NATIONAL INVITATIONAL CONFERENCE ON HOME CARE QUALITY: ISSUES AND ACCOUNTABILITY

VOLUME I: SUMMARY OF PROCEEDINGS

1989
Office of the Assistant Secretary for Planning and Evaluation

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This report--which summarizes a national conference held at the Madison Hotel, Washington, D.C. on June 1-2, 1988--was prepared by the Office of Social Services Policy with the U.S. Department of Health and Human Services. For additional information, you may visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the Office of Disability, Aging and Long-Term Care Policy, Room 424E, H.H Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The DALTCP Project Officer was Pamela Doty.
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Volume I: Summary of Proceedings

1989

Prepared for
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

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We are also grateful for the enthusiastic participation of over 300 attendees at the conference who generously contributed their time and ideas. The views expressed in these proceedings are those of the conference participants. No official endorsement by the Department of Health and Human Services is intended.
INTRODUCTION

More than 300 practitioners, regulators, payers, and other interested parties attended the National Conference on Home Care Quality: Issues and Accountability, sponsored by the U.S. Department of Health and Human Services, on June 1 and 2, 1988, at the Madison Hotel in Washington, D.C. Volume I of the conference report presents the keynote address by Otis R. Bowen, Secretary of the Department of Health and Human Services, summaries of the opening and closing general sessions, and summaries of the breakout sessions. The conference agenda and participant list are included as appendices. Volume II presents a research agenda for home care quality. Prepared by Pamela Doty, Ph.D., Senior Analyst in the Office of the Assistant Secretary for Planning and Evaluation, the research agenda highlights issues and themes raised by conference attendees as well as speakers and includes feedback received from participants following the conference. Volume II also cites recently published and ongoing projects related to the issues discussed at the conference.

Robert B. Helms, Assistant Secretary for Planning and Evaluation, called on conference participants to help set the Federal government's home care quality research agenda for the next few years. New initiatives in home care fielded by Federal and State governments have led to growth in formal home care services.

Several other factors are also fueling the expansion of home care. Earlier hospital discharges under Medicare's Prospective Payment System have had a significant impact on the demand for post-hospital home health care. An increase in the number of the elderly, especially those "oldest old" whose long term care needs are greatest, and a desire by the public to find alternatives to institutional care have increased demand for less medically oriented types of home care as well.

Between 1966 and 1987, home health agencies certified by Medicare increased by almost 400 percent—from 1,275 to 5,794. The number of proprietary or for-profit agencies has increased the most, largely in response to the 1980 Omnibus Budget Reconciliation Act that removed the ban on Medicare certification of for-profit agencies in those States without licensing laws. Previously, State licensure, and often certificate-of-need approval, had been required of for-profit agencies. Although accreditation programs exist for homemaker chore services, Medicare/Medicaid certification is limited to agencies offering nursing and other health-related services. Moreover, registries of independent providers are not eligible for certification or accreditation. It is estimated, therefore, that only half of the approximately 12,000 organizations delivering home care are certified or accredited.

Conference sessions dealt with many of the major issues of the burgeoning home care industry. The opening session presentations set the tone dealing with such issues as the definition of "quality" in home care, difficulties in measuring quality, adequacy of the home care work force, and the appropriate regulatory roles of the Federal and State governments.
The need for more effective quality assurance mechanisms was a theme throughout the conference. The strengths and weaknesses of quality assurance efforts through government regulation and voluntary self-policing of the industry were debated vigorously. The strong influence of the Medicare certification process in setting standards was stressed. State and local government representatives discussed how they go about assuring the quality of social services funded via Title XX, the Older Americans Act, or State programs.

Private standard-setting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations, the National League for Nursing, and the National Home Caring Council, emphasized their commitment to maintaining high quality accreditation programs. They also stressed the advantages of voluntary accreditation.

The recent role of Congress in mandating more stringent Federal regulations in response to quality concerns was outlined. The effectiveness of State regulatory requirements was examined as well. Strategies were also proposed to empower consumers of publicly funded home care services.

The role of research in identifying measurable quality assurance findings was a central conference topic. The Robert Wood Johnson Foundation, the National Center for Health Services Research and Health Care Technology Assessment, and the Health Care Financing Administration pledged their support for more and better research. Methods of developing reliable information by focusing on outcomes were detailed. Methods were also delineated that take into account the distinctive nature of home care in contrast to institutional care. Ethical issues involving, for example, the rights of clients were discussed. The needs of special groups of home care clients, such as AIDS patients and children, were also reviewed. Presentations in the closing session reflected the new interest in home care as conference participants were urged to develop innovative and dynamic research proposals.
I am happy to have this opportunity to speak to this conference on home care quality. The issue you are addressing is among the priorities that I have listed in what I call "The Bowen Agenda." The Department of Health and Human Services is sponsoring this conference to bring together three groups of people who need to talk with one another if we are to improve the quality of home care: researchers, regulators, and, of course, the hands-on practitioners who deliver home care.

We need to talk about home care quality for several reasons, not the least of which is the rapid growth of home care services. It has been nothing short of phenomenal. From 1974 to 1985, Medicare outlays for home health services grew by an average of more than 31 percent a year. And in the fiscal years from 1985 to 1986, Medicaid outlays for this purpose grew by nearly 30 percent. Growth in more recent years has slowed somewhat, but most see this as only temporary. The underlying truth of the matter is that we are spending more and more public money on home care, yet we are not really sure that we are getting true value for it.

We do know for certain that home care meets with the enthusiastic approval of people. Receiving care in your own home is an immensely popular idea. If you are an older person, it means you may get to leave the hospital sooner. Better still, it may mean postponing or avoiding altogether the need to go into a nursing home for there is, indeed, "no place like home." But the very fact that home care services are delivered in the person's own home poses something of a problem for us--and it is this very problem that brings us here today. Part of the problem stems from the fact that home care takes place outside of an organizational setting where care can be observed, measured, and evaluated. Also, we know something about how to measure quality in a hospital because we have been at it for some time now.

A second aspect of the problem is how to establish accountability. The fragmentation of the home care service system and the mechanisms that fund it can make it difficult to decide just who is responsible for what. This makes it doubly important that you address the whole range of home care services from the medically intensive ones to those that are primarily social services. Difficulties notwithstanding, it is important that we assume a strong Federal role in ensuring quality home care services. First of all, we have a responsibility under Medicare to be prudent buyers of care. But it is also in keeping with this administration's strategy to make health care more competitive. If we are to create a medical marketplace, we must ensure alternative settings for delivering care.
Putting "the right patient in the right setting of care at the right time" does not just make sense medically. It also makes sense economically. It is absolutely vital to the establishment of a working medical marketplace that the most appropriate care be delivered at the lowest feasible cost. Medicare's Prospective Payment System has created an economic incentive for hospitals to discharge older patients as soon as they are well enough to go home. But this very incentive to discharge means that there have to be sound alternatives to care for those who are still in the convalescent stage of their illness. This makes it imperative that home care services not only be available, but of good quality as well.

Beyond all these considerations, I have a few personal observations to make as one who was once a family physician. Back when I was practicing medicine, the family physician had the major responsibility for ensuring that his patients received quality care. This responsibility was deeply impressed on us when we were in medical school. We felt it was a vital part of that unwritten compact that we called "the doctor-patient relationship." And we believed it would be an abrogation of that compact if government or a third-party insurance payer were to take over this responsibility.

But times have changed. Back then, medicine was as much an art as a science. So little was known or developed then that ensuring quality care was a fairly simple obligation for the doctor. Those days are gone. Today's health care has reached a level of technological and organizational complexity that goes beyond the scope of the family doctor.

Today many specialized personnel other than the family doctor are involved in delivering care. Indeed, much of the post-acute and long term care that today's patients receive is outside the direct supervision and control of the patient's personal physician. So it simply is not feasible nowadays to hold the family doctor personally accountable for this care.

The family physician, however, can prescribe medically centered home health care, such as the services of a registered nurse or therapist, and should learn more about the home care options available and the coverage rules for public programs. But usually these providers of home care do not work for or report directly to the patient's physician. So it is highly unlikely that the physician will be aware of the quality of home care provided, unless the patient complains about it or the condition worsens because it is so bad.

There is an even greater distance between the family doctor and those who provide home support services of a nonmedical nature. These social services do not even require a physician's prescription. Yet many patients living at home need meals prepared for them, housekeeping services, or someone just to look in on them from time to time if they live alone. Indeed, at times, the availability and quality of these support services can mean the difference between staying in a hospital or nursing facility and going back home. Frankly, as a doctor, I do not know how one can measure the
therapeutic value of being at home. But I have often observed that it makes all the
difference in the world to a patient's sense of well-being, and probably to the recovery.

I am the first to declare that government has a solemn responsibility in these
times of public deficits to ensure that the taxpayers' money is wisely spent. Medicare
must indeed be a prudent shopper for health care services. But this does not absolve
us from constantly seeking that optimal mix of high quality service and reasonable cost.
And as we seek that ideal mix, we must be ever mindful that sometimes better is
cheaper. This is precisely the area in which you at this conference must apply your
know-how and share your insights because the task of ensuring quality is far from
getting any easier and is in fact getting harder.

There are several other factors as well. Firstly, new categories of home care
patients have emerged: persons with AIDS, ventilator-dependent children, the growing
number of elderly with Alzheimer's, and the increase in working adults who now survive
head injuries and other once-fatal conditions. All of these home care patients are going
to place unprecedented pressures on the skills and resources of those who provide
home care services.

Secondly, the elderly, who are the biggest users of home care services, keep
increasing in number. From 1967 to 1984, their number went up from 19.5 to 27.7
million. Sometime early in the next century that number will grow to over 50 million.
More of them will live to age 85 and beyond, and 25 percent of Medicare home health
services are used by the elderly in this latter age group.

