ended up doing more than that because of the tools." The QIO was described as "very active in sending us information on a regular basis." (See *Home Health Quality Improvement* website noted on Attachment B: Programs and Tools that Contribute to Geriatric Home Care Excellence). "Our state surveyors have been a great help." Another mentioned her state association of home care and hospice as helpful. Participants also acknowledged the tension involved in asking for help from the same organization that provides accreditation, such as The Joint Commission, which is discussed later.

III. GAPS IN CARE AND MOST DIFFICULT ASPECTS OF CARE

Following the discussion of what was working well, participants were asked to describe major gaps and challenges facing geriatric home health care providers and identify issues that were personally most difficult. Not surprisingly, the programs that participants valued and identified as working well were addressing some of these gaps. Participants identified specific gaps where a cascade of problems frequently led to significant deficits in geriatric home health care. It should also be noted that in each group, participants described a number of gaps in care that are common to all areas but particularly acute in rural areas, e.g., lack of staffing and travel funds.

Major gaps include:

A. Uncoordinated fragmented home health care.

This pervasive problem was seen as one of the major factors holding home health care back from being successful and taking an extreme toll on older adults. Its origins were seen as largely a consequence of system fragmentation related to funding and policies, that has over time, expressed itself in problems of day–to-day delivery of home health care. Participants explored how they, as providers and experts could address these gaps, at least in part, through new strategies and collaborations. They 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) leading to ineffective or non-existent implementation of care. They described situations where a chain reaction of gaps or errors in implementation could lead to serious problems, and possibly hospitalization or institutionalization. They identified the following contributory factors:

1. Poor integration of effective and reliable tools into practice:

For example, a nutritionist noted the availability of tools for nutrition screening and individuals at risk, but the lack of standardized use through out the country. Others gave specific examples of effective tools that were infrequently used (see Attachment B. Programs and Tools that Contribute to Geriatric Home Care Excellence).

2. Lack of follow through after an assessment:

Even when an assessment tool was available, follow through was often absent according to many. One geriatric care manager commented on "wonderful information, references, frameworks" available on the Internet but there is also "the gap trying to implement some of the simplest things in those fabulous plans, trying to get somebody to help monitor somebody, somebody to transport them to a social outing, coming up with a medication alert system that actually works in a rural setting without an Internet." Asked about cases in which nutritionists have been brought in to do an assessment, a nutritionist asked, "And then in real life, what happens next? Where is the follow-through on that? Where is the reassessment? Where is the monitoring of tolerance or improvement or

adverse events?" A Physician's Assistant spoke for many when she observed the difficulties of coordinating the "diverse needs of this population, which are …much more than medical needs alone." Another participant noted the "real lack of care management process or being able to follow through" with those who need it. This is tied into lack of care coordination over time.

3. Lack of analysis of underlying causes of preventable problems:

Participants across the regions identified four key areas where they saw major gaps and a lack of understanding of underlying causes that could short-circuit the effectiveness of geriatric home health care. Their examples often cited the neglect of multi-disciplinary contributions as a contributing factor in such problems. The four areas are:

- ***Medication management oversight*:** The complexity of home medication management was a common concern among the participants. An agency director in a rural area noted the increasing number of "poly-pharmacy patients" where it is difficult to "teach and get them back to a level of independence where they can manage their medications wisely." "Mismanagement of medications is one of the reasons that our folks cannot live safely at home." A consulting pharmacist spoke about the challenges with adherence, and the assumption that somebody else is taking care of the medication problems for the older adult (e.g. the pharmacist). She spoke about multiple pharmacists and physicians, and "duplicate therapy." While acknowledging that there is "not enough money" to send a pharmacist to the patient's home, there are "triggers and flags" that could be used (but are not currently) by nurses, care manager, and social workers. Others spoke about the need to redesign bottles so that "arthritic hands" can hold them, and large font prescription labels (to make it more geriatric friendly). A pharmacist saw the gap in effective medication management oversight by a pharmacist or the inter-disciplinary team as the personally most difficult aspect of home health care. Indeed, for many, medication access and oversight in the home is one of the personally most difficult aspects of their work.
- ***Safety and functioning*:** A director noted that her agency's services often had to be stopped "because the individual was not [safe] anymore." An occupational therapist described a situation of an elderly patient falling at home despite documentation of the fall risk and emphasized the need for identifying underlying causes, and to do so, the potential benefits of interdisciplinary collaboration. She noted that often there is a falls risk assessment carried out, yet the patient continues to fall. In one case, she recalled that the "nursing documentation [of fall risk] was all over the place" and "patient difficulty managing the medication." The patient was hospitalized due to falling. When the agency resumed care for this patient, "they put PT in"…which "started a plan of strengthening." In retrospect, this participant observed "this person did not fall because they were weak; this person fell because they were not managing their medications." This participant would have preferred having an OT to go in and look at daily habits

