Transcript: May 2015 CardioLAN Webinar

Panel Discussion on Leasons Learned

Cindy Sun: Hello, everyone and welcome to the May 2015 HHQI CardioLAN webinar. We'd like to thank all of you for taking the time out of your schedules today for join us for this meeting. It's one of our special meetings each year that we really look forward to. It's when you have a chance to really hear from the people who are doing the work like yourselves. These are the agencies who are inputting data and making changes to the cardiovascular plans in their agency. It's a chance to have the opportunity to share with each other and learn from each other what's going on because we know all of this is new to everyone. We thank you for taking the time to join us today.

With us on the call today, we'll hear from later our agency representatives which include Diane Arcilla, Emilie Smith and Joy Owens. I'll introduce you a little bit more formally as we get along through the session.

From the HHQI side, we have Misty Kevech, who's an RN Project Coordinator, and we have Stacie Deslich who's the Health Data Analyst with us today. For those of you I haven't met, my name is Cindy Sun and I'm an RN Project Coordinator as well.

Just a few little ideas of what's going on. This session is being recorded for those who are unable to make it to the session for the live feed and they want to be able to learn at a later date. All the lines are currently muted. We will be unmuting the lines if you are on the phone a little later in the call so take this as a moment, if you don't mind, and mute your own line so that we don't accidentally eavesdrop on your call. We'll open them up for discussion and Q&A as we progress.

For those of you that are watching on the computer and listening through the computer speakers, please feel free to use the Q&A option on the right-hand side of your screen and start sending your questions in. We want this to be an interactive session but due to the volume, that's the reason we mute everything out but we don't want to squelch any opportunities that we all have to share.

With us today, the first thing we'll go ahead and do is turn everything over to Stacie Deslich who will give us a little bit of information on the HHDDR news and information. Stacie?

Stacie Deslich: All righty. Thanks Cindy, very much. Thank you, and welcome to everyone who has joined us today for the webinar. Today's webinar promises to be really interesting

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and engaging. I'm so excited to hear what the agencies are doing. It's a really great opportunity, I think, for all of you and for us to hear how things are going.

The registry closed on the 14th of the month and the reports are ready. New data became available for abstraction on the 15th and several agencies have already abstracted and submitted their data.

Remember last month, the CardioLAN webinar followed so closely after the registry closed, I didn't really have much data to share with you. This month, I'll wrap both months into one update right now.

For both months, Tobacco was the most abstracted measure. It was followed closely by Blood Pressure and Aspirin as Appropriate. Cholesterol continues to be the least abstracted but it's growing nonetheless. The measure rates are holding steady. We're really just on the edge of coming to the point where we'll hope to see some movement in a positive direction. I'll talk a little bit more about that in just a minute but first, some congratulations are in order.

Fisher Titus Home Health Center in Norwalk, Ohio was the first agency to close their data for January. A special shout out goes to Alison Likens, RN from Fisher Titus. According to her agency, the credit for the quick submission goes all to her. Great job, Alison and congratulations, Fisher Titus Home Health Center in Norwalk, Ohio.

Another congratulations goes out to Pekin Memorial Hospital Home Health in Pekin, Illinois for being the first agency to close out the month of February. Your fast and accurate data submission is a demonstration of your commitment to improving cardiovascular health of your patients in your agencies. Great job to both of you. That's excellent!

I'm going back to what I said about measure rates and improvement. It's hard to expect improvement without some action. One action that you can take is to push your data in a positive direction by downloading and using any of the many tools and resources in our cardiovascular BPIPs. Misty Kevech will be along later to tell you more about them and the latest in the educational resources we have.

This brings me to this month's challenge. I'd like everyone who submitted data to really study your HHCDR report and start to incorporate some of those wonderful BPIP tools that we have for you and begin tracking improvement. You can see how you're doing and get an idea of what helps, what doesn't work so well, and on which areas do you really need to focus. Begin using the registry to help you set and meet some goals for improvement. This is how the registry works. You give

some data and then you get back some ideas and an idea of how you're doing. Then, you can actually see things improving.

I also wanted to remind everyone, if you submitted all 6 months of data and are ready for Milestone 4 (the Assessment of Data Milestone), HHQI will be contacting you and saying, "You've submitted your data. Would you like to do this assessment of data with us?" Cindy will have more information about that later on or if you have any questions, you can always contact us.

Speaking of milestones, here is a quick poll question, I think. There it is! "Where along the road to cardiovascular health improvement is your agency currently?" Are you at Milestone 1, 2, 3 or 4? We know nobody can be beyond 4 because it just hasn't happened yet. Go ahead and pick that or chose your milestone.

While you're doing that, I will quickly review some important HHCDR dates to remember. The March data became available for submission last Friday the 14th and it will close out the 15th. Let me say that again so it's clear. Data becomes available on the 15th and it closes on the 14th. I am so sorry. I have gotten myself all tongue-tied.