Thirdly, there are new developments in portable medical technology. These
make it possible for some patients to receive certain high-tech services at home that
were once available only in hospitals. As high-tech medicine is infused into home care,
the job of ensuring quality is going to get more complicated, not less.

All of these emerging factors are affecting a home care industry that is still far
from solving its quality assurance problem.

Last year, the Office of the Inspector General published an eye-opening report on
the current state of Medicare services performed by home health aides. It found that,
while these aides performed most of their personal care tasks well enough, they were
doing only half of what they should be doing in areas that represent an extension of
nursing and rehabilitation care. For example, aides often failed to give catheter care,
foot soaks, or special skin care, and failed to assist with dialysis or to record the intake
and output of fluids. They would neglect to take temperatures, pulse, and respiration, to
supervise exercises or to record the patients' progress in achieving daily living needs.
This study laid the blame for these shortcomings on a lack of attention in training and
on-site supervision by registered nurses. This needs looking into. It seems to me it is
something that can be remedied.
Another problem that needs attention is the training and pay of home care workers. Some say it is not always equal to the responsibilities we expect them to handle. But if that is so, then we face an issue that may not be easy to resolve: Just how far can we go in establishing training standards for home care workers without over-professionalizing the service and pricing home care out of the market? I hope you will give this rather sensitive issue your careful attention.

I also hope you will take a good look at how we should go about measuring the quality of home care. We already do this in several ways, one being the setting of "conditions of participation" for home health providers. We monitor all this through a system of surveys and certification, operated in conjunction with each State. We also fund peer review organizations. Recently they have been given a mandate to review post-acute care, including home health care. Under the Medicare home- and community-based long term care waivers, States operate their own quality assurance programs. They must, however, provide us with assurances that appropriate quality safeguards are in place. Experiments are underway to apply the ombudsman program of the Older Americans Act to home care as well as nursing home care to give consumers an independent outlet for voicing their complaints. So we have these quality review mechanisms in place.

The trouble is that they often do not relate to one another in a coherent way. And medicine has not come very far in creating a coherent and useful structure for measuring quality. But recent times have seen the development of a unifying concept of quality assurance that holds forth some promise.

Quality is viewed from three perspectives. The first emphasizes structure. The adequacy of the physical structures and organizations that provide care and the professional qualifications of those who give it are examined. The second involves process. It is a measure of how well specific procedures are carried out and whether those procedures meet the criteria of reasonableness for a particular patient with a particular condition. The third is a bottom-line measure of quality called outcome. Or, put another way, what happened to the patient? Did he or she live or die, or get better or worse, as a consequence of the care?

Right now, quality assurance is strong on measuring structure, but not so good at measuring process or outcome. We appear not yet ready to fully measure all three as a kind of cross-check on the others. That is what we ought to be shooting for. From your perspective at this conference, making use of this structure, process, and outcome concept might offer you some useful points of departure when you start to talk about measuring the quality of home care services. I am far from suggesting that this conference go it alone. Your value here will be to lay the groundwork and set directions. out of your dialogues here should come issues to which researchers can begin seeking answers.

Particular attention needs to be devoted to developing outcome, input, and process measures of home care quality; determining the training and supervision needs
of home care workers; and coming up with guidelines that will tell us when home care is appropriate and, if so, at what level of medical intensity. You might also want to provide some guidance in how we should go about forecasting the labor pool for home care workers and how we can better understand what motivates people to enter the field and stay in it. Finally, you might help shed light on how we can do a better job of telling consumers how to judge the quality of home care they receive or how to pick a home care agency that will best meet their need.

In closing I have only this to add: The work you do here can be seen in its narrowest sense—as merely a job of defining the problem to be accomplished with the perspectives and expertise you bring to this conference—but I would suggest to you that if you see your mission only in these terms, you may very well fail your purpose here. To succeed requires in each of us a capacity to care about those your work here is meant to help.

I take leave of you now filled with the cheerful conviction that I am talking to just such a group of people. You would not be here were it otherwise. It is my own heartfelt wish that you succeed in your efforts because there can be not the slightest doubt that you are indeed performing important work here that will ease the plight of many people. I pray that you proceed in that hope and spirit and I thank you for being so attentive.
OPENING GENERAL SESSION SUMMARY

HOME CARE QUALITY: IDENTIFYING THE ISSUES

Moderator: Pamela Doty
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Presenters: Val Halamandaris
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Nancy Smith
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U.S. Senate Special Committee on Aging and Legislative Aide to
Senator John Heinz
Washington, D.C.
Speakers at this opening general session put forward key issues in home care quality that were discussed more fully in the following two days of breakout sessions. Major topics included the need for improvement in training and supervision of home health aides and other unlicensed home care workers, strategies for empowerment of clients, and the expanding regulatory role of the Federal and State governments. The nature of the quality assurance responsibility of home care agencies was also discussed.

Great stress was placed on the need for research in two broad areas. Research is needed to find out exactly what kind of quality problems exist. There is anecdotal evidence but little information available resulting from rigorous, generalizable reporting systems. Research is also needed to develop ways of measuring quality that speak to the distinctive features of home health care. The important differences between home care and institutional care should be addressed in developing quality assurance procedures.

The six speakers expanded on these topics. Elma Holder’s presentation centered on an example of how one elderly client named Violet suffered from inept care. Her experience served to spotlight flaws in the selection and training of home health aides as well as in the administrative procedures of agencies. Although most of the aides who cared for this 80-year-old woman were indeed caring, only some were well trained, and several admitted they had no training at all. Absenteeism was not unusual. There were attempts at theft and check forgery. When complaints were registered, the agency did not take effective action and the client even experienced retaliation. There was never a home visit by a supervisor.

Violet was not able to die at home because of a failure of the system. Toward the end, she suffered through a night of extreme pain, receiving extremely poor care from an aide who had never before attended a dying person. In the morning, the day shift aide did not show up and the agency could not send one until noon. Violet had to be transported to a hospital where officials insisted on painful tests. She died there three days later.

The irony of this particular client’s experience was that she happened to be a politically active advocate for a national home health care program. She was characterized as one who, had she recovered, would still be promoting a national program despite her personal experience. According to her friend and informal caregiver Elma Holder, Violet would be highlighting the need for better training for the aides and better monitoring of the system.

A portrait of home care aides also emerged from the session. They generally have little formal education. They are untrained initially and receive very little orientation into the home setting. They are paid very low wages with no benefits or guaranteed working hours. Generally, the pay scale begins at the minimum wage of $3.35 per hour depending on the agency and labor supply. It was alleged that many
potential home care workers join the fast food industry instead because they can obtain higher wages and better benefits and hours at McDonald's or Burger King.

In a study, 15 aides were asked to rank their needs. Behind better salary and benefits, they cited the need for respect. It was emphasized that they are not unskilled workers, that the work requires a good measure of skill. But motivation is lacking because of the insufficient training and compensation. There is no career ladder in the field. In one example, the aides were given a raise of 10-15 cents across the board instead of raises tied to level of skill or seniority.

The three components of skill, motivation, and supervision were cited as essential to improving the quality of aide services. Recommendations included that training for aides must be paid by the employer, continuing education must be provided and perhaps linked to certification, decent wages must be provided, a career ladder must be established, and timely supervision must be guaranteed. One suggestion was that Medicare could reimburse based on the level of skill required of the aide.

The concept of client empowerment was viewed as a way to enhance a basic advantage of home care, that the home environment can be a positive factor in outcomes. A well-publicized and well-accepted statement of client rights would strengthen the role of the client in influencing his or her quality of care. Rights statements would include provisions like these in the Code of Ethics of the National Association of Home Care:

1. The patient is fully informed of all his rights and responsibilities.
2. The patient has the right to appropriate and professional care relating to physician orders.
3. The patient has the right to choice among care providers.
4. The patient has the right to receive information necessary to give informed consent prior to the start of any procedure or treatment.
5. The patient has the right to refuse treatment within the confines of the law and to be informed of the consequences of his action.
6. The patient has the right to privacy.
7. The patient has the right to receive a timely response from the agency to his request for service.
8. A patient will be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed. The patient has the right to reasonable continuity of care.
9. The patient has the right to be informed within reasonable time of anticipated termination of service or plans for transfer to another agency.

10. The patient has the right to voice grievances and suggest changes in service or staff without fear of restraint or discrimination. A fair hearing shall be available to any individual to whom service has been denied, reduced, or terminated or who is otherwise aggrieved by agency action. The fair hearing procedure shall be set forth by each agency as appropriate to the unique patient situation (e.g., funding source, level of care, diagnosis).

11. The patient has the right to be fully informed of agency policies and charges for services, including eligibility for third party reimbursements.

12. A patient denied service solely on his inability to pay shall have the right of referral.

13. The patient and the public have the right to honest, accurate, forthright information regarding the home care industry in general and the chosen agency in particular (e.g., cost/visit and employee qualifications).

Charles Sabatino noted that the Commission on the Legal Problems of the Elderly of the American Bar Association is studying client rights statements in various States and will propose the elements that should be included in an effective one.

Several other ideas for enhancing the client's influence were discussed. There should be accountability from the inception of the service. The care plan should incorporate the client's perceptions of needs; too many times the client is just given a plan. Clients should not be allowed to control the situation but their perceptions and preferences should be considered. One example was given in which a client's home was infested with cockroaches and the care worker set about finding him another place to live. All the client wanted was someone to call the exterminator, but that was not in anyone's job description.

There should also be a system of accountability for services that could be as simple as a checklist with questions for the client: Did your worker show up today? Were you given your pill? Were you given a bath? How did you get those bruises on your arm?

There is a need for effective grievance mechanisms. Models might be the State ombudsman programs mandated by the Older Americans Act for long term care and a hotline program mandated by other Federal legislation.

