Transcript: March 2018 CardioLAN Webinar

At Your Service:
Benefits of Working with Your QIN-QIO

Cindy Sun: Hello, everyone and welcome to the March 2018 HHQR Cardiovascular Learning Action Network or what we call our CardioLAN. We're thrilled you can take the time to join us. Whether you're listening to the archive recording or whether you're joining us live, we know that your time is valuable. And our goal is to provide enough information that gives you a start as to maybe it's something you hadn't thought about for your cardiovascular improvement. Today, we have some fantastic guest presenters talking about At Your Service, Benefits of Working with your QIN-QIO.

Before we get too far into this or get started, I wanted to go over a few housekeeping issues. This is being recorded. The archived recording of this event will be found under the cardiovascular health tab on the HHQI website, the same place where you can locate the slides for today's event. All the phone lines are currently muted and they're going to remain muted throughout this so if you have any questions, we encourage you to use the q&a box and the hat box located on the right side of your screen. If you are not seeing those, look in the upper right hand corner and you'll see the icon. If you click on the icon, then it will populate it so you can use it.

We'll get to as many questions as we can throughout the session. Now, as always, because you are on the CardioLAN, we do like to keep you updated as to what's going on and campaign updates. Just a few updates I'll share with you and these are pretty exciting ones. First of all, if you didn't already know, just in the past couple of weeks, we crossed the 20,000 participants and 6,000 home health agencies joining HQQI. That means you guys are part of that and we really want to thank you for that.

It's beyond what we ever imagined when we started HHQI that would have it would grow to this number and this volume. This is just the start. We're already starting to look at 30,000 participants and we're starting to aim for 6,500 home health agencies, so as you continue to work with different folks, make sure to get the word out. That's our goal. We create evidence based tools and resources, but we just want people to know that they're out there because only you at the agency can decide what is best to be used for your patient population, so we want to thank you for that. We also have an announcement for a new Cardio Milestone 4 achiever, visiting health services from the Dalles, Oregon reached Milestone 4 within the past week or so. We want to say congratulations to them.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

For those of you that aren't familiar, Milestone 4 is the Assessment of Data Reliability. That indicates that the data that they are entering into the HHCDR has been assessed and has been deemed reliable. That is a big deal. You know when we're working on quality improvement, we want the data to be accurate.

Okay, one more announcement about the HHCDR changes. This is a big change month. I know many of you have been listening to this for four or five months now, and you're like, oh my goodness. Let's get on with it. Well today is actually the day coincidentally of the CardioLAN day for these changes. When you log into the HHCDR, first thing you're going to notice, our visual update. It has had a facelift. Nothing has changed other than the appearance and I got to say it looks a lot nicer. The other thing that you will notice is the measures have changed. Today is the day when you see your January 2018 discharges, those are the episodes discharged in 2018 of January, you will now have the option of cholesterol measure, which is going to be changed. If you're used to the LDL measure, that has been sunsetted. It is no longer available.

We're now looking at a statin measure. The question and I'm paraphrasing, was this patient taking or prescribed statin? Yes or no. You're also going to have the option for cardiovascular, excuse me cardiac rehab. Did the patient receive a rehab referral while under your care? Now remember, that can be on discharge, so it's a yes or no question. Those are your new options. The final thing about the registry that I just wanted to touch on is starting in April, it's that time again for the annual evaluation, so starting in April, if you are a qualified agency, which means that you've entered least three months of data in the past year, you will start to see the option of providing us feedback on the registry. Remember, this is an annual thing. Some of you have done this every year since 2014 and we want to thank all of you for your input.

Many of the changes that have come into the registry are because of you guys and this input that you've provided us so we take it very seriously and we thank you, so any input that you have, you'll start to see that evaluation popping up in April and anytime that you can, take five minutes or so to fill it out and give us some feedback, we would appreciate it.

All right, let's talk about the objectives for today. Upon conclusion of this webinar, we hope that you're going to be able to define the role of a QIN-QIO in the national quality improvement landscape. We hope that you're going to be able to discuss a minimum of three ways that QIN-QIOs are supporting home health quality improvement, and then we also hope that you're going to be able to access contact information for your local QIN-QIOs.