One thing that you can do is access these slides on our website. This is a great slide to use as reference. I actually printed it out and hung it up. I'm able to look each month and see, "Okay the data is going to be closed on the 14th and new data is up on the 15th." It's a nice, handy reference to have. You also have an idea of when your report will become available. Sorry for my tongue-tie there.

With that, I am going to go ahead and pass it back to Cindy.

Cindy Sun: Thanks, Stacie. We really appreciate that. I hope everybody takes into consideration the challenge that Stacie gives to us every month. She's very good at motivating us along in this process. One thing I did want to share in regards to Milestone 4, as Stacie was saying, we have had a couple questions about this being an audit. If you're not familiar with Milestone 4, it's basically an assessment of the data reliability that has been input into the registry after you've submitted 6 months of data on any 1 or more topic areas.

What this is about, it's really quite simple. It snowballed into people thinking it's an audit and we're turning all of this over to CMS and things like that. No, no, no, no, no. You know how it is if you have a clinician who is coming in and starting with OASIS. Maybe you do this annually anyway. You're looking at having somebody else assess the same patient and making sure that that OASIS item is being assessed and the data is being recorded. One big question it is asking is if they're doing it accurately. It doesn't mean that it's right or wrong. It's just, are

they answering what that question is asking? M2020, is a great example. Are they assessing the patient's management of oral meds when they walk into the start of care visit or when they leave from the start of care visit because as you know, we all know that that can change quite a lot over that 1 to 2 hour start of care visit. Just making sure that the question is being answered correctly.

Instead of having an extra person at your agency re-abstract for the HHCDR to ensure that everybody's doing the same thing, we just sit around at HHQI and try to think of what can we do to make things simpler. One thing we can do here was like the registry. Instead of having 12,000 agencies out there trying to create a way to measure ABCS on their own, why don't we just create the registry instead of you having to decide what patient fits into what measure based on what ICD-9 code. We can take care of that. All you have to do is open the registry, answer a few questions, and you're done.

The same thing with this. Instead of you having to find a second person to re-abstract information to make sure it's accurate, we're just offering our services. What we would do is randomly pick out 30 episodes of care that you've already submitted or less, depending on how many you submitted, let you know which patients those are. You send us the records, copies of them encrypted. All that's taken care of. We just abstract the same information blindly, the same way you do. We don't look at your answers. We just do it based on the records you send. We do a crude agreement and then we send the information back to you. It does not go to CMS. It is not an audit. It's just a way of helping to make sure that you understand that you're abstracting correctly.

We've talked to the agencies around the country who have been abstracting incorrectly. I know you're probably sitting there saying, "Oh, she's talking about me." No, really, seriously, I'm not. There's many times that there's just been simple misunderstanding of the wordings and maybe someone hasn't had a chance to watch the HHDDR Overview webinar and look at the data definitions and look at the FAQs and how it expands. It's very simple to do, to misunderstand something. We're just trying to help you make sure that any changes that you make to your program and your process is based on accurate data.

Again, I'm just choosing M2020, the oral med question just because that's one I think we can all relate to, who have been practicing in OASIS since 2010 when that changed. It's 1 that, it's just the same thing, just making sure that answering the question and we're all answering it the same.

When you have abstracted 6 months of data like Stacie mentioned, we'll reach out to you and just say, "This is an option, if you want it." We take it from there. Real simple, real easy, not looking at any drama. If at any point and time, this data

becomes part of a research and all this highfalutin stuff, that'll be years and years and years down the road. That's not what we're doing right now. All we're doing is just trying to help out so that you're not abstracting a couple of years' worth of data and only to find out that you were misunderstanding a question.

Okay. That's about Milestone 4. Sorry about that. I will mention that that … I'm going to back here for a second and this tool, the HHCDR dates to remember... Stacie is a data analyst, and we don't let her out very often. This is actually a tool that was recently posted in the past few days on the data resource site. Go ahead and grab it, print it, post it on your bulletin board wherever it is that you sit if you're the ones abstracting. This will give you an idea of the dates of when everything is due. It'll help you keep track of when to expect that data to be shown in a report.

All right. Now, let's get to why you're really here today. It is to hear from our guest speakers. We're very pleased to mention with us today, we have Diane Arcilla. Diane is very nice to join us from New Jersey today. She's from the VNA of Somerset Hills. Then, I will introduce the rest as we progress.

Diane, I'm going to turn it over to you to share your experiences and lessons learned from this entire project.

Diane Arcilla: Thank you, Cindy. Thank you for having me. I am calling in from Northern New Jersey. I am the Director of Quality Care Management here at the VNA of Somerset Hills. I have staff education and QI in a couple of other areas that I work with. We started inputting information into the [HHCDR] in July of 2014. I have to say, I was very hesitant at first about doing it. I thought that it would be a lot of work.