and routine and how they affected the patient's ability to manage their medications. That approach "has everything to do with not just isolating tasks in an assessment" but using an interdisciplinary approach to analyze potential sources of problems that are preventable/manageable.

- ***Nutrition support****:* Some participants identified involuntary weight loss as a common problem among older adults. They identified several gaps. Specifically, a nutritionist highlighted the reality that there are "no actual regulations that require a systematic process of nutrition screening to identify older adults at risk and then a system that involves a more comprehensive assessment for those who are at risk and an actual development of a nutrition care plan and intervention." Others spoke positively about meal programs such as *Meals on Wheels* but often qualified their comments by noting the often long waiting lists to get in or an actual absence of programs in a region. Some participants underscored that availability was an important step but at times, not sufficient to meet the needs of older adults. Specifically, these programs offer one meal a day for five days, which may be inadequate given the individual's circumstances, or neglect appropriate nutritional content for particular health conditions. Another gap is the lack of "continuity from hospital discharge to the home care environment in terms of what an older adult has received in terms of nutrition support in the hospital. Lack of nutrition training for informal caregivers also compounds the problem." Another observed, "we know that involuntary weight loss occurs in up to 65 percent of older adults who are then admitted to hospitals or long-term facilities and this decreased food intake is directly related to either an inability to shop or prepare or consume adequate foods and beverages."
- ***Mental health and cognitive impairment support***: Participants spoke about gaps in addressing mental health issues such as patient depression as well as cognitive issues such as dementia, including mild dementia. Many agencies are wrestling with how to best manage home health care patients with mild cognitive impairment. "The whole focus of home care revolves around that patient or a caregiver being able to learn new information to engage in their care."

4. Poor interdisciplinary planning, communication and implementation:

Underlying the implementation gaps described above was the lack of engagement (or appropriate engagement) of a range of therapeutic disciplines into care planning –often tied to funding and/or reimbursement for services. Put in terms of fragmentation of care, this kind of interdisciplinary gap was described by some participants as the most personally difficult aspect of home health care. Concerns were expressed throughout the groups about not incorporating (or using properly) the skills of social workers, occupational therapists, and pharmacists, in particular. A professor noted that while social work services have to be made available in home health care, "there is no requirement that social workers see patients at all or participate in their planning. Social workers are dependent on skilled personnel (e.g. nurses) for referrals in order for them to open a case. They cannot do their own independent case finding and that is a problem

because if there is a lack of understanding between social workers and other members of the home health care team with regard to what social workers do." In fact, some of the benefits of including social workers were their abilities to assess for depression and follow through, assist with family preparation for care giving, and link families to financial and other resources, the absence of which may lead to adverse outcomes.

5. Inadequate physician involvement:

Outside of a few established programs, physicians, literally, do not make house calls and more broadly, there often isn't comprehensive medical oversight of these complex clinical situations. A physician observed, "The average home care patient is really quite a sick individual, medically ill and unstable with a 30 percent likelihood of hospitalization within 60 days of enrollment in Part A Home Health. Yet they are being managed almost entirely without physician input in the majority of cases." Another spoke about the "fragmentation of physicians," referring to the various specialists that might be involved in care until the patient "is no longer able to access physicians' offices, and then we have no one minding the ship."

