STRATEGIES TO CARE FOR PATIENTS IN RURAL SETTINGS

Misty Kevech: Welcome, everyone to the Quarterly Underserved Population Network Webinar today. Today's title is Strategies to Care for Patients in Rural Settings. I'm Misty Kevech, CRN Project Coordinator for HHQI. We also have other members of the HHQI team on the call today. We have Shanen Wright, our director; Cindy Sun, who is also an RN Project Coordinator; and Misty Dyke and Andrea Lefkay, our communication team. So, a few housekeeping measures so we can begin the presentation. The slides are posted on HHQI's website. And you can find those in the chat box. Misty Dike will post that for you. And also, if you need to locate your chat box, because we're going to actively use it today. Go to the top right corner, and you'll see "participants" and "chat," and a Q&A. So you're going to use both the chat and Q&A today.

So open up your chat box. You're going to be able to type into the box there. You now can see the link where the slides are located. You can download those. The Q&A, when you do put in questions, we ask for you to put them in as they come to you throughout the presentation. When you're typing into chat, use "All Participants" so that we can see all of your chat. Everyone can see your ideas. That's "All Participants." And then in the Q&A, we'll be collecting those, and we'll address those in the Q&A section. Alright, great. All the phone lines are muted, because we'll have too many people on the line. But we are, like I said, going to use chat and the Q&A today.

So we're very excited. We've been actually planning this webinar for over a year for you. We know that there are a lot of barriers and issues in rural settings. I'll introduce you to our wonderful speakers in just a few minutes.

Today's presentation offers 1.25 hours of Continuing Education credits in our HHQI University for nurses. And I'll talk about that towards the end, more specifics. You need to watch this live, or if you're doing this as a recorded webinar, that's absolutely fine. You'll need to complete the last fifteen minutes of work, which is some reflective questions and evaluation in the University. I'll show you that information later. The CEs have been approved by the Alabama State Nurses Association, which is credentialed through the ANCC. If you have any questions whatsoever, contact us at our mailbox, which is HHQI@QualityInsights.org. And that will also be up on the last slide for you.

So, today I wanted to give you an agenda because we have a lot going on. I'm going to go over a few rural health facts to get us started. We're going to do some polling questions. We're going to have our expert speakers addressing several key barriers with some intervention strategies that they have done. And we really hope that you might suggest more, put those into chat, other things that you've done. Because we learn from each other. We'll do another chat question and some case scenarios. And then we'll provide you some great resources at the end, and the information about the CEs.

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So let's get started with some national factors. 15% of the US population live in a rural area, and most states have some type of a rural area. The people that live in rural areas tend to die from heart disease, cancer, unintentional injury, especially with car accidents and tractors and things like that for the more younger population. But also with chronic lower respiratory disease than our counterparts in the urban settings. Rural residents tend to be older and sicker than the urban counterparts. An interesting study that was just done not too long ago shows that the life expectancy gap is increasing between the rural and the metropolitan areas. So there's even been a recent study that looked at Appalachia and there's been a significant decline in the life expectancy for those that live in the Appalachia area.

Some rural risk for poor outcomes. If you're on this call, you know you live by a lot of this. Travel distance to the specialty and emergency care is more extensive. There is exposure to specific environmental hazards. There is a higher cigarette smoking rate, and we've covered that in our best practices package related to smoking. High blood pressure, obesity, there's less leisure time physical activities. It's more doing work on the farm, the garden, whatever, so there's less leisure time activity. Or less income to do those. Less use of seat belts. As well as higher rates of poverty and less access to health care and insurance.

So our first polling question, and Misty is going to be putting that up, and it should pop up for you to answer. What are the top two? So select two out of the category, of barriers that your agency tends to encounter. So select two. We'll see what everybody has to say. It takes a minute here.

Okay, great. As we wait for that to pop up, to give me the results, I'm going to go ahead and introduce you to our two speakers. We're very fortunate today to have Renee Grisham. She's the executive director of Mississippi HomeCare of Eupora. She has thirty two years of experience, including home care, hospice, hospitals, clinics, and other management positions in various health settings. Diana Lecher is the director of the Home Health and Hospice at Chadron Community Health Hospital for the past eighteen years. She is also the director of the cardiac rehab department, and the wellness coordinator at Chadron Community Hospital, which is also a critical access hospital in the northwest corner of Nebraska. So, I'm waiting to see if we have our polling results, so just coming in.

We're pretty much all over the place, but staffing is the big issue, as well as limited community resources tended to be the higher picks. As well as travel and transportation. We're going to cover some of those today. But, if you have some good ideas, or some problems we can also chat as we go along. So the first part we're going to take a look at is insufficient reimbursement. And Renee's going to be covering that topic for us because she's been dealing with it and has come up with some unique ideas. So Renee, I'm going to turn it right over to you.