There is also a need for consumer input in home care program policy and development. Consumers should sit on panels at the community, State, and Federal levels.
Another aspect of client empowerment is the teaching that should be part of the job for a well-trained home care aide. The client and family will become more comfortable and secure as they learn from the aide about care techniques and equipment.

The role of the Federal and State governments was discussed, especially in the context of the present level of quality of home health care. Val Halamandaris expressed the industry's view that the quality of care is extremely high now and has been historically high, especially compared to nursing home care. He expressed concern that pressures generated by Federal and State policies may reduce quality.

The Medicare Prospective Payment System, using diagnosis-related group classifications, has resulted in the discharging of patients from the hospital sooner. This has increased the use of Medicare home health care by 38 percent.

At the same time, however, the industry is concerned because reimbursement has gone down and denials for payment have increased. Also, the three percent denial rate went up 12 percent on the average; in some States it went up 33 percent. In addition, the average number of visits a client on Medicare could expect decreased from 27 to 12. All in all, it is alleged, fewer people qualify for fewer benefits because of rule changes.

In addition, industry representatives complain that the amount of paperwork has increased by 50 percent over the last three years and nurses who normally work in the field providing care have to be brought into the office to do this paperwork. These nurses are worried about malpractice because they know they cannot provide decent care with just 12 visits so they are beginning to leave the home health field.

Another problem, as the industry sees it, is that States are trying to cut costs by contracting directly with individuals and bypassing agencies. Still another problem is the increase of unregulated fly-by-night operations.

Representing the congressional staff perspective, Nancy Smith responded that there are quality concerns in the home health industry and this is the reason Congress is moving to beef up regulatory standards. However, she stressed that Congress is not on a "witch hunt". Recently, Congress passed legislation to require that States set up toll-free hotlines and investigative units for home health care. Also, funding for peer review organizations was doubled so they could begin to move more aggressively into such areas as home care, nursing home care, and physicians' offices. She also pointed out that Congress and the States will probably be dealing with non-health related home care in the future.

Kathryn Schulke spoke from her experience as a nurse who has worked for both nonprofit and proprietary home health agencies. In her view, some home care agencies let quality slip by not training and motivating aides because they are overly concerned with profits. She suggested that the Federal and State governments establish policies
that provide positive financial incentives to promote quality and discourage promoting profit-making at the expense of quality.

Peter Shaughnessy identified a need for more research on the definition of quality including quality measures covering the usual range of structural, process, and outcome considerations as well as a suggested paradigm of global, focused, and broad measures of quality.

Global measures were defined as those that pertain to all clients in a given agency, such as mortality rates and staff mix. Focused measures were defined as those that pertain to specific types of patients, such as diabetic patients and congestive heart failure patients. Broad measures were defined as those that would come somewhere between global and focused measures.

Peter Shaughnessy suggested that several points should be considered in conducting research on ways of measuring quality of care that take into account the unique aspects of home care. The positive value of the home environment in contrast to the institutional environment can have a big impact on quality of care as well as cost.

In addition, there is less control over care in the home than in an institution because the provider is a guest. A new dimension is the knowledge that both the client and family gain from the aide in learning about self-care.

Finally, all agreed that compliance with quality standards cannot be measured as easily at home as it can in an institution. Nevertheless, providers should still be held accountable for effective service.
BREAKOUT SESSION SUMMARIES

MEASURING HOME CARE QUALITY: HOW FAR HAVE WE COME IN DEVELOPING OUTCOME-ORIENTED MEASURES? WHAT IS THE Appropriate MIX OF STRUCTURE, PROCESS, AND OUTCOME MEASURES?

Moderators: Pamela Doty
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Washington, D.C.

Tony Hausner
Health Care Financing Administration/ORD
Baltimore, Maryland

Presenters: Karen Barger
Executive Director
Visiting Nurse Association of Coastal Georgia
Savannah, Georgia

June Gray
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Topics addressed in this session included the quality assurance program of a small home health agency in Georgia, an analysis of how to tailor outcomes research to the distinctive nature of home care, a project to develop outcome measurement scales for home care, and procedures used in certification surveys of Medicare-certified home care agencies.

Karen Barger described the quality assurance program of the Visiting Nurse Association of Coastal Georgia in Savannah, a nonprofit agency that provided 23,000 visits last year, which has internal and external components. The internal component is defined as procedures developed by the agency itself and the external component is defined as related to oversight by outside parties such as Federal and State licensure reviews.

The internal component consists of staff selection processes, orientation, ongoing in-service training for professional and nonprofessional staff, supervision, standardized nursing plans based on nursing diagnosis, and a self-audit of the professional disciplines.

An auditing process identifies problems that are corrected through the training of practitioners on an individual or group basis. The charts with problems are then re-audited eight weeks later to measure improvement.

There is also a Utilization Review Committee composed of two nurses, a pharmacist, a nutritionist, and a physical therapist, all volunteers not employed by the agency. The committee meets quarterly and each member reviews 4-6 charts. Committee members are requested to ask these five questions: Was the assessment right that directed the client to a home health agency? Were the services right for the client? Were the client's total health needs met? Was there consideration of other community agencies that might have been needed in addition? Were services coordinated for an integrated plan of care?

Twenty percent of all visits are reviewed on a yearly basis. Revised versions of an already established patient satisfaction questionnaire and a physician evaluation of services will be introduced in the near future. The development of a peer review process is 18 months away but could be linked to client satisfaction or outcome criteria.

In their discussion of outcomes research at the session, both Peter Shaughnessy and Bernadette Lalonde emphasized outcomes related to changes in patient status rather than utilization outcomes (e.g., hospitalization use, emergency room use).
Shaughnessy discussed using two "time points" to judge whether or not a transition from one stage to another was successful. The patient's mobility status could be measured this way. This approach also emphasized tracking the stability of this change: Did the patient progress steadily during the time period? Or was there some regression and then progression, some back and forth, that eventually resulted in the final positive result?

In one example, patient outcomes were compared in home care and nursing home care. It was stressed that the comparisons will be deceiving if the analysis does not adjust for case mix. In the instance of catheterization, nursing home care may outshine home care because it is a difficult procedure to carry out as well in the home environment. This would bring up an issue of patient placement. However, when the outcomes data in this example were adjusted for case mix, the results did not show much difference in general between home care and nursing home care.

It was also strongly suggested that the community health nursing model should be used in developing outcome measures rather than the medical model because home care is predominantly nursing care provided by a variety of caregivers--the registered nurse, practical/technical nurse, and the homemaker/home health aide.

Emphasis was placed on the need to relate outcome measures to goals that the nurse and patient develop together. Additionally, the definition of clinical indicators that are the most predictive of care quality should be developed by the nurses themselves.

That approach was incorporated into one aspect of Bernadette Lalonde's project in Washington State. This ongoing federally funded project to develop outcome scales for home care was described in detail. The input of staff members from the Washington Home Care Association was utilized.

Five scales have been developed and two more are completing the development process. The scales are broad-based rather than diagnosis-specific so they can potentially be used for all clients. They measure outcomes on an intermediate basis rather than a long term basis and they measure client centered outcomes rather than service utilization outcomes.

The scales were tested in pilot programs over a six week period. They take 5-15 minutes to administer. They were designed to be much more sensitive to changes than other scales. For instance, a distinction is made between upper body dressing and lower body dressing instead of just dressing in general. A client's progress is charted in specific increments.

One agency used the scale to reform its approach to easing pain reported by clients. After the need for pain relief was stressed by a set of clients filling out the questionnaire, a new procedure was started to alleviate the problem. At specified intervals, there was consultation with the physician on modifying pain medication. As a
result, the responses on the follow-up survey showed the agency had reduced the number of clients complaining of pain.

Widespread use of these scales by the home care industry could facilitate case management, improve the quality of care, test outcome practice measures, and allow aggregate data collection across agencies.

June Gray reviewed procedures for carrying out certification surveys of Medicare/Medicaid participating home health agencies. The survey consists of ten conditions of participation. It covers compliance with local, State, and Federal regulations; the agency's organization, services, and administration; and other quality assurance requirements.

June Gray presented figures to show the categories with the highest number of deficiencies for the 5,984 Medicare-certified agencies at the beginning of 1987. They were Policies (18 percent), Plan of Treatment (13 percent), Compliance with Physician Orders (12.7 percent), Clinical Record Review (12.6 percent), and Coordination of Patient Care (9.7 percent). Wide variations were found within regions of the country.

Although surveyors do make some home visits, much of the data collection and analysis is done by reviewing agency records. Some agencies simply modify their paperwork after the fact to look better. Since a new Federal law requires an assessment of the client at the beginning of service, this allows comparison of the client's original condition to his or her present condition. June Gray recommended that administrative law support the surveyor in judging the client's change in condition by seeing the client rather than by just studying records.

The benefits to the Federal government would be to identify outcomes appropriate for measuring home care quality, provide data for interagency comparisons, and provide data on client centered outcomes to facilitate process outcome studies.

Samuel Kidder and Thomas Hoyer briefly outlined the new survey and certification requirements mandated by the Omnibus Budget Reconciliation Act of 1987 and the Health Care Financing Administration's plans to write regulations implementing these new statutory provisions.
EMPOWERING CONSUMERS: POSSIBILITIES AND LIMITATIONS

Moderators: Katie Maslow
Office of Technology Assessment
U.S. Congress
Washington, D.C.

Brina Melemed
Consultant, Long Term Care
Bethesda, Maryland

Presenters: Elizabeth Mullen
Director, Women’s Initiative
American Association of Retired Persons
Washington, D.C.