6. Poor coordination across providers, creating silos of care:

These examples were given as ramifications of poor coordination of care:

- ***Information disconnects – "so people tell their stories over and over."***
  Discussed by many, one participant referred to "disconnectedness of our healthcare system…so people tell their stories over and over." Another spoke about not being able to get information from hospitals, making it very frustrating to go into the home. Another spoke about the "information gap between providers…medical records and systems that do not talk to one another…and service coordination issues." Along with a lack of communication among the various community services that provide care for an older adult, "The primary physician out in the clinic may not even know the patient was in the hospital or does not get a discharge plan." A consulting pharmacist described gaps when a patient is transferred from a long term care and/or rehab facility to a community setting. "There are medication therapy reviews conducted in long-term care setting that don't seem to follow the patient either to the community pharmacist or to the new attending physician." Others elaborated on challenges regarding medication management in the community, including the struggle related to some doctors not being "interested in what everybody else is doing."
- ***After the case is closed- "right back where they were, Never-Never land."***
  An administrator noted the lack of mechanisms for sharing information across providers and when one agency has concluded its work, "often we rely on the client or their caregiver to pass that information along but that does not seem to work out well in my program." Another described the period following discharge

when the patient finds themselves "right back where they were…because the handoff between provider types is really lacking."

- ***Lack of appropriate referrals to palliative care.*** Many participants were engaged in palliative care, either through transition programs or hospice, and were particularly frustrated by lack of fit between care needs and referral parameters. Noted one participant, "we will get a lot of therapy referrals that when you take a look at it, it is obviously that this person probably needs palliative care but no one is comfortable really talking about that, and so it is just easier to make a referral to therapy. If the person fails, frequently they may end up back in the hospital because it is not an appropriate referral and more cost is incurred before the appropriate help is ordered for that patient."

B. Lack of patient/family involvement in care planning and implementation.

While viewed as a crucial aspect of successful care, there are often significant challenges, including:

1. No caregivers:

A nurse executive noted a "true lack of reliable caregivers." She continued, "we serve a very rural area and find a great number of people that we could keep at home if we had even the slightest support from somebody reliable in the family." With regard to cognitively impaired patients in particular, "it is very frustrating for a therapist to go back and back and back without a caregiver in the home. They are wasting the resources and it becomes an access issue for other patients who may need much more acute rehabilitation."

2. Lack of necessary time to teach and support for patients and caregivers to learn how to self-manage:

One participant observed that the implementation of the care plan usually falls on family members or informal caregivers and it "takes time" before patients and/or families "can pick up and carry through." Some noted the lack of training for family and informal caregivers. An occupational therapist and consultant to agencies noted that a "medical model" approach that does not focus on overall functioning is "still very much in play with the Medicare-certified home health system." This participant viewed this approach as preventing "the patient from being the best self manager" and creates barriers to "allowing the patient to drive the plan of care as well as providing the kind of personalized education that will be the best for that patient to be able to make a good decision." Another participant noted the lack of specialized training programs directed at family caregivers.

Moreover, another observed, "People either cannot read or language is a barrier for them to be successful." Health literacy is sometimes an issue, "in either following directions or

filling pillboxes." In a post group comment, a participant expanded this view. "During the call, there were comments made about care transitions from acute hospital to home, skilled facility to home or emergency room to home. I also see critical gaps in care from physician office to home. Health literacy issues for older persons are an issue when considering instructions for management of medications and other health care issues, such as wound care or medical equipment use. Formal home care agency support is not always in place for these older community members. Health literacy awareness is poor in all settings of the patient care continuum."

C. Workforce issues--the sheer lack of numbers.

Many participants spoke about the lack of available skilled clinicians and direct care[3] workers to provide geriatric home health care. For some participants, this was the personally most difficult aspect of their own work. "We have marvelous new initiatives like 'Money follows the person'…and I have testified many times before the state legislature regarding what I see as the 'emperor's new clothes' aspect of this…we're acting like we're putting all these programs in place and we don't have a workforce to care for people." Compounding the lack of workforce is the issue of turnover. An agency director noted that in her state, "the turnover rates are so high—we don't have any infrastructure to keep people engaged with skills updating." Some workforce examples:

1. Direct Care Workers—"competing with the casinos" (and others):

"I think the biggest problem that I have encountered in home care" noted one agency director "is in the area of caregiver recruitment and retention," and the "constant in and out of these people, in part, because of low pay, [and] because of lack of benefits. The wages need to be better than they are across the board for both homemaker companions as well as for certified nurse aides. Many of the caregivers are working without benefits." She noted that these direct care workers typically have irregular schedules making it hard to insure them. "We are trying to build a private pay home care system on the backs of underpaid per diem-type caregivers and that I think is at the base of a lot of the problems." In addition, agencies are unable to compete with employment at "casinos…McDonald's and Wendy's" which "is a staggering challenge." An agency director also noted competition for employees with the private sector, where direct care workers "work within the more affluent areas...and are out there on their own and are passed on by word of mouth through the community, the grapevine," to those that can afford them.