After a number of discussions with Judy Miller, I wound up agreeing that we would start with the Aspirin area. I thought that would be the easiest for me to abstract from the computer. We do have electronic health records so it does make it easy for me to pull up med lists and to see the kind of care that the patients are getting. I did look at the Aspirin indicator for the first 6 months. What I learned when I was going through it was that in a lot of the patients, aspirin or an equivalent was not necessarily ordered. What I had decided to do about half way into it was to send out information to the staff. I felt that there was a need for them to hear about this Million Hearts® [initiative] and what was going on with cardiovascular health.

I summarized the best practice intervention package for them for the Cardiovascular Health Part 1. That dealt with the Aspirin as Appropriate and the Blood Pressure Control.

After sending that out to them, I did notice an increase in the number of patients that had had aspirin ordered or something of the equivalent. The nurses, they have responded well to that. Just in learning from this, I said that I would give out the information and then I'll come back to it again later on in a couple of months.

I moved on then to the Blood Pressure indicator. I've been doing that one now for the last 2 months. That now actually is a very easy one to extract from the record because you just go to the vital signs. It asks you about the last blood pressure that was taken on the date of discharge. That one has actually been a very easy one for me to do. We're doing well on that one so I may do it for another month to finish out the quarter. Then, I think I'm going to move onto the Smoking one.

I haven't gotten to the cholesterol one yet. I'm not sure that will be as easy to abstract from the medical record. I'm not sure how much of that information we have, but I think with the electronic health record, that is a question that we do ask. That should be something that's easy for me to pull out, also.

Cindy, I'm glad you went over about the Milestone 4 because that's where we're at. I was wondering about where we would go with that but I do have to just say that this was something that I was reluctant to do in the beginning. It has actually been a great learning experience for me on what it takes to prevent these million heart attacks and strokes. I think it's been great for the staff also. It's allowed them to become familiar with HHQI and the Best Practice Intervention Packages because we all see it in the office here but how much of that actually gets out to the staff and what are they aware of that's happening? It's opened my eyes to education that the staff has needed and also just areas that are just going to help us and the patients in general.

That's all I wanted to say for now unless people have questions. I guess I'll answer them as they come in or I'll hand it back to you, Cindy, or on to Emilie.

Cindy Sun: I'll take it just for a second but I want to thank you for that because sharing this information and I'll be honest with you, I work with agencies and many of you on the call, I'd probably worked with you throughout. I don't know who was where. I didn't realize, Diane, that you were at Milestone 4 so... Congratulations. That is a big deal. There are not that many agencies in the country that are at Milestone 4 as we speak so... yay! Kudos.

Yeah, with you or with anyone, as you start to have questions about Milestone 4 as we continue to progress through, just get in touch with us. We're happy to walk you through the process. I'm glad we're able to clear up some of that.

All right. Let's go ahead and onto our next speaker today. We have with us, from Hawaii, we have Emilie Smith. Emilie is coming to us from Castle Home and Personal Care in … Oh, I'm going to just mess it up. Kāneʻohe. I always mess it up, Emilie.

Emilie Smith: Not too bad. Kāneʻohe.

Cindy Sun: Okay. The rest of us, most of us on the call today are looking at closing down our day but Emilie has come into the office early to join us today live. Thank you. We'll turn it over to you.

Emilie Smith: Thank you very much. Castle Home Care is probably not as large of an agency as you just heard about, the VNA. It creates some different challenges when we decided to come on-board with this project because we don't a QA department on site here. In September of 2013, we actually separated out as a hospital-based agency and became part of Western Health Resources, corporate entity of Adventist Health that's based in Roseville, California. Our QA program is really corporate-based. We don't have a dedicated QA or PI staff locally. The implementation or development of these programs really relies on myself and the clinical manager.

We went into this with a little bit of hesitation in terms of how much time commitment this would be, but what we found is not as bad as we thought. To begin the program, we decided to take on the two areas that would be most easily abstracted. That's the Aspirin and the Blood Pressure that we'd have an electronic medical record as well. We thought we could get that information fairly easily.

The Cholesterol, that would have been a bigger challenge. We don't always have labs, as many of you know. That would be more time commitment for us to find that information. Then, Smoking, we thought that we'd have the least ability to make change in that particular area. We went with the Blood Pressure and Aspirin. It wasn't difficult to give those smaller agencies like ourselves. We'd admit about 125 patients a month, for those of you trying to get an idea. It took us, to do our 20 to 22 charts, we've only been on the program 2 months, by the way, about a half an hour. One of us read through the chart. The other of us read through the questions. We did this as a tag team so we're able to get the abstraction done within a half an hour.

As I've said, we've only been in the program 2 months so we just got our first report actually yesterday or the day before the first report came out. What we did find is a couple of interesting things. First of all, we misread the Aspirin question. We were excluding anticoagulants that we shouldn't have. Even with that, when I looked at our data for February, which was just posted, we still were in alignment.

