Transcript: December 2014 CardioLAN Webinar

HHCAHPS & Cardiovascular Care in the Home

Cindy Sun: Hello everyone and welcome to the HHQI Cardiovascular Learning Action Network called the CardioLAN. It's December 2014 and this is our monthly meeting coming together of all the cardiovascular improving focus in the country and we want to welcome everyone. Whether you are listening to the archives recording or whether you are participating in the live event, we thank you for taking the time out of your day to join us and we hope that you will be to take a few pieces of information to your clinical practice once we finish webinar.

So with us on the call today we have the HHQI team which consists of Stacie Deslich, who is a health data analyst. We have Misty Kevech, Crystal Welch and myself for those of you who haven't met. My name is Cindy Sun. We are the three RN project coordinators for HHQI and we're very excited to be here today and we're excited that you are joining us. With us also today we have Rita Grimes representing Qualidigm, and I'll formally introduce you to her in just a few minutes. She is our special guest speaker today, and we're very pleased to have her.

Just a few housekeeping things before we get started. As I've mentioned this is being recorded and this is recorded because as we all know sometimes our schedules don't quite work out to where we want to join something or we're not able to, so it is recorded on the website. All lines are currently muted. This is my impersonation of someone begging leave, take a moment if you don't mind and mute your own lines. The only thing worse than us eavesdropping in on your conversation is to eavesdrop and broadcast that private conversation on a national level and then record it for prosperity. So please just take a moment and mute your own line. We will be unmuting the lines later on in the call for a little Q&A.

So the way the call is going to work today and the agenda will go on. As we mentioned Rita will be along to present HHCAHPS and Cardiovascular Care in the Home Using Data to Improve Patient Experience of Care followed by Misty Kevech, RN Project Coordinator. She is going to talk a little bit about tools and resources that are currently available to help move this HHQI, excuse me HHCAHPS information into the practice setting.

She will be followed by Crystal Welch stopping by just to provide a few campaigns of this because one of the benefits of participating in this informal workgroup is to be one of the first people who hear of upcoming HHQI events. So if there is an event that's upcoming and interesting to you, you can get in and register before meeting capacity.

And then finally we're going to introduce a new section called Stacie's Corner and that's what we are informally calling it and that Stacie Deslich will be along to talk about the Home Health Cardiovascular Data Registry with some fun facts and interesting tidbits such as what agency was the first agency to close up the month in November. Who actually was the agency, or the first agency to close up all four of the ABC assets. What was the most popular measure that was abstracted. So those types of things Stacie will be along to share with us after that and then we'll open it up all of the lines for Q&A and get as many questions as we can on the call today.

So at this time, I would like to introduce you to formally Rita Grimes. Many of you know her already but in case you haven't, you can see her credentials are on the screen and Rita is a consultant for Home Health Care at Qualidigm. She serves as Project Manager, the lead for Home Health Consulting Contract and educator and trainer and is a key resource for Home Health Administration and Quality Improvement staff in data analysis, data abstraction, compliance and quality improvement. Rita has over 30 years professional nursing experience, was in practice in both the US and in Canada in outpost, emergency, critical care and community nursing. Prior to joining Qualidigm Rita worked as Vice President of Performance and Quality Improvement Leading Team whose work resulted in reduction of hospitalization rates and excellent in coding and review practice. She managed the implementation of best practices for women care, medication management, pain and depression screenings and agencies.

She directed and led the Health Information Management of the HIM Department to ensure record accuracy, access and confidentiality. Rita has also coordinated and led educational presentations on OASIS and depression screening and interventions at the Connecticut Association for Home Care at Home. She continues to work with UConn researches to ensure proficiency and standardize depression screening. Rita continues to train providers in the Home Health Physician's Practices, hospital-based case management and outpatient clinics and chronic care management and transition of care. Rita is an active member in a number of professional organizations including National Quality Institute, Health Care Compliance Association, American Nurses Association, American Health Information Management Association and finally Rita holds an MSN from the University of Hertford and earned her BSN from the University of Victoria in Victoria, British Columbia, Canada. She has license as an RN and certified in diagnostic coding, OASIS, chronic care management and is a certified CHAP consultant. So with this we'd like to welcome Rita and with that, Rita I will turn it over to you.

Rita Grimes: Thank you Cindy for that introduction. I am delighted to be here to talk with all of you about patient's experience of care and its significance in the chronic care management.