2. Lack of skilled professional staff:

[3] 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.

There are two gaps here, first, a lack of sheer numbers, and secondly, a gap created by reimbursement structure. Participants specifically noted gaps in availability of nurses and access to or use of specialists important to geriatric home health care. In particular, they noted the lack of certain disciplines such as physical therapists; social workers for psychosocial or psychiatric assessment and treatment; pharmacists or nurse specialists to perform medication therapy review; occupational therapists to examine home safety and assess mobility; and registered dietitians to address complex nutritional needs. A participant who consults with agencies across the country noted that the lack of manpower "in the therapy professions," not just in rural areas but metropolitan areas as well, is "huge." She observed that agencies in need of therapists "either beg, borrow, or steal, either because they are in a hospital department and doing the visits on the way home after their regular job, or are contract." She noted the disconnect between these therapists and the home health care professionals--the difference between "doing therapy in the home and doing home health therapy, two very different things."

3. Lack of qualified physicians*:*

In one western state, "there are a lot of little towns scattered here and there [with] only one geriatric-certified physician." There are "huge needs" with regard to availability of geriatricians in rural areas, noted another participant from a western state. A "real crisis" occurred in one town where no physician was picking up Medicare patients. A physician spoke about the challenges of attracting young physicians to home care as a specialty when other specialties are higher paying. "They may love doing home care, it may represent everything that they have ever wanted to be in medicine, but they're just not going to do it. They can't afford to do it, and we shouldn't expect them to do it." This person went on to describe the hospitalist model, which was created to fill a significant gap in coverage, and recommended something similar be created for home care physicians.

D. <u>Lack of geriatric training for all disciplines and levels of care and lack information sharing about best practices.</u>

In an eastern state, an agency director noted "a very serious lack of access to geriatric skills training…a real serious difficulty getting the geriatric competency, training, and ongoing skills that will give these people (direct care workers as well as home health care professionals) the tools to do this kind of work." For example:

1. Inadequate training for direct care workers including private duty:

An agency director observed that along with a lack of available direct care workers is the lack of training. "We are seeing higher care needs with folks that are being discharged from the hospital and therefore staff is requiring more training than we have ever seen." Another participant noted a "huge concern" with private duty agencies and direct care workers that take over when Medicare leaves off that "do not have the training and

supervision to administer or monitor medications." Direct care workers employed by home health agencies to work in Medicaid programs perform primarily the nonprofessional kind of care (e.g. bathing). One participant spoke up saying, "we've surveyed folks in our region and have found in terms of direct care workers, people don't feel qualified to do this type of work because these are very hard patients to take care of."

2. Nursing schools with inadequate enrollment capacity in general and limited attention to geriatric home health care:

Another participant drew attention to the issue of a "terrible shortage within nursing schools." She provided an example of a local community college that had 400 applicants for 40 spots, and a majority of these applicants were working as nursing assistants or home health aides." Moreover, geriatric home health care is typically at the periphery of nursing curriculum. Noted one nurse educator, "we should be moving it from an add-on to the core [curriculum]."

3. Lack of interdisciplinary training*:*

Speaking about working with area organizations (e.g. hospitals, assisted living, home care agencies) a participant noted "what we find sad is that we are having much more difficulty working with our academic groups around us and getting students doing interdisciplinary things before they ever get out into the practice world. We [have] to play catch up after they get into the practice world." Lack of interdisciplinary care noted above reflects fragmented and limited reimbursement, but also a fundamental lack of knowledge and practice related to what other disciplines can contribute to geriatric home health care.

4. Inadequate collaboration between academia and the practice community:

"I think home care would really benefit from research to identify how much service is enough service for different types of patients, how many visits is the right amount of visits for patients with chronic illnesses who also have co-morbid mental problems." Another observed, "The research is not getting translated into practice and I think a closer relationship between academia and our practice sector would certainly help."