Our compliance was the same as the total registry, even though we probably were better than that, given that we excluded a lot of patients that we shouldn't have. We should see a real big switch in our data as we move forward.

The second thing we noticed and we tried to track a little bit was the patients with the blood pressure treatment. Those who didn't seem to have a follow-up plan or recommendations within the plan of care for blood pressure, they appeared to be more rehab focused. We have a lot of rehab-only cases. We're going to have to take a closer look at that to see is that true and then, based on that, maybe make some changes, perhaps calling in more nursing into some of these cases that could have used that, the nurse for medication management or blood pressure management. That was just something we sensed as we were reading through the records.

When we started making note of that in the notes section of the chart reviews but at this point and time, we've not implemented any changes because as we said, we just got our data yesterday. We'll just move forward from here but it is not a hard process to go through. I'm looking forward to hopefully being able to make a change in our community. Cardiac disease is one of the highest readmission reasons in our community so I think we can make a change.

That's all I have for now.

Cindy Sun: Thanks, Emilie for that. I did not remember that you had problems with the question. I hope you didn't think I was talking about you. Those of you that are,

Emilie Smith: Oh, no.

Cindy Sun: … on the line, when I talked about misunderstanding the question. It's easily done, absolutely easily. Yeah, it's wonderful to know that you are still in the same level of compliance even though you misread the question. That's really interesting. It will be good to see how it is once you're including all those patients.

Emilie Smith: That's right.

Cindy Sun: Nice job!

Emilie Smith: Thank you.

Cindy Sun: All right. I've received a note from our next presenter, Joy Owens. Unfortunately, Joy had a family emergency and just got home from the hospital as we speak. If she joins us, that's fine but of course, we all understand how those things occur.

Some of the comments that Joy had made that I felt would contribute nicely to today's session. Joy has been in a particularly interesting situation in that they have only just started abstracting in the past month or so but what was interesting with her is she was able to see this entire process of the ABCS, the implementation of the cardiovascular care into the home health setting from a different perspective.

She is part of an ACO, an Accountable Care Organization. For the past, I don't know how many months, she's been working with the physicians on what is called the PQRS or the Physicians Reporting System. The Physician's Quality Reporting System is something that aligns directly. In fact, those are the measures that the HHQI measures are taken from directly. We call these HHQI measures because we adapted them ever-so slightly to the home health setting. As with copyrights, any time you change any text, you want to rename it, but the concrete information of the age of the patients that qualify for which of the ABCSs and which of the medications as Emilie was just mentioning, qualify in place of the aspirin, all of that information is exactly the same as what the physicians in the country are required to comply with. If they do not comply with it, they receive monetary penalty.

Now, that is not the case in home health. We have this luxury position. Ours is a voluntary process that the physicians – our upstream providers, our referral sources – are required or penalized to meet these exact same ABCS measures that we talk about here in the cardiovascular data registry.

Joy came into this as asking "This is exactly what I'm doing for the physician." That's how she stumbled onto the registry. She's able to see the alignment of it and how the physicians are responding in regards to the cardiovascular registry and the encouragement she's receiving to make sure that the agency is working as part of that.

One of our next questions is asking about ACOs. "Are you currently participating with an ACO?" The polling question is yes; or no, you're working on it; or no. Now, I know many of you have talked to us about being part of an ACO. We've heard phenomenal benefits of it but we've also heard some different varying of opinions. We'd like to hear that from you as well.

Of course, I am not very good in substituting for Joy. She has some great ideas and input. Like I said, if she does join us, we'll make sure to put her right on, but if not, hopefully we can invite her back and she'll agree to come back and talk to us at another time.

As everybody is completing this second polling question, I'm going to go ahead and let's move on to Misty Kevech, RN Project Coordinator. Misty's going to share some of the newer features in the educational aspect. As Misty is continuing on with this, go ahead and start submitting or continue submitting your questions in the Q&A box. As soon as Misty is finished, we will unmute the lines and start hearing. Let's have discussion and communication in regards to what our speakers are talking about today.

Misty, I'll turn it over to you.

Misty Kevech: Thanks so much, Cindy. Can you hear me?

Cindy Sun: Yes, we can!

Misty Kevech: Okay. Always afraid that my mute doesn't come off. Thank you. I was very fascinated by those presenters already. I think there was some really great points. I really want to come back to what Stacie started us with, too, about with your challenge of finding a tool.

I know you're finishing up a poll question but I'm going to throw out a chat question after we give you a little more time with your polling question, too.

I'm going to tell you about what's new. We have lots of cardiovascular materials, as Stacie mentioned earlier. Then, if you've participated on these calls, we talked about a lot of the different resources but as you're getting your data now, as you're really starting to dig and look at the several months or 6-months worth of data, you're starting to identify areas of need. That's when you go and look for the resources. It's not the other way around. "Cool resource, let's try it," and, "Oh, but let's see how it works with our data." You got to look at your data first, figure out what the area is.