So our objectives for today are to describe the collection process of HHCAHPS, operationalize an HHCAHPS improvement plan and to align specific areas of need with implementation of preventative cardiovascular care.

Whenever I think about a problem or situation in home health, I attempt to stick closely to our mandate from the office of management and budget and the national quality form and that is to provide care that is safe, timely, effective, efficient, equitable and person-centered. I find that using the acronym speed to frame the situation works well in all care and agency decisions. So, for example, on a care decision points, clinicians will often step back after developing their plan of care and ask you know is this care plan that was developed collectively safe, timely, effective, efficient, equitable and person-centered? I also find on the agency level, your administrator when making decisions will step back and ask do policies, procedures, staffing and programing allow for the care teams to provide speed care.

We also that person-centered care is critical to effective disease management. Essentially, is the provision of safe, effective and timely care but through the cooperation among the physician and an informed and respective patient and family as well as the whole **corduroy** of health care team members. We also know that person-centered care fundamentally requires patient engagement at every step of the care process and that every step in effectively managing the disease process. As we know that critical to patient engagement is good communication. So we in the industry have worked to really hold

our communication skills, to really practice our listening and really learning from patients and families and the care team.

Good communication can inform your team about the patient's goals of the care, any obstacles to achieving self-care and that's really fundamental to increase both the patient's confidence in managing their complex disease process and also the care team's. HHCAHPS data allows us to view the patient's experience of care through the eyes of family, patients and truly doesn't form our practice. The care key care is to effective disease management. It's really required for care providers to view all care experiences through patient family's eyes.

So HHCAHPS survey was developed through research process by the agency for Health Care Research and Quality and it's endorsed by the National Quality Forum. Report in HHCAHPS is required for participation in Medicare and Medicaid Program since 2012 and those agencies who did not comply with the requirement for reporting saw a two percent reduction in annual payment update reimbursement rates. And it is anticipated to be a major factor in a performance based-reimbursement system.

So we know there are five measures, two global, three composite and we know that there is a risk adjustment for differences in case mix across agencies. The survey itself is available on the HHCAHPS website in five languages and can be easily downloaded.

So Medicare-certified agencies are required to contract with an approved survey vendor. A listing of approved vendors can be accessed on the website you see on your screen that the listing you see indicates that the vendors have met all requirements for conducting a survey. So do visit that site.

Current reporting on the HHCAHPS website reflects the data collected for four quarters between April 2013 through March 2014. So this data collection period is over, however a period reflects current reporting that is publicly available.

We are currently in the 2016 data collection period that began in April 2014 and will run through March 2015.

There are two exceptions to the reporting requirement. The first exception relates to when you became Medicare certified so if you were not certified throughout the entire data collection period of April 01, 2013 to March 31, 2014, you are exempt from reporting. Though you are exempt I will mention that you are likely collecting some data about the number of eligible cases in order to prepare for the next phase of reporting.

The second exception relates to the number of eligible cases. So for example if you were Medicare certified for the entire data collection period and you had fewer than 60 eligible unduplicated patients, so 59 or fewer with the same in the same data collection period then you are exempt from reporting. However you absolutely must submit a Participation Exemption Request Form from the HHCAHPS date collection information requirements. The form can be found on the website listed on your screen just a caveat that CMS' file on the deadline for filing an exemption, so for the fiscal year 2016the current period you must file and exemption request by March 31, 2015.

So vendors can provide some very valuable feedback on some questions and that truly does help you if you know in real time responses to questions and issues or concerns that may have arisen if respondents

indicate that they would like to be contacted, you are able to reach out to patients to further explore any issues involved with the care.

Additionally, some vendors are able to cross reference OASIS data with composite measures. So just as an example the composite measure Specific Care Issues may talk about, have you talked about medications, can be referenced in the OASIS process measures. Any inconsistencies can be waded out to explore for example whether teaching approaches were adequate and met the needs of the patient.

So quickly we're going to go over the measures and we're currently seen posted for national averages on the home health computer website. So the first measure, global measure, is overall rating of care. These are patients who gave their home health agency a rating of 9 or 10 on a scale of a 0-10. Question #20 of the HHCAHPS survey and the national average is currently 84% and that's for the data collection period April 2013 to March 2014.