5. Lack of opportunities among geriatric home care providers to share information about implementation of best practices:

The discussions revealed that even in small groups, information about training, regional resources, effective strategies, and useful assessment tools were not known. The lack of a geriatric homecare network was evident as was the interest in staying in touch and exchanging information among the Regional Practice Focus Group participants. Home care agencies and providers are relatively isolated with a dispersed workforce and in general, lack connectedness for communication and sharing best practices and

management strategies, despite successful targeted federal, foundation, and professional organization initiatives. In one example, a participant described a home care oriented training program at a university. However, it became clear that this resource is not well known regionally or even by agencies in other parts of the state. An agency director asked whether there was a way "you could let the rest of Utah know about that?"

E. Need for guidance for quality improvement.

In response to a question regarding organizations that they view as helping with best practices, participants discussed the tension and potential fear of reaching out to an accrediting organization. With regard to two important accrediting agencies, participants had mixed views or were dissatisfied with regard to their helpfulness with quality improvement.

1. Accrediting Organizations:

Participants expressed mixed experiences in working with The Joint Commission and other accrediting agencies. One person described being partially motivated by The Joint Commission accreditation requirements, citing examples of nutrition assessment and identifying specific interventions and follow-through for patients with different levels of asthma (e.g. mild, moderate). Another person acknowledged The Joint Commission as a good resource, "but there is a fairly significant aspect of potential threat in the sense of regulatory enforcement associated with those kinds of relationships that's not present when you talk to somebody at the QIO." Another viewed The Joint Commission as a good resource when "looking for ways to improve quality in a generic-type role…, I'm just not sure how much they understand home care." Another participant, with over a decade experience with a Community Heath Accreditation Program (CHAP) accredited agency, expressed frustration, "we have received very little, if any, assistance in that regard with quality initiatives." Two participants, one of who was a former surveyor, stated costs of joining accrediting agencies were prohibitive. As one explained, "we did not feel that we were getting the benefit out if it." Instead, they were using state surveyors, state associations of home care or state hospice associations. However, another person described how The Joint Commission was "undergoing a comprehensive review of all its standards" that may position the agency to be a more helpful resource to home care agencies in the future.

2. Quality Improvement Organizations (QIOs):

The lack of support for quality improvement was seen as particularly acute given the absence of a focused home health care initiative in the CMS Ninth Scope of Work (2008-11) for Quality Improvement Organizations (QIOs). Given participants' positive experiences with QIOs, concerns were expressed in each group that "great initiatives with potential for a lot more work are being dropped" in CMS' next scope of work. This loss of QIO support for home health care is going to "hurt us" noted one. Another person

acknowledged The Joint Commission as a good resource, but noted "there is a fairly significant aspect of potential threat in the sense of regulatory enforcement associated with those kinds of relationships that's not present when you talk to somebody at the QIO." QIOs were described as able to "interact effectively with the provider community"; being there to help them without the burden of accreditation or oversight; and offering a "more informed and modern strategy to improve quality than the more punitive."

F. Gaps in funding and policy associated with current practice gaps.

Inadequate funding and reimbursement were recurring themes as the source of inadequate or insufficient care of older adults in their homes. Specifically, the participants noted:

1. The emphasis on episodic rather than coordinated, long-term care:

Mentioned repeatedly, this issue is viewed as a pervasive problem affecting the ability of agencies to provide high quality geriatric home care. One observed "we have acute care home care now but we don't have a lot of long-term chronic care home care. I think there needs to be a model out there that allows for that so that we can monitor and care for these patients long-term." One agency director in a southern state said "regulations just stifle us sometimes."

2. Interpretation of 'improvement' is driven by funding rather than evidence:

With the agreement of other participants, an agency director discussed the lack of "evidence based protocols" to determine "when rehab is not beneficial anymore….this whole idea of when you plateau with rehab may not really be correct. It is almost always driven by the reimbursement system than by any good evidence-based care or how long people continue to improve."

3. No, or highly limited reimbursement for certain clinical experts:

As discussed earlier, the participants identified interdisciplinary gaps in care due to reimbursement guidelines. They described a "very old mindset" that certain elements of care, i.e., use of a clinical dietitian are not billable services. This was a recurring theme. In addition, there was no reimbursement for collaborative aspects of care.

