SUPPLEMENTAL MATERIAL - ONLINE ONLY

Detail of Major Themes: Home Care Priorities for Education, Research, Practice & Management

Priority 1: Generate and Use Evidence Based Guidelines	
Categories	Codes and Detailed Statements
1.1 Education Priorities:	**Prepare** generalist and specialist nurses to deliver evidence-based care and work autonomously at the top of their professional licenses.
Best practices and evidence based care for patient and caregivers	Develop and disseminate evidence-based and expert consensus statements (white papers), how to help family members to care for persons with disability, mental problems, and chronic disease, need for education on how to facilitate patient self-care, motivational interviewing and health coaching techniques, Including family or paid caregivers as part of target for assessment, goal setting, teaching, counseling and evaluation of outcomes
Patient-centered care	Understand patient risks (infection, falls) and mitigation of those risks, understand issues/barriers affecting patient/family adherence, adapt care to patient's cultural/language needs
Evidence-based disease management	Disease management best practice, use evidence-based practices successfully in home health, best practices when caring for patient with chronic disease, cancer, wounds, evidence-based practices to improve medication management, provide online evidence based resources
1.2 Research Priorities:	**Demonstrate** the value of home care and what works, for patients, caregivers, public health/community impact.
Generating evidence base for practice	Development of evidence based practice for home care, what evidence based practices in other settings are effective in home care? Improve the quality and outcome of health service at home, effective strategies to improve patient outcomes, effectiveness of specific nursing practices, impact on health outcomes when nursing procedures are followed, public health impact, identifying the types of patients that most benefit
Patient and caregiver education and engagement	What strategies can home healthcare nurses use to effectively promote patient health and well-being? Identifying best practices for comprehensive assessment and teaching of both patient and caregiver, determinants of caregiver stress, best ways to provide caregiver support, how to obtain patient/family engagement in participation of goal setting, attitudes of families and elderly towards home based care
Safety and management of chronic conditions	Patient safety – predict potential for fall, medication error, or infection based on answers to initial assessment, finding or testing tools to improve management of prescription medicines for home care patients, consider how numbers of visits per day/week impact patient safety, outcomes, and staff efficiencies, to what degree are 'safe patient handling' strategies being used in home care? Safety in home care/environment including the patient/family home and community/neighborhood…how can we better assess and intervene to protect staff?
1.3 Practice Priorities:	**Integrate** evidence-based care and teaching strategies into basic and advanced home care to improve patient outcomes.
Evidence based practice	Integration of evidence based practice into home care nursing, access to current evidence and guidelines, access to continuously updated evidence-base, population best practices that are evidence based
Safety risk management	Safety in home care, care giver safety and wellbeing, safety and quality during home care nursing, patient safety, prevention of infection, staff safety, indicators of risk for pressure ulcers and falls
Patient-centered care	How to engage patients in shared decision making, teaching strategies for patients/families, trusting relationship with all family members, non-rushed approach, thorough investigation of home environment
Advanced practice and specialty care	Care of the chronically ill and older persons, palliative, hospice care, bereavement care, Subspecialties such as mental health nursing, care of children, patients living with AIDS, Alzheimer's dementia, complex wounds, diabetes, heart failure, need for advanced practice nurses and clinical nurse specialists. Knowing when your agency needs… a psychiatric nurse, wound care nurse, diabetes educator, etc.
1.4 Manage-ment Priorities:	**Ensure** staff and management have access to evidence-based practice guidelines and decision support tools.
Evidence based practice	Evidence based practice guidelines developed for home care, revise operational model for delivery of nursing services to evidence-based rather than cost containment
Accountability	Accountability, efficient and effective care, patient satisfaction, comparison of outcomes (hospitalization and infection rates) for Registered Nurses and Licensed Professional Nurses
Clinical outcomes	Medication management, patient safety management, end of life care for dying patients who refuse hospice, non-pharmacological management of behavioral and psychological symptoms of dementia
Safety	Risk stratification, risk reduction, caregiver safety and well-being, early recognition of patient changes to reduce re-hospitalization

Priority 2: Design Better Systems of Care	
Categories	Codes and Detailed Statements
2.1 Education Priorities:	**Cultivate** a culture of continuous education at nurse and organization level to keep current on new technologies and approaches to home care.
