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The Home Health Quality Improvement (HHQI) National Campaign: Uniting Providers To Improve Quality Of Care

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The Centers for Medicare & Medicaid Services (CMS) launched the Home Health Quality Improvement (HHQI) National Campaign's second phase on January 13, 2010. Since that time, nearly half of all Medicare-certified home health agencies in the United States have become active participants in the voluntary initiative, with open enrollment continuing right now at www.homehealthquality.org.

Current and potential campaign participants will find that the campaign has been designed in a very flexible manner. This flexibility is reflected by new participants being able to join at any time and instantly gain access to free tools and resources that can be implemented at a self-directed pace. These materials are vetted by panels of national experts in home care and are fully modifiable.

For providers who have yet to join the HHQI movement, an overview follows along with a success story from a campaign participant in Tennessee. A comprehensive listing of the campaign's primary educational offerings, called Best Practice Intervention Packages (BPIPs), is provided in Table 1 (page 30), along with a sample resource table from the January 2011 Cross Setting II BPIP in Table 2 (page 30).

Campaign Overview

The HHQI National Campaign is a grassroots initiative that works to unite home health stakeholders and multiple health care settings with a shared vision of reducing avoidable hospitalizations and improving medication management. It is funded by CMS, which is an agency of the U.S. Department of Health and Human Services. The campaign is being conducted under contract by the West Virginia Medical Institute (WVMI), which is the federally designated Medicare Quality Improvement Organization (QIO) for West Virginia. The campaign began with a kickoff summit in Baltimore, Maryland on January 13, 2010. Campaign goals include reducing avoidable hospitalizations and improving management of oral medications for home health patients, especially Medicare beneficiaries.

The 2010-2011 HHQI National Campaign was created in the mold of the campaign's first phase, which launched in 2007. A key enhancement to the latest HHQI National Campaign is an expansion of its scope to include health care settings beyond home care. Although the campaign is primarily used by the home health community, partnerships have been formed with other provider settings, including state and national stakeholders in the hospital, physician office, and long-term care settings. The HHQI National Campaign has also closely collaborated with the Care Transitions Quality Organization Improvement Support Center (QIOSC) at the Colorado Foundation for Medical Care (CFMC) to share best practices and lessons learned from both the HHQI National Campaign and the fourteen states currently participat-

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ing in the QIO Program's Care Transitions pilot project. Collaboration with Care Transitions QIOs and other entities has been a key element of expanding cross-setting influence in the campaign's second phase, and offers the opportunity to provide current information and resources to providers across the continuum of care. The Care Transitions project has been prominently featured in previous editions of the Remington Report, and more information is available at http://www.cfmc.org/caretransitions/.

Registration is required to participate in the HHQI National Campaign, but there is no cost associated with the program. The point of the simple registration process is to allow the campaign to evaluate participants' use of resources and overall effectiveness of the campaign and its materials. Initially, registration was only open to home health agencies, but in October 2010 registration opened to all health care providers.

The focal point of the HHQI National Campaign's educational efforts is multimedia Best Practice Intervention Packages (BPIPs). These comprehensive learning resources are designed to educate home health agencies, and to offer resources for providers in other settings. These resources are released at regular intervals (see **Table 1**). The BPIPs, as the name implies, focus on specific best practices. Best practices are supported through evidence-based research, and many providers are familiar with them. For example, having a way to identify patients at risk for hospitalization is a best practice that most non-hospital health care providers readily recognize. Another familiar best practice is making a concerted effort to conduct a complete medication reconciliation. Along those same lines, home health agencies will, ideally, be able to identify patients at risk for falls, and will communicate essential information when a patient is transferred to another setting.

HHQI BPIPs provide guidance and resources to assist providers with implementing these and other best practices. **Table 2** gives examples of how to use BPIP resources to meet quality goals. The table corresponds to the January 2011 Cross Setting II BPIP, which guides agencies in improving care transitions of chronic care patients using three strategies: disease management, self-care management support, and telehealth.