The first thing I do want to let you know is as of beginning of May, our newest Focused BPIP, Cardiovascular Health for the At-Risk Populations. For the at-risk populations, we looked at race and ethnicity because certain groups, especially African-American and Hispanic populations are a little higher risk in a lot of different areas for cardiovascular health. We took a look at gender differences. We focused in on females, and we also looked at some transgender issues that affect, with some of the hormone therapy. We also took a look at higher risk regions, certain areas of the country. We know that the South and the Midwest are our highest regions. If you live in those areas, they tend to have a higher obesity, decreased activity and a higher rate of tobacco smoking usually and also health literacy which really goes across the whole gamut of our country.

We took a look, we wrote this package geared to the clinician but also the leadership. There are sections that you can pull some information out of there related to the cardiovascular including therapy, some tips and ways that you can integrate this into even home health aide and social worker aspects.

Okay, with that, we're going to move onto our next slide. We added new, which was new for this phase of our campaign. For you being cardiovascular, it's great because they're all focused on cardiovascular health. We have four video BPIPs that are up. They're about 8 minutes each. The first is, "Are you at risk for a heart attack or stroke?" That's a patient video. You're working on cardiovascular health, a really good tip here is to show this during a team meeting. It can be downloaded onto laptops, tablets and used in the home as an educational piece. It can be used to reinforce, to supplement the education that's already being provided by your nurses and your therapists. Very easy way for them to look at the risk factors, to identify that themselves as patients as “at-risk”. Great, great resource.

Then, we have the two lifestyle modifications, part 1 and 2. They're clinician driven but actually, you could really, for a higher literacy level, could even use some of the video pieces or a section of the video with patients, but really good talking about the general principles of the six lifestyle management modifications.

The newest one that came out the beginning of the month is the clinician video on race and ethnicity and really highlighting the ethnic factors. I gave you a real brief synopsis of a few of the areas but this is a way that you could again use at a team meeting or send out the link for your staff to watch and be able to have dialog and think about your populations that you serve and those that are a higher risk because if we can really reach our patients and emotionally tie them to the knowledge that they're at risk and we want to help reduce that risk, that's why the medication is to help bring your cholesterol down, that's why that aspirin is going to thin your blood enough to help reduce stroke or heart attacks.

This is three clinician videos and one patient video, but look forward to June because on June 1st, we will have three new videos that will be posted. I didn't have them up right away so I will let you know. I have to find my notes. Sorry. I'm just not locating my list here at all. It is ones related to diabetes and blood pressure medications and heart disease. I believe we have one on taking your own blood pressure. I can't remember what the third one is without having my list. I apologize for that but do look for those. They're coming out the first of June. They're all clinician videos. We have more coming in July and August.

Next slide, please. With HHQI University, it is free, it provides continuing education. If this is new to you, check it out. There is a link that's within the PowerPoint or just go to the Education tab on HHQI and there is a sub-tab that will

take you to the University information. It's free and free continuing education for nursing. The nursing CEs are approved through the ANCC that are accepted in almost every state so it's for nurses that need continuing ed for the re-certification, perfect. As well as it is a perfect way for you to share education to your clinicians without having to do training yourself.

With HHQI, we create and help find and provide you lots of tools and resources and ways to educate but the University was established so that we could help you one more step, to help roll out some of the education. You can see the topics that we have and the CE hours that are available there so you can pick and choose or just really refer it to self-enrollment. Yeah. They will need to enroll in both HHQI general campaign and here just because the resources are on the general campaign and can take the courses and get the free CEs immediately. They'll get a certificate. Therapists or social workers, they're still applicable. Some of your organizations will allow you to use certificates from another organization for some of your state credentialing or national credentialing. That really is individual. We are just providing the nursing CE specifically but a lot of times these certificates will work for some states.

That's what I have, Cindy. I can turn it right back to you.

Cindy Sun: Thanks, Misty. We appreciate that. Just one of the things we wanted to bring forward on these types of meetings and calls is to make sure that everyone is aware what is new in HHQI. One of the benefits of joining this particular sharing, learning action network is to be aware of what is going on in HHQI so that you can use it if it fits into your current QAPI plan or your current plan.

With that, Shanen, if it's all right, we'll go ahead and open up the line. First, take this as a warning. We're getting ready to unmute the line. If you are on the phone, please mute your own line and don't put us on hold, if you don't mind. We'll go ahead and start and open to see if there are any questions.

If we could, let's start with the Eastern part of the country. Anybody in the East have any comments or questions for our speakers today? All right. How about going with the Central and Western part of the country today? Oh, you guys are quiet. This is your day. This is your meeting.

We've had quite a few questions come in through the different chat feature in the Q&A. Those of you that are on the computer, we'll go ahead and read some of your questions. These are addressed to Diane. Give me one second. Okay. Diane, the first question is for you. "Have you had a good response from your local practitioners and physicians with getting aspirin ordered?"