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Renee Grisham: Okay, thank you Misty. Good afternoon everyone. Okay. So I'm the director of Mississippi HomeCare Eupora. This map shows our service areas. It's a fifteen county service area in north and mid-Mississippi, which is for the most part rural. The largest town in our area is Columbus, and it has a population of about thirty thousand. So, all of our other six offices in the area are of course much smaller. And nurse practitioners are probably some of our biggest health care providers in this area.

What we have run into most recently, is insufficient reimbursement with the biggest one being Medicare HMOs. They have gotten very popular in our area because they offer lower premiums than the traditional Medicare. But they pay home health on per visit, and not episodic. They also only want to approve thirty days at a time, and the average approved visit per sixty days is only fifteen. They will approve more if someone has, say, a wound vac or IV antibiotics. But, they're very stingy, I'll say, with their approval of visits.

These HMOs also really widespread market to the elderly, and I say the uninformed because a lot of times, when we get a referral for someone that we think has Medicare and then when we run it, they're on an HMO. And they don't even know it. They thought they were signing up for a drug card, or something to help them pay their premiums. And then if they don't have Medicaid or a gap insurance because of the cost of the premiums, they can't afford to go back to traditional Medicare.

And then in Mississippi, and I don't know if this is across the base or not, our Mississippi Medicaid has gone to an HMO model. And they use two specific plans in our region. A lot of these don't even include home health benefits. And, people who get put on Medicaid, especially babies and children, and pregnant women, they don't even have a choice. They're automatically just put on these HMOs. Very few of them will have home health benefits, but the majority of them don't. And if they don't, it's at the very state minimal for Medicaid reimbursement, and often, that is just denied. Also, if they do have home health benefits, it only covers a nurse and an aid. It won't cover any therapy. And then, it's also limited on the number of visits they will let you have.

Another big thing we run into with the Medicare HMOs, and I verified this the other day. If someone gets physical therapy, and we of course have to send our notes into them very routinely. Once it's documented that a patient can ambulate a hundred feet, they deny any further therapy visits. So, documentation of medical necessity has really been a focus of ours with the therapist getting them to understand that we need to add in, if they can ambulate a hundred feet, with what effort, how much assistance, et cetera. Because they will deny it without... you could even send it through a medical peer review, and sometimes it still gets denied.

So, what my company, HLC Group, some of the strategy that we've done for this is work very hard, continuously working to be in-network providers with the specific HMOs that most clients in our service area select. And then, for some other HMOs that have a really high denial rate, if we're in network, we will admit them for one episode. Because we

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know we're safe with that. But, if the patient needs to be recertified, then we have to get that approved by our State Director after the medical necessity has been reviewed. That has helped with decreasing denial. Because if we review it, say we don't have the documentation there, that gives us the chance to look into it further, document further before we set them up for recertification.

And then, like I mentioned, providing education to our field clinicians on what constitutes the denials, and what documentation is needed to show necessity of the services. We have seen a decrease in denials as we focus more on educating field clinicians.

That's all me.

Misty Kevech: That's great. That's wonderful.

Okay, so if we could turn to the next slide, please. I think, Diana, you have control. Thank you. That was wonderful. So I hope, if you had some similar problems with reimbursement, that you can kind of see how they've been working around and continue to decrease the amount of denials that they've been getting. And increasing their documentation. Hopefully you gathered a couple of good tidbits there. We're going to move into geographical distances, and we're going to be listening to Diana present on those areas. So, go ahead Diana.

Diana Lecher: Hello, and thank you for inviting me. So I'm going to talk about geographical distance. And that goes without saying. Here is where I live. And we call this the panhandle of Nebraska. I'm just maybe thirty miles from South Dakota, and my service area is about twenty miles from Wyoming. It only takes about two and a half hours to get down to Colorado. A little trouble with the slide, there we go. To give you a visual, we're up here, but our service area... because we're kind of out in the land where, in most of our area, there are more cows than there are people. We go along this Highway 20, this red line. You can see above us, we've got the Pineridge Reservation. So we can go up to the border and we can go down south about thirty, fifty miles. And then we go a little bit past our east and our west side. That'll give you kind of a perspective of how we deal with this mileage.

Now, of course, you can't talk about mileage without talking about the cost of travel. I think I've heard that home health providers drive more miles than the post office. That is because the post office can just go whenever they want. We can't go during the Price is Right and all those kinds of things. What we've done is we've decided to purchase vehicles. That has been cheaper for us than paying mileage to our employees. We had a little kickback at first by a few nurses because that mileage check paid for their car. But in the end, our fast action has greatly increased that the nurses are not having flat tires on their cars, they're not putting hard county road miles on their vehicles. So that fleet has saved us some money.