Another key function of BPIPs is to show agencies how to implement best practices through real-world applications, branded as *Insights and Success Stories*. The *Insights* feature is a unique BPIP component that lets providers share their quality improvement know-how, so others can learn from their experience. The best practices are practical and relevant, two important factors in adult learning. For example, in one of the *Success Stories* included in the Cross Setting II BPIP, SunCrest Healthcare's Corporate Director of Program Development shares the agency's strategies to use telemonitoring to successfully reduce the hospitalization rate for its heart failure patients. The Director explains how the agency helped its nurses to become more expert in caring for heart failure patients through a comprehensive educational program, which is adaptable for other agencies to pursue. The SunCrest *Success Story* follows this campaign overview.

Starting with the Fall Prevention BPIP released in July 2010, the HHQI National Campaign added a *Focus* section in each BPIP to provide information on current trends, models, and concepts for leaders. The October 2010 Cross Setting I BPIP provided advice from several experts, including Jane Brock, MD, Chief Medical Officer for the Colorado Foundation for Medical Care (CFMC). Dr. Brock explained how community-based efforts are the key to reducing hospital readmissions. The January 2011 Cross Setting II BPIP excerpts important aspects of the Patient Activation Measure (PAM) and includes research on the measure's effect on home care.

Another key enhancement of the HHQI National Campaign's second phase has been the adoption of social networking resources to enable multiple methods of communication among participants. These resources include an open online discussion forum related to home health quality, a Facebook page to connect participants, a Twitter feed to keep members abreast of campaign and health care news, a campaign blog, and monthly online Live Chats to allow participants to interact directly with campaign contractor staff and stakeholders. These resources are collectively known as MyHHQI and are easily accessible to campaign participants from the front page of www.homehealthquality.org.

The campaign also hosts periodic Webinar broadcasts of the nation's leading experts in home health quality and transitional care. These well attended, interactive events have featured prominent home care leaders such as Steven Landers, MD, of the Cleveland Clinic, experts in transitional care such as Northwestern University physicians Luke Hansen and Robert Young, and a description of the implementation of a transitional care model in a Georgia home health agency. These broadcasts are archived on the campaign Web site, and participants receive notification to register as the events debut throughout the campaign.

In addition to communication tools and innovative interactive Webinars, the HHQI National Campaign offers home health participants free, monthly, agency-specific HHQI data reports based on their OASIS transmissions. These reports are provided to each participating agency through a secure Web site, known as HHQI *Data Access*. HHQI *Data Access* helps participating agencies track their progress in improving acute care hospitalization and oral medication management rates and provides access to current agency data. Signing up for these online reports is a simple process that can be initiated at www.homehealthquality.org.

The HHQI National Campaign offers a wealth of quality improvement tools and resources. Many resources are appropriate for multiple provider settings, which is crucial as health care insurers make the transition to a shared care model, which emphasizes collaboration to ensure

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Table 1

BPIP Release Schedule

Release Date	Topic
January 28, 2010	Fundamentals of Reducing Acute Care Hospitalization
April 28, 2010	Medication Management
July 28, 2010	Fall Prevention
October 28, 2010	Cross Setting I: Improving care transitions and aligning with other health care providers
January 28, 2011	Cross Setting II: Improving care transitions with chronic care patients through: disease management, self-care management support, and telehealth
April 28, 2011	Cross Setting III: Innovative ideas to help prepare for health care changes

Table 2

Cross Settings II BPIP Resource Table

Agency Goals	First Steps	BPIP Resources
To effectively educate clinicians to care for patients with advanced disease	Invest in educational resources for staff.	- BPIP offers success stories to show how agencies educated staff
	Look to community experts to provide assistance and up-to-date information.	- BPIP recommends Agency for Healthcare Research and Quality Clinician Guides - BPIP recommends standards and guidelines from national disease-based organizations (e.g., AHA, ADA)
To effectively utilize telemonitoring and telephone support	Examine patterns of use and protocols for assigning services.	- BPIP offers experts' telemonitoring advice
	Evaluate hospitalization rate for target population before and after telemonitor use.	- BPIP recommends using Telephone support to manage Chronic Disease
	Drive home importance of assigning scarce resources with inspiring real life stories where technology made a difference.	- BPIP offers Home Telehealth Disease Management Series featuring Patient Selection Criteria: Home Telehealth for Heart Failure
To encourage patients to begin self-management on day one of admission	Educate staff about the importance of patient self-management.	- BPIP recommends Partnering in Self-Management Support: A Toolkit for Clinicians
	Distribute resources to patients to foster self-management.	- BPIP offers Self Hospitalization Risk Assessment
To work effectively with other health care providers	Take the lead to improve care transitions in your community.	- BPIP Focus section offers Palliative Care Track: Focus on Care Transitions - BPIP Focus section outlines advantages of working together in *What's In It For Me?*