The next global measure is likelihood of recommending. If the patients reported yes, they would recommend the home health agency to friends or family. One question from the survey and that's Question #25 and the national average currently is 79%.

A composite measure called care of patient. These are patients who reported that their home health team gave care in a professional way. Now you can see on screen Medicare did define what is professional way and that is there were no problems with home health care. The patients felt providers were always gentle, always respectful and always up-to-date on patient's treatment. This involves four questions, #9, 16, 19, and 24. Current average is 88%.

The next composite measure is communication and these are patients who reported that their home health team communicated well with them. CMS has defined communicated well as meaning that we explained services before giving the services that we gave advice promptly, that we always said when staff would arrive, we always explained things clearly and we always listened carefully. This is the top order. These questions were coming from #2, 15, 17, 18, 22 and 23. The national average is currently 85%.

Special Care Items is the next composite measure and those are the patients who reported that their home health team discussed medicines, pain and home safety with them. This is a challenge for many, many agencies especially in the area of teaching the side effects, pain etcetera can be very, very challenging. The questions involved here #3, 4, 5, 10, 12, 13 and 14 and the national average currently is 84%.

So this is where we could enter the good talk, okay. So how do we approach readings that were either did not meet the agency threshold for improvement or did not meet the national averages that's your benchmark. So let's take a look first at your operations if your measures are not comparing well. These are just some examples of those agencies who do perform well. So, for example, ask do you have designated HHCAHPS champion? This is typically the person that most often is recognized as the face of the patient experience of care. They may be, they may be the person who brings the information to employees and to partners about the patient's experience. They may be the person who posts the HHCAHPS results or reports firsthand what they're hearing in the field. These are often people who patrol the block so to speak. Talking with providers and patients, listening, seeing and experiencing provider communications styles. Communication among patient schedulers and these are people who

are aware of challenges to communication in the home environment. So ask yourself do you also have procedures for check-in?

Now check-in is just a simple basic tool. It's based on principle that by checking in before any engagement that you set the foundation for patient family and provider interactions. Check in can help on you know common appreciations of where everyone is in that particular day before you even engage in your teaching or addressing specific, larger objectives of care. So for example it might look like this. Know what's important to the patient by routinely asking. So what's important to you now in this moment or what are your current concerns or what is your greatest concern? We know that unless we are able to take care and clear the slate with any anxiety or stressful situation that we're unable to proceed any further with any care objectives. Also it's good to check in a telephone triage manner. So many agencies do cold calls to existing patients and families within the care episode. So they can determine whether there are adjustments to care that are needed and I'll mention again it really is imperative to have, imperative to have a smart goal and this is really specific measureable goal based on the patient's objectives for care. So knowing what the patient wants out of his or her episode is really a step toward patient engagement and is critical to overarching objective of how to achieve self-management. Check-in can quickly establish what's important or pressing for the patient or family.

So many successful agencies have incorporated very powerful procedures and techniques to inform them about patient's experience. I've seen firsthand clinicians who really lack confidence and using some of those motivational interviewing techniques largely because they have not practiced motivational interviewing. So we find that it is critical to establishing effective communication. Building provider confidence and as well as patient engagement. Ultimately that communication can really boost research scores. The patients are engaged and if they are engaged you know they're listening.

Walk about the agency and hear what' staff relate to in terms of how they are communicating with patients are well as responding to request for more information or to their needs.

Also critical is walking with staff in the field and in the office to observe their interaction with patients, families and in the office to observe their interaction with patients' families and between care partners. You know when communication or engagement techniques are observed or felt to be less than optimal, it is critical to invest in staff trainings for motivational interviewing or the use of some of those chronic care management techniques. We know communication is so complex at the best of times, and this is largely due to just the complexity of communication to begin with. I grew up in a family of nine children and it was considered a coup to be able to get your point across. So in large, very complex situations with family and family members, it's critical to have the skills and to have an ideal situation for communicating, teaching and getting to the heart of matter.

Your investment in clinician training I can't stress enough. It would help build staff confidence as well as patient confidence and ultimately will improve the patient's experience of care.