I will tell you on a personal note from just me to all of you out there that are working on the cardiac work and really working in anything in home health, my personal objective for you today is that the end of this, you're going to take a

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

minute, maybe a minute and a half, type out an email and send it to your QIN-QIO if you're not already working with them and just to find out what is going on in the home health world in the QIN-QIO world, see what they're doing and if it aligns with what you and your agency are currently working on and if it is, great. If it's not, maybe think about doing an every six month check in because things happen quickly in the QIN-QIO world, which we're going to talk about. Just knowing what is going on and how home health is in their scope of work is something that may be an untapped resource for you.

Let's talk about these QIN-QIOs. Quality Innovation Network-Quality Improvement Organization. That's the QIN-QIO. In 2014, there was a redesign, used to be one QIO per state but then there was a regional collaboration and it became 14 regions. The idea for this is coming from, and I'm just going to to take the language straight off of the CMS website. The idea is to bring Medicare beneficiaries, providers and communities together in data driven initiative and increase the patient safety, make communities healthier, better coordinate post-hospital care and improve clinical quality.

If you think about it, that's exactly what home health is about. The idea of a QIN-QIO is by serving regions of anywhere from two to six days, each QIN-QIO is going to be able to help the best practices spread, but then also accommodating local conditions and quality factors. QIN-QIOs are skilled in creating opportunities for providers to learn from each other, applying advanced improvements, analytical methods, engaging patients, families and structuring process for sustaining positive change. I think that's what you're going to see today with our presenters.

Let's go ahead and get started because I know this is what we're all here to talk about today. What we've done is we've invited two QIN-QIOs and some of the agencies they're collaborating with to share their stories, to share what they've been doing and what's working, what the benefits are and this way, start thinking about it as you're hearing them talk and to see will this align with what you're currently doing.

First, I would like to introduce the New England QIN-QIO guest experts. I'm going to start with Melissa Gordon, who is the QIN-QIO and then she'll introduce her collaborative partners. Melissa Gordon is a senior director at Qualidigm and has over 27 years of experience in the healthcare industry. At Qualidigm, she oversees the strategic operations of home health consulting division and works directly with the home health agencies to advise and recommend quality improvement strategies. She is also the regional home health lead for the New England QIN-QIO. Ms. Gordon has done both clinical and operational roles for the nonprofit Medicare certified home healthcare agency and prior to Qualidigm, she served as the director of continuum care management and manager of transitions of care at the Visiting Nurses

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

Association of South Central Connecticut. Ms. Gordon is a registered nurse and holds an MBA from the University of New Haven. Melissa, I'll turn it over to you.

Melissa Gordon: Great. Thank you, Cindy. Hello everyone, I'd like to just take off of what Cindy said about the structure of the QIN-QIOs and tell you a little bit about the New England QIN. The New England QIN-QIO is administered by Healthcentric Advisors in partnership with Qualidigm and we serve all six New England states. Across the region, the New England QIN-QIO works with healthcare providers and stakeholders to enhance experience and outcomes for Medicare beneficiaries. Some of our areas of focus include cardiovascular health and Million Hearts of course, care transition, community antibiotic stewardship, diabetes care, immunizations and vaccinations, medication safety and adverse drug event prevention.

Our team of clinical analytics and quality improvement experts provide tools and education and assistance to support New England healthcare providers. This regional approach affords healthcare communities the opportunity to connect, learn from others and share their innovations and successes throughout New England. As the regional home health lead, I have the opportunity to coordinate innovative and improvement home health initiatives across New England. Today, you will hear some of what we're doing over the last couple of years to assist our agencies and their patients to improve cardiovascular health, quality of care, reduce readmissions and help mitigate the challenges of the industry.

I'd like to introduce my presenters today. Barbara Katz is an RN MSN and is Vice President of Clinical Program Development for Community VNA Healthcare and Hospice. She's a graduate of the Yale School of Nursing. Barbara has been a family nurse practitioner, a healthcare manager and healthcare consultant. She is responsible for agency marketing, business development, community health promotion, innovation initiatives and value-based purchasing efforts. She has been active in the agency's clinical outcome improvement efforts and in collaborating with other state and regional healthcare improvement organizations. She is currently writing a book on reducing healthcare fragmentation and connecting the dots of care for better patient care outcomes.

Kristin Smith, who's a registered nurse and an MSN, has been at VNA Community Healthcare and Hospice for 14 years. She's a complex care manager, who is also certified as a healthcare coach and certified in integrated chronic care management. She received her Master's in Nursing from Quinnipiac and is currently