



Advancing the Agenda for Home Healthcare Quality *Conference Proceedings and Findings*

PENNY HOLLANDER FELDMAN, PhD, AMY CLARK, BA, AND LORI BRUNO, MPH

On March 31 to April 1, 2005, the Center for Home Care Policy and Research of the Visiting Nurse Service of New York assembled approximately 80 home healthcare stakeholders from across the country to advance the action strategy for measuring, improving, and assuring quality in home healthcare. A specific aim of the conference was to disseminate relevant research on organizational change and evidence-based practices to influence patient safety and quality of care. Attendees worked together to identify high-priority action steps and recommendations at both the organizational and policy levels. This article reports the conference's proceedings and findings.

“Advancing the Agenda for Home Healthcare Quality” was the second conference in a biannual series hosted by the Center for Home Care Policy and Research to develop an agenda and a strategy for moving home care quality forward. By fostering dialogue among researchers, experts, and stakeholders both inside and outside the home care industry, we aim to promote information sharing across traditional healthcare “silos” (i.e., groups that operate relatively independently of each other, such as home care nurses and health services researchers) and serve as a catalyst for positive changes in practice and policy. Support for the second conference came from both the Robert Wood Johnson Foundation and the Agency for Healthcare Research and Quality.

Quality performance has become a strategic priority for home healthcare agencies

across the country. Greater financial pressure to deliver care economically, the emergence of publicly reported quality measures, and concerns about the impending implementation of pay for performance all have heightened providers' interest in seeking and implementing care practices with the potential to improve both the management and quality of care.

However, a major barrier to improvement efforts has been the relative isolation of the home care industry from mainstream academic and professional initiatives to establish national, evidence-based guidelines and standards. Such guidelines have been developed for patients with a variety of acute and chronic care problems. However, most apply to patients in hospital, ambulatory, and nursing home settings. Little or no attention has been paid to the home health setting, and home care providers have lacked well-organized infor-

mation about what knowledge is applicable to them or how to apply it.

I. Setting the Stage

Building on Past Work

The conference opened with a brief review of the “manifesto” generated at the first conference in June 2003. The theme for that initial conference was “Charting the Course for Home Healthcare Quality: Action Steps for Achieving Sustainable Improvement” (Feldman et al., 2004). The manifesto included the following six broad aims:

- Improve and develop the home care knowledge base
- Infuse all aspects of care management and delivery with the best available evidence and information
- Engage patients, caregivers, and physicians as partners in care
- Empower middle managers and frontline staff
- Support continuous collaborative learning and teaching
- Continuously advocate for quality

The goal in sharing this list of quality aims was to encourage the participants to build on the work of the initial conference.

Purpose and Expected Outcomes

The overall goal of this second conference, held in 2005, was to advance the action strategy for measuring, improving, and assuring quality in home care. Specifically, the main objectives were to:

1. Disseminate the existing evidence relevant to selected *high-priority patient conditions or problems* and identify how to incorporate this knowledge into home care practice
2. Communicate aspects of the emerging research on *organizational environment and patient safety* that can be applied to the home care setting
3. Promote within the home care setting *knowledge utilization and practice improvement strategies* shown to be effective in other settings
4. Refine an agenda for identifying and testing additional *promising practices and practice improvement strategies* in home care

By the close of the conference, participants were expected to identify key strategies for accelerating change and advancing the home health-care quality agenda.

II. Presenting the State of the Science

Keynote Address

Mathy Mezey, EdD, RN, FAAN, the Director of the John A. Hartford Foundation Institute for Geriatric Nursing in the New York University Division of Nursing, presented an inspirational address on *Re-focusing Home Care* to advance the agenda for home care quality. She focused on the gap between the demand

for effective geriatric care and the serious lack of preparation among health professionals. Dr. Mezey emphasized the importance of the home care nurse's role in providing high-quality care for the geriatric population. She identified best practice models to improve geriatric home care and described positive outcomes related to geriatric best practices, stressing that there is a strong evidence base that patients do "better" when the provider has competencies in geriatric care. Dr. Mezey described the following benefits of geriatric care as demonstrated by peer-reviewed studies:

- Reduced morbidity
- Less delirium, less use of physical restraints, fewer medications, and fewer falls
- Shorter lengths of hospital stay
- Fewer hospital readmissions and longer time between discharge and readmission
- Higher patient and family satisfaction
- Higher staff satisfaction