Patricia Murphy
Director, Ombudservice for Home Care Clients
Community Council of New York City
New York, New York

Ellen Reap
Survey and Certification Program Review Specialist
Health Standards and Quality Bureau
Health Care Financing Administration, Region III
Philadelphia, Pennsylvania

Carmine Striano
Director of Professional Relations
Keystone Peer Review Organization, Inc. (KeyPro)
Lemoyne, Pennsylvania

Tony Young
Chairperson
Personal Assistance Services Together (PAST) and Fairfax Opportunities Unlimited, Inc.
Springfield, Virginia

The panel confronted a broad range of topics: How is client involvement ensured in quality assurance of home health care? How is client satisfaction measured? Are clients satisfied with the home care currently being provided?

Regulatory agencies can help empower home care beneficiaries through home visits. Ellen Reap noted that, as of 1985, home visits were added to the inspection
The home visit verifies that patient needs are being met and all appropriate treatments are being provided. Specific policies govern home visits. The agencies contact the beneficiary and gain written consent for the visit which the beneficiary can cancel at any time.

HCFA also administers a complaint process. All complaints are evaluated at the State level to determine if they should be referred to the Federal authorities. Serious allegations are investigated within two working days. The States make unannounced visits to providers in investigating consumer complaints. The number of complaints by home care beneficiaries is often low for several reasons. Many beneficiaries live alone or with family where their care is largely unobserved. They often do not understand the process of filing a complaint with the proper government agencies. Many fear loss of benefits if they do complain.

The Omnibus Budget Reconciliation Act (OBRA) of 1987 will have a major effect on quality standards for home health services. The law formalized patient rights and compelled the States to establish complaint hotlines and to create units to investigate consumer complaints.

Carm Striano reported that peer review organizations (PROs) have recently been directed to undertake consumer outreach. Through a review of sample cases, PROs assure that the quality of care meets professional standards. The Keystone Peer Review Organization, Inc. (KeyPro) of Pennsylvania has prepared a pamphlet explaining the right of patients to appeal decisions and the right to a review of their case. KeyPro has established a beneficiary hotline and responds to all complaints. In responding to a complaint, the organization reviews the case to determine the quality of care. KeyPro has also developed a speakers’ group to educate senior citizens on these issues.

Patricia Murphy explained how ombudsman programs can facilitate consumer empowerment. Ombudsman programs serve both the independent but disabled client and the dependent client, for whom the ombudsman program is most important. Consumers should be able to define their needs and understand their plan of care. On a community level, consumer empowerment can be accomplished through consumer advocacy groups, which are often able to push State regulatory agencies into action. According to Patricia Murphy, consumers should be involved in developing government regulations but should not supervise home care or assess the technical quality of care.

Elizabeth Mullen of the American Association of Retired Persons (AARP) stressed that the home care industry must be held accountable to those it serves. There needs to be a sufficient number of providers who can offer a full range of affordable and high quality services. Providers have certain responsibilities:

- Delivery of high quality care.
• Comprehensive needs assessments.
• Care plans developed with the consumer.
• Services appropriately documented.
• Education and training consistent with the needs of the scope of service.
• Employees supervised by professional personnel.
• Care that reflects standards of practice.
• Client Bill of Rights with a clearly defined grievance procedure.
• Quality assurance programs include consumer input.

Pressure on providers often lowers the quality of care. Cost containment and quality assurance can be seen as conflicting issues. A shortage of providers means that they sometimes engage in questionable hiring practices. A fragmented provider system is a hindrance to coordinated care. The regulatory framework sets only minimal, not normative, reimbursement standards. There are insufficient licensure requirements. Recommendations for government action included requiring licensure of all home care workers, developing a standard definition of home care services, and mandating certification training and continuing education of paraprofessionals.

Recent legislation strengthened the conditions for participation in Medicare by including a client Bill of Rights, homemaker/home health aide training, and improved surveys.

AARP educates the public on home care and how it can be accessed. AARP is currently doing a study on the role of volunteers in home care. Another study is being done on the value of case management.

On behalf of AARP, Elizabeth Mullen offered the following recommendations to the Department of Health and Human Services:

• Develop a systematic method of collecting information from patients.
• Monitor and evaluate the effectiveness of OBRA.
• Study whether quality is increased by paraprofessional training.
• Determine whether ombudsman and hotline programs improve access to and quality of care.
• Examine the role of physicians in home care.
According to Tony Young who is active as a consumer advocate for the younger disabled populations, the key to quality assurance for long term personal assistance service lies in helping the client to monitor the quality. The provider and client must be full partners in the needs assessment and service design process. The client should be involved in training and managing those who will come into his or her home. Another helpful procedure would be an independent grievance procedure with a third-party mediator. The consumer should be able to terminate an unsatisfactory situation without the fear of losing service altogether. Emergency services should be improved, as should recruiting and referral services.
POST-ACUTE CARE: THE EFFECTS OF DIAGNOSIS-RELATED GROUP (DRG) PAYMENT REFORM ON HOME HEALTH

Moderators: Robert Clark  
Office of the Assistant Secretary for Planning and Evaluation  
U.S. Department of Health and Human Services  
Washington, D.C.

William Saunders  
Chief, Long Term Care Coverage Branch  
Office of Research and Demonstrations  
Health Care Financing Administration  
Baltimore, Maryland

Presenters: Rosalie Kane  
Professor  
School of Public Health and School of Social Work  
University of Minnesota  
Minneapolis, Minnesota

Shelah Leader  
Health Policy Analyst  
Public Policy Institute  
American Association of Retired Persons  
Washington, D.C.

Korbin Liu  
Senior Research Associate  
Urban Institute  
Washington, D.C.

Kenneth Manton  
Research Professor  
Duke University  
Durham, North Carolina

Barbara Phillips  
Senior Researcher  
Mathematica Policy Research  
Princeton, New Jersey

There is a lack of definitive data on the Prospective Payment System (PPS), but the rate of growth in Medicare outlays has dropped sharply to the lowest level ever. Some of the effects of PPS discussed by the panelists included placement of patients in
home care after hospitalization, strong pressure to discharge patients faster, and to discharge patients who are too sick for family care. Shelah Leader noted that the American Association of Retired Persons (AARP) has received 2.2 million requests for its pamphlet "Know Your Rights," indicating the extent of unmet needs for home health care. The RAND Corporation is conducting a study on home care as a substitute for traditional institutional health care. However, data are not available on readmission rates for discharged hospital patients. The research agenda should include studies on the role of fiscal intermediaries. These studies should result in the production of data on the clinical condition of discharged hospital patients. AARP conducted a panel on patients who had been hospitalized that provided the first solid data on PPS beneficiaries.

Korbin Liu reported on the study he and Kenneth Manton conducted on utilization patterns of post-acute care by functionally disabled Medicare beneficiaries. Special attention was given to hospital readmissions and mortality. The results indicated a decline in the average hospital length of stay and an increase in post-hospital home health episodes of care. Mortality declined following the use of PPS and home health utilization increased. No adverse effects of PPS on Medicare beneficiaries were uncovered.

Barbara Phillips described Mathematica Policy Research’s survey in progress of post-acute care for frail elderly Medicare recipients, particularly those over 85. The study is looking at quality challenges and patterns of combining services among hospitals, rehabilitation centers, nursing homes, and home care agencies as they relate to outcome measures. Two key questions are what factors account for the type of post-acute care chosen and why. Factors include patient, discharge, and hospital elements. The survey, which is funded by the Heinz Foundation, will also study the caregiver burden to develop a better view of home care challenges, including rehabilitation, case management, education, personal care, quality of family care, and quality of service needs assessment.

Rosalie Kane reported on a related study concerned with access to post-hospital care and denial of services in conjunction with PPS. The major question being addressed is whether Medicare beneficiaries are getting adequate care. The goals of this study are to identify and validate guidelines for defining minimally adequate care and to develop a risk classification system identifying outcomes, using data to determine a broad range of measures. Potential applications include the extension of this study to other areas, such as process measures and adverse outcomes, and its use by researchers and consumer groups in care planning.
ISSUES IN THE RECRUITMENT, TRAINING, MOTIVATION, AND SUPERVISION OF HOME CARE WORKERS

**Moderators:** Pamela Doty  
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Suzanne Resner  
Division of Nursing  
U.S. Public Health Service  
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**Presenters:** Robert Applebaum  
Assistant Professor  
Miami University  
Scripps Gerontology Center  
Oxford, Ohio

Jeff Barnes  
Policy Analyst  
New York State Department of Social Services  
Albany, New York

Rebecca Donovan  
School of Social Work  
Hunter College  
New York, New York

Jo Eleanor Elliott  
Director, Division of Nursing  
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Rockville, Maryland

Elizabeth Gordon  
Vice President for Clinical Services  
Kimberly Quality Care  
Boston, Massachusetts

John Mullin  
Clackamas County  
Social Services Division  
Oregon City, Oregon
A major topic of this session was the need for methods to ensure quality of care. The development of new methods is important because close supervision of home care workers is difficult. Some examples include a consumer checklist, a supervisory checklist for the home health agency to complete each month, random home visits, and such support programs as a recognition lunch for workers.

Low salary for home care aides is a major problem. They are usually poorly educated, poorly trained, and poorly paid. Additionally, more research is needed on the best methods to help the aides improve the quality of care.

Jo Eleanor Elliott reviewed the Public Health Service Division of Nursing activities related to issues in recruitment, retention, and supervision of home health care workers. Recently, the Division held a conference on home health care. The Division also provides leadership in response to legislative initiatives through Title VIII of the Public Health Service Act. It currently funds demonstration projects to improve care and access to care, continuing education of nurses, and advanced nurse education in home care. A sample survey of nurses will give an indication of how many nurses work in the home care field. The Division has also developed criteria for home care nursing.

The Health Resources and Services Administration will be funding demonstration grants for home care service. Much-needed research on the outcomes of care is eligible for funding from the National Institutes of Health. The American Nurses Association has issued standards for home care practices for registered nurses.