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Now you might think when I talk about RN and LPN that I'm going to say we lean to an LPN. But we have found it is more cost effective to use the RN. The RN, if I used an LPN to travel 30, 40, 50, 60 miles. One of those two patients probably needs to have a home health aide supervisory visit, or a recert, or a discharge, admit, a resumption of care. We've found that the RN gave us more bang for our buck, and they could do more of the cares that were necessary. We do utilize an LPN, but we utilize the LPN right here in our town of Chadron, because the LPN doesn't have to drive far and she can fill in for little things. And it was ruining our continuity of care when the RN had to take the LPN visits.

I also was lucky enough to find an RN on my west side, and an RN on the east side of our area. So they're located over there, and it can save them miles. They both have a car parked in that town, so they can primary with those patients, and not have to travel. And good job satisfaction for them, because they don't have to drive 60 miles to work every day.

PT and PTA is conversely different than RN/LPN, oddly. My PT and my PTA work in collaboration with the inpatient at our critical access hospital. So they can plan the schedule, looking at the home health patients that might need an eval visit, or some other things that a PT requires. They can kind of bounce back and forth and still get good continuity of care. The PTA certainly has saved us money in our salaries.

Back to the east and west, I do have store rooms. One is in a rural health clinic, and one is just in a little back end of a building. I rented a room, it's not a branch office, there's no private health information there. It's simply a place where the nurse can stop, they can chart, they can pick up supplies. Just a nice little parking place, and really a store room. Another one was, we were using the medicines from our hospital and driving them was getting to be problematic. So certainly switching to a PDM with our hospice, that allowed us to use the local pharmacies so we didn't have to drive those.

Communication is probably the biggest issue when you start talking about all of these miles. What we do is send out what we call the daily. On the daily, every morning you can check, and we send it out at night right before we leave. There's a schedule on there, so you can understand the med A, or the acute home health patients that are seeing multi disciplines. We put out when the therapist is going, when the aid is going, when the RN's going, the OT. So that we can have some good continuity and not all showing up on the same day.

A patient isn't a patient. They're not all equal in their needs, and we do home health and hospice. So we ask the nurses to all chime in, and they tell us if they're a green the whole week. I'm a green on Wednesday, I'm a red on Tuesday. Thursday, I'm orange. So that just says, green, I can help somebody. Orange, I'm doing okay, but red, can you send me some help? It was a nice way to kind of visually see what each were doing. It has all our admits, so you can see what admissions are coming up, and it has our discharges so you can understand when people really were discharged.

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Hospitalizations are on there. Hospice deaths are on there. And then of course we went ahead and put on there any overdue documentation. If something's getting late, they see that. So first thing in the morning, they log in, they'll see that information.

And of course, you can't talk about communication without the EMR. We do a conference call, which sounds easy, but it was a lot of work to get a good phone. Everyone calls in on Thursday mornings and talks about those Medicare home health patients. It only takes maybe fifteen to thirty minutes, depending on whatever. Secure texting is good. The big thing is, we have to tell our referral sources, because they don't understand that, yes we'll take the patient that is sixty or seventy miles away from our office. But they have to be a safe patient to live sixty or seventy miles from our office. Are they capable? Do they have good caregivers? And make sure we set up the expectation that we're not going to be there every day, because they live so far.

I think that's it.

Misty Kevech: Wonderful. Great tips. I hope everyone's getting excited, because we keep hearing both from Renee and Diana, some good tips as we continue to go forward.

We're going to next take a poll, not a poll but a chat activity. So find that chat box. If you don't have it open, look at the top right, look for the little chat icon and click it open. Click "Send to All Participants" so we can all see that. Perfect. And here's the question. What strategies has your organization found successful with addressing the two barriers? We only covered the two barriers to start with. Insufficient reimbursement or geographic distances, either staff or patient. Go ahead and type them in. We want to hear from you to see if you have some other ideas to share. We'll start putting those into the chat box. That will be "Send to All Participants." Right underneath that, you can type right in that box. I think I'm hearing some really great and unique ideas. I know many of you on this call have those ideas too.

Misty, make sure that if I'm missing anything, please let me know too, Misty Dyke.

Speaker 4: I've not seen anything come in the chat box so far. Let me check settings and make sure that's right.

Misty Kevech: So just type in "Hi" just to make sure that the chat box is working and you know where it's located. Get it started. It's one of those things. I've warned you at the beginning this is going to be interactive, so you have to work a little bit. Alright. Maybe go ahead and type them in as you think about them. But we're going to go ahead and move on, because we have some more great topics. You can always type in some things that you're doing as we progress.

The next topic that we're going to cover is disease management. With disease management, it can be a barrier, especially in rural health. I'm going to make sure that I

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get the slides back to Renee. There we go. I'm going to go ahead and turn it over, and we'll start with disease management, Renee.

Renee Grisham: Thank you, Misty.

So, as we said earlier, rural health has a very high rate of diabetes, heart failure, diabetic ulcers, hypertension, COPD, pneumonia, I should have added those. I know that's common to all rural areas.