Panel Discussion

To close the first day of the conference, four members of the home care community participated in a panel discussion to share their unique perspectives on the *Use of the Collaborative Quality Improvement Model in Home Care*. The panel was composed of a collaborative organizer, a frontline nurse manager, a quality improvement organization representative, and a home care agency CEO (see sidebar, "Panelists"). The discussion focused on the "real world" impact of the Breakthrough Series Collaborative Model designed to change practice and improve

quality in home care. Panel members identified several key benefits of the model for promoting practice improvement:

- Emphasis on shared goals and challenges, which provides a forum for shared learning
- Opportunity to explore practice "gaps" in a safe environment
- A model for introducing and integrating evidence and best practices into daily care
- A "grassroots methodology"—PDSA (plan-do-study-act)—that encourages small tests of change
- Reliance on outcomes measures and benchmark reports that allow staff to identify opportunities for improvement and to track and monitor the progress of implemented strategies

Recap of Themes From Day One

Challenges and opportunities specific to the home care industry that surfaced during the discussions on the first day of the conference included:

- How do we integrate holistic nursing with condition-specific protocols?
- How do we focus on "patient care" not "paper care?"
- How do we create a safe environment for testing and learning, to promote quality improvement?
- How do we facilitate thoughtful, informed change at the frontline?
- How do we move from management by "inspection" to management by "engagement?"

- How do we keep the “eye on the prize” in a constantly changing environment?

Concurrent Sessions

Throughout most of the second day, participants attended two concurrent sessions of their choice selected from five topic areas. Commissioned papers, which were distributed in advance of the conference, provided the research content for each session. At the concurrent sessions, the authors provided a brief description of the problem addressed, an overview of research findings, and major recommendations for practitioners and policy makers on the corresponding topic area. Key findings and authors’ recommendations from each paper are summarized here.

Lessons From the Science of Improving Function:

Implications for Home Care
Dorothy Baker, PhD, MSN, RN-CS (Yale University School of Medicine), noted the increased interest of home care agencies in improving the functional abilities of older patients because of policy changes, such as the implementation of OASIS and publicly reported outcome indicators (Baker, 2006). She outlined recent research findings that can guide home care clinicians to efficiently and effectively improve the functional abilities of older adults.

KEY FINDINGS

Evidence supports the integration of the following concepts into practice:

- Behavior change strategies (e.g., “transtheoretical” or “stages of change” model)

**Commissioned papers,
 which were distributed in advance of
 the conference, provided the research
 content for each session.**

- Physiology typical of aging and hazards of immobility
- Multifactorial etiology and interventions to effectively address geriatric syndromes that result in functional dependence

AUTHOR’S KEY RECOMMENDATIONS

- Work groups of frontline staff can develop systems to integrate nursing and therapy assessments and interventions to prevent functional decline
- Home care administrators should play a key role in developing systems that support frontline staff in testing and adopting new practice patterns essential to managing geriatric syndromes

Knowledge Transfer and Utilization: Implications for Home Health Care

Tracey Bucknall, PhD, RN (University of Melbourne School of Postgraduate Nursing), addressed the complexity of incorporating existing research findings into clinical practice (Bucknall, 2006). She provided an overview of translation science and emphasized the potential application of this knowledge to home care organi-

zations to improve the delivery of patient care.

KEY FINDINGS

The challenges to effective translation of research into practice include:

- The type, quality, and volume of evidence available for adoption
- The characteristics of the clinician or adopter of the evidence
- The channels for communicating the evidence
- The healthcare system delivering the evidence or context
- The role of the patient on evidence uptake

AUTHOR’S KEY RECOMMENDATIONS

- Target opportunities for practice improvement by analyzing OASIS data to identify variances from national norms and within an agency
- Assess clinicians’ knowledge of evidence and employ “expert” clinicians in consultative roles
- Promote teamwork and social networks
- Schedule regular audits of OASIS data to evaluate progress in knowledge translation

- Establish a feedback system highlighting the impact of practice decisions on patient outcomes
- Incorporate patients in decision making about care management

Effective Pain Management: Lessons From a Nursing Home Research Project

Katherine Jones, PhD, RN, FAAN (Yale University School of Nursing), described the difficulty of improving pain practices in the home care setting as a result of such circumstances as (1) limited knowledge and misperceptions relative to pain and pain management; (2) under-reporting and undertreatment of pain, especially in the elderly; (3) re-