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"The focal point of the HHQI National Campaign's educational efforts is multimedia Best Practice Intervention Packages (BPIPs). These comprehensive learning resources are designed to educate."

delivery of health care by the most appropriate health care practitioner. The HHQI National Campaign rallies home health agencies, hospitals, physician offices, and other providers to continue their quality improvement efforts. The next section offers a sample Success Story from a campaign participant in Tennessee, as featured in the January 2011 Cross Setting II BPIP.

HHQI *Success Story:* SunCrest Telemonitoring Program Focuses on Heart Failure

SunCrest Healthcare had several corporate goals when the Southeastern home health agency started its telemonitoring program for heart failure patients, but one of the main goals was to lower its acute care hospitalization (ACH) rate. Eighteen months and 180 telemonitors later, the agency cut its ACH rate in half, according to Karen Malin Garfield, the Corporate Director of Program Development for the Tennessee-based agency.

"We started out with 30 percent [of congestive heart failure (CHF) patients re-hospitalized within 60 days of hospital discharge]," said Garfield. "Within six months, we got down to 16 percent. Now we're at about 12 percent for our CHF patients on telemonitoring." Garfield had extensive experience in critical care and cardiac nursing but did not have a home health background when she joined SunCrest a year and a half ago. When she left bedside nursing, she worked as a clinical applications specialist for a large national company that made patient monitoring equipment. That led to a long career in implementing programs and services for hospitals and providers.

Garfield's technical expertise came in handy as SunCrest compared telemonitoring vendors and selected a brand whose name would be recognized by hospitals. Then Garfield took a good look at the two groups who would use the equipment on a daily basis: patients and nurses.

"I didn't realize how sick these patients would be, and I didn't realize that additional education was needed for our field nurses to effectively take care of them," she said.

About 20 percent of the agency's home health patients have heart failure, atrial fibrillation, or hypertension, the three main heart-related diagnoses that cause patients to be re-hospitalized, she said. These fragile patients, whose health is very unstable, need specialized nursing care, she said.

"The home bound heart failure patient is extremely complicated," said Garfield, and those who treat them must be knowledgeable of the latest medications. "Home health nurses often have to generalize because they tend to a wide variety of patients. Our goal was to provide extensive education on CHF to our nurses. This would help them to focus on caring for this complex patient population."

So Garfield set out to turn the generalists into specialists. To do that, she hired a representative of the Vanderbilt University School of Nursing to prepare three cardiac nursing DVD sessions. In addition, the instructor went out with the nurses to do on-site training. Then she put together a clinical pathway that tells nurses what to teach on each visit so as to avoid introducing the telemonitor on the first visit.

"So much takes place during the first visit that we wait until visit number two to bring in all the equipment," said Garfield.

Next up, she created patient handbooks that incorporated recommendations from the American Heart Association and the Heart Failure Society of America and explained when to call SunCrest and when to call 911.

Finally, she focused on the expertise of the telehealth nurses who assess the data from the telemonitors. She recruited six nurses whose critical care experience allows them to review patients' numerous medications with them and their home health nurses.

With outcomes improving, Garfield's short-term goal is to maintain their ACH rate or, preferably, to drive it down below 10 percent into the single digits as the agency unveils telehealth for other diseases.

The agency is rolling out a chronic obstructive pulmonary disease telehealth program and hopes to have similar patient outcomes.

"It's not so much the technology," said Garfield. "It's more about having a disease management program along with the technology that's allowed us to get the outcomes we have."

The Time Is Now

The home health providers who are active HHQI National Campaign participants are encouraged to fully utilize the wealth of resources described in this article and in Tables 1 and 2. For those agencies not yet participating, the time to join is now. Membership gives providers a flexible implementation timeline, a wealth of modifiable resources, and free social networking connections. We encourage you to be a part of this groundbreaking movement. For more information, visit www.homehealthquality.org or contact hhqi@wvmi.org. **RR**

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