Some of the strategies that our home health has undertaken to keep their hospitalization rate down, and to provide better health for the patient, is that we do what's called front loading. All new patients, at start of care, or a ROC, or any time there's a big change in their condition, we front load visits. What that is, is seven contacts by the staff in the first seven days. That can be visits, calls, it's usually a combination of say a visit every other day with a phone call on the opposite days. And this may extend to two weeks. We especially took this up in the Columbus office a couple years ago when the hospital had a high rehospitalization rate for pneumonia. We initiated daily visits for seven days on all pneumonia patients. Because, as we know, the elderly can relapse very quickly, and if they don't get their medicine, they can relapse. We saw a drastic reduction in rehospitalization. So, we don't always do the daily visits, but we do the front loading, and that's just a standard.

We also have telehealth for disease specific populations. Telehealth may not be the right word for it. We have a calling center that, for patients with hypertension, COPD, MI, diabetes, and pneumonia, we set them up for phone calls not only from our staff but from the central location which follows a script. They call the patient two to three times a week the first two weeks, then once a week. If anything in that phone call comes out that we need to know, they send an email to that office, and if it's serious, they follow it up with a phone call. That lets us know we need to call that patient or send the nurse out and check on them. No matter how many times you tell the patients to call us first, they don't.

And then, we also developed some disease specific specialist tools, is what that should have said, on diabetes and wound care. Plus we do have a wound care specialist. Not in my provider, but in the one next to the same country. And we do have some diabetic educators that we can contact by email for advice.

We do focus on teaching and assisting our patients with their chronic disease. Our goal is to help them self-manage their illness. One way we do that is we will provide them with scales and automatic blood pressure cuffs if they need one. We keep scales in our cars when we go out, we make sure every CHS patient has scales. We can even, on the rare occasion, order talking scales and the oversized scales. And we also will pay for, and order, an automatic blood pressure cuff so they can check their blood pressure daily or however often they need it. We use patient education materials, and we provide medication bags.

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This is an example of one of our educational materials. We have these on heart failure, COPD, diabetes, pneumonia, hypertension. The field clinicians keep these in their car. We educate the patients on the green, yellow, red. If you're having these symptoms, you're in the green. If you're having these symptoms, you're in yellow. Of course, if you're having these, you definitely need to be calling us. And we encourage them to put these on their refrigerator. We review them every time we go out. We're like, "where are you today." And we've seen this definitely helps the patient with understanding when they need to seek help or when they might need to just call somebody. Or go to the emergency room.

We also have what we call our healthcare journals. In this journal is an emergency contact list, a page for us to write their current medications. A log for their vital signs. A log for food. Other educational information. These are given to them on admission. The admitting nurse fills out their emergency contact list, their medication list. Every clinician enters their vital signs, makes updates to their list. We also encourage our patients to take these to the doctor visits with them, so the doctor can see what their weight's been doing, what their blood sugar has been doing.

We also provide medication bags. We all know patients love to keep all their medicine in their Walmart bags. We encourage them to keep their current medicines in this. They should check medications every visit. We get them in the habit of keeping their medications in this, so that when they do go to the emergency department or to the doctor, they have all of their medicines right there, handy, and hopefully the current ones. And not some they've drug out of somewhere. We try to keep them just taking the ones they're supposed to, of course.

And that's some of our strategies that we've used. It's a struggle in the rural area, as you know. We have seen some progress using these strategies. Of course, I'm welcome to any other suggestions anyone has.

Misty Kevech: Wonderful, thank you so much Renee. I think those were great ideas. They really follow the evidence using the self-management tools. Getting med management. Really trying to get accurate medications. The bag technique, taking things into the ED or the physician office is also an evidence based strategy. Yours is a beautiful strategy. And it also promotes what organization they're already with. I think that's a great idea with your medication bag.

If you have questions for Renee, go ahead and put those also into our Q&A box. Or, I hear the chat is very, very active. We thank you guys for putting it in. Unfortunately, we're not able to see it on our end as the presenters. So if you're going to put anything into chat, could you put that for All Participants, and that way, we can also see what you're asking. If you've asked a question, please either repost that, or put that in the Q&A. I apologize. I probably said that wrong in the beginning a couple times. We'll continue to look for your chat questions and ideas that you're doing. What are you doing with disease management? Renee said they are accessing some specialists. They

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have wound specialists, and I believe a diabetic specialist. Those are very important. Hard to come by, perhaps, but sometimes worth the investment. That might be some dial up you want to hear from Renee in the Q&A section as well.

Alright. Diana, if you'll change the slide to the next slide for me. The next area we're going to go into, I know everybody has this problem. Inadequate care transitions. You don't get enough information, or the right information. Diana's going to tell us a little bit about what they find, and what they're doing about it.