Panelists

Robert P. Carpenter, CPA, MBA, MCSE, CHCE (home care CEO perspective), President/Chief Executive Officer, Visiting Nurse Association of Texas

Anne Lockwood, MPH (quality improvement organization perspective), Outpatient Interventions Manager, Carolina Medical Review

Sally Sobolewski, RN, MSN (collaborative organizer perspective), Director, Practice Improvement, Visiting Nurse Service of New York

Adele Pike RN, EdD (frontline nurse manager perspective), Director, Center for Excellence in Home Care Practice & Education, Visiting Nurse Association of Boston & Boston College School of Nursing

strictive reimbursement and regulatory systems; and (4) staffing levels and turnover rates that hinder comprehensive assessments and continuity of care (Jones, 2006). She presented recommendations founded on lessons from an intervention study conducted in the long-term care setting.

KEY FINDINGS

- Improving pain practices is difficult because of patient, staff, physician, and organizational barriers
- Nurses are reluctant to administer strong pain medication, even when it is ordered
- All caregiver categories need to be included in educational programs
- Improving the capacity of providers to improve clinical care processes is more likely to be successful
- Simple approaches are preferred over complex interventions

AUTHOR'S KEY RECOMMENDATIONS

- The agency must own the problem and the solution: leadership commitment, involvement, and stability are essential in delivering effective pain management
- Multifaceted interventions are required that include all caregiver categories
- Educational materials must be culturally and linguistically appropriate
- Opioids and around-the-clock dosing must be acceptable options for treatment in appropriate cases
- Medical/nursing school curricula must include more

content related to pain management

Transitional Care: A Critical Dimension of the Home

Healthcare Quality Agenda

Mary D. Naylor, PhD, RN, FAAN (University of Pennsylvania School of Postgraduate Nursing) discussed transitional care research related to the older patient population in the home care setting (Naylor, 2006). She provided factors contributing to the gap between best practices and current practice, as well as ways to integrate and translate these best practices into home care.

KEY FINDINGS

- Transitional care is complex and presents the research community with a number of opportunities and challenges
- Research has found that the components of effective transitions lie in three core domains of relationships, management, and information
- Best practices for transitional care have not been widely adopted in home care because of cultural, structural, and financial barriers
- Partnerships among researchers have formed to translate evidence-based models of effective transitional care into the "real world" of clinical practice

AUTHOR'S KEY RECOMMENDATIONS

- Contributions of clinical scholars to date provide a blueprint for immediate changes that can be made

to improve transitional care, and the domains of *relationships, management, and information* should be used as the framework for these recommendations

- Reimbursement of transitional care services should be implemented to ensure adoption of best practices

Organizational Climate: Implications for the Home Healthcare Workforce

Patricia W. Stone, PhD, RN (Columbia University School of Nursing), and her coauthors focused on the evidence of organizational climate factors and their relation to patient, employee, and organizational outcomes (Stone et al., 2006). They compared the home care climate to that of other healthcare settings, introduced an organizational climate model, and made recommendations for integrating that model into home care.

KEY FINDINGS

Evidence shows that

- Organizational climate affects job satisfaction, intention to leave, and employee health among clinicians and other healthcare staff
- Employee satisfaction affects staff performance
- Staff performance affects patient satisfaction

Publication of Conference Papers

The commissioned papers are published in a special home care issue of *The Journal of Healthcare Quality* 2006, 28(1).

Final recommendations emerged in two broad domains—patient care and staff empowerment—with facilitating organizational and policy changes identified for each domain.

AUTHOR'S KEY RECOMMENDATIONS

- An assessment of employees' perceptions of organizational climate should be conducted routinely to understand the work environment
- Key aspects of organizational climate and outcomes should be assessed before and immediately after implementation of changes to evaluate the effect of the change
- Home health agencies should consider benchmarking with one another in the area of organizational climate

III. Promoting Change in Home Care Quality

The goal of each concurrent session was to generate a list of top action steps necessary to make advances in home care quality. The top strategies proposed by participants in the respective sessions are enumerated in Table 1.

After the concurrent sessions, participants reconvened in two workgroups and a closing plenary session to share the top action steps identified, identify cross-cutting themes, and discuss “high-leverage recommendations” with both industry and government ramifications. Participants addressed such questions as: Would carrying out these recommendations significantly improve patient care? What recommendations are missing? Does the rationale make sense? Are the recommendations feasible? What steps at the organizational and policy levels would facilitate their implementation?