Another approach is to routinely consider your HHCAHPS and the context of your OASIS reports. So, for example, when looking at your composite measure again for specific care issues consider M1510, this is to the patient exhibit symptoms of heart failure and the action taken is scored a #4, patient education or other clinical interventions taken. Is that consistent with for example a 98% of the time process measure on OASIS that we are teaching. If 98% of the time we're teaching are our teaching methods effective? You know teaching has taken on a whole other skill level and we're not always prepared to

really delver on that. So I often, I often find in my visits to observe teaching and to observe communication that we are not taking the time to chunk down the information, so to really chunk down how many steps will it take for example to teach patient the side effects of the medication. We often don't allow time for the patient to chew on the information and then again are we checking back with the patient to see what was retained and what might I do to improve my teaching techniques? So field observations for patient teaching and specific training on patient teaching is critical.

Agencies also report great success on their HHCAHPS when they've invested in chronic care management and what I mean by that is not only do they have the education on chronic care management but the agency has come out with a strong statement about this is our standard of practice. Many agencies are providing opportunities for certification and really the crux of the matter with chronic care management is not so much the pathophysiology. It really is building staff confidence with communication and teaching techniques. It also helps to really build collaboration across provider communities for effective and consistent care approaches and care messaging. In many of the agencies where I instruct on chronic care management, I encourage them to train with care partners. So bring to the table and to the training sessions their physicians. I've had classes that have had physicians, physician practice staff, staff from the diabetes center, hospital case management staff, skilled nursing facility staff. We've had nurse practitioners, we've had CFOs in our class as well as clinical support staff in our sessions and something really fundamental happens there. We start speaking the same language and we improve consistency with our messaging.

Use IT and EMR applications and more and more as a move around the country a researches of pathways but real specific alerts to patients when there are variances with objectives that have been set for their care and really will allow time to make adjustments in care when care is being given. You know HHCAHPS takes the commitment by leadership as well. To think outside the box, so often we limit how we think about care issues from the perspective of agency's day to day operations.

What we are talking about here is really a dramatic shift in perspective that begins with decision processes that always consider care based on that speed acronym. So at this point I want to thank you for allowing me to speak to about our experiences today and I believe I'm turning this over to Misty or Cindy. Thank you.

Misty Kevech: Thanks Rita. We're going to go ahead with the next slide and then Cindy will come back and entertain some Q&As but I will throw in a plug if you have questions you can always put them into the chat or the Q&A box in the meantime. Taking the information that Rita had presented which I thought was great insight, great information related to the HHCAHPS and how do we take that the next level. She has given me some great tips and implementation at an agency level and so what I did is I took her six domains that she started with earlier in the presentation and kind of did a spin related to the cardiovascular. So thinking about it at an agency level, how could we integrate the pieces that will impact the HHCAHPS. So we'll kind of stop, start into clinical care.

So we'll see, looking at the clinical care we can take and integrate and best practice evidence based strategies from cardiovascular health you know through our BPIPs, through ABCs, through the resources that we have out there and by doing that we're going to improve clinical outcomes. We're going to improve patient care and as we talk about evidence based practices and consistencies through all of our

disciplines talking about best practices the patient will realize as well as their family that what we're doing and how we're trying to implement, how it affects their care.

I am going to talk a little bit about action planning several times because I think that's significant. I think we kind of talked about that before and especially when we were talking person's standard of care we need to engage that patient at first place, we are not going to get anywhere with disease management if we aren't engaging that patient and for them to be part of and to the see the relevance of the clinical care in what we are doing in our care planning we need them to be involved and action planning is one of those measures and I'll talk about that in just a minute

If we ask and we assist that patient with managing their blood pressure, cholesterol and smoking, these are three of the critical areas that we can improve that patient's quality of life as well as the quantity of life. So again taking those and really engaging that patient and understanding why we are doing that for the clinical care we are going to make a difference in that domain. Now the person in the care giver centered experience in outcome that really takes a big focus on HHCAHPS because, we can, how we impart what we are doing, it's for the benefit of the patient and for them to be involved, so we can display that we really care about that patient and their heart, we are trying to reduce heart attacks and strokes, we care about that person and their family and to able to help teach them these strategies and work with them to reduce the risk.

