Introduction to the Home Health Collaborative

Improving Cardiovascular Health

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• Led and administered by Healthcentric Advisors
  – Focus areas: MA, ME, RI

• Partner – Qualidigm
  – Focus areas: CT, NH, VT
Welcome new members!

Connecticut

Kathy Roby kroby@qualidigm.org

• Advanced Home Health Care Agency, INC.
• All About You! Home Care
• All Pointe Home Care
• American Home Health, Inc.
• Bristol Hospital Home Care
• Constellation Home Health Services
• Hebrew Health Homecare & Hospice
• Hartford Healthcare at Home
• Interim Health Care of Hartford

• Keep Me Home, LLC
• Masonicare/Masonicare Partners Home Health and Hospice
• New England Home Care
• Salisbury Visiting Nurse Association
• Salute Homecare
• Stratford VNA
• Visiting Nurse Association of South Central CT
Welcome new members!

Massachusetts

Pat Donovan McLeod pdonovanmcleod@healthcentricadvisors.org
Barbara Corning Davis bcorning-davis@healthcentricadvisors.org
Karen Evans kevans@healthcentricadvisors.org

• Southcoast Visiting Nurse Association

New Hampshire

Georgette Verhelle gverhelle@qualidigm.org
Leslie Molleur leslie.molleur@hcqis.org

• Interim Health Care
• Lakes Region Visiting Nurse Association
• Nurses PRN Inc. DBA Silver Touch HHC
Welcome new members!

Rhode Island

Brenda Jenkins bjenkins@healthcentricadvisors.org

Vermont

Gail Colgan gcolgan@qualidigm.org

Maine

Doreen Bedaw dbedaw@healthcentricadvisors.org
Home Health Quality Improvement (HHQI)

• Are you registered on the site yet?

• Let’s walk through www.homehealthquality.org
  – Home Page: Registration tab
  – Complete all fields
  – Agency champion and a back up
  – Explore the site and all of its resources
Welcome to the HHQI National Campaign

Since 2007, the Home Health Quality Improvement (HHQI) National Campaign has been dedicated to improving the quality of care provided to America’s home health patients. Whether you are a home health practitioner directly providing patient care, or an allied partner with a stake in improving the quality of care that home health patients receive, we are here to help you with evidence-based tools, timely data reports and a wealth of ongoing educational opportunities. All of our resources are absolutely free and available to everyone. Please explore our site to learn more about this initiative of the Centers for Medicare & Medicaid Services (CMS). Working together, we can make a real difference in patients’ health care and ultimately, their quality of life.

Campaign Resources: Discover our free resources to help improve your patients’ outcomes, including Best Practice Intervention Packages (BPIPs), Data Access Reports, Webinars and the unique HHQI Community of engaged stakeholders united to improve health care quality.
Join the HHQI Cardiovascular LAN

• Let’s get registered:
  – Under Cardiovascular Health, click on CardioLan
  – http://www.homehealthquality.org/Cardiovascular-Health/CardioLAN.aspx
  – Click on the blue button on the left and complete the registration
  – Select your Quality Measures
    • A B C S-which one will you work on?
    • 6 Measures to choose from
Join the Cardiovascular Health Movement

Since the launch of the national Million Hearts® initiative, an added emphasis has been placed on improving preventive cardiovascular care throughout the healthcare industry. In support of your cardiovascular health improvement efforts, HHQI invites home health agencies and other stakeholders to join the new Progressive Cardiovascular Learning & Action Network (CardioLAN). The CardioLAN is a diverse group of individuals from various healthcare organizations—such as home health agencies, associations, and QIN-QIOs—who share a commitment to improving preventive cardiovascular care.

Benefits of Joining the CardioLAN

Participation in the CardioLAN provides increased support from HHQI and networking opportunities through monthly teleconferences and webinars. These monthly events provide an interactive forum for sharing cardiovascular knowledge and the application of free resources such as HHQI’s Cardiovascular Health Best Practice Intervention Packages (BP/IPs) and the Home Health Cardiovascular Data Registry.