Final recommendations emerged in two broad domains—patient care and staff empowerment—with facilitating organizational and policy changes identified for each domain. In the domain of patient care, meeting participants expressed strong consensus that home care is in a unique and pivotal position to improve patient transitions, particularly from hospital to home, and in doing so to greatly improve patient safety and outcomes. In addition, after much discussion about the feasibility or appropriateness of redefining home care to focus predominantly on the restoration of patient function,

Table 1. Top Action Strategies Proposed by Participants in Concurrent Sessions

EVIDENCE-BASED PRACTICES		
Improving Function	Transitional Care	Pain Management
<ul style="list-style-type: none"> • Redefine “Home Care”—change focus from “servicing” to “restoring,” medical language to lay language, disease to function, and hierarchical authority to horizontal authority • Create supportive environment to facilitate creation of interdisciplinary teams, requiring a shift in roles and responsibilities • Redesign roles and training—include home health aides, nurses, educators, multidisciplinary teams • Engage the consumer—explicit goal setting, cultural sensitivity, readiness to change, keep simple, change public expectations • Use simple, lay language and the “stages-of-change” model to set and achieve realistic patient goals • Update “Hazards of Immobility” and publish in <i>Home Healthcare Nurse</i> and PT/OT/SLP journals 	<ul style="list-style-type: none"> • Use explicit criteria to identify patients who need care and determine critical data elements that should travel with the patient • Revise regulations—look at restrictive policies and criteria, redesign home care system to support care coordination • Craft a transitional care benefit that incorporates the science—patients at risk, complete information, swift service—and matches consumer need • Transform home care services to meet transitional needs—frontload services, expect crises, demand quality/accurate information, follow with telehealth/phone, demonstrate return on investment • Increase awareness of home care and care coordination—educate providers, consumers, government, insurers; public media exposure • Reform education in medical/nursing schools and practice settings 	<ul style="list-style-type: none"> • Use innovative care strategies for effective pain education and interventions—pharmacist, APN, hospice, comfort care kits, patient/family best practices • Employ systems of evaluation and improvement—transition planning, standing orders, communication prompts/scripts, 485, protocols/guidelines, toolkits • Improve staff education—ongoing commitment, multidisciplinary, all caregiver levels, simple/useable tools, ongoing competency assessment (not just medications) • Improve patient/family education—public awareness, sociocultural issues, toolkits, consistent with staff education • Take holistic approach to pain management—link pain to function, comorbidities, depression, health beliefs, patient-family efficacy • Improve communication across the continuum
ORGANIZATIONAL CHANGE		
Knowledge Transfer and Utilization	Organizational Climate	
<ul style="list-style-type: none"> • Commit to being a “teaching/learning organization” with associated resources and implementation activities • Identify clinical expertise/leadership and promote consultative roles—APNs, other certified practitioners • Build organizational capacity and infrastructure for analyzing and delivering knowledge/information at the local level—increase use of APNs, multidisciplinary clinical councils, social networks • Look at own data (including OASIS) and “marry it to the evidence” • Use quantified data measures to identify local variances, establish feedback system for monitoring, and evaluate impact of knowledge transfer activities • Use knowledge transfer/utilization of evidence to make patient self-management and decision making a priority 	<ul style="list-style-type: none"> • Identify best practices for development, education, and training of managers—frontline, middle managers, and leadership staff • Identify best practices for retention and recruitment • Develop benchmarks for organizational practices that support clinical practice and quality outcomes • Identify best practices in agency communication—within industry, from other industries • Implement operational collaboratives to measure and improve key organizational activities and outcomes • Raise the quality bar for entering and staying in the home care market 	

Note. APNs = advanced practice nurses; PT = physical therapist; OT = occupational therapist; SLP = speech language pathologist.

