Transcript: April 2015 CardioLAN Webinar
The Role of Therapists in Cardiovascular Care

Cindy Sun: ... Coordinator, and Misty is the primary author of most of the Best Practice Intervention Packages, so we’re very fortunate to have her, and we are also lucky to have Stacie Deslich with us today. She is the Health Data Analyst, and I won’t call her an author, but I’ll call her the primary “doer” on the Home Health Cardiovascular Data Registry. For those of you I haven’t met, my name is Cindy Sun, and I am an RN Project Coordinator as well today.

So I would like to get started and mention a few little things that are going on. First of all, all the lines are currently muted if you are listening in on the phone. We will remind you though that we are going to un-mute the lines a little later in the call, so if you don’t mind, please just take an extra ten seconds right now if your phone has a mute feature, and go ahead and mute it. We would really appreciate not eavesdropping on your conversations a little later in the call. We also want to encourage everyone to use the Chat feature or the Q&A box in the right-hand side of your screen to start sending in your questions as soon as you have them. We’ll get to as many Q&As as we can during today’s call, and if we don’t get to them all, we’ll address that a little later in the call as well.

So on the agenda today, we are going to go ahead and get started with a few campaign updates, and then we’ll toss it over to Stacie Deslich for a little bit of a HHCDR update, and then we’ll get to the main presentation. We’ll follow that with a few educational resources that are free and evidence-based to support the content that is going to be discussed on today’s call.

So a couple of things we are going to ask – as you can see right here – a polling question, so if you can go ahead and answer the polling question and think about it. If you are a home health agency, where along the road to cardiovascular health improvement is your agency currently? Are you on Milestone 1, 2, 3, 4 or 5. I will give you a hint; no one is on 5 yet. So if you don’t mind, just take a few seconds to answer that, and we’ll have a couple polling questions throughout because we really like these meetings to be more of an interactive group effort, as though we are all sitting in the same room together. These are the Milestones to help with knowing where you are as far as that goes.

Let’s go ahead and while you are answering that question, go ahead and get started with a few campaign updates and mention that as of an hour ago, we...
crossed over the 12,500 participants currently engaged in HHQI. Of those 12,500 participants, they are representing 5,184 CMS-reporting home health agencies.

We are very pleased to announce that the April 2015 Agency of the Month is Sutter Health Auburn Faith VNA & Hospice from Auburn, California. Remember this is a random selection of all of the home health agencies who have submitted an application. It's just a very short little questionnaire, and – here is the key – they are in or around 20th percentile for ACH or in or around the 80th percentile for Oral Meds. So we really would like to congratulate. This is a high quality of care that Sutter Home is contributing, and I know that many of you out there are doing the same. So don’t forget to register so you can be in the running for the Home Health Agency of the Month.

We would also like to mention that there are new CEs available through HHQI University, as well as the video resources are included in the new cardiovascular BPIPs. Those can be found under Education, and we’ll talk a little bit more about that as the call progresses.

I’ll also mention that on April 22 at 2-3pm Eastern, the *Chronic Health Issues Affecting Hispanic Patients* webinar for the Underserved Population will be presented. Remember, as part of this group, we want you to be aware of what is going on in HHQI so that you can reserve a seat if this is something that interests you. During this webinar, you’ll learn about chronic disease issues such as diabetes and hypertension affecting the Hispanic population. Discuss health issues and barriers affecting elderly people in Hispanic communities, and discover ideas to reduce barriers and improve patient outcomes. The guest speaker will be Viviana Lorenzo. She is a RN, BSN, Hospice Case Manager at VNA Health Group. She is a chairperson of marketing and public relations for the National Association of Hispanic Nurses. This will be a very interesting webinar. We hope that all of you will participate because the Hispanic population has quite a few specific issues that we can address independent of everything else. More HHQI resources, since we’re speaking about Spanish here and Hispanic population. More HHQI resources are now available in Spanish.

There are also two free hands-on webinar workshops – I shouldn’t have said *webinar*; that was my fault – these are actually *in-person workshops* that will be presented by HHQI. They’re going to be located in the western side of Minnesota as well as in Chicago. So if you are in that area and you are interested, these will be free. The HHQI team will be onsite, and we would like to welcome all of you and please join us. If you like more information about that, please feel free to contact us at HHQI.

Finally, live assistance opportunity is coming up, Thursday, May 14. We want to
just remind everybody, that is the next LiveChat. If you haven’t participated in a LiveChat before, I want to encourage you to do so. That will be going on, and we want to just make sure that you are aware of it so that if you are free on May 14, you’ll join us.

Okay, so with that, we’ll go ahead and put up the second poll question. Has your agency made any changes related to cardiovascular care in the past year? If you don’t mind, just give that a quick answer. While you are answering that, we’ll go ahead and turn everything over to Stacie for HHCDR News and Information.

Stacie?