We can use that action planning, I was talking about. We have lots of action tools, I have some slides at the end that will give you lots of references with links. So we look at it with action planning and doing an action plan itself, it's really asking the patient what their goal is, another point that we had made earlier is with communication. We need to listen not do all the talking, so we need to listen what they want which usually is something non-medical completely. Then we need to help them figure out an action plan to accomplish their goal and obviously we can tie in the medical component phase. In addition to that we need to communicate that across all of our team members, so we are all focusing in on that patient's goal in their planning. We'd also mentioned teach-back. Teach-back is an excellent tool. It is really using that technique to see if we have taught that patient not as a patient understood it but did we teach it the right way in the right format, in the right adult learning style that is compactable for that patient, was it how literate, was it in the right language that it needed to be at, it did I break it into pieces like she talked about chunking and letting the patient chew on that information and then check back. So, teach-back is an essential component with especially disease management and with cardiovascular health.

Another way it is the change of how we do. We do a lot oral education, maybe some written education to supplement, but interacting in games and activities is a great way, while we know our time is very limited in seeing patients in the home one of the new things that we are going to be including in our upcoming practice packages or especially are focus practice packages, is quick ideas, ideas that you can do for games and education. I will give you an example of one, simple is to take one of the weekly supermarket fliers and talking about diet and creating a planned a plate that the patient is going to do or what foods are high in sodium or high in fat, use a marker or a pen and let them put circles around good food choices and Xs around bad food choices.

I am going to use that activity in a few minutes when I talk about some under-served issues too. So there are some simple things but we are going to provide some ideas to get staff started to think outside

of the box. When we talk about safety we usually think about solve but if we can decrease that persons cardiovascular risk and that really is in keeping that patient safer, it's also keeping them home and reducing hospitalization, emergent care and falls and improving the cardiovascular medication is really critical because we have issues with patients, with hearing, but most of the time when we really dive and investigate those are hearing issues and think that we can resolve and work around because we have to understand where that patient is coming from to help them to be at hearing, sometimes natural I know that we usually where we look for but there is a lot of reason and so here is another tip with medication that I have taught with HHCAHPS is you need to break that up, just like Rita talked about chunking, chewing and checking but we even need to do that on each individual visit. You need to lay out, have them pull out the medicines when we get there. We get the bottle, gives us the chance to check for reconciliation and relish on every visit is most ideal and then it gives us the chance to at least make sure that our frequency and durations are correct.

I might go on to teach about something else and then come back to the medicines in the middle of my visit. Now we talk about maybe the side effects, read and that's important for disease management, and then certainly prior to finishing up the visit, I want to come back again and it's a chance first us to close the loop, making sure that they understood, we can do good teach-back, did they understand they are taking the meds correctly, why they are taking them and how it's going to help prevent hospitalization, heart attacks strokes. So it's the chance for us to break that out.

The other issue that we see a lot in home health is that we see a lot of medication teaching early in the episode and we work our way down and we get ready for discharge. It's essential to really beef up our medication teaching towards the end of episode as well because we are getting these patients ready to be self-managers and to go into the community without home health. So we really want them to understand and are able to hear going forward and also that they are able to see the significance in continuing their medication.

The other factor to keep in mind from HHCAHPS most of the time, it's anywhere up to 60 days or around 60 days post-discharge. So the impression that we leave that patient with is really going to be important versus thinking back 30 days, 40 days, 60 days prior how we may have done a lot of that upfront. Meds are so important they should be carried to every single visit in the importance, but really beefing that up we want to keep them out of the hospital and also out of the ED and actually even additional physician visits.

So let's take a look at efficiency and costs. I think I actually covered this already in the first and avoiding the extra physician visits what I mean here is that if we can keep the patient from having unnecessarily to go to the physician offices well that helps our partner, the physician in getting clocked up seeing extra patients, but we will help these patients to able to manage their disease much better and for them that not having to have extra transportation that they might have had to take for, they have to get dressed and go out that would be burdensome to them and also getting family members to take off from work to go with them or to come and help take that patient. So that really does as help that patient as well as the physician.

We need to create a team approach to cardiovascular health. It is not just about the nurses. It's and I am going to talk about that in the next section with care coordination. It is the entire team. We need to be doing this together, so with that I am moving to care coordination.

It is essential that minimally that we are all taking vital signs, unless your state law prohibits that. So for home health agencies, the first thing I am going to tell you that you need to look at to your policies and procedures, you need to look at your state regulations and requirements for each of your disciplines. For therapy, the therapist should unless it is prohibited by your state, the National Associations for PPs, OTs and speech encourage and recommend, for disciplines to be taking vital signs, therapists really need to know what the blood pressures are related to their plans of caring how the patient is responding anyway to exercises. So in a lot of cases it's PT only or PT-OT only and they are able to identify hypertension issues where nursing could be integrated or meds could be adjusted based upon reporting those elevated blood pressures.