Diana Lecher: Okay. Thanks again.

You know, I think first, I want to talk about the why this is my passion. I think if I have mostly home care providers on, this will be a little repetitive. I started my career as a nurse in the hospital, in a critical access hospital. I thought I did a really good job of educating them. The pharmacist comes out and talks to them. And we send them home. But we have a different perspective, don't we, in home health. They're really arriving home pretty unprepared for whatever reason. Certainly, med reconciliation.

The first thing you learn when you start home health is that nobody, nobody is taking their meds right. And with DME, I don't think the hospitals can always predict what's going to work in that home. I had a referral on a weekend. I saw the patient, I was getting ready to leave, and there was a little oxygen E tank. Green tank, over in the corner. And I said, "well, what's this about?" And she didn't know, and there was nothing on the referral source about oxygen. And the patient was transferring from Colorado using a national company who forgot to notify the Nebraska branch. Nobody had told us about the oxygen this poor lady had come home on. We just see things that not everybody does.

Certainly, discharge instructions. Hospitals, I think they do a very good job, but when we get into home health, we realize that it's more complicated than that. Compliance is a problem. I'm sure you guys have all had your examples, but I think my favorite one that helped me understand this problem. My husband is a college educated gentleman, and he went for minor outpatient knee surgery, and the nurse did a wonderful job of explaining signs and symptoms and pain pills and avoidance of constipation. And she left, and he turned around and looked at me and he said, "I assume you got all that." So it really speaks to the value of teach back and what we need to do.

So, I have this perspective and this passion to make things better. We decided with that perspective and with home health agencies getting such poor referral information, that is our story. It as a side note to say that I think that the rural agencies, it's much worse. We don't have liaisons in Denver and in Rapid City and Scottsbluff and Lincoln and Omaha. We can't put a liaison at those hospitals. A lot of our referrals are coming from at least two to five to seven hours away when they have a big procedure. It's hard to get the paperwork we want. So, all of these stories and these situations where we've been surprised. We thought we just had an IV patient but we also wound up having a wound

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care patient. Or we had a patient that we didn't realize had a new colostomy. I mean, those stories are very real.

We decided to start a group called Transitions of Care along that Highway 20. You remember that visual, the red line of us along Highway 20. And, what we decided to do is to involve many groups. Excuse me, I got behind on my slides. And on this team then was the hospital, so the hospital's DON, the hospital's assistant DON, a pharmacy person, a pharmacist. A discharge planner, which is a social worker. Physical therapist, occupational therapist, a quality manager, myself, the home health director and hospice. A diabetic educator, and a physician assistant from our local clinic participated. We went to all the facilities along that Highway 20. They all have an administrator, they all have a DON, and they all have social services. We asked them to join us for this group with the goal of improving our transitions.

There we go. So, there is Chadron, and we're in the center. Only population 5,700. That might be when college is in session. And then we've got our little populations off to the left and the right. So we're dealing here with three nursing homes, three assisted livings, one critical access hospital, and of course the home health and the hospice.

So, we had our group. It went very well. We met quarterly for a couple of years and worked on little projects together, which we thought were very effective. I went to the Nebraska Home Care Association's meeting. And there at the booth, for the Great Plains Quality Innovation Network, was Paula Sitzman, who had helped me with various projects through the years. And so, I told her about our group and what we were doing with transitions. And she said, why don't you try some exchange visits? I said, I didn't really feel up to the task. So good old Paula, and Tammy Baumann came out to Chadron. Drove over seven hours out here to stay with our group to do exchange visits. And I think, what I want you to really notice on this slide, is that staff are both senders and receivers. And I'll come back to that.

So when you're talking about an exchange visit, I in home health then would, in theory, would explain what our process is for home health. How do we communicate with referrals? I would be telling the other people in the group. How we communicate with referrals, what we need for the transition of care, what kind of information we receive, and how we're trying to understand what happened when they were in the hospital, or the nursing home, or the clinic. We all know that just sending a written note does not always give you a full picture. We told them in our exchange visits about med reconciliation, how hard it was, and were meds really refilled, and what meds were actually in the home. We often weren't aware of the education that the hospital had or had not given them. And, we discussed our processes with when they go to doctor's appointments or other places.

So out comes Paula, day one. I get the group, everybody wants to come. I'm pleasantly surprised. Everyone along the highway wanted to come to this two day event. The first morning was very good. Paula Sitzman and Tammy Baumann were there in the morning.

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And they provided all of this. They talked to us about care coordination, best practices with meds they see, patient family engagement ideas. They talked about starting a community charter. They talked about why we needed to communicate, best communication techniques, they gave us these wonderful tools from INTERACT. INTERACT 2, now I think it's called. They have interact tools for home health, interact tools for nursing homes, interact tools for assisted livings. Talked about med reconciliation, health literacy, and then this PAM tool.