Diane Arcilla: That is a very good question. The person who's had the most dealings with the practitioners is our telehealth nurse. How she has been choosing to handle it is she does a lot of coaching with the patients and educating the patients on it. We are starting to see more orders for the aspirin.

Specifically though then, can I speak to how the physicians are responding to it? I can't point to any particular physicians and say, "Oh, they've really gone on-board with this and now they're ordering the aspirin and they're looking at anybody who's high risk." It's happening more through the patients and educating them that way.

Cindy Sun: That sounds great.

Judy Miller: Can I ask a question? This is Judy. I just want to follow up on that question with Diane. Judy Miller, New Jersey. Are the physicians mostly cardiologists, Diane or family practice or a variety?

Diane Arcilla: It's really straight across the board. We have a lot of cardiologists that we deal with but we're also dealing with a lot of just family practitioners, internists. All different.

Judy Miller: Thanks.

Diane Arcilla: You're welcome. Hi, Judy, by the way.

Judy Miller: Hi, Diane.

Cindy Sun: Judy and Diane, this is your relationship. For those of you that are in the audience that aren't familiar, Judy Miller is from the QIN-QIO in New Jersey. Diane has been working with her as many of you on the call today are working with your QINs, that's the reason that they know each other. Just to understand the relationship.

Now, Judy and Diane have been working together for a number of years I know but the beauty of us and home health and health care, we are pretty small community and get to know each other pretty well.

All right. Thanks for that. The next question is for Emilie. It's basically the same question. "What kinds of responses have you had from the community in regards to asking for aspirin?"

Emilie Smith: As I said, we have just gotten our data so we haven't made any changes to our practice at this point and time so I don't have a sense for how successful staff are or aren't at this point and time. Just too premature yet.

Cindy Sun: That's totally understandable. Like to hear from the rest of you out there today. I would be interested to know if you are hearing positive or any push-back. I've heard from a few people independently who have been very surprised at the positive response, even though the patient wasn't supposed to be on aspirin, the fact that the home health agency reached out to the physician and asked for it, it brought a whole new light to the fact that the physician had an aha moment. It's like, "Oh, you're focusing on this as well?" That helps to strengthen not only the relationship and the bond between the agency and the physicians in the community, but it also let the physicians know some of the focus of where your agency is. Take credit for the work you're doing. Open that up for anyone that does have any input on that.

While we're doing that, the next question is coming in and asking Diane, "What type of clinical interactions are you finding for the blood pressure measure?"

Diane Arcilla: Clinical interactions? Do you mean … Oh, in the plans of care? What I'm looking in for the clinical plans of care, I'm looking at if they actually specifically have a goal set up for high blood pressure or for the cardiovascular disease and whether or not the patient is on medication and whether there's any interventions on teaching the patients about medications and taking the blood pressure medications and then looking at the blood pressure, that final blood pressure just to see, is it within normal limits?

Cindy Sun: That sounds like a really good plan. A good way to do an overview, and that's where I think most people are, is either just starting this process or are able to join that and understand where you're coming from.

I know it's a quiet group today out there, but are any of you in the audience working on blood pressure? If so, what are some of the findings that you have discovered? The phone line is open. Go ahead and feel free or you can put your comments in on the chat window.

Hearing some of you out there. Not sure if we're supposed to but while we're waiting for this, I'll go ahead and mention that some of what we see on the comments on the HHCDR side is that we're still seeing quite a few comments that in the comment section where you type it in after you've submitted your entry, finding that the patient is a therapy-only patients. That's coming in in the comments. Now, I'm not tying that back to what you're entering, but I will assume that if it's a therapy-only patient, the reason you're writing that in is possibly that the patient doesn't have blood pressure or hypertension was not addressed.

Remember, guys, even if the patient is therapy-only, they are coming in and … Well, they're not coming in. You're going to them but they are having an

interaction with the health care provider. Even if the patient is a therapy-only case, they should have blood pressures addressed and taken.

If that is something that is not going on in your agency, it's something you may want to consider looking into the rationale of why it's not being done and understanding that it is within the scope of practice and we have a couple of different resources from the experts, from the American Physical Therapy Association.

The APTA who has recorded a couple of different webinars for us. One was here on this call in April, last month. One was on the Underserved Populations webinar that was in January. They were very specific in how to assist agency leaders and how to help therapists understand what the scope of practice was. All the while, understanding that if a therapist has not or if anyone has not completed a skill, even though they were taught 10 to 15 years ago, if they have not accomplished or addressed that skill in 10 years, they're probably not going to be very proficient in it.

That's something else to keep in mind. Once you do make sure that your policy does include that blood pressures will be assessed by all disciplines, including therapists. If your therapists have not done this recently, that's something to make sure to work on some remediation and make sure that you're not asking them to do something they're not comfortable with.