Basic, advanced, and continuing education	Education at nurse and organization level. Understanding home care as part of the health care system, continue education of staff nurses and management to achieve and maintain high level of professional practice. Continuous nursing education, keeping knowledge up-to-date on best practices for common situations, procedures, and diseases. Motivational interviewing, critical thinking, documentation, management of caseload and complex situations, nutrition, best assessment tools to monitor patient risk
Safety and risk management	Understanding and mitigating patient risks in home care setting, overall care of high risk patients and those at risk for re-hospitalization, caregiver safety and wellbeing, identification of risks for patients, development of patient care based on individual risks, vulnerabilities for the patient at transition of care
Use of medical technology and electronic resources	Technology use in home care. Management of patients with a central line, ventilator, home infusion, feeding pump, etc. Telemedicine, provide online evidence based resources, link patients/families with resources, how to determine rates of adverse events (considering number of events in relation to number of patient days, rather than only raw number of events).
2.2 Research Priorities:	**Evaluate** home care service delivery and staffing models to determine best outcomes for patients and workforce.
Models of care coordination	Evaluation of current home care clinical service delivery models that would lay groundwork for suggesting new, more efficient models. Examine how using auxiliary personnel, technology, and delegation can be used to improve care delivery. What models of practice achieve the best patient outcomes at the lowest costs? Community-based nurse care management, home based primary care and chronic care management, accountable care organizations, transitional care collaborations.
Optimizing staffing & visits	Does length of visit, frequency make a difference in outcomes? Consider optimal utilization of visits for outcomes, Frontloading of visits, and other strategies to effectively avoid hospitalizations, more research on continuity of care, weekend staffing, value/effectiveness of dedicated admissions/transition nurse, effectiveness of regular caseload/care management vs. per diem staffing on accountability, and outcomes including patient/family satisfaction.
Outcomes of care	Effectiveness of interventions to reduce/prevent hospitalizations. Can re-hospitalization be predicted from admission assessment? Does home health care result in reduction in re-hospitalization risk compared with matched patients not receiving home health? Benefits of early discharge from acute nursing facility - are costs reduced for patients/payers with home care versus when follow-up treatment occurs in an outpatient facility or clinic.
Workforce issues	Retention, recruitment, and attrition of registered nurses, clinical supervision in home care nursing, nurse satisfaction with employer and effect on longevity, stress and how to manage a load of heavy patients, nursing productivity, autonomy, leadership, nursing skill-mix, staffing ratios
2.3 Practice Priorities:	**Embrace** interdisciplinary care coordination and management, and new roles for advanced home care nurses to bridge gaps in healthcare system.
Need for new advanced practice role	Need for new role (clinical nurse specialist) to transition between home care and outpatient clinic [consistent with patient centered medical homes, accountable care organizations and bundled care arrangement involving primary care providers and community-based clinics and health centers]
Care plan management & coordination	Case management and care coordination, care planning, care plan appropriateness, identify meaningful goals of care and care plan, effective strategies to improve care coordination in home health, decision support and communication between health care team members and care settings
Interdisciplinary teamwork	Working effectively with other team members to identify meaningful goals of care, Communicating effectively with other disciplines and providers, multidisciplinary integrated care pathways, When to make referral to other disciplines, what belongs to nurses vs social workers, occupational therapy
2.4 Management Priorities:	**Develop** infrastructure for nursing excellence through use of electronic resources/record and decision support.