National Recognition

When you join the CardioLAN, your organization will be included in the table below and recognized for your commitment to cardiovascular health improvement. More than 700 HHQI participants have already joined. Click on your state below for a current list of cardiovascular health improvement leaders in your area.
Home Health Quality Improvement (HHQI)

• What are the measures?
  – Diabetes LDL-C Control
  – Ischemic Vascular Disease (IVD)-Use of ASA
  – HTN Controlling BP
  – HTN Controlling BP Follow up plan
  – IVD and a Complete Lipid Profile, LDL-C Control
  – Tobacco use-Screening and Cessation Intervention
Home Health Quality Improvement (HHQI)

- Data Collection Process
  - HHCDR Process Flow chart
- Data Abstraction process
  - HHCDR Chart Abstraction tool
- Registry Data Entry Process
- Review your reports!
HHCDR Process Flowchart

Follow the steps below to get the most out of HHQI’s free cardiovascular resources.

**STEP 1**
1. Review Cardiovascular resources:
   - Cardiovascular BPIPs
   - Join the CardioLAN
2. Register and create Data Access account
   - Resource: Data Access tutorial

**STEP 5**
Access HHCDR on the 15th of the month
1. Login to HHQI Data Access
2. Click HHCDR on brown tool bar at top

**STEP 6**
Following your internal process from Step 4, complete data abstraction
1. Select Month and Year of discharged patients to be abstracted
2. Select measure(s) A, B, C, and/or S (based on Step 3)
3. Abstract required number of episodes of care (maximum of 12 per selected measure)
   **Optional**
4. Abstract additional patients beyond the required amount to make stronger report

**STEP 2**
Determine the HHA’s cardiac focus for improving cardiovascular care

**STEP 4**
Develop internal process for collecting and entering data into the HHCDR. Consider the following options:
1. Select one person and an alternate to be responsible for abstracting and entering all required data on a monthly basis
2. Include the HHCDR Chart Abstraction Tool as part of the discharge process for clinicians and submit to data entry staff to enter data when episode populates in HHCDR (approximately 6 weeks after discharge)
3. Incorporate chart abstraction and HHCDR data entry into monthly chart review process

**STEP 3**
Select the Aspirin, Blood Pressure, Cholesterol, Smoking measures on which your agency wishes to focus.
- You will have this choice each month – you can select any, several, or all
- Consider where required chart abstraction items will be found in your agency’s patient records
- Resource: HHCDR Chart Abstraction Tool & HHCDR Overview webinar

**STEP 7**
Complete abstraction and ‘Close out the month’ by the 14th of the following month

**ONGOING**
Access and evaluate HHCDR Report on the 23rd of the month
Data Abstraction Tool

HHCDR Chart Abstraction Tool

Complete for home health episodes of care with a minimum of 15 days encoring (discharge/transfer) in the reporting month.

General Patient Info
Patient ID (HXX20)
SOC Date

Did the patient have both a Medicare and Medicaid number on the record?

YES
NO

Aspirin As Appropriate
Did the patient take aspirin or other anti-thrombotic (clot/disease, plaques), or ticlopidine (ticlid) during this episode of care?

YES
NO

Contraindication noted in record

Blood Pressure Control
What was the last blood pressure recorded during this episode of care? (If more than 1 BP reading on same day, select the lowest systolic and diastolic for the day)

Systolic:
Diastolic:
Date:

Was a follow-up plan to obtain better blood pressure control included in the record during this episode of care (such as dietary changes/restrictions, increase exercise, weight loss plan, medication adherence, medication adherence, medication changes, or pain management)?

YES
NO

Cholesterol Management

Is there documentation in the medical record that the patient received a cholesterol screening within the 12 months prior to this discharge date?

YES
NO

Please indicate which test results were documented in the patient’s record? (Mark all that apply)

High-density Lipoprotein (HDL)
Low-density Lipoprotein (LDL-C)
Please enter LDL-C value

Date:

TLC:
Cholesterol
Other, please specify:

Smoking
During this episode of care, was the patient smokers for tobacco use by the home health agency?

YES
NO

If yes, was the patient identified as a current tobacco user?

YES
NO

If yes, did the patient receive tobacco cessation counseling/intervention (by the home health agency, such as brief counseling, 3 minutes or less) or pharmacotherapy?