I will give a plug for we have an upcoming webinar in January and with the Underserved Population Networking Calls and Misty Dyke is going to put that into the CHAP window for you, a link to get you there but on January 29th from 3 to 4 PM we are going to be having two physical therapists that are going to be presenting on those topics and if I get back to the right page, I can find you that information. Sorry, lost my screens here. There are two speakers, Bud Langham he is a Physical Therapist as well as the Chief Clinical Officer of Encompass Home Health and Hospice and Ken Miller is our Fellow Physical Therapist, and he is the Clinical Educator at The Catholic Home Health. So they will be presenting our several sessions that we are going to be dealing related to leveraging therapist in all aspects; that will be the first one.

The next point that I have is reinforcing our cardiovascular teaching and tools. It's more efficient and remember for the HHCAHPS the more we go over the information, the patient is going to obviously learn it better, but it is going to stick in the memory more that we are coordinating, we're all working around the same tool, it could be his zone tool, could be a stop like tool, it could be monitoring their blood pressures and writing them down and we are reinforcing did you check your blood pressure, did you write it on to the sheet and then it is a great way to show care coordination for us and it shows that to our patients and their family.

If we focus our teaching around the patient's goals and strategies and all of that, our home health aids included, if we are all privy to what that patient wants to do, and then that helps us with our care, it helps the therapists integrate their home exercise programs or help the patient to use safety bars and safety measures to get in and out of the shower safely. And Community & Population Health is last to educate clinicians on weight, ethnic and disparities. We will be having our next package I put out is a blood pressure and smoking sensation as the focus package in February but I am just to give you update in May we have a cardiovascular health focus BPIP on the Underserved Population, but there is a lot of information within the package there to help you think about can they afford those foods, like I explained with the ad before, that's a good chance to talk about foods that are in season and that they will be able to use and obviously if we are using culture sensitive materials, and we will talk about their diet, then we really attune and they remember that we care about them and their culture.

Okay, now and next several slides I am not going into detail on. I am just going to let you know there are resources obviously the Cardiovascular Health Part 1 and 2. BPIP. I talked about action plans. There are several of those out are there. We will have a new cardiovascular version coming up that you can even tie into cardiovascular health where they able to choose what measures that they are going to work on.

The next slide, Persons Under Care – We have lots of information we did talk about, motivational interviewing that's really critical with the BPIP management in trying to understand and to be able to motivate that patient. Remember we are in the short time and going to be discharging that patient after their total resource about teach-back, there are some exam tools. We have some Spanish versions, emergency care planning, what to do when symptoms occur and team approach. There is information about using the self-hospitalization risk assessment where the patient is involved or the family is and lots of other patient tools about that are cardiovascular are perfect for this presentation.

With care coordination personal health records and also discharge criteria, there are some great resources available for you. Obviously we have our Underserved Population package with tons of information that is really a resource guide for you to pull where you are having problems, working with patients whether it is literacy, if it is underserved region etcetera.

I would do questions and send it back to Cindy for rest of our presentation.

Cindy Sun: Thanks Misty and thank you both for you and Rita. We appreciate the content. It was really good. As all of you are starting to formulate your questions go ahead and use the chat window on the right of the slide and while you are thinking about your questions of what's going on, we are going to go ahead and turn it over to Crystal Vouch and then followed by for Stacie Deslich for campaign updates and then of course the fun facts about the HHDDR, so Crystal.