We spent the whole morning in this mini in-service. And then we split groups. And so, half of the group went up to listen to the hospital and go through all of their processes with transitions. Half of the group came down to our home health agency, and listened to what we do. What's important, what's hard, what works well, what we need. And then, they flipped, and that group went upstairs and we came down.

Then, the next morning, the hospital went back out. The hospital went to the west, and the home health went to the east, and we went to the nursing homes and the assisted livings. And they told us their processes, walked us around the facilities. For the hospitals, the first time they've been in any of these facilities too. Walked around, learned from each other about what was easy, what was hard, what worked.

And here's the "aha" moment. We knew the most valuable item for us when we receive a patient from the hospital is a discharge summary. But the problem is, we can't get a discharge summary when a patient goes from a nursing home to home health. And, vice versa. If the home health needs to move a patient back to a facility, or to a higher level of care. The nurse from the nursing home said, well, you know, I write a summary of stay about what happened here in their Med A stay. I said, could I have it? And she said, sure. And then I thought about our discharge summaries that we do for patients. You don't necessarily need to give a patient a discharge summary if they're going into a facility, but wouldn't it be helpful for that facility to get a discharge summary from us that would speak to the problems we had at home, and why this didn't work at home, and why they need to go to the nursing home. We would all be so much better informed.

And, I think we wouldn't want to miss, I really enjoyed this. It's what they gave us, Paula and Tammy. The answers, as we came together to learn from each other and to share and hear what's hard for us, and what works well. The answers were in the room. We all come from a different place, and we respected all voices. Everyone has a bright idea. Work together to identify challenges, and focus on the solutions, with input, discussion, and decisions as a group. Leave with a sense of accomplishment and purpose, and acknowledge the difference you're making in your patients' and residents' lives.

And here we are. This was a slow day, but this was our group here along Highway 20. I'd welcome any questions. Thank you.

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Misty Kevech: Wonderful. Thank you so much, Diana. If you have questions for either Renee or Diana, or things that you'd just like to bring up, perhaps. It's not something that we've covered today. We might be able to entertain it. Put that into the Q&A, or into the chat. But make sure that the chat goes to all participants so that we're able to see that.

Alright, while we're waiting for your Q&A, we're going to do another chat activity. Go ahead and find your chat box. Do the "Send to All Participants." Here's a scenario.

The patient was discharged from the hospital with exacerbated heart failure after a ten pound weight gain and inappropriately taking diuretic. The patient is still weak, a little unsteady on their feet, so nursing, PT, and OT are ordered. He lives with his elderly wife about sixty miles from the office. What strategies could you do, at your organization or any organization, to reduce the clinician's travel time? Let's take a look at that travel time. We heard some suggestions before, but let's see what you can come up with in the chat, that you could do here. Send it to all. Great. Now I'm seeing... thank you, it's nice being able to see all of your great ideas.

Assigning clinicians that are closer to the geographic area. Telehealth - and telehealth was talked about earlier too - could be monitors, it also could be phone monitoring. You heard the example about using a service, or yourself could be making the phone call to that patient. Sending several team members together.

Have the physical therapist assist the RNs with CHF disease process teaching. And I'll tell you, that is really part of care coordination. Using your disciplines to their full scope of their practice. Know what your state regulations are. But in a lot of states, to do obviously weights, vital signs, can be done by all of your therapists, perhaps. And also your home health aides. So you need to look at your state regulations, but nationally, the regulations do allow that. Unless your state has a different member. You could take advantage of your aid doing the bath by doing the vital signs, making sure that patient got weighed, look to see when the last weight was done. You may have to have that care plan attuned to what you're looking for. Physical therapists, and even your speech therapist and occupational therapist can all do vital signs if it's within their scope of practice. They're going to need education, they're going to need equipment, they're going to need to have some competency testing just like really all of us should. Even the nurses, because sometimes, we're not taking blood pressures accurately, we could always use a little brush up.

Those are great suggestions. I love the idea about team members going together, too. That might reduce your travel time down if they're able to caravan together. Great, great ideas. Sometimes, as you see, it takes some brainstorming. I think you've seen that with both Renee and Diana, it's teamwork. It's discussing how can we create that? Asking the staff, what might be a better way? Just like the cars. Initially they weren't real happy about losing their reimbursement check, but in the end, it is a lot better when they don't have to deal with all of the repairs to the vehicle, and the wear and tear on

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their cars. Plus, they made it very convenient by having it parked, so they didn't have to drive into the office.

Also, thanks Justin, about going on a different day. That is part of front loading visits that was also mentioned. Front loading visits is an evidence based practice. That does not mean you have to go out every single day. In the rural health areas, we definitely can't do that. But if you stagger your visits, your disciplines making their visits, and it's coordinated, you can get more bang for your buck. Especially if you're using each of the disciplines to the highest level of their scope of practice. The zone tools that we saw, or the stop light tools for patient self-management. All disciplines can educate on that. And the aid can even say, don't forget, you can use... to take a look at the little took that's on your refrigerator. When you have those symptoms, make sure you look to see what you're doing. So, there's a lot that an aid can also do with that. We acutely have an aid course that's coming out August 1st that is talking about hospitalization. There will be some really good information and some examples of that occurring in that as well.