Elizabeth Gordon focused on the lack of well-defined job descriptions for home health personnel. The scope of practice for registered nurses is well defined from State to State. However, the scope of practice for licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) is less well-defined. As the home care worker shortage becomes more acute, there is more use of LPNs and LVNs. Training requirements for paraprofessionals vary widely among the States. The length of training required varies from 16 to 120 hours. The titles used in different States also vary widely.

There is no central registry or board for home care workers. Regulation by such boards would allow the competency of the individuals to be assessed more easily. In States with mandatory ongoing continuing education there is no follow-up procedure to make sure the education is completed. It was recommended that national regulations should be established that define the scope of practice of LPNs and LVNs and that the minimum training should be standardized.

Jeff Barnes described three studies New York State is carrying out regarding the home care labor force. New York's Long Term Care Policy Coordinating Council (LTCPCC) advises the Governor on health care policy. LTCPCC is studying recruitment, retention, and motivation of home care workers. High turnover and falling recruitment are becoming problems in New York. LTCPCC's research includes a
survey to every agency in the State, a labor market study, and a survey of current and former home care workers.

These studies have two broad goals: (1) providing baseline data to document the extent of the problem in the State; and (2) helping the New York Legislature develop policy. One of the issues that will be studied is compensation of home care workers. Wages can run as low as $3.45 per hour and the average range is $4-$5 per hour. The study will concentrate on compensation package, rate reimbursement, wage security, and wage increase strategies. The rate of retention of home care workers is difficult to document because of reporting problems. Some data indicate that home care is a labor market entry mechanism. One possible method of attracting other potential home care workers is by offering day-care services. There also needs to be more support of home care workers to prevent burnout. Many times workers infer that they constitute a temporary work force because of the way the work is assigned. A new aspect of the study will concentrate on recruitment.

Rebecca Donovan reported the preliminary findings from her study of New York City’s home care workers. Publicity regarding these findings provided the impetus for a recent campaign to improve wages and benefits. In New York City there are an estimated 60,000-70,000 home care workers. The survey was done of 404 home care workers. The workers in the study were exclusively minority women and 54 percent were born in the United States. The foreign born came from 26 countries with a large contingent from the Caribbean. The average age was 47 years old. Some 86 percent had children and 75 percent were the sole wage earners for their household.

The Medicaid office controls the terms of employment so there is little leeway for the vendor agencies in their employment practices. The most common salary for the previous 12 months was $5,000. Annual income is low because the worker is treated like a temporary and the work tends to be intermittent. Some 80 percent reported that they were unable to acquire adequate housing. Eighty-five percent reported that they did not earn enough money as home care aides to buy food for themselves or their families. Negative aspects indicated were isolation, lack of training, lack of supervision, and marginalization of their position. Fifty-two percent reported suffering from psychological stress symptoms. However, most of the workers felt that they were doing important and valuable work. Fifty-two percent reported that they were somewhat satisfied with their jobs. In New York City home care workers have begun to unionize. Through the unions workers have gained benefits and wage increases.

John Mullin described how the Clackamas County Social Services Program in Oregon and the Medicaid State-funded Oregon Project Independence Program addresses recruitment, training, and supervision of home care workers. Both programs recognize the importance of flexible hours, vacation time, and training requirements.

The Client Employee Program of Oregon’s Project Independence Program was able to obtain unemployment coverage for home care workers. It developed a clearinghouse project to screen, check references, and provide a minimum amount of
training. A registered nurse was added to the staff to help employees working with clients requiring special assistance. The program provided respite, hospice, and chore services; a Seniors Resource Guide to encourage people to be smart consumers; and a case management system called risk intervention.

In Oregon, adult foster care is an important issue. Recruiting in the rural areas of Oregon is a problem and wages remain low. Adequately trained employees are in short supply.
Topics included State quality assurance programs for home care, long term care assessment and management programs, a systems view of home care quality, and an overview of quality assurance.

The lead speaker, James Focht, described a study, funded by the U. S. Department of Health and Human Services, being carried out by Macro Systems that
focuses on State activities in home care quality assurance. The challenge is the difficulty in obtaining an overview, given variation among the 19 States in the study. The report will include profiles of each State covering a generalizable picture of program organization and history of home care services, the degree of fragmentation, service delivery mechanisms, resources, demographics, availability of providers, and community involvement as well as regulatory standards and methods.

The basic question is whether there is a tendency to be less critical when care is given in the home and whether standards are compromised as a result. Issues include standard definitions, outcome measures, licensing of providers, case management, and risk management.

Nancy Mumma's presentation described efforts to contain home care costs in Oklahoma by coordinating various State agency funding and organizing a local voluntary effort by non-professionals to provide home care. Contributing factors were Federal cutbacks, loss of revenue sharing, and methods to improve accountability. Agency coordination prevented duplication of services for proposals, contracting, monitoring, and evaluation. A survey of referrals was recommended as a good mechanism for measuring quality.

Results included services more responsive to client needs, better coordination of State and local services, cost reduction, ability to serve more clients, collection of aggregate data, and services provided at 50 percent less than Medicare. Recommendations included Federal and State coordination of reimbursement; more research on process, outcomes, cost, and quality of care; more flexibility of service needs for chronic and long term care; and client-centered approaches to quality assurance.

Maryann Nardone described quality assurance under Pennsylvania’s Long Term Care Assessment and Management Program. Local agencies perform assessments and offer alternatives to a long term care facility. Supplemental services are available to the individual and all services are pre-approved. The population is well-defined and a standard assessment tool is used. All staff receive standard training. The client caseload is identified. Direct providers are not allowed to perform assessments and on-site monitoring is done. Maryann Nardone recommended that the research agenda include service protocols on client care and family care.

William Foley of the Rensselaer Polytechnic Institute presented a systems engineering view of the home care delivery system. The systems definition of quality is delivering the right services to the right people at the right time. Issues in focusing on the right people include the opportunity for home placement, discharge planning, and screening those who will benefit most from the kind of assistance home care is best suited to provide. Issues related to the right time include identification of problems, resources available to solve the problems, specification of goals for these services, and availability and accessibility of services when required.
A decision-making tool was devised that achieved economy of home care resources in reviewing prospective clients for home care placement. A client classification system to match clients to home care programs and a uniform client assessment for care planning were devised.

Innovative delivery and payment systems, productivity improvements, and introduction of technology are needed in dealing with the "right time" issue. Since demand cannot be anticipated, accessibility is the greatest challenge.

Darrel Balmer presented an overview of Illinois' quality assurance approach. Structure, process, and outcome measures are incorporated into contract reviews of vendor performance. This process determines the continuation of contracts for the agencies. Technical assistants are used for the compliance review. The threat of corrective action is an incentive to improve quality. A thorough review is conducted following corrective action. The results showed that compliance reviews were strengthened and plan of care reviews were more appropriate.
The issues discussed at this session included enforcement of outcome measures, whether quality deteriorates when flexible survey cycles are used, the effectiveness of voluntary accreditation, and recent changes in the omnibus Budget Reconciliation Act of 1987 (OBRA) designed to raise quality standards and improve the survey and certification process.

Mike Goldman of the Health Care Financing Administration highlighted the following new requirements mandated by OBRA:

- Each patient must be informed of his or her rights in advance, including the right to express grievances, to confidentiality, and to information on services provided.

- Home health agencies will have to notify State survey agencies of all changes in ownership.
• A home health aide training program will be developed. A regular performance review must be conducted, and after January 1, 1990, no home health agency may use an untrained person.

• Training standards will be developed for personnel using durable medical equipment.

• An individual plan of care for each patient is required.

• Home health agencies are subject to an outcome-oriented survey process, based on home visits, to ensure that services promote the highest functional capability of the patient receiving medical, nursing, and rehabilitation care.

• Prior notification of a survey visit is subject to a fine.

• Facilities found to be providing substandard care will be subject to an extended survey and a review of policies to determine compliance. Penalties may include intermediate sanctions (civil fines and suspension of Medicare payments) or termination.

• A toll-free hotline will be established for client complaints, monitored by an investigative unit.

• Peer review organizations (PROs) will review specific complaints of beneficiaries.

Charlene Harrington discussed her study in progress of the quality of home care in California and Missouri. This study looks at the quality of care, the extent of State regulations, and changes that have occurred. Statistical data were obtained from key providers, State regulators, consumer organizations, PROs, home care agencies, and State legislators. Preliminary results indicate that the number of regulations are decreasing because of budgetary restrictions. The study is also measuring the extent of State licensing, which is decreasing, as well as Medicare/Medicaid certification surveys. Because of resource constraints, there is a lack of surveyors, and fewer than half of the home health care agencies are surveyed annually.

Questions were asked about State priorities for certification and the kind of enforcement actions taken if there is a lack of compliance. Enforcement is limited, but there is some decertification action. It was suggested that State authorities hear few complaints because consumers do not know which agency is responsible for regulation. Also, the States do not have the resources to respond. Half of all complaints are about unlicensed agencies. There is a funding problem if regulations are expanded, and one political barrier to expansion is the influence of interest groups.

Quality problems were found in personnel policies, supervision, clinical records review, administration, and coordination of patient services. Coordination among the
various agencies is also problematic, and there are few resources to focus on outcome measures.

Changes in the Federal survey and certification process have occurred because of the increase in the number of proprietary agencies, the use of diagnosis-related groups in the Prospective Payment System of Medicare, and the growth of the elderly (over 75) population.

Marly Auerbach presented the view of a home health agency director whose agency is subject to Medicare/Medicaid regulatory standards. She criticized Medicare/Medicaid quality requirements for not being integrated with reimbursement and expressed the opinion that increased scrutiny has not improved care. Home care agencies did not have sufficient input into the development of Medicare Form 485 (for filing reimbursement claims); consequently, this form is difficult to relate to the plan of care. This results in less time for clients and more time on paperwork, increasing the cost to the agency of compliance. Surveyors who determine noncompliance do not have a home health care background; therefore the need for inter-rater reliability is crucial.