Clinical operations	Risk stratification and triage of newly referred patients, effective infrastructure and operations to support care delivery, Improvement and implementation of change in individual performance and processes of care, Continuity of care and communication between staff, allocation of resources to effectively meet both needs of staff to manage patients and needs of patients aiming to remain in home
Care plan management & coordination	Nursing role and effective participation in developing multidisciplinary plan of care, management within an integrated system, How to use care management to tie all the pieces of the assessment together, Managing complex patient in the home, develop effective patient/family centered care initiatives
Information technology and documentation	Increase knowledge of health information technology and how it can be used in all phases of home care management, medical file building and data organization, electronic records management and use of standardized forms, Information and database management, decision support

Priority 3: Develop Leaders at All Levels	
Categories	Codes and Detailed Statements for each of four sub-themes
3.1 Education Priorities:	**Advance** home care through emphasis on advanced practice training in home care and role of interprofessional care team members.
Inter-professional communication	Advance home-based care as interprofessional rather than just nursing, build on current interest and activity to advance academic-practice partnerships, effective interprofessional collaboration, multidisciplinary education, Interpersonal communication, work in an interdisciplinary setting
Teamwork and leading teams	Team/case management strategies, effective communication amongst teams, coordination of care, Create expert working group, Effective case management and care coordination
Specialty care	Study how specialties impact patient outcomes and nursing resiliency, pre-registration education on community care, and post-registration specialist education on home care, what specialists' knowledge can be brought to the patient at home? Advanced generalist training in assessment and management of geriatric syndromes, advanced training for care of special populations
3.2 Research Priorities:	**Understand** the relationship between nurses' education level, communication across health care team & outcomes.
Interprofessional care and communication	Improving new tools to facilitate communication between the members of care team, physician engagement following office visit – discharge instruction sheet updated with medications, wound care, etc. to prevent phone contact after patient informs [home care] clinician of changes, inter-professional communication, partnership with medical team and other agencies, communication between multiple disciplines: physical therapy, medical social work, medicine, standardization of clinical language
Specialized and advanced practice	Care of children and the elderly, dementia care, cognitively impaired, palliative care, end of life care and care planning, bereavement care. Wound care management, infection prevention, urinary catheter care to reduce infection and complications, Infection rate in home care setting after discharge from hospital
Education and credentialing	Consider the role of nurse education level and outcomes, education to understand evidence-based care and research, Is there a difference in outcomes between baccalaureate and lower degrees. Understand relationship of educational preparation and clinical outcomes. Need for professional organization and certifications recognizing home care nurses and organizations to support clinical management leadership and input on practice decisions, evidence based practice, and shared governance
3.3 Practice Priorities:	**Define** excellence in home care through consensus on minimum competencies for home care nurses, and home care specialty certification.
Utilization of education	Develop competence in comprehensive home-based assessment and care management, education of nurses in how to provide patient teaching that engages the patient and leads to a measurable level of understanding, Identification of strategies to build mutually regarding relationships with nurses
Recognition through certification	Certification for home care nurses, certification would be valuable to organizations, assure adequate knowledge base, clinical education – currently state association along with a few consulting firms provide the majority of home care education web based learning – currently management focused
Defining excellence	Time management vs productivity, identify methods for assessing compliance with agency nursing procedures, excellent assessment and intervention skills, physical assessment appropriate to diagnoses & co-morbidities, what is important and what is not, home evaluation, family dynamics, care planning
3.4 Management Priorities:	**Be a change agent** to create conditions for optimal team relationships, care delivery, and community partnerships.
Leadership development	All nurses in management need to be leaders and change agents related to policy and practice, identify how general management and leadership principles, processes and approaches apply to home care, identify issues and approaches needed for working with staff who are in the field, increase management's knowledge of health information technology and how it can be used in all phases of management, support and understanding for staff that are in the field and dealing with numerous problems. Provision of guidance and education regarding problem solving, prioritization, etc.
Recruitment & retention	What empowers home care nurses? Commitment to staff development, education, and continuing education, mentorship of field clinicians, transition to practice residencies for new graduate nurses AND nurses new to home care, work life balance for home care nurses, workforce shortage, especially supervisors, and paraprofessionals. Identify how clinicians could work toward advanced practice roles as clinicians, researchers, in informatics, or management and administration.