Stacie Deslich: Alright. Thanks so much, Cindy. Well, things are coming along with the registry and participation continues to grow, thanks in no small part to all of you, our Network Coordinators, and the QINs. Usually this part of the CardioLAN webinar reviews all of the cardiovascular data registry highlights. Now as you know, the registry closes on the 14th of each month. So it closed on Tuesday and the data was pulled bright and early Wednesday morning. The data reports are currently running, so unfortunately, I don’t have a whole lot to mention regarding registry highlights. I will let you know as far as the abstraction of the measures go, the tobacco measure continues to be the most abstracted and that is followed closely by both hypertension and aspirin is appropriate. Now as more data is submitted to the registry, that gap between those measures is closing, which is to be expected. Now even the cholesterol measure is being selected for abstraction more often, so that’s great that we are having more agencies abstract more data. As we know, more data is better; it leads to a more robust registry. So congratulations to all of you for your amazing efforts at recruiting agencies and encouraging participation in the registry. It's an awesome job that you guys are doing, and it's very much appreciated. Also, next month, we’ll be able to review the highlights that we are not able review on this webinar so, look forward to kind of double-highlights next month.

Some more good news, if your agency or agencies with whom you work closed out their data submission by the 14th, they can expect to see that data reflected on their data registry report right around the 23rd of this month. The most recent data for the registry were made available for abstraction yesterday on the 15th. So please encourage agencies to begin or to continue abstracting and submitting data.

Now I often, towards the end of my little part, I issue some sort of a challenge each month. Since we weren’t able to really review much data, this month’s challenge will be a little bit different, maybe a little softer and squisher than data challenges. I’d like for each of you to find something positive that you see
happening with this registry. Maybe a reluctant agency began abstracting, or maybe you heard some positive feedback about the registry or the reports, or maybe if you’re an agency, you went ahead and took the plunge and you started abstracting and you discovered that it’s really not that difficult and it is a fairly user-friendly system, or maybe you reached out to HHQI for some help and got it. We just really like to hear the successes. Feel free to pass along any successes to us, and we enjoy highlighting those successes. Now this isn’t to say we don’t want to hear about the trouble because we also do want to help you to be successful with this, but that was the challenge for this month. So take care, and enjoy the upcoming presentation – I am sure it will be fascinating – and have a fantastic month. With that, I’ll pass it back to you, Cindy.

Cindy Sun: Thanks, Stacie. I don’t think any apologies are needed for squishy challenges for those that are not data oriented, so we welcome that. As Stacie was saying, because of the dates and the timeline, that is the reason for not having any agency recognitions this month. It’s not that agencies didn’t do phenomenal work; it is just simply that, if you think about it, the registry closed just 48 hours ago and that’s not enough time to get done what’s needs to be done in order to make that happen. So we’ll be very happy to celebrate multiple agencies in next month’s CardioLAN.

So with that, we can see of the polling question, has your agency made any changes related to cardiovascular health? It does look like the majority has said yes to Other; a lot have said yes to documentation changes; and some are just in the planning stages, which is fine. This a new progression, and it’s going to take time, and everybody is at a different stage along the way. We’ll talk a little bit more about next month’s call as we complete this call today. That’s the purpose of next month, just to share what’s going on and what’s working because everyone is at different stages along the integration of cardiovascular health into either your QAPI plans or into your quality improvement plan.

So with that, we’ll go ahead with the final polling question, if you don’t mind. How frequently do your patients with a diagnosis of hypertension receive a blood pressure assessment? And this a policy issue. What is your policy, and what’s going on in your agency? Is it every visit; is it every skilled nurse visit; is it about once a week depending on how many visits they have? Maybe you’re not really sure, or possibly that you are not working at an agency, and that’s completely fine as well.

So while you are completing the final polling question, I’ll go ahead, and it is my pleasure to introduce today’s guest speakers. Bud Langham is a physical therapist for 15 years and has held leadership roles at a variety of post-acute settings. He
currently serves as CCO of Encompass Home Health and Hospice and is based out of Dallas, Texas. He leads the company efforts to promote evidence-based practices, patient-centered care, and innovation care practices with the goal of achieving the highest level of quality and patient satisfaction. Bud has published various articles on value-based purchasing, case management, and morality for the physical therapy in the home. Bud attended the University of Oklahoma for his BS and MBA. He and his wife, Jill, have been married 15 years and they have three boys – oh dear, three boys, Bud – Nathan Cole, 9; Matthew Ryan, 7; and Bennett Shay, 1.

Dr. Ken Miller is a Clinical Educator for Catholic Home Care where he provides staff development through its interdisciplinary orientation, competency and preceptor program. Additionally, he serves as a guest lecturer and adjunct teaching assistant at the DPT program at Touro College in Bay Shore, New York. He has presented at the Combined Sections Meeting of the American Physical Therapy Association (APTA) and the Annual Conference of the National Association for Home Care & Hospice (NAHC) on a variety of topics, including: objective testing, professionalism, interdisciplinary team modeling, osteoporosis, differential diagnosis of dizziness, documentation and home health regulation.