Marly Auerbach's recommendations for improving survey and certification standards and processes included the following:

- Distinguish between long term and short term acute care.
- Strengthen standards jointly.
- Coordinate reimbursement policy and survey development.
- Consult health care leaders.
- Work with providers on reimbursement policy.
- Consider the cost of compliance.
- Increase certification criteria.
- Do not require as much paperwork.
- Work with home health care providers, not against them.
ACCREDITATION PROGRAMS: STRENGTHS AND WEAKNESSES

Moderator: Ruth Galten
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National Association for Home Care
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Presenters: Nola Aalberts
Director, Homemaker/Home Health Aide Division
National Association for Home Care and Acting Director of Accreditation and Education
National Home Caring Council
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Maria Mitchell
Senior Vice President
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Anne Rooney
Associate Director
Hospice and Home Health Accreditation Programs
Joint Commission on Accreditation of Healthcare Organizations
Chicago, Illinois

Ellen Yung-Fatah
Nurse Consultant
District of Columbia Department of Consumer and Regulatory Affairs
Washington, D.C.

This panel focused on the accreditation programs of three national professional groups and an accreditation commission established in New Jersey to assist the State Medicaid program. The issue of private accreditation programs qualifying to grant agencies "deemed status" under Medicare was debated. If an accreditation program is assigned the authority to grant deemed status by the Health Care Financing
In the development process, four versions of draft standards were reviewed by some 7,000 health care professionals, professional and trade associations, and consumers. The standards were also discussed at regional conferences and JCAHO staff members made some 60 presentations at national meetings. The standards focus on the interaction between the care worker and the client.
Pilot surveys were conducted at home health agencies around the country. The agencies were asked not to prepare for an accreditation survey because the intent was not to accredit but to find out if the proposed standards were realistic as ways to improve the quality of care. Seventeen organizations participated and the standards were modified according to the results.

Representatives from 18 professional and trade associations make up a Home Care Advisory Committee that is involved in the new accreditation process. The accreditation program not only includes home health agencies but also equipment management firms and personal care and support services organizations.

The survey process includes a minimum of four home visits for each organization. Some 70 peer reviewers will be trained by this fall. They will be nurses with clinical and administrative experience in the field, equipment managers who have owned or managed an equipment company, and pharmacists.

Maria Mitchell characterized the Community Health Accreditation Process (CHAP) of the National League for Nursing (NLN) as setting a standard of excellence rather than going along with the more common minimum safety standards. The NLN has been accrediting home health agencies for 25 years. CHAP is a subsidiary of NLN with its own board of directors.

The standards and criteria were broken down into the five key areas of planning, organization and management, finance, human resources, and operations and service delivery. A major emphasis is placed on management and finance.

The NLN has done quite a bit of work in the area of outcomes in home care and the standards focus on outcome measures.

The accreditation process includes an agency self-appraisal, a site visit, and home visits. In general, two site visitors stay for four days. They typically include a professional with experience in a service delivery area and one with experience in the management and finance area. Site visitors undergo rigorous training. A consultation approach with the agency is stressed. The agency is left with a clear view of any problems and a good idea of how to build on the strengths. A board of review composed of 12 home care managers then makes a decision based on the site visitors' report.

According to Nola Aalberts, the National Home Caring Council Accreditation Program is geared to the homemaker/home health aide component of the industry. The council was founded at the request of eight government agencies and 26 national organizations for the express purpose of developing standards.

Standards are set for training at the beginning of employment, in-service training, and specialized training. Emphasis is placed on case supervision (i.e., monitoring specific tasks done for the client) and administrative supervision (i.e., monitoring payroll
and personnel records). The standards also require an annual evaluation of services, a periodic in-depth self-evaluation, and consumer input. Community agencies that fund the agency’s programs or that refer clients are surveyed.

Board members and staff members on all levels are interviewed during site visits. Case records are reviewed. Hiring procedures, reference checking, and performance evaluations are studied.

Debate on deemed status centered on whether or not the JCAHO and NLN would be able to abide by Federal rules and regulations if their accreditation programs were given the authority to assign such status. In the view of Ellen Yung-Fatah, the two organizations could not meet the standards and should not be empowered to grant deemed status. Representatives of both organizations responded vigorously that they would be able to meet the requirements.

HCFA announced last year that it had decided to give authority to the two organizations to grant deemed status, but the Omnibus Budget Reconciliation Act of 1987 stipulated that such a decision could not take effect until new Federal rules on the conditions of participation in the Medicare program were released. That was not expected until the last few months of 1988.

One of Ellen Yung-Fatah’s concerns about the ability of the two organizations to meet the requirements was the contrast between the three year review cycle of the accrediting organizations and the required one year survey and certification review cycle. Another of her concerns was the problem of how special compliance reviews will be funded because private accrediting bodies generally bill the client agency for reviews. Will the accrediting bodies pay for follow-up reviews when problems are discovered if the agencies are unwilling to do so?

Her third concern was that the organizations’ approach of stressing consultation and education in motivating agencies to comply voluntarily with regulations might be at odds with their role in enforcing standards. Similarly, Ellen Yung-Fatah asked whether accrediting bodies could move fast enough to satisfy timeliness requirements in compliance investigations. She also questioned whether they could carry out the required home visits.

Finally, Ellen Yung-Fatah expressed doubts about whether the accrediting bodies could protect the individual client’s rights under the Freedom of Information Act. Conversely, she asked, would the accrediting bodies agree to release information on abuses by agencies to the government, given their policies of protecting the confidentiality of their surveys?

In rebuttal, the representatives of accrediting bodies stressed that their organizations do conduct special follow-up surveys and pay for these themselves. The consultation approach was defended as not being inconsistent with the regulations. It
was emphasized that the accrediting bodies could move in a timely fashion to carry out compliance reviews and satisfy the specific requirements regarding home visits.

The ability to protect client’s rights was also asserted as a key strength of both home health accrediting organizations. The organizations’ representatives also stressed that the results of their investigations would be sent to the Federal government and in this way could become public record even though disclosure procedures have not been finalized.
The AIDS population was discussed first. Peggy Beckman stated that home health care agencies will be dealing with more AIDS patients in the future because their number is increasing and the best way to provide care is at home. The United States has 42,000 reported AIDS cases as well as 1-3 million people infected with the human immunodeficiency virus of whom 60 percent are expected to develop AIDS.

What are the needs of the AIDS patient? Confidentiality must be closely protected and the AIDS patient's right to medical care must be upheld. Reimbursement for health care is needed because many AIDS patients lack private insurance. Data should be collected on the costs of AIDS care.
Because many AIDS patients are homosexuals or intravenous drug abusers, there are differences in culture and values that the health care system should understand. A comprehensive home care program would have these essential components:

- good quality assurance criteria and standards;
- knowledge of local epidemiology;
- a strong system of case management;
- a multi-disciplinary approach;
- staff education on the management of symptoms and psychosocial issues;
- staff support mechanisms;
- ongoing evaluation and monitoring of care; and
- better data collection.

When dealing with AIDS patients, the worker generally confronts a very complex nontraditional family structure. There are also issues involving the care of terminally ill patients. Statistics show that AIDS patients will die within 2-3 years following diagnosis.

Another issue is the shortage of nursing home beds for AIDS patients. Those with AIDS are reluctant to seek hospice care because they are usually young and vital. There is also a problem of recruiting people to work with AIDS patients.

Children make up a second population frequently served by home care workers. Linda Maurano described the Pediatric Home Health Care Services of Children’s Hospital National Medical Center. Home care returns as much responsibility for care as possible back to the family. Family values and participation play a central role in home care for children. The package of services should be designed to serve children on a wellness-illness continuum. There is an increased need for home care for children for several reasons. The number of children disabled by chronic illness has doubled over the past 25 years. The technology that was once available only in the hospital has been miniaturized and is available in the home setting. Children can be cared for at one-fifth of the cost at home.

There are some significant differences between pediatric care and adult care. The focus of teaching is on the caregiver (parent, etc.) not the care receiver, and extra emphasis is placed on family unit. Children often do not meet the criterion for adult home care of being homebound so another more accurate standard needs to be developed. Children get sick quicker and their condition is more fragile.

Staff members caring for a child should have pediatric experience. They must be taught that they are to care for the child, but not replace the parent. Administrative costs for pediatric home care are much higher. Usually the social and psychological factors in a family situation make caring for the child difficult so health care workers need support to prevent burnout.
Ann Hallock described New York State's personal care program which has 70,000 clients and deals with several different client groups. One client group in particular, the adult disabled under age 65, want self-directed care. The Medicaid personal care program provides three levels of assistance of nutrition and environmental support, personal hygiene, and health related tasks. The personal care program only permits the third level for self-directing patients with a stable medical condition who are chronically but not acutely ill. Even though the program is State supervised, it is administered at the local level.

Many of the clients have been the self-directing physically disabled. In New York City an agency, Concepts for Independence, was established to be run directly by disabled people. The board of directors includes one representative from each of the disability-related organizations in the city. This organization was set up as a home attendant vendor. In this arrangement, the disabled client actually does the hiring and firing, and some training of the home care worker. Concepts for Independence acts as a fiscal intermediary and keeps employment information, prepares paychecks, and provides a registry of potential emergency workers. It also provides peer support in managing home care workers.