Communication & community partners	Develop capacity to initiate, grow and sustain meaningful partnerships with primary care, acute care, long-term support services, etc. Interprofessional communication and coordination as transitions become more effective and all must work together to engage patients/families and improve care and management, Forming partnerships (accountable care organizations, bundled care, transitional care) to optimize exchange of information, facilitate transfer of patients across settings and providers, Interface with secondary & tertiary care, discharge planning, community partnerships and collaboration

Priority 4: Address Payment and Policy Issues	
Categories	Codes and detailed statements for categories within each sub-theme
4.1 Research Priorities:	**Be rigorous** in designing studies that demonstrate the value of home care, and communicate results to payers & policy makers.
Integration of home care into basic and graduate education	Create guidelines for integration of home-based care principles & practice in undergraduate, graduate, and doctoral curricula, core competencies for home-based nursing practices, identify core curriculum (both clinical and regulatory) for orientation of new home care nurses, develop post-graduate specialty areas for home care, advanced training for care of special populations, define, develop, and disseminate body of knowledge and standards of practice for home care, certification process for home care
Centers of excellence	Create Center(s) for Excellence in Home-Based Care
Documentation of assessment and care for payment	Understanding the financial aspects of home care, including knowing how to document and code [bill] for financial viability, documenting for reimbursement, how to answer assessment questions for documentation and payment, how to interpret reports of care quality and outcomes of care
4.2 Education Priorities:	**Create** centers of excellence, certification programs, and include principles of home care payment and policy in graduate and undergraduate curricula.
Technology & informatics	Use of technology in home care needs to be studied: telemedicine, telehealth, use of tele-monitoring, do electronic health records promote/hinder the nursing process and effectiveness of care? Decision support models, use of the electronic health record/Informatics
Financial considerations & care models	Understand effect of reduction in home health payments on management practices and staffing/caseload/productivity, understand effect of accountable care organizations and bundled payment systems on home care, home care financing, payment models, reimbursement
Need to consider complexity when measuring value	Rigorously designed intervention studies, including comparative effectiveness of chronic disease management strategies, It is very important to make the highly contextual, local and invisible work performed by home care nurses visible, closely examining organizational and clinical process issues that directly affect how nurses practice in the current (and historical) environment … that show direct financial impacts to prepare providers and clinicians to plan for (not react to) change in the health care delivery system and evolving roles of home care nurses. In studying outcomes, take great care to drill down to clinical realities in home care and efficient measurement of differences that home care makes.
4.3 Practice Priorities:	**Advocate** [for yourselves] to have the resources (staffing and equipment) needed. Understand that documentation of nursing care is key to getting resources
Documentation of care	Documentation of clinical outcomes for home care, home care nurses with improved ability to document their care, specific clinician documentation for all – to know where to search for a specific issue
Human resources	Form network for home care nurses to share information, grow in their specialty, enough resources, mainly manpower, staffing, staffing/skill-mix ratios
Technological resources	Electronic medical record proficiency, optimizing information technology and electronic medical record systems, develop point-of-care electronic medical record access through decision support systems or easy to use electronic references, available and working equipment required to perform duties
4.4 Manage-ment Priorities:	**Learn** to lead with increased regulations, meeting clinical and financial objectives while preserving (human) resources.
Leadership under financial constraints	How managers can lead in times of limited resources, supportive management style, management needs to understand the complexities of this work and the emotional demands that the staff are under, Minimizing negative effects of reduced home health payments on patient care and home health care staff, Help for home care nursing management to implement change for nurses in the changing health care environment, find solution to getting all work completed in work day, use of acuity system with productivity system, workload demands are much higher than in previous years, patients are much sicker, requiring more extensive care, Regulations and expectation have increased as well.
Knowledge of regulatory issues	Regulations and expectations [for productivity and outcomes] have increase, compliance with regulations and standards, what is compliance, what matters, and what does not? Being attuned to policy factors influencing home care practice, increase the educational preparation for home care nurses to the baccalaureate (university) or require post-basic specialty training
Need for financial knowledge	Support for development of care models that are financially sustainable, fiscal management, effective use of resources, efficient and effective care, financial knowledge, understand payment models, maximize reimbursement strategies, capitalize on emerging (reimbursable) transitional care initiatives for both post-acute and long-term/palliative care patients.