Table 2. High-Leverage Recommendations for Improving Home Care Quality

PATIENT CARE
<ol style="list-style-type: none"> 1. Transform home care services to meet the needs of patients in transition across healthcare settings 2. To the maximum extent possible, engage patients and home care clinicians in a joint effort to manage illness, restore function, and/or delay the severity of functional decline <p>Facilitating Organizational and Policy Changes</p> <ul style="list-style-type: none"> n Redesign home health agency structures and roles to support multidisciplinary teams—include nurses, aides, therapists, educators n Synthesize best practices for improving patient functional outcomes; develop/execute strategies to implement them; monitor progress via OASIS measures n Develop/implement strategies to improve communication within home care agencies and across the continuum of care n Influence government to <ul style="list-style-type: none"> • Establish standards for information transfer across settings—substantive and technical • Establish standards for transitional care • Create a transitional care benefit and pay for it
STAFF EMPOWERMENT
<ol style="list-style-type: none"> 1. Commit to being a teaching/learning organization with associated resources and implementation activities 2. Invest in staff knowledge and skills 3. Promote and reward teamwork and quality care <p>Facilitating Organizational and Policy Changes</p> <ul style="list-style-type: none"> n Identify/implement best practices for development, education and training of managers and frontline staff n Build organizational capacity and infrastructure for analyzing and delivering knowledge/information at the local level—increase use of APNs, multidisciplinary clinical councils, social networks n Partner with academia to align curricula with home care needs; work to require home healthcare/gerontological care training in all health education programs n Implement operational collaboratives to measure and improve key organizational activities and outcomes n Experiment with measuring productivity in terms of financial and clinical outcomes rather than number of visits n Reward performance accordingly n Influence government to <ul style="list-style-type: none"> • Revise the HIM11 and other regulations to grant more autonomy to home care nurses and optimize patient care • Implement “pay for performance” that shares savings from reduction of high-cost adverse events

Note. APNs = advanced practice nurses; HIM11 = Home Health Agency Health Insurance Manual-11.

the group concluded that overemphasis on “restorative,” as distinct from “supportive,” care might do a disservice to patients for whom the best of care might not yield significant improvement in function. Thus, the group recommended that “to the maximum extent possible” home care clinicians engage patients in a joint effort to “manage illness, restore function and/or delay the severity of functional decline.” In the domain of staff empowerment, three themes emerged: investing in staff knowledge and skills, committing organizational resources to collaborative teaching and learning, and introducing organizational incentives to promote and reward teamwork and high-quality care. In both the patient care and staff empowerment domains, participants further outlined a variety of organizational and policy changes that would facilitate achievement of their major recommendations. All are summarized in Table 2.

Conclusion

The home health industry is committed to improving patient safety and the quality of care provided. Diverse stakeholders, including home care executives, quality specialists, home care regulators, nurse educators, industry representatives, patients, and their advocates, all have important roles to play in accelerating the pace. This conference provided a forum for such stakeholders to promote change through open communication and consensus on critical issues in home care. ▲

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Penny Hollander Feldman, PhD, is Director, Center for Home Care Policy and Research, Visiting Nurse Service of New York, New York, NY.

Amy Clark, BA, is Research Analyst, Center for Home Care Policy and Research, Visiting Nurse Service of New York, NY.

Lori Bruno, MPH, is Research Analyst, Center for Home Care Policy and Research, Visiting Nurse Service of New York, NY.

Address for correspondence: Penny Hollander Feldman, PhD, Center for Home Care Policy and Research, Visiting Nurse Service of New York, 107 East 70th Street, New York, NY 10021 (pfeldman@vnsny.org).

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Top Cancer Organizations Launch First Online Portal of Asian-Language Cancer Information

The Asian American Network for Cancer Awareness, Research and Training (AANCART) and the American Cancer Society (ACS) have launched a searchable online database of Asian-language cancer materials. This effort is supported by the National Cancer Institute (NCI), part of the National Institutes of Health.

The Asian and Pacific Islander Cancer Education Materials Web tool (APICEM) is designed to help Asians and Pacific Islanders with limited English-speaking abilities gain access to information on how to reduce their risks of preventable malignancies, including cancers of the breast, cervix, colon, liver, lung, and stomach.

The new Web resource is located on the American Cancer Society Web site at <http://www.cancer.org/apicem>. The database catalogues and provides links to print materials written in the following languages: Khmer, Chamorro, Chinese, Hawaiian, Hmong, Ilokano, Korean, Samoan, Tagalog, Tongan and Vietnamese, as well as English-language materials culturally tailored for Native Hawaiian populations. Additional languages and topics will be added as more materials become available.

To view the Asian and Pacific Islander Cancer Education Materials Web Tool: Questions and Answers, please visit <http://www.cancer.gov/newscenter/pressreleases/APICEMQandA>.

For more information about cancer, please visit the NCI Web site at <http://www.cancer.gov>, or call NCI's Cancer Information Service at 1-800-4-CANCER (1-800-422-6237).

For more information about NIH and its programs, visit <http://www.nih.gov>.