Connie Zuckerman addressed ethical issues posed by in-home care from a legal perspective. The United Hospital Fund of New York recently completed a study of home care in New York City that documented the change from a system of care dominated by nursing homes to one in which a growing number of elderly clients receive services in their home. Despite large numbers of clients receiving home care, very little is known about the quality of the care. Medicare had certified about 5,000 home care agencies by 1984. From a medical and consumer law perspective, home care agencies are businesses that are isolated from the operation, scrutiny, values, and peer review involved in more conventional medical care. As of yet, there has been little focus in the area of bio-ethics on issues raised by home care. Recent literature on legal issues in home care reflects a defensive risk management approach. Home care has not been subjected to the intense regulatory scrutiny of hospital and nursing home care. It is not susceptible to the peer review that occurs in congregate settings. Many elderly clients cannot be self-directing in terms of their care and comfort needs because they have diminished mental capacity. Who will monitor these interactions in the private home? Elderly home care clients live in a netherworld without official or self-appointed advocates. These issues raise a series of questions:

- Who makes decisions for the elderly with regard to the determination and provision of appropriate levels of home health care?
- Are some of the elderly too readily transferred from home care to institutions?
- What role is played by agency policies?
- Is there any social or ethical consensus about the appropriate family responsibility in the home care setting?
• Should we be encouraging or demanding family responsibility in home care?

• How are the wishes of clients with diminished mental capacities respected?

    The courts have ruled that patients capable of making decisions have the right to decide on proposed medical care even if the consequence of refusal is serious injury or death. What is the responsibility of home health care providers on this issue?

    Ethical issues and values often lie hidden by financial and regulatory imperatives. It is difficult to disentangle issues of client rights, autonomy, quality, and ethical concerns from the issues of cost control, payment, and reimbursement. It is imperative to recognize the primary role of clients.
The contributions to home care research of three major research funding sources were outlined in this concluding session. Representatives of the National Center for Health Sciences Research and Health Care Technology Assessment (NCHSR), Health Care Financing Administration (HCFA), and Robert Wood Johnson Foundation also discussed their organizations' future research agendas.

Jerry Weston highlighted three of the two dozen or so past projects on home care funded by NCHSR. The first was a study of comprehensive home care programs for the elderly. Conducted by Susan Hughes at Northwestern University, it evaluated a collaborative home care program involving five voluntary hospitals on the north side of Chicago.

The program differed from that of most Medicare-reimbursed home health care in that services were not restricted to patients requiring skilled nursing visits and no limits were placed on the number of visits. It also bridged the gap between nursing and medically oriented visiting nurse services and social service homemaker services.
The evaluation used a quasi-experimental design with a nonequivalent control group and pre-hospitalization and post-hospitalization measures of two groups of homebound individuals over the age of 60. The findings included a significant reduction in the rate of institutionalization for those receiving comprehensive care and a reduction in their unmet needs. These positive findings were accompanied by a decline in functional status. The researchers suggested that the subjects might have reported greater prevailing disability in order to retain compensated support for their daily activities.

The second study was a randomized trial of a new approach to home care. It evaluated the impact of a nurse practitioner/social worker team approach to home care for patients with chronic or terminal illness who wished to be treated at home rather than in an institution. The project was conducted by the University of Rochester Medical Center and the Visiting Nurse Association of Monroe County. Ann Marie Groth-Juncker at the University of Rochester was the principal investigator. The program included a 24 hour telephone service by team members and home visits by physicians as necessary. It emphasized supportive care by family and friends. The findings showed that this team approach was very well received by patients and their families. The patients were institutionalized for fewer hospital days (38 percent less institutionalization) and fewer nursing home days (59 percent less institutionalization) than nonteam-care patients. Costs were ten percent lower for team-care patients.

The third study, entitled The Effects of an Emergency Alarm System for the Aged, was done by Sylvia Sherwood at the Hebrew Rehabilitation Center for the Aged in Boston. It resulted in one of the first technologies approved by Medicaid for reimbursement for use in home care.

The Lifeline system was the focus of the study. It automatically dials for help if a disabled or high-risk person living alone does not respond to a telephone call at a preset time.

Factors considered in the research were health status, quality of life, institutionalization, cost of formal and informal health services, and time of death. The findings indicated that Lifeline users felt more comfortable living alone. They also showed that nonusers required 13 days in a nursing home for every one day required by users. Cost of care savings were also shown.

Three ongoing projects were described as well. The first, entitled the Impact of Diagnosis-Related Groups (DRGs) on Public Home Health Nursing services, is being conducted by Elaine Kornblatt Phillips of the University of Virginia School of Nursing. The major component of the project is a study of resource use before and after DRGs. The sample is 20 percent of the recipients of home nursing visits made by agencies in Virginia. Agencies are especially eager to participate in the study because it involves analyzing patient records to get a handle on some of the nonreimbursable costs such as telephone consultations and paperwork. The second is a study by InterStudy of
Excelsior, Minnesota on the delivery of home health services by health maintenance organizations (HMOs). It is based on a supplement to a survey of HMOs conducted for the Federal government each year. The research includes studies of innovative agencies and statistics on the HMOs providing home care, types of eligible enrollees, the scope and types of services, and quality assurance provisions.

The third project, conducted by researchers at the University of Maryland, examines the impact of home care on the family of an infant being monitored for apnea.

For the future, NCHSR is particularly interested in considering process and outcome studies for funding. Several examples of methodologies that need refinement include:

- Construction of a valid and reliable system for classifying home visits in terms of the presenting problems that are potentially amenable to health care provider interventions. This "reason-for-visit" taxonomy would group patients in an organized and retrievable fashion, which would facilitate evaluations of interventions and patient education efforts.

- Development and testing of measures of case mix and severity of illness as a basis for the intensity of care required in a home visit or episode of care. These measures can be used to describe the practice of home care providers. Coupled with a reason-for-visit taxonomy, these measures would provide a basis for the development of DRGs for home health practice.

- Development and adaptation of methods for assessing the quality of home care. They should accommodate a wide variety of acute and chronic problems. Methods for measuring patient outcomes should be developed and tested. There is a particular need to examine relationships among patient assessment, care plans, and patient and family outcomes.

- Development of a uniform needs assessment instrument. This instrument should evaluate the functional capacity, nursing and other care requirements, and social and familial resources of an individual.

Linda Hamm described studies funded by HCFA that have involved the history, payment approaches, and quality of home care. She noted, in particular, a project to develop outcome scales for home care being carried out by Bernadette Lalonde in Seattle, Washington, whose preliminary findings had been reported earlier in the conference. Five scales have been developed and two more are in final stages of development. They measure client-centered outcomes rather than service utilization outcomes. A study on the impact of the Prospective Payment System (PPS) on nursing home care and home health agencies is being conducted by Peter Shaughnessy at the University of Colorado. He also had reported preliminary findings earlier in the conference.
HCFA is also sponsoring a related project to compare the quality and cost of care provided by capitated (HMO-type) and non-capitated (fee for service) organizations at the University of Colorado. The project is comparing the care for Medicare patients receiving home health services immediately after hospitalization with those who do not start home care until at least 30 days after hospitalization. The emphasis is on process and outcome quality measures.

A recent contract was awarded to the Georgetown University School of Nursing to collect and analyze data about home care patient characteristics, resource use, and outcomes. The goal is to develop a classification system that predicts resource use and outcomes.

A pilot study is being conducted by System Sciences on the impact of Medicare's PPS on post-hospital care. Researchers have developed medical condition guidelines for high-risk patients that examine process and outcome measures. There are plans to award a contract next year to apply this methodology to a nationwide sample of patients.

A four year study to develop outcome-based quality measures for home health services is scheduled to be awarded this fiscal year. The results might potentially be used by HCFA in the future in a variety of ways. For example, the measures could be incorporated into the HCFA survey and/or peer review process. New quality assurance systems could be established, possibly using incentives or sanctions. Or the measures could be used to assure quality under alternative payment systems for home health agencies. Additionally, HCFA is developing a national demonstration project to test the quality and effectiveness of home care services for Medicare-covered Alzheimer's patients and their families.

Andrea Kabcenell reported that the Robert Wood Johnson Foundation has embarked on a reordering of priorities this spring, and quality of care in home care fits in very well with the new priorities. Examples of subjects the foundation would like to address are developing sound techniques to measure and assure quality of care and altering financing, training, and delivery of care to improve the outcomes of care.

There are three projects underway currently. A multi-State study on support services for the elderly is designed to show that there is a private market for such services. It is run mainly out of visiting nurse home health agencies. Peter Shaughnessy is conducting a project to develop ways of identifying indicators of quality of care in home care. The Community Council of Greater New York was awarded a grant to test an ombudsman program for low-income, frail elderly receiving home attendant services, which was described earlier in the conference.