Okay, very good. Here is another one. We plan for nurses to see patients in the area that the nurse lives in to limit the travel time and mileage. Perfect. Ideally, if you're able to get that, I hear from agencies a lot of times that they have a hard time hiring social workers or perhaps people in those areas. Creating partnerships, just like we heard with the Highway group, may also open you up to getting some per diems or some PRN nurses that may be willing to do some visits in those further out areas as well. Great ideas. Thanks everyone.

If you have any questions, please put those in. I'm not seeing anything at this moment, so I'm going to go ahead and move on to the other slides. But we'll come back and we'll double check that I haven't missed something. I do see something, I see a question here.

"What is the comparison for money spent, and money saved, with using company cars?"

I'm going to go ahead and hand that back to our panelist.

Diana Lecher: That would be me. This is Diana. I guess I'm not sure that I did a complete cost analysis. It was really done by my CFO here at the hospital. I do think it was definitely... we lease the car for a short period of time and then we kept them. It was hard for those years where the gas prices were terrible, but now that the gas prices are better for us, I think it's dramatic. I was giving nurses 5 and 600 dollar checks a month. Once you get these cars, they weren't very fancy cars. Some of them were all wheel drive, certainly, because we need that out here. I don't have facts, but I can assure you that the amount of money spent was a lot less. And then the car can be driven. We drive until there are 200,000 miles on them. So, I hope that's helpful enough for you. But when you look at the cost of those checks, and we bought them one at a time. One vehicle, then another vehicle, then another. So, we're only making payments on one car at a time, pretty much.

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Misty Kevech: Perfect. Thank you so much, Diana.

Please put in your other questions, and I'm going to go ahead and move on to some resources for you.

So, CMS just recently came out with the Rural Health Strategy. I think this is a good resource to have in your hands. They really have five objectives. They want to really apply that rural lens to CMS programs and policies, so that's good. And improve access to care through provider engagement and support. Advance telehealth and telemedicine. There are proposals out there to begin looking at payment for telehealth for home health. A little differently, but there is some proposals that are out there. Keep your eye on that. Empowering patients in rural communities to make decisions about health care. Leverage partnerships to achieve the goals of the CMS Rural Health Strategy.

I also included, and the link will be on your slides, Rural Health Open Door Forum. And I sit in most of the times for most of the calls. Not all the calls, but about every four to six weeks. Just like the Home Health Open Door Forum. It gets canceled sometimes, or the timing is a little different. There is a sign up, and I think I'm sending you this, so you can sign up for the Rural Health Open Door Forum. They talk about different initiatives that are occurring. I think it's very beneficial to know what's going on with perhaps some changes in those safety net hospitals. Because that might impact the care in my community that we might be serving. But it also is a great place. They do a Q&A. To really promote the aspect of home health. What you can do, what are some of the issues and barriers on a national call. Don't go by one or two calls. Sit in several and get a feel of what's going on, and then you may feel more comfortable providing or speaking up on those calls. I think there's great information.

Another resource site I think is valuable is the Rural Health Information Hub. It's sponsored by the Health Resources and Services Administrator, which is HRSA. And I've given you the link. They have a variety of information. I tried to just pull some of the ideas that you can look for there. There's an online library to look for grant information. I know I have a question that I'm going to come back and throw about the cost of blood pressure cuffs and scales and stuff. I know a lot of agencies do it, and just use that as part of their care, so I'm going to come back and ask that question in a minute. Looking for grants, I know many agencies have gotten grants to help cover those costs.

Topic specific state guides, rural data visualization, case studies and conversations. And then they have all kinds of tool kits. There are many more. I just picked out ones that would perhaps be applicable, that you might find some great resources for you.

And, let's see. Some HHQI resources. We have an underserved population best practice package that is a large package, but it covers tons of areas that are related to the underserved population. Rural is included. You may find some value there. We also have our HHQI University, which is separate from our website. Where you can take courses.

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We have a couple courses I think are very relevant. The Meals on Wheels: Delivering Health, Independence, and Food. It talks about Meals on Wheels is different in every area. And they can adapt and provide additional services that not all of them do. So, it may be worth partnering with the Meals on Wheels, finding out what they can do. They may even be able to get some grants to help with some additional needs within the community.