It may take a little bit of a skill training and making sure it's part of your annual competency because as you know, 5 millimeters of mercury reduction in blood pressure has tremendous impact on the life expectancy and the quality of life and health of our patients. Even 5 millimeters, we want to make sure that our clinicians are accurately accessing that as well. Those tools and resources are available in the HHQI BPIP to help with whatever you may need. Just wanted to throw that out.

Diane Arcilla: Yes, Cindy. It's Diane. I just want to comment on that also. When I was first starting looking at the blood pressures, although they were always blood pressures because our clinicians, therapists and nurses do the blood pressures, I wasn't always finding a care plan if it was just physical therapy in there for blood pressure specifically.

That is something that we stopped and we looked at with the staff. I know this is come up in the past also as far as, is our medications and teaching of medications side effects in their scope of practice? As you said, some of them are just not familiar or they haven't done it in a while and they're not comfortable with it. We did have a speech therapist who we had to go over with him, how do you take a

blood pressure because some people haven't done it, like you said, in a really long time but it is in their scope of practice.

Cindy Sun: It is. I think some of this situation does … Again, I have this great physician where I get to speak to agencies all over the country. I know that across the board, I talk to agencies who either are contracting out the therapy visits. They're having to go through a therapy contracting agency and requiring that agency to require the therapist to take blood pressures. All of this was addressed by Ken Miller and Bud Langham on those previous webinars. I'm just mentioning that for those of you who are out there that if you are in that situation and you are stuck because you have to think about what kind of quality of care is that patient receiving if they're not even getting a simple blood pressure check. Especially, if they're receiving physical therapy because of the implications on the body when the patient is receiving therapy, how can you tell if they're getting ready to go down on you if they're getting ready to pass out, if you're not taking the blood pressure, especially the recent post-op patients.

It's great that you identify that, Diane, and were able to see that it was a need. You're way ahead of the game but again we should have expected that. You've got 6 months of data in here, okay?

Okay. There's a couple more questions coming in. One is about asking if it's too late to join the registry. That answer is absolutely not. It is never too late to join the registry. Episodes of care dating back to discharges in July of 2014 are available and waiting for each of you if you are a CMS-reporting agency. Please feel free to join in at any point and time. If you have any questions, definitely let us know.

There is an HHCDR overview webinar that we want to encourage you to view, knowing that 37 minutes is a long time in home health and that's the length of the webinar, but that's where the data definitions are reviewed. We've heard from many agencies. They've watched it multiple times to get all the information. We want to encourage you to do that.

Now, we have another question that is come in. Emilie, I think this is for you. "Great point about rehab only patients." The question is, "Do your therapists review their own medications or use the nurses for the med review?"

Emilie Smith: Oh! See, right now, there're the nurses. We do not have nurses reviewing all their meds at this point in time but that has come up as a point of discussion here as to whether or not there should be more nursing involvement. It becomes a resource issue primarily but at this point, they're doing their own review.

The other piece we'd like to take a look at along with this blood pressure, with its noted that the rehab staff, those patients seem to be the ones that wasn't addressed and their plan of care is whether or not if it wasn't addressed, whether the blood pressure was in normal limits or not. We didn't try to look at that connection but I think we will moving forward was the blood pressure normal or not normal and it wasn't because that's another issue then, if education wasn't provided.

Cindy Sun: Oh, yeah. Definitely. You also mentioned in talking about why you selected blood pressure based on your patient population.

Emilie Smith: I think there's a high incidence of cardiovascular disease in our community. Blood pressure is just an easy one to measure. I think an easier one in home health to take action on as is the aspirin. Those two seem to be the easiest ones to have, I guess, the biggest bang for the buck for the time we had to commit. We could probably do the most work on those particular areas.

Cindy Sun: What about smoking?

Emilie Smith: I didn't feel like smoking, we could make a big impact, quite honestly. I really had a sense that in Hawaii, there's a real big effort for anti-smoking. There's a lot of bans on where you can smoke. I felt that that we could have probably less of an impact on that in the long run given our short stays and doing the other two.

Cindy Sun: That's what I found really interesting when you mentioned that. It's really, each of us knowing what are the needs in our community. Only you at the agencies know this. You can decide, do you have more patients with hypertension. If so, address the blood pressure first, or do you have the more of the cardiovascular wound non-healing arterial disorders? If that's the case, aspirin and cholesterol. Of course, smoking goes across the board but if you are such as Emilie is in Hawaii and don't have that level of need for … Not that smoking is not important but just as you were saying, the biggest bang for your buck. It's common sense to go ahead and go with what areas do focus best in your community. Want to encourage you to reach out to your communities and to decide from there.

That will tell you, for those of you who are new to the registry, most people find aspirin and/or smoking to be the easiest measures. If you're starting out and you're a little apprehensive which I think everybody would be. I know I certainly would be, choose one of those two. Then, depending on the navigation of the easiness of the navigation of your system and your EHR, blood pressure is not too difficult to do either.