YES
NO

Not Applicable (medical reason not to screen the patient for tobacco use noted in the record e.g., limited life expectancy, other medical reason)

Not Applicable (medical reason not to counsel the patient for tobacco use, e.g., limited life expectancy, other medical reason)
Home Health Quality Improvement (HHQI)

- “B P I P” Best Practice Intervention Package
- Cardiovascular Health I - Aspirin and Blood Pressure Control
- Cardiovascular Health II - Cholesterol Management and Smoking Cessation
- How can you use these effectively without overwhelming your staff?
Home Health Quality Improvement (HHQI)

- Select *only* 1-2 of the 6 measures to work on
- Identify the section of the BPIP that relates to that measure only
- Use the staff/patient education materials, podcasts, etc. for that measure only
- A targeted approach will decrease the stress on you and your staff
- Let’s look at one example....
Home Health Quality Improvement (HHQI)

• Measure 204: Use of ASA therapy in patients with Ischemic Vascular Disease

• Staff Training:
  – 4 pages of clinical education; 20 min podcast; sample bulletin board

• Patient Education:
  – 4 English/Spanish handouts

• Data Collection:
  – Abstraction tool

• Reporting
Million Hearts® Campaign

• What is this?

• Let’s look at a wider picture…..promoting the health of the whole community

http://millionhearts.hhs.gov/index.html
February is American Heart Month

One in 3 American adults has high blood pressure. Million Hearts® offers new resources to help Make Control Your Goal.

What's New

- New CDC research reveals that a majority of commercial, packaged toddler foods, as well as snacks for both babies and toddlers, are high in sodium content or contain added sugars.
- A new report issued in support of Million Hearts® highlights health plans and physician practices nationwide that have achieved excellent results in cardiovascular care, including high rates of hypertension control, cholesterol management and smoking cessation.
- Million Hearts® Messages to Millions is designed to provide consistent, science-based Million Hearts® messages. Message maps provide key and supporting messages that stress the steps that can be taken by consumers, health care providers, and other audiences to help prevent heart attacks and strokes. The messages can be adapted for other audiences.

The Initiative

Million Hearts® is a national initiative to prevent 1 million heart attacks and strokes by 2017. Million Hearts® brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke.

Join the Conversation

- Become a fan of Million Hearts®
- Follow @MillionHeartsUS
Million Hearts® Campaign

• Register your agency as a Healthcare Provider
• Activity to promote cardiac wellness
• Examples:
  – Lunchtime walkers
  – Healthy snacks in the vending machine
  – Posted NO SMOKING policy
  – Heart Healthy food at company events
INTERACT for Home Health

• **Inter**ventions to reduce **Acute** **Care** **Transfers**

• Interventions and tools to facilitate **Transitions of Care**

• Proven effective in the Nursing Home world

• Newly released for Home Health

http://interact2.net/home_health.aspx
Interventions to Reduce Acute Care Transfers

Home Health Tools New!

Overview of the INTERACT Quality Improvement Program for Home Health

- INTERACT Home Health Version 1.0 Tools
- Using the INTERACT Home Health Version 1.0 Tools In Every Day Care
- Home Health V 1.0 Tool Implementation Guide 2013

Quality Improvement Tools for Home Health

- Acute Care Transfer Log
- Quality Improvement Tool for Review of Acute Care Transfers
- Quality Improvement Summary Worksheet
- Implementation Checklist

Communication Tools for Home Health

For Communication Within the Home Health
- Stop and Watch Early Warning Tool
- Stop and Watch Early Warning Tool - In Spanish
- SBAR Communication Form and Progress Note For Home Health

For Communication Between the Home Health and Hospital
- Home Health Capabilities List
- Home Health to Hospital Transfer Form
- Home Health to Hospital Transfer Data List
Peer-to-Peer Sharing

• What is working well?

• Goal: to improve the outcomes of our patients episodes of care.

• By working together, sharing ideas, helping one another, everyone’s outcomes will improve.

• Sharing processes, suggestions, ideas on monthly webinars
HHQI Cardio LAN

• Every third Thursday, an educational webinar is offered by HHQI related to this project

• Have your registered for this month’s webinar?

• HHQI website – archived webinars
Q & A

How can we help you?
Contact

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