The Meeting the Needs of the Caregiver and Care Receivers is a course that actually takes two of our webinars and puts them together. So, really good for looking at helping to work with caregivers, especially those with dementia type patients, and looking at the caregiver through a different lens as a clinician. Trying to really figure out and reduce their stress level so we can really get the most bang for our buck with our caregivers. And also Partnering with Patients to make Non-Compliance a Thing of the Past. That is something, a trait that is often associated with some patients in rural settings. Learning to talk differently. Using the OARS model, and a little bit of motivational interviewing here. Getting that patient engaged. So, those are some great resources for you.

There are nursing CEs attached with all of those. And then there are a few UP webinars that we've had that I think you may find interesting. Hospital Discharge and Rural Transitions Planning, this is from Montana from a university and hospital system, what they did, and really good information about how they work through their discharging and trying to improve that transition. The Value of Home and Community Based Services talks about how the community based services can be a great partner to home health. And hopefully you're selecting, though you may not have as many choices as others would have in an urban setting to be able to find one that is really focused on improving, reducing hospitalizations, improving outcomes. But you could work together and do some partnering together, especially with disease management.

Coordinating Veterans' Health Care, there is a lot of things that veterans are available. It kind of taps in to that. I know I'm just in the process with my dad. We just got an alert system, so he has a falls alert system now that was free for him. They offered several different models. There are many things that are available with the veterans. I hear people, a lot of agencies don't like to work with the veterans. They tend to not get paid, they have denials, it's a little difficult. But creating that relationship, really, it pays off. And then also, Making the Most of Telehealth. If you've not done telehealth, this could be a really good starter for that.

And, some additional resources. SBAR and communication skills. We have some tools there that really could help with that communication. I love the idea of the daily communication tool that was used earlier. How you share that information. It was excellent. By having something very simple and consistent, and that's the whole point about SBAR. That consistency. And that you constantly use it.

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Before I go into the next webinar, I see questions. I'm going to go grab those first. Okay. Lots of questions. Sorry about that. I see Diana has been busy answering a couple of these too.

Diana Lecher: Yeah, that was the information that was given to me from my CFO, maybe that would help people consider, what helped made our decision.

Misty Kevech: Wonderful.

Diana Lecher: The other thing is, someone had mentioned exchange visits, and the referral sources are so far away. We have that problem. Most of our referrals are from further away. It was the process of exchange visits with the local nursing homes and the hospitals that helped us develop better processes to use with those hospitals that are seven hours away. So even if you can get one local nursing home, or two, to participate, I think that was enough to help us. We still haven't solved the problem of those big city hospitals, but we certainly know how to communicate better with them. And what to ask for.

Misty Kevech: And I also think, through that process, you know what the information is that you need or want to have. That you can add to your intake information. That you can decide to work on ascertaining those from the bigger hospitals. It's more difficult and more challenging, but it's information that you really want or need that you can look for up front when you're initially getting that intake.

Diana Lecher: Yes.

Misty Kevech: Okay. Great. So great. Alright.

I'm not seeing anything else that I missed. There was a lot of great information there being shared.

Our next UP network is October the 18th from 2 to 3 eastern. It's on Utilization of Occupational Therapists with Medication Management. We have two guest presenters, Dr. Martha Sanders, and Dr. Tracy Van Oss. And they have written many articles, journal articles related to using OTs with medication management. I'm always on my little soap box, because OTs can do so much to improve adherence, as well as accessibility and being able to manage. It should be an excellent presentation. It's not available to sign up yet, but you can always click on the slide, that will provide you the link to sign up for our mailing list if you haven't already done so.

And, the continuing education. With the handouts that you download on this slide, it's a little link for you to enroll. You'll just go to click and enroll to your university. If you've never been there before, you will have to set up an account. If you're not sure if you've been there before, and you're not sure of your username, and it doesn't seem to work, email us at HHQI@qualityinsights.org. We'll look it up. We really like to... it will allow you create a second account, but we really prefer you to keep one. So all your courses

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and certificates are in one. And you don't take a duplicate course. It's like, I've already taken this once before, but it might be in another account. So we really try to do that for you. Or have you try to do that up front. And we do check, that helps check that on a monthly basis. When you go into enroll, you're going to go to the Underserved Population course catalog. It'll have a whole listing. Find today's title. Click it, and then you follow the little apples. The flyer is real easy to follow.

And, before, I know we're just right at the hour. I want to thank very much our two speakers. I thought it was very valuable and great information. I thank all of you for providing all of the information, even in chat, and the ideas that you have. I really want to thank for sharing the expertise for Renee and Diana, today. And being able to hopefully give you some ideas that you can take forward and implement into your organization.

And if you are interested, we also do have a live chat on August the 17th from 2-3. That's live chat on August 17th, from 2-3 eastern. You can type in other rural issues or barriers that you have, or some strategies that you might want to share with each other. It's no talking, it's just typing in as a chat. You can find that by going to our regular website at homehealthquality.org. And click on the networking tab, and find live chat.

With that, I want to hope you have a wonderful afternoon.

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