4. Inadequate funding for community long-term care:

Medicaid waiver programs are viewed as highly successful but so "under funded that most of the home health agencies can't afford to be part of it." When agencies can afford it, "The need is so great that you have patients on the waiting list. The concept is great; again, it's a funding issue." Some mentioned the need to assist frail elderly who

fall between the cracks: they do not qualify for Medicaid but do not have adequate income to pay for private home care. In particular, they cited gaps such as:

- ***Lack of funding for basic personal support and home assistance.*** Participants mentioned lack of funding for home health aides for personal care, and, where necessary, social workers and care managers that could help older adults stay in their home. One area identified by several participants was the special care needs of patients with mild cognitive impairment if they are to remain safe in their homes. Another need was for this type of assistance so that family caregivers can get occasional respite.
- ***Omission of preventative care in home care.*** While nurses and therapists "are able to slip in some heath promotion and prevention, it is not built into the system of pay under Medicare or most other third-party payers."
- ***Under funding of community programs.*** These play a crucial role in keeping a person at home, but "a lot of times simple kinds of things like transportation and meals" are not funded.
- ***Non-reimbursable equipment and/or service (e.g. tele-health.)*** Lack of funding for durable medical equipment that keeps people safe in their homes was the most difficult challenge for an occupational therapist, and many agreed. Hearing assessments and hearing aides are also not covered, yet greatly impact the quality of life.

5. Special Issues in Rural Home Health Care:

An agency director serving a rural area discussed a broad access challenge by noting, "Just having the medical care in some of the small rural areas is a problem, let alone having a home care agency that can survive with the number of patients that they would have and being able to find enough staff." (This participant noted, "tele-health is helping with that"). In addition, participants mentioned:

- ***Inadequate reimbursement for rural travel.*** "Funds have been cut and we are in a rural area, and so the travel is huge for us; often difficult to even get caregivers to go out to provide these services because of the travel time and mileage involved." [Note, these focus groups occurred during a time of soaring gas prices, but participants saw as challenges not only the cost of gasoline but the sheer amount of travel time to visit rural elderly, for which compensation is inadequate. As a result, rural agencies bill for far fewer patients in a given day than can urban agencies.]
- ***"Lack of a medication alert system*** that actually works in a rural setting without an Internet and without good connections."
- ***Even fewer geriatric trained physicians than elsewhere.*** This national gap was seen as even more acute in rural areas. For example, a participant noted that in the central region of a western state, "there are a lot of little towns scattered here and there and we only have one geriatric-certified physician. I think there is a

huge need for more geriatric-trained docs to meet the needs of the elderly, folks that really have a clear understanding of aging."

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 regarding strengths and deficits in geriatric home health care. 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 and hints of imperiled agencies and other practical challenges were highlighted.

Participants provided numerous examples of what was currently working in the delivery of geriatric home health care, ranging from core practices, to emerging strategies of 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.

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 regions shared an aligned view of 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 multidisciplinary care); and (3) 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 vital to excellence in geriatric home health care. Interestingly, they integrate three kinds of relationships, with patients, with colleagues, and with the broader group of professionals involved in the emerging field of geriatric home health care.

Moreover, throughout the discussions participants continued to emphasize the importance of collaboration and of multidisciplinary efforts as a key to successful geriatric home health care. This was reinforced by many of the programs and strategies they cited as

working well and by their interest expressed during the discussions in staying in touch with the others they had met in the group. Further, some participants had chosen home care in mid-career in part for this reason and could compare it to other work environments. Many participants seemed to be self selected to work collaboratively, which they viewed as intrinsic to effective geriatric home health care. At the same time, participants acknowledged frustration regarding the frequent failure to implement and compensate this approach.

Findings from discussions also suggest that there is strong interest 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. The recommendations below are derived from priorities identified in the focus groups.

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 (OT, PT, and SW).
    - 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 for 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 including palliative care and 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 that 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 of agencies, providers, academic institutions, professional organizations, and other regional and national resources.
- Integrate best practices of 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 leaders regarding manpower, reimbursement, and training needs.
- Link with professional and state based groups and (e.g. the American Association of Home Care Physicians) to educate 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 provide 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 the priorities and recommendations to advance a national agenda of excellence in geriatric home health care.