Thanks for bringing that out.

Misty Kevech: Cindy, this is Misty. I'd like to throw in, too. I think taking a look at that Cardiovascular At-Risk Population Focused BPIP that just came out. If you're going to start looking at some of those populations that Emilie just talked about, the good place we break it down by each of the measures, by different racial and ethnic groups. You're absolutely right. Smoking is not a problem that's usually seen in the Asian and the Hawaiian populations. You would not get the biggest bang for your buck, but in retrospect, then, and for the American Indian population. Also, in certain parts with the African-American populations, that may be a bigger or way for you to make the biggest impact. If you have a higher percentage. Again, looking at your makeup of your data report to see your patients that are at risk. That's all. Thank you.

Cindy Sun: No. Thank you!

All right, guys. We're going to open the lines 1 more time for final questions from everyone. Does anybody have any final questions for your speakers today? All right. Hearing none, we're going to go around and ask for final thoughts. Let's start with Stacie, our health data analyst. Stacie, do you have any final thoughts for the day before we close?

Stacie Deslich: Basically, I just want to reiterate my challenge to go ahead and start looking. I feel like some agencies only have one or two months abstracted. That's no problem. Just wait until you have enough data where you can start to see some trends and start to take a look at how things are going.

Definitely, I want to reiterate that if you haven't started, it's not too late. Never think that it's too late and never think that it's something that you can't do. We're here to help you. We have a whole team, each of us has our different parts, so whatever part you might be struggling with, we're happy to help. There are other agencies involved here on this webinar who are happy to interact and help each other. Definitely just give it a go and see what happens. That's all I have.

Cindy Sun: Thank you. We do like your challenges every month.

How about Misty Kevech? Final thoughts?

Misty Kevech: I do and I'm going to piggy-back right off of Stacie. As you look at your challenge and you now have to think about a tool or resource, as Stacie said, you have resources. You have your QINs to reach out to. You have us to reach out to. Let's help find you a couple tools that might serve you well for that area of where your data shows a need. Let us help you pick out a few things and then you determine what's valuable, modify it to meet your population. That's it.

Cindy Sun: Thank you. We'll go to Emilie in Hawaii. Final thoughts?

Emilie Smith: I just want to say make use of your resources. I think that's a good point. We are in this project that the encouragement of our QIO, Mark Marabella at Mountain Pacific Health and Maggie Okey. I really appreciate their help and support. That's really been the driver for us to get this going. Actually, we didn't put in a whole lot of time yet, yet we're already seeing where we have opportunity. I think it's worth the time.

Cindy Sun: Thank you for that.

Diane, wrap us up today, out of Jersey.

Diane Arcilla: Out of Jersey! I would say that if you're reluctant to start, you should just really give it a try. I was reluctant in the beginning. I have found it to be a great learning experience. If you want to try when you don't need to do all four, just pick one. Pick the aspirin or pick the blood pressure. They really are the easiest ones to do. It is not time-consuming. It is really beneficial in the end.

Cindy Sun: Thanks for you guys for sharing that with us today. We really appreciate you joining us.

Just a few updates on HHQI, just to let you know the current count. As of this morning, we are closing in on 13,000 participants. The question is, who's going to make that 13,000 cross over that line? We have 12,920 representing 5,265 home health agencies.

We do want to mention the May 2015 Agency of the Month is the Visiting Nurse Service of Northeastern New York. If you're not familiar with the Agency of the Month, that is an award that is given to any agency randomly selected from those who are currently at either the 20th percentile in ACH or better or at the 80th percentile or better in oral med. There's a short little form to fill out to be included in the drawing that's located on the front page of the HHQI website. Down at the center you can just click on the Agency of the Month logo. It will take you into the questionnaire.

We do want to remind you on June 11th is the next HHQI LiveChat. For those of you in the Illinois area, all surrounding states, the next HHQI free hands-on workshop will be on July 17th. Please register that as a space-limited area. We will be closing that when we cap out so register early if you are in that area. We look forward to seeing you then.

Our next CardioLAN meeting or webinar as we are in here today will be on June 18th from 2:00 to 3:00 Eastern. You will receive your invitation on June 17th, the day before and just as you did today. It might be the morning of but it's usually the day before. We want to encourage everybody if you're not already, if you're listening in on someone else's invitation, you're welcome but at the same time, we want you to have your own. Please make sure to register for the CardioLAN so you'll receive your own invitation each month.

With that, again, please allow me the opportunity to say thank you so much to our guest presenters today. We really welcome the opportunity to share with you your peers that are going through this process so that we want this session to be available to where you can learn from each other and share experiences just like Diane and Emilie did here today. With that in mind, all of us from HHQI would like to say to all of you, "Thank you and have a wonderful afternoon." Bye-bye.

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