He serves as the Chair of the Practice Committee of the Home Health Section (HHS) of the APTA. Additionally, he is a member of the Editorial Board of the GeriNotes Publication and Journal of Novel Physiotherapy and Physical Medicine, and he is a manuscript reviewer for the journal of Geriatric Physical Therapy. Dr. Miller has authored numerous articles for the Journal of Geriatric Physical Therapy, GeriNotes, and the Quarterly Report Newsletters on many topics.

You can see that this is our great pleasure. We are thrilled to have today Bud and Ken to present and continue the discussion on utilizing the skills, the knowledge level, and the talent of the physical therapist in the home health setting. So with that, Bud, I will turn it over to you.

Bud Langham: Thank you so much, Cindy. I really appreciate it. I know Ken and I are excited to be back and doing this again. We had a great time last time, and it seemed like we had a pretty good response, so we are very happy to be back. Ken, I think we need to work to shorten our bios.

Ken Miller: I think you are correct on that one.

Bud Langham: Well, I think this is a good time for this particular conversation about the role of therapist in cardiac care, especially as I look at the polling results. I hope I am not giving away something I shouldn’t be, but when I look at the polling results how...
frequently your patient with the diagnosis of... I can’t see the whole question. Gosh, I missed the question there I shall miss the question there.

Cindy Sun: That’s okay. This is Cindy. It was the diagnosis of hypertension.

Bud Langham: Yeah. Is it how frequently did they get vital signs? What’s the rest of the question, I can’t see it here.

Cindy Sun: It was blood pressure. You can go back one slide if you like to see the question but yeah it's just, how often did the patients with a diagnosis of hypertension receive a blood pressure assessment?

Bud Langham: How often did they receive a blood pressure assessment? I see that at least a quarter of the time, the answer 26% of the time it looks like the answer to that was “every skilled nurse visit” which makes me assume that we still have a lot of folks out there that are having difficulty getting therapists to step up and be part of the team and assess the patient in a comprehensive way. So, this is a good time to have this conversation.

Today we are going to try to talk a little bit about the role of PTs, OTs, and SLPs in the care of homebound patients with cardiac conditions. We are going to cover a little bit of the same information we covered previously about scope of practice and professional expectations. Then, hopefully, Ken and I can provide some insight on how to reset those expectations and just based of our conversations that we had last time, I know this is really a need. So I am going to through this first slide and then really let you talk about scope of practice again just to give everybody a reminder on the next slide about where we get that information.

For the purposes of this call, to be able to provide care for this type of population in the homebound setting, in our setting where we are trying to care for these people in their homes, therapists do have to have at least a basic understanding of at least these following bullet points. So they’ve got to have the basic understanding of cardiac physiology and pathophysiology, and we get that information in our schools, in our training. So we have to sometimes go back and remember it or remember that we are lifelong learners, and so we can never just forget the very vital anatomy related to cardiac care.

We also have to have a basic understanding of pathophysiology of functional decline, and this is where we go a little further. So we go beyond the pathophysiology and think about how it’s impacting functional achievements and functional activities in the home. The primary reason the therapist interacting with
the patients in the home is due to functional limitations that result from body function and body structure impairments. So, it is not enough to know the pathophysiology; you’ve got to know how that pathophysiology of heart failure, hypertension, etc., how that impacts the patient’s ability to function safely in their home.

Then, vital sign assessment and interpretation. Getting people to do vital signs is one hurdle, and appropriate interpretation and action is another hurdle. Auscultation of heart and lung sounds... we’ll talk more about that.

Common cardiac medications. It has to be basic understanding of cardiac meds and resources to be able to act appropriately. We have to be able to understand how those medications affect symptoms, activity, exercise prescription, as well as side effects and interactions.

OASIS and cardiac conditions. We have to have at least a basic understanding of how cardiac conditions are tracked in the OASIS that we perform today, at least the basic level.

Then Ken’s favorite topic, and I am hoping he’ll jump in here and then talk about this a little bit more as we get to the slides, is really at this point in time, we have to move toward a paradigm of caring for these patients where we utilize objective tests and measures with cut-off scores, normative values for this particular population that are evidence-based and well established in our literature. That’s something that Kenneth has really done a great job of the last several years of promoting in the industry, focused specifically on the home health practice.

Ken Miller:

Thanks, Bud. As far as objective tests go, most of the objective tests that we have been talking about over the last several years have been tests that were initially developed and validated all the way back in 1999, back in 1986, and actually even further back. So these tests are not anything that’s new to the industry clinicians, but it is newer to the industry. With 2011 changes, it became mandatory to use these measures. At this point in 2015, you know, when I do chart audits around the country, I am noticing that the measures are now in the charts much more regularly. That is a very good thing to see that we are able to document objective measures on the patient’s functional level.

But where I am not seeing areas that need to be improved are really, how do we use the numbers? You know, like Bud said, we have to have cut-offs, and we have to know where the patient is functioning. What does the number tell us? You know, when it comes to blood pressure or it comes to heart rate, you know that’s standard physiology. We understand low heart rate or high heart rate means
certain things; high blood pressure means certain things. Then we have to make clinical decisions based on a high blood pressure, whether it is a phone call to the nurse, to the physician, possibly a 911 call. Is that patient symptomatic?