The Robert Wood Johnson Foundation is interested in entertaining other bold new approaches to home care quality assurance.
APPENDIX A. AGENDA

NATIONAL CONFERENCE ON HOME CARE QUALITY: ISSUES AND ACCOUNTABILITY

The Madison Hotel
Washington, D.C. 20005
June 1-2, 1988

Wednesday, June 1

8:00 am - 9:00 am
(DOLLY MADISON BALLROOM)

Breakfast and Registration

9:00 am - 9:15 am
(DOLLY MADISON BALLROOM)

Welcome

Robert B. Helms, Ph.D.
Assistant Secretary for Planning and Evaluation
Department of Health and Human Services

Arnold R. Tompkins, J.D.
Deputy Assistant Secretary for Social Services Policy
DHHS/Office of the Assistant Secretary for Planning and Evaluation

9:15 am - 10:45 am
(DOLLY MADISON BALLROOM)

Home Care Quality: Identifying the Issues
(General Session)

Val Halamandaris
National Association for Home Care

Elma Holder, M.S., Ph.D.
National Citizens Coalition for Nursing Home Reform

Charles Sabatino, J.D.
Commission on Legal Problems of the Elderly, American Bar Association
10:45 am - 11:00 am
Break

11:00 am - 12:30 pm
(BREAKOUT SESSION NO. 1)

(1) Measuring Home Care Quality: How Far Have We Come in Developing Outcome-Oriented Measures? What is the Appropriate Mix of Structure, Process, and Outcome Measures? (EXECUTIVE CHAMBERS I & II)

Moderator
Tony Hausner
Health Care Financing Administration/ORD

Karen Barger, R.N.
Visiting Nurse Association of Coastal Georgia

June Gray, E.D.D., R.N.C.
Health Care Financing Administration, Region IV

Thomas Hoyer
Health Care Financing Administration

Bernadette Lalonde, Ph.D.
Lalonde Research & Consultation Services

Samuel W. Kidder, D.Ph.
Health Care Financing Administration

Peter Shaughnessy, Ph.D.
University of Colorado

(2) Empowering Consumers: Possibilities and Limitations (DRAWING ROOMS 1 & 2)

Moderator
Katie Maslow, M.S.W.
U.S. Congress, Office of Technology Assessment

Elizabeth K. Mullen
American Association of Retired Persons

Patricia Murphy, M.P.A.
Community Council of New York City

Ellen Reap
Health Care Financing Administration, Region III
(3) Post-Acute Care: The Effects of Diagnosis-Related Group (DRG) Payment Reform on Home Health  
(DRAWING ROOMS 3 & 4)

Moderator:
Robert Clark, D.P.A.  
DHHS/Office of the Assistant Secretary for Planning and Evaluation

Rosalie A. Kane, D.S.W.  
University of Minnesota

Shelah Leader, Ph.D.  
American Association of Retired Persons

Korbin Liu, Sc.D.  
Urban Institute

Kenneth Manton, Ph.D.  
Duke University

Barbara Phillips, Ph.D.  
Mathematica Policy Research

12:30 pm - 2:00 pm  
(DOLLY MADISON BALLROOM)

Luncheon Break

Keynote Address

Otis Bowen, M.D.  
Secretary  
Department of Health & Human Services

2:00 pm - 3:30 pm  
(BREAKOUT SESSION NO. 2)

(1) Measuring Home Care Quality: How Far Have We Come in Developing Outcome-Oriented Measures? What is the Appropriate Mix of Structure, Process, and Outcome Measures?  
(EXECUTIVE CHAMBERS I & II)

Moderator
Pamela Doty, Ph.D.  
DHHS/Office of the Assistant Secretary for Planning and Evaluation

Karen Barger, R.N.  
Visiting Nurse Association of Coastal Georgia

June Gray, E.DD., R.N.C.  
Health Care Financing Administration, Region IV

Thomas Hoyer  
Health Care Financing Administration
(2) Empowering Consumers: Possibilities and Limitations
(DRAWING ROOMS 1 & 2)

 Moderator
 Brina Melemed
 Consultant, Long Term Care

 Elizabeth K. Mullen
 American Association of Retired Persons

 Patricia Murphy, M.P.A.
 Community Council of New York City

 Ellen Reap
 Health Care Financing Administration, Region III

 Carm Striano
 Keystone Peer Review (KeyPro)

 Tony Young
 Personal Assistance Services Together (PAST)

(3) Post-Acute Care: The Effects of Diagnosis-Related Group (DRG) Payment Reform on Home Health
(DRAWING ROOMS 3 & 4)

 Moderator:
 William Saunders
 Health Care Financing Administration

 Rosalie A. Kane, D.S.W.
 University of Minnesota

 Shelah Leader, Ph.D.
 American Association of Retired Persons

 Korbin Liu, Sc.D.
 Urban Institute

 Kenneth Manton, Ph.D.
 Duke University

 Barbara Phillips, Ph.D.
 Mathematica Policy Research

3:30 pm - 3:45 pm
(MOUNT VERNON SALON)

Break
3:45 pm - 5:15 pm
(BREAKOUT SESSION NO. 3)

(1) Issues in the Recruitment, Training, Motivation, and Supervision of Home Care Workers
(DRAWING ROOMS 1 & 2)

Moderator
Pamela Doty, Ph.D.
DHHS/Office of the Assistant Secretary for Planning and Evaluation

Robert Applebau, Ph.D.
Miami University, Ohio

Jeff Barnes
New York State Department of Social Services

Rebecca Donovan, D.S.W.
Hunter College School of Social Work

Jo Eleanor Elliott
Public Health Services

Elizabeth L. Gordon
Kimberly Quality Care

John Mullin
Clackamas County Social Services Division

(2) Accountability of State and Local Programs
(DRAWING ROOMS 3 & 4)

Moderator
Floyd Brown
DHHS/Office of the Assistant Secretary for Planning and Evaluation

Darrel Balmer
Illinois Department on Aging

James M. Focht, M.P.A.
Macro Systems

William J. Foley, Ph.D.
Rensalear Polytechnic Institute

Nancy Mumma, M.S.
Community Service Council of Greater Tulsa

Maryann Nardone, D.S.W.
Pennsylvania Department of Aging

5:30 pm - 7:00 pm
(MOUNT VERNON ROOMS)

RECEPTION at The Madison
Thursday, June 2

8:00 am - 9:00 am
(MOUNT VERNON ROOMS A, B, & C)
Continental Breakfast

9:00 am - 10:30 am
(BREAKOUT SESSION NO. 4)

(1) Issues in the Recruitment, Training, Motivation, and Supervision of Home Care Workers
(MOUNT VERNON ROOM A)

Moderator
Suzanne Resner, R.N., DN.Sc.
Public Health Services

Robert Applebau, Ph.D.
Miami University, Ohio

Jeff Barnes
New York State Department of Social Services

Rebecca Donovan, D.S.W.
Hunter College School of Social Work

Elizabeth L. Gordon
Kimberly Quality Care

John Mullin
Clackamas County Social Services Division

(2) Accountability of State and Local Programs
(MOUNT VERNON ROOMS B & C)

Moderator
Pamela Doty, Ph.D.
DHHS/Office of the Assistant Secretary for Planning and Evaluation

Darrel Balmer
Illinois Department on Aging

James M. Focht, M.P.A.
Macro Systems

William J. Foley, Ph.D.
Rensalear Polytechnic Institute

Nancy Mumma, M.S.
Community Service Council of Greater Tulsa

Maryann Nardone, D.S.W.
Pennsylvania Department of Aging
10:30 am - 10:45 am  
(MONTICELLO ROOM)  
Break

10:45 am - 12:15 pm  
(BREAKOUT SESSION NO. 5)

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<td>Medicare/Medicaid Survey and Certification: Strengths and Weaknesses</td>
<td>George Greenberg, Ph.D.</td>
<td>DHHS/Office of the Assistant Secretary for Planning and Evaluation</td>
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<td>Charlene Harrington, Ph.D.</td>
<td>University of California</td>
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<td>Accreditation Programs: Strengths and Weaknesses</td>
<td>Ruth Galten</td>
<td>National Association for Home Care</td>
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<td>Anne Rooney</td>
<td>Joint Commission on Accreditation of Health Organizations (JCAHO)</td>
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<td>Ellen Yung-Fatah</td>
<td>District of Columbia Department of Consumer &amp; Regulatory Affairs</td>
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<td>3</td>
<td>Special Needs of Special Populations and Ethical Issues</td>
<td>Marcy Gross</td>
<td>DHHS/Office of the Assistant Secretary for Planning and Evaluation</td>
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<td>Peggy Beckman, R.N.</td>
<td>Inova Home Care Professionals</td>
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12:15 pm - 2:00 pm
Lunch Break (Reconvene at 2:00 pm)

2:00 pm - 3:45 pm
(BREAKOUT SESSION NO. 6)

(1) Medicare/Medicaid Survey and Certification: Strengths and Weaknesses
(MOUNT VERNON ROOM A)

Moderator
Pamela Doty, Ph.D.
DHHS/Office of the Assistant Secretary for Planning and Evaluation

Marly Auerbach, R.N.
NCOSS Nursing Services

Mike Goldman
Health Care Financing Administration

Charlene Harrington, Ph.D.
University of California

(2) Accreditation Programs: Strengths and Weaknesses
(MOUNT VERNON ROOMS B & C)

Moderator
Ruth Galten
National Association for Home Care

Nola Aalberts
Foundation for Hospice & Homecare

Carol H. Kurland
New Jersey Medicaid Program

Maria K. Mitchell
National League for Nursing

Anne Rooney
Joint Commission on Accreditation of Health Organizations (JCAHO)

Ellen Yung-Fatah
District of Columbia Department of Consumer & Regulatory Affairs
(3) Special Needs of Special Populations and Ethical Issues  
(DRAWING ROOMS 1 & 2)

Moderator:
Aurora Zappolo  
Health Care Financing Administration

Peggy Beckman, R.N.  
Inova Home Care Professionals

Ann Hallock  
New York State Department of Social Services

Linda Maurano  
Childrens Hospital National Medical Center

Connie Zuckerman, J.D.  
Montefiore Hospital

3:45 pm - 4:00 pm  
(EXECUTIVE CHAMBERS II & III)

Break

4:00 pm - 5:00 pm  
(EXECUTIVE CHAMBERS I, II, & III)

Summary and Conclusion -- General Session

Moderator
Mary Harahan  
Director, Division of Disability, Aging, & Long Term Care Policy  
DHHS/Office of the Assistant Secretary for Planning and Evaluation

Linda V. Hamm  
Director, Division of Long Term Care Experimentation  
Health Care Financing Administration

Andrea Kabcenell  
Robert Wood Johnson Foundation

Jerry L. Weston, Sc.D., R.N.  
Senior Research Manager, Division of Extramural Research  
National Center for Health Services Research
APPENDIX B. PARTICIPANTS

NATIONAL CONFERENCE ON HOME CARE QUALITY:
ISSUES AND ACCOUNTABILITY

HONORED GUESTS

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