Crystal Welch: Sure, thank you Cindy. I just really have three quick announcements I wanted to let everyone know about. I will just begin with an announcement that the current participation with the HHQI Campaign currently stands at 11414 participants from 5019 agencies and of course these agencies have access to all the free education in that resources that Misty just mentioned. Just three quick things, on December 1, HHQI posted revised versions of the cardiovascular health best practice intervention packages or the B Tips that we refer to and these packages were originally released in August and November just a year ago, but the industry guidelines related to hypertension and cholesterol management were announced in December 2013 right after those came out. So the revised cardiovascular B Tips are now available and include the most current information and just another thing to remember is that we are excited to provide even more key patient tools including the one I just mentioned in Spanish. So look for the Spanish version to be coming out also before the first of the year. And we know many health agencies need translated tools for patients and families so each month HHQI will be posting a Spanish version of some of our key patient tools. I know that this is good news for many agencies. And all of our tools are free and they are public domain. So please feel free. If you can't use them feel free to customize them to your agency. If you want to add your own logo impersonalize them to meet your needs don't worry we do ask get ask if they can be altered and yes they are public domain and you can add your agency logo to those, no problem. And then lastly, I just wanted to make everyone aware that if you want to or you like bounce off your "improvement questions" we have a chance for you to do that and there is also a good chance that others want to join with you. So HHQI has a form called Live Chat and this is held once a month. The next Live Chat is going to be Thursday, January 9 at 2 pm eastern time. This is just a perfect opportunity just to not work with those around the nation along with HHQI team members and other home health agencies around the nation. Live Chat is a casual online form where you can just learn from each other, ask questions, and bounce around some things. We have some polling questions that we pop up there and of course share the best practices. So we hope that you will join us and if you go to HHQI, sorry homehealthquality.org you can actually set an

email reminder so that you can remind yourself to join in on that Live Chat. Homehealthquality.org go to the network tab, next push the Live Chat and you will be able to set an email reminder. So, there are some other announcements but since we are short on time I would just like to encourage those just to visit homehealthquality.org, go to the news tab click on the most recent addition of our inside addition December newsletter and check us it.

So with that I am just going to go ahead and turn it over to Stacie Deslich. Stacie.

Stacie Deslich: Thank you so much, Crystal. I appreciated that and thank you all for joining us today. I too will make my comments abbreviated since we are running short on time. So there is a polling question that's come up on your screen if you would like to answer it about which data registry measure do you think was most abstracted and then at the end of my little talk I will let you know which one it was.

So, as Cindy mentioned at the beginning of this call, the portion of the webinar will include a basic overview and discussion of the happenings in the HHCDR the Home Health Cardiovascular Data Registry or what I call the registry for short because it's mouthful.

The registry just closed for the first month at on December 14, 2014 and the next month's data is now available for abstraction. So agencies can go ahead and abstract the next month. The reports for the previously abstracted data are currently in production and we hope to or we plan to have them available around the 23 of the month along with all the other HHQI reports. When the reports become available we will be able to discuss how to interpret them and use them to improve the cardiovascular health of your patient population. So, make sure to look for more about these reports in future CardioLAN webinars.

So for some highlights kudos and shout-outs with the registry, first I would like to congratulate the entire state of New Jersey for having the most home health agencies abstracting data this month. Way to go and get a jump on things. That's awesome. I am sure next month other states will give you a run for your money. So keep up the great work and continue to involve more and more agencies.

Now, I would like to recognize two specific agencies for outstanding activity in the HHCDR. First is the VNA of Somerset Hills Home Health from Somerset Hills, New Jersey. VNA of Somerset Hills was the first agency to close out a month of data in the registry. Now, they beat out several other agencies by only a few hours. It was really awesome to see such tremendous participation so quickly after the registry open. It's a great job and again congratulations VNA of Somerset Hill.

Secondly, I would like to recognize and give a shout out to Healthcare Resources from Arlington, Texas for being the first agency to abstract and close out all four measures. Spectacular job. Again, next month I fully expect to see more agencies abstracting all four measures which will help to give a larger group for comparison free to those measures. Again congratulations to Healthcare Resources from Arlington, Texas for setting the bar high.

Now finally the little fun fact from our polling question. Earlier you know Cindy had put a little tidbit out there that we would have some fun facts and so today it is about which measure was most abstracted. It looks like everybody has voted and 25% of you were correct. It was the aspirin as appropriate

measure and following aspirin were blood pressure control and smoking which were **tied** for second nearly, smoking was a tiny bit behind and cholesterol **brought** up the rear.

So before I leave you today I would like to challenge all of you to select cholesterol or better yet select all four measures for abstraction this month. Let's see how much we can improve and increase participation in the registry.

That's all I have for you today and I look forward to speaking with you next month. Cindy, I will pass it back to you.