When it comes to the objective tests, we need to do the same thing as far as using them in a clinical way and using them for critical decision-making, such as the patient that scores very poorly on one objective test related to endurance, well that’s going to tell us, that will correlate to the limited ability with their function. If a patient is short-of-breath just standing up out of bed, can we imagine that they are not going to be able to walk safely outdoors to the car? So that shortness-of-breath question on the OASIS is critical to help establish that patient is homebound and, in fact, is entered the risk adjustment for when the data is publicly reported.

Let’s move onto the next slide. As far as, how do we determine what a clinician is able to do therapy-wise? We really need to go to back to the educational level to see what they were trained in schools. That is available very easily. You can contact the different educational facilities nearby, different colleges and Universities, but as far as what we are allowed to do by licensure, that is mostly dictated by each state. Federal law does have some impact here and there, but for the most part, it is state law and the state practice acts that determine what physical therapist, occupational therapist, and speech language pathologist are allowed to do. When it comes to cardiopulmonary and this specific topic, they are all allowed to take blood pressure; they are all allowed to take heart rate and pulse rate; and they are all allowed to take respiratory rate. They are all allowed to take pulse oximetry as far as the federal statutes are that’s silent on that matter. As far as on the state level, I don’t know of any state law from my knowledge that precludes the clinician from taking vital signs. As far as the professional associations, ASHA has come out with a multi-scaling document in support of speech language pathologist doing these vital signs of what was not typically taught in their education.

So just know that as far as the states where you are practicing in, you would want to go to the state practice act for each of the disciplines. As far as with the silent part, silence is tricky in regards to... well, now I don’t have an answer that they can do it or not do it. That’s where you really need to do the due diligence of looking at what the clinicians are taught in their training, and then if it is truly silent, then what you would like to do, you should do is establish competency related to whatever skills and tests that you would like the staff to perform out in the clinic. Alright Bud, if you want to move on with the slides, that will be fine.
Alright, let's jump into cardiac physiology and pathophysiology just briefly, and then I'll go through kind of an example of that pathophysiology of functional decline. So when we are talking about physiology and pathophysiology, therapist need to have a basic understanding of cardiac physiology, like anatomy of the heart, the ventricles, the atria, valves, the flow of the blood, pacing mechanisms. When somebody comes into home health from a different setting, from an outpatient setting or maybe even from a hospital setting but especially from a clinic setting, it may be important to sit down with them and just do a basic review of this type of anatomy related to the type of conditions we see in our setting. So I wouldn't take it for granted that they had a good understanding of this or that they remember it from their school days, but I would say it’s a good idea to just to sit down and review with them and to suggest, I believe in almost in every state, clinical education units or CEUs are required by states for licensure in almost every state. So suggest that they line up their CEU tracks with the setting that they are practicing in now. And if your agency does provide some kind of a reimbursement for continuing education – whether it be provide those courses or to provide funds for those courses, put something in place so that you have some kind of approval mechanism so you can make sure that if your agency is funding or supporting education that you are paying for classes that are aligned with this particular setting. So I think that a good way to help. Then promote that with your clinicians to remind them to go out and seek these kinds of courses.

Same is true with pathophysiology. Go over the most common cardiac conditions that you see in your setting with your agency relative to your programs and kind of talk through what are the common conditions, what are the body structure and body function impairments that are derived from each of those common conditions and help them understand.

On the next slide, it’s just an example of the tool that we use at Encompass to train and teach not only our therapist but also our nurses about how one common cardiac condition, like heart failure, can lead to a progressive functional decline. So this goes back to the need to understand, at least the basic level of pathophysiology, so that you can understand what we are really trying to do in the home. And so we talk to through this slide and just kind of point out that it goes step-by-step. You have cardiac muscle dysfunction that initiates heart failure; so there is your body structure impairment due to that cardiac condition. The cardiac muscle dysfunction leads to a weakened heart that’s unable to pump blood effectively, and that leads to a loss of the normal flow of blood through the system and blood begins to back up in the congestive example here. Fluid begins to collect in the lungs, in the liver, and subcutaneous tissues, and in cavities. Then the body’s compensatory mechanisms kick in, and that leads to additional problems. Now we have poor cardiac output and that triggers vascular
constriction, which limits peripheral blood flow. As we all know, our large skeletal muscle groups are so dependent on peripheral blood flow. So bad blood flow leads to reduced levels of oxygen to your large muscle groups like your quads, and your gluts, and your core muscles, making them less able to work. Then that leads to an increase in activity intolerance, leading to limitations with mobility and ADLs, and then patients become less able to care for themselves, leading to depression, falls, and then hospitalization. Then we get into the cycle of decline. So we try to connect the cardiac conditions to the body structure and body function impairments, and then try to connect that back to functional limitations and then loss of independence at home, so people can see that this is all part of why we are here. And so nurses may intervene at different steps in this flow or this process; therapists may intervene at different steps, but everyone has a role. And I think it’s really important when we are talking about cardiac conditions especially – the same is true of respiratory... when we are talking about these conditions, to help paint the picture for clinicians so they can see how a condition can lead to a functional impairment like a limitation in the ability to stand up off the toilet. So that they can see that functional limitation may well be related to this cardiac condition. I think it is significant in terms of training, and so when we use this example or others like it, it seems to kind of connect the dots for folks.