Cindy Sun: Thanks Stacie and yeah I was one of the not 25% on that when I thought it was going to be blood pressure so thank you for educating all of us. So, let's go ahead and open the line for Misty Dyke if you don't mind and see if there are any questions. I am not seeing any questions in the window but I just want to make sure that we do have a couple of minutes for maybe a one or two questions but this is your warning. For preparing unmute all the lines. Make sure that your line is currently muted or else we are going to eavesdrop.

So, does anyone have any questions out there? So I think it's a really good…Hello.

Misty Dyke: That was just me Misty I was letting you know that the lines are unmuted.

Cindy Sun: Sorry about that. I am sorry I am talking over top of somebody. I apologize for that.

Judy Miller: Can you hear me, this is Judy?

Cindy Sun: Hi Judy, yes we can hear you. Is this Judy Miller?

Judy Miller: Yes it is of course.

Cindy Sun: From New Jersey. Thank you for joining us today.

Judy Miller: Of course I know. Can you clarify the next chat date, Crystal I think said the 9th and I think that's a Friday.

Crystal Welch: Yes, you are correct. Misty Dyke if you could – I think we did change those around I think it would be a Thursday, is that correct so it would be the 8th?

Misty Dyke: We have actually moved to January one, normally that will be on the second Thursday of every month; however, for January, we moved it to that Wednesday so it's January 7.

Crystal Welch: Oh January 7, oh my goodness, we are hopping all around; I apologize for that. I think I probably looked at the 2014 calendar. I am not in the 2015 frame of mind but thank you very much Judy for catching that. So the Live Chat will take place January 7 at 2 pm Eastern.

Cindy Sun: And while we have a moment and now that we know that Judy is on the line I would like to talk to, just mention that each of you as home health agencies in this country that is all 50 states and territories and district of Colombia each of you now has access to a quality improvement expert in your state, free of charge QI and QIO. We mentioned this because this is a limited opportunity. This is

something that and home health we have not had this opportunity for the past five to six years and now it has come back around we want to make sure that all of you are aware of this that you do have experts to the quality improvement experts in your state that's just Judy Miller who was just on the line and she is the lead for New Jersey. So I want to mention that you have this opportunity, please take advantage of reaching out to your quality innovation network quality improvement organization person who is representing your state.

Now at HHQI we are always here to help, but there is just of few of us and this way you can have somebody in your state help with aligning what your projects are and how they can help with that. If you are not familiar with who is representing your state that list is found in the data resources. You will feel long list network coordinators represent many states have multiple people, but if you look next to their name the one that has the QIN-QIO insignia next to their name. That is the person that you will want to reach out to for quality improvement assistance and if you are not comfortable or can't figure it out or you can't reach the list or whatever or maybe you are contacting them and not able to reach them successfully just contact us and we will be glad to help you facilitate that call at least to find out what the opportunities are and to make sure that you are not missing out on anything. So with that we will pause for one more time for if there is any question.

All right, hearing none just a couple more updates as you heard already on the call today that HHCDR is open. In the past month we had greater than 500 episodes of care that data was entered into the registry. We want to thank you for that. Those are the go-getters because that was first month the registry was opened so yay give yourself a hand but the registry is now open for the second month. Those of you that have already participated in the registry you have probably reached your milestone, number two is not number three when the reports are posted in a couple of weeks. If you download your report you will probably reach the milestone three so keep that in mind those insignias which will be a logo and a certificate. The links will be emailed to you within the coming weeks and you will be able to download this and be able to use them when you are marketing as you too.

The next cardiovascular learning action network the CardioLAN will be on January 15 at 2 o'clock eastern in the same location. Remember we will send out the webinar or webex invite to those who are already registered. If you are not registered and you like to be contact us and we will be happy to show you how to do this. In the next meeting the focus will be on immunization, influenza and how this impacts cardiovascular care. Remember your cardiovascular patients are the some of the highest risk patients that you care for and being that we all know what's in the news right now. We felt that is a very timely topic. We are very fortunate to have an immunization expert coming into the call to talk about this. So we want to invite all of you to mark your calendars for that.

Now the final thing I will just say is that as you are chunking, chewing and checking as we heard today remember it's the season to enjoy not only your family, your friends, your coworkers and of course. Please take a couple of minutes and enjoy your patients and your caregivers because you know that they are enjoining you as well. So from all of us today HHQI to all of you across the country we would like to wish you a wonderful holiday season, and we wish you peace. Have a nice day everyone. Bye bye.

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