Uh oh. That slide isn’t wanting to advance. I may need a little help.

Cindy Sun: Bud, you may want to use the arrow at the top of your screen.

Bud Langham: I am trying to.

Cindy Sun: You can pass the ball back to me if that... ah, there you go.

Bud Langham: There, it finally went forward. I am going to hand it back to Ken so he can talk about vital sign assessment and interpretation.

Ken Miller: Well, you know, all of our home health agencies, we’ve developed care plans. We have 485s. We get supplemental orders. What we end up putting in place are alert orders: I want to communicate with the physician if the blood pressure is 160/90 or greater or less than 90/60. We get parameters for heart rate at less than 60 or greater than 100. Sometimes you may get them for pulse oximetry; sometimes you may get them for respiratory rate. You know, all of that information about the orders of when to notify the doctor is really just the starting point of using that data clinically to be able to really affect change not only for that patient’s function, but really for that patient’s overall health and their whole quality of life.
When it comes to someone that has a blood pressure that’s 120/80, and you look at that patient and that patient has +3 weeping edema in the their lower extremities, if I just go by the blood pressure 120/80 and I don’t put the other pieces together, such as I am listening to the lungs and I can hear rales and crackles; I hear these abnormal breath sounds. If I don’t look and see that their legs are swollen and that they are weeping, and I just say, “Oh, blood pressure is 120/80. I don’t need to do anything about it,” then we’ve really missed the mark on what we’re in there to do. When it comes to clinical decision-making, we can’t put every clinical decision on the 485 or it’ll be [as big as] the Bible and it will have no meaning because we can’t read through all of that in the matter of patient encounter.

So therapist, therapist assistants, they should all be assessing vital signs, but you really need to take it to the next level and not only have them do the vital signs and know what the parameters are related to, reporting it to either the nurse or a physician, but know when the patient is decompensated, and know the sooner they are able to identify that the patient is decompensated and have a intervention plan such as a call to the doctor to have a PRN Lasix medication added, or patient goes to the physician and they need to have an IV Lasix or something else to happen or some other diacritic or they need to have digitalis or something. These are the things that help keep these patients out of the hospital. Something so simple as daily weight is something that home health aides, all of therapy clinicians, and the nurses should all be involved with. Yet when I read the charts, it’s surprising that I look at charts in all disciplines, and daily weights are not recorded. It might be discussed at the start of care, but beyond the start-of-care visit where they first mention “you need to do this,” there is no follow-up later on to see that it’s been done.

With this population, we have to assess; we have to interpret; we have to be able to problem-solve. Really, the biggest piece of all this is communication. When it’s something that is out of our scope of practice – such as prescribing medication, that is not what therapists do – we need to hand it off to the right clinician to make sure that that patient is treated as effectively as possible and also as quickly as possible. Agencies need to really look at the communication models that are in place with their hand-off. Is the hand-off strictly to a computer, an electronic record with a note from one clinician to the next? That may or may not be timely. Is it just through email; it is just through tasking; is it through texting? There are so many more mechanisms of communicating, and sometimes having three ways of communicating can also make it more confusing because you are not sure where to look for the information. So being clear about when to communicate and what mode of communication will have a great impact on this population. So Bud, you can move on to the next slide please.
So what about auscultation? In my agency, this is probably one of the biggest barriers that we have is, what we therapists even the speech language pathologist who are working on patients with aspiration and pneumonia, it seems like the stethoscope just stays in the bag if they have one in the first place, and really that’s just doing the patient a disservice. All the clinicians are instructed and trained in their undergraduate and graduate professional education, how to auscultate, and the matter of how *should* they be doing it. I think we all in agreement that yes, we should be doing it. I think that the resistance to doing it is a matter of feeling uncomfortable with what they are doing and not feeling that they are competent because it may have been years since they were trained and now asking them to just do something without having support and new training, I think that’s a recipe for failure.

So when you want to implement auscultation, if you don’t have that as part of your policies now, set it up with first having training sessions. Not only training sessions cognitively where you go through Powerpoints, but go through sessions where there is practical or lab component. That way, we can make sure that they get their hands on that stethoscope. They are able to know what you know what they are listening to, whether it’s the lower lobes or the upper lobes, or what they are doing. So we want to make sure that they feel comfortable with it. Then as far as therapist documenting S3 and all of the different abnormal heart sounds, you don’t have to go in-depth with that. We’re not cardiologists. We should be able to identify normal or abnormal. Going beyond that, if I was specializing in cardiac treatment, cardiac rehabilitation, then I would want to be more exact when I’m documenting, but suffice it to say that for the generalist clinician, abnormal or normal, in my agency, that would be sufficient, and I will be happy if you are able to see that on a regular basis. These sources are available online, and you can see that as the bottom bullet on the slide.

So, let’s move on to cardiac meds. Bud, do you want to take this or would you like me to go over this slide?

Bud Langham: Yeah, I’ll jump back in and take this one. So when we talk about cardiac meds, I want to go back to the definition of a Drug Regime Review. When we have this discussion, like we spoke about last time and its good for practice session, I really want to ask therapist to think about it like this... we are looking for potential adverse effects, and we are looking for drug reactions. We are looking for things like ineffective drug therapies, significant side effects, significant interactions, duplicative therapy and noncompliance. And so we ask the clinicians when they are in the home, if they have patients who are symptomatic, to look back at their medications. Ask the patient if they have taken their medications as they were
prescribed and then report any abnormalities. We do train our therapy staff on common cardiac medications.

This is an example training slide from one of the older presentations that we’ve done here at Encompass on cardiac meds. You can see how we broke it down. We really tried to simplify it and just keep it very simple. We give this to them so they have it as a resource as well. They have the class of the drug, the purpose, the action, and the side effects. Trying to keep it simple and easy for them to remember and really drilling in on the significant side effects. Trying to put those as primary, so we don’t ask them to memorize all this stuff but just give them the resources and reminds them that they have had this information in the past.

There is a wonderful book called *Pharmacology for Physical Therapists* by Barbara Gladson, I believe is her name. That’s the book that we reference back to a lot. Barbara Gladson is a PT and writes specifically for physical therapists. So, again, at the bottom of this particular training slide, we just have a statement that says “Therapists are healthcare professionals and as such they should have a basic understanding of these medication concepts. It is crucial to the health of patients and the success of our interdisciplinary heart failure program that therapists have an active role in medication management.” It doesn’t look the same as the nurse’s role, but it is critical that they have an active role that they report ineffective drug therapies, vital signs outside parameters are the issues that could be related back to medications.

I’m going to do OASIS real quick, and then hand it back over Ken for how to reset these expectations again, and then we can have that conversation. We also remind therapist that cardiac information, as everybody on this call knows, is included in the OASIS documentation. At discharge for patients with heart failure, these questions are going to have to be addressed, 1500 and 1510. We make it very clear to our therapists and OASIS training, that if you show up to 1500 and you mark Not assessed, there better be a really good explanation because that is not an acceptable response for somebody who had the diagnosis of heart failure. And I’ll just tell you, I’ll be honest, we still have clinicians, and I still see this from time to time, that on M1500, show up on this question and say, “Well, I’m a therapist, so not assessed.” Because they think this question is asking specifically about them instead of about the agency’s care of the patient. So we remind them that even though they are a therapist, they have a role in helping these patients avoid hospitalization and age in place in their home. That means looking for signs and symptoms and responding to them appropriately, even if that means just notifying the nurse to get some help because they don’t put comfortable caring for those patients. OASIS, we go through that quite heavily, so they are prepared.
Now I’m going to give it back to Ken to talk about resetting expectations and engaging therapists.

Ken Miller: Well, this is always a difficult conversation to have, especially for a non-therapist to have with a therapist. In my agency, we have an interdisciplinary training program we just set up. We try to eliminate the discipline silos, so we have therapists and nurses report to either therapists or nurses. And often times when the nurse supervisors have concerns about a therapist, they’ll go to one of the other therapists in the organization that is in administration, and they’ll say, “Well, I need you to take of this and talk to that person.” One of the things that I always try to do is try to explain how a therapist might think to a nurse so that they get a better appreciation for the therapist is thinking, what their role is, and how they will act and perform their function. So I think the very first thing is that nurses and therapists need to become more comfortable with the each other’s roles and be honest about the expectations that, you know what, we need to do this; it’s for the patient. They think this is our report card. Go back to OASIS data; go back to Home Health Compare and say, we are being judged and graded on this, and when we move to value-based purchasing, we are going to be rewarded or penalized on this. We can’t stay in business if we are not trying the best and showing the best outcomes to our patients.

Going to MedPAC recommendations... MedPAC has made many recommendations and making just about all of us on the phone call shiver and then hope that it doesn’t go into place. There are many recommendations that would be prohibitive for patients to have access to care. This is a political message, but know that what MedPAC has recommended has impacts that could limit access. We need to do all that we need to with vital signs, and medication management, and being involved in all the best practices for cardiac patients to show that what we are doing is having an impact and truly a value for the government, that we are less costly than a patient being in the hospital or through a revolving door, in and out of the hospital or clinic or a physician’s office.

The Balanced Budget Act of 98, the Affordable Care Act of 2010 – I would bring up highlights, and that’s what we do at our agency. I show the good, the bad, and the ugly in our industry. I go over the pricing; I go over the PTS system because it’s critical that the therapists know, and the nurses know, how the payment is generated and how important that OASIS is related to creating that care plan, creating the payment, and then creating our outcomes, whether it’s process or outcome measures.

So if reimbursement changed tomorrow, what value would you bring to this agency and our patients? It’s very disheartening to me when you go to patients’
homes, and the patient says, “You know what? I don’t think I need you anymore.” Or the insurance may not pay for it and the patient’s like, “Oh, okay. That’s fine. You don’t have to come back.” I wonder what value the patient’s really thinking we are to them in their home. So we need to think about what are value is as part of the whole related to the whole health care industry in our country.

So let’s move on to some ideas. You want to have your therapists... you know, my organization, Bud’s organization, we have had therapists been able to move up through the ranks and into different positions, whether its PI or MRU departments, or whether it’s in leadership roles or supervisory roles. I think it’s critical for any organization to survive moving forward to have interdisciplinary representation at all levels of the corporation or the organization. Bringing different disciplines brings in different thoughts, different schools of thought, and you can make decisions from a broader scope. Having a larger vision helps to make the decisions a little bit easier and may also make you have some decisions made that you would not have considered if it was my own discipline.

Standardized competencies and self-assessments. My organization was famous for having competencies. Yes, it does cost money to bring people in for training, but you have to be committed to the process of bringing these people in for training and for competency and assuring that the staff are safe with the patients. We have our staff do self-assessments. We ask them when we first start orientation, areas of need, so they can self-assess themselves. We have student programs. Student programs have many self-assessment tools that could be adapted. The American Physical Therapy Association (APTA) has wonderful resources for their students, clinical instructors, and the student programs that you can adapt for PT, OT, and SLP at your agencies that are already fully licensed.

Have regular meetings. Sometimes people are in rural locales. It might be difficult to drive into the meeting. GoTo Webinar, GoTo Meetings are new technologies that can bring people together and save distance, save travel time. These are things to consider adding into the organization. Electronic learning platforms... again, the key to getting the clinicians the knowledge that they need. Most clinicians that I find are very receptive to the information when it’s provided. They’re really looking to try to have the most best practice information, and they would like to provide it, but sometimes they are stopped for it, and they are just not sure where to even go to get it. We could work on those areas; that would be very helpful. I think it will make a difference for clinicians’ practice.

Engage the staff in QAPI. Get the therapists involved in QAPI, so they can understand the broader scope of following the trends. Why do I have to fill-out an incident report? If you have therapist involved in that process, they could explain
it to the other clinicians, and not only the other therapist but nurses as well but from a different point of view.

Engage the staff in Medical Review practices. Engage the staff in solutions. Give them a voice and ask them. Sometimes at the beginning of our meetings, rather than starting with our agenda, the first bullet point is, does anybody have anything that they need to discuss? We give a timeframe; we say we have about 10 minutes to discuss. It’s an open floor for 10 minutes, and then we need to move on. Otherwise, it could become a gripe session and become a very long meeting about complaining, but we definitely give them a chance to voice what their concerns are. I think that’s about it. Bud, do you have any ideas to add to the list that we have here?

Bud Langham: No, I think you covered it Ken. I think we can hand it back over to Cindy at this point.

Cindy Sun: Thanks, you guys. I think you brought up a lot of really great points. Just to recap of mentioning because I think what you hit upon, is something that we hear at HHQI frequently from the agencies, and it’s just a reminder to everyone to continue as you are progressing and integrating the skill and the knowledge that your therapists bring to the table in this integral part of caring for the patient, is to remember to add simple things, such as vital signs and assessments, to competencies. It’s the same thing as if you have skilled nurses who have been caring for home health patients for years, and then all the sudden, you are introducing IV therapy. Yes, they were trained in IV therapy that was possibly 5, 10, 20 years ago, but have they actually inserted a catheter into a patient’s vein in the past five years? No. So we would include that in competency. It’s just the same thing with our therapists.

And many of you, as we have heard, do have therapists who are fantastically doing all of this already, but in case they are not and then checking and ensuring that they have that comfort level and not just expecting them to rely back on what they were trained on, which might be a few years ago. I want to thank you both for bringing that up, as well as making sure the equipment is in working order because that’s another thing, and just really tapping into this wonderful workforce and skill sets that the therapist bring to the table.

So we’ll go ahead and move on to Misty Kevech who will be talking about the cardiovascular education aspects to what we have to offer at HHQI, so Misty I’ll turn it over to you.

Misty, you may have us on mute.
Well, I’ll go ahead and start. Now, I know that I am not as good as Misty Kevech, but I will just mention as far as the HHQI cardiovascular education, looking at the therapy, we want to remind everyone that there are evidence-based resources available in the Blood Pressure Control & Smoking Cessation BPIP. This is not only... it’s a Focused BPIP that is turnkey text not only for the therapists but also for patients looking at all different clinical aspects of it. The Cardiovascular Health for the Underserved Population BPIP will be available and published to everyone on May 1, so mark your calendars. There will be a discipline section specifically for therapists, so you may want to either pull that out and send it to your therapists or just let your therapists know so that they can access it themselves. And the Race & Ethnicity Cardiovascular Risk Factors clinician video will be available with this BPIP on May 1, 2015.

Looking at the HHQI University, the current courses that are available, remember those are free CE's. The CE's are specifically for nurses, and the only reason for that is simply that it is much easier. There is a national accreditation body for nurses whereas for other disciplines, such as therapists and social workers, it required going to all 50 states. So currently – not saying permanently – but currently, we’re only offering the CE's to nurses, but every person in the agency can take the courses and receive a certificate of attendance. We encourage that to occur so that everyone is on the same page as far as what’s going on. Again, looking forward to being able to offer it to all disciplines, but for right now, it is just nurses, and we are sorry about that.

We’ll go ahead to the next slide. I want to just remind everyone, again, that the Underserved Populations Network webinar that was held on January 28 is the initial part of this discussion between Bud and Ken. Just phenomenal amounts of information, even beyond and above what we talked about today.

We will go to the next slide. Again reminding on April 22, 2-3pm, Chronic Health Issues affecting Hispanic Patients. We encourage all of you to reserve a seat. That is a limited-space only webinar. Of course, it will be recorded, but we want to encourage you again, being part of the CardioLAN, to get in there and grab your seat early.

We will go on to the next slide, and this, CardioLAN webinar. I want to remind you that at couple of times a year, we hold one of these meetings specifically for sharing of information and networking amongst the agencies and all of you that are actually out there doing the work. We want to encourage you. The next time we’re going to do that is next month which is May. I see there are two different dates, but is actually on May 21, 2-3 Eastern. It’s the third Thursday of every month; that’s how the CardioLAN is setup. Next month is going to be all about the
agencies, and we want to hear from you ahead of time if you have success stories you would like to share or be willing to share. Also, as Stacie was saying, we like to hear the obstacles as well. This will be not only networking, it’ll also be kind of brainstorming and sharing the obstacles and seeing what other agencies have accomplished to make this happen. So the registration link is listed here on the slide. Remember, you will be, as part of the CardioLAN, you are going to be invited. There is no reason to reserve a seat; you have a seat. You are part of the CardioLAN; you are going to receive the invitation the same as you always do the day before. So we want to encourage you to come and bring all of your issues and questions.

Now with the questions today, Ken and Bud, if it’s okay with you before we go ahead and get out of here, we’ll just go ahead and ask a couple of the questions that came through. One of them was, what research-based tools do you recommend for documentation – a 6-minute walk test, a 2-minute step test, or any other suggestions?

Ken Miller: If you have therapists in your organizations that are members of the Home Health Section of the APTA… we recently, I believe actually, I think it’s two years, wow. Time flies. We put together tool box that has many different tools including the 2-minute step test. It includes a 30-second chair-stand test. It includes using a rate of perceived exertion. There are many other tests that are available related to patients’ aerobic capacity, their muscle strength, their risk of falling, their balance, their gait. So I highly recommend going to the Home Health Section website or have the clinicians in your organizations that are members. They get the resources free. If you don’t have any members of the Home Health Section in your organizations, then it is available for purchase privately. The Home Health Section website is www.homehealthsection.org. I do recommend going there. Another place that you could go for other measures, it’s a free site, is rehabmeasures.org. If you go to www.rehabmeasures.org, you can get plenty of tests. A third site would be the American Physical Therapy Association has a website called ptnow.org, and they also have objective test available on that site. As far as occupational therapist, most of the measures that we put together for the Home Health Section are just as appropriate for OTs, and as far as measures for speech language pathologists, if you go to the ASHA website, they also have a list of tools that would be appropriate for speech therapists to use in the home setting. So those would be my recommendations for finding objective tests.

Bud Langham: Ken, I would just jump in there, and tell me if you agree, and I think that you do. These tests that you mentioned are fantastic; they are easy to do. They can be done by any of the disciplines, and so I would just like to throw out there too that there is nothing that gets me more excited in my organization than to see one of
our nurses do a 2-minute step test, or 2-minute walk test, or a 6-minute walk test, or use those same objective tools and measures to quantify a person’s limitations. Do you have any issues with nurses doing any of those tests at all?

Ken Miller: Not at all. None of the tests that we just briefly touched on or the tests that are in the resources. None of them have conclusions that you have to be a specific discipline to do the test. Most of the tests are really easy to learn how to do. It takes just a moment, few minutes of training honestly to do a test, maybe up to 10-15 minutes for some of the more complicated tests, but even those more complicated tests are easy and it can done by any discipline, nursing included with the other therapy disciplines.

Bud Langham: Exactly. It gets me so excited to see nurses doing objective tests and measures. The requirements aren’t the same, of course. They are for therapist to document objectively in terms of functional outcomes and reassessments, but if you think about substantiating medical necessity for an episode of care, those objective tests did a great job at that, so I would just throw that out there to the group as well.

Cindy Sun: Well, thank you both for that, and we want to thank everybody for joining us today. If we did not get your question, and we have quite a few questions that came in, we will be posting and we’ll send out an email to let everybody know where the answers are posted, and they will be posted in the next week or so.

We want to thank all of you for joining us today, and especially to our special guests, Dr. Ken Miller and Bud Langham. With this, we will say goodbye. We hope everyone has a wonderful week, and thank you for staying a few minutes over. Have a great day everybody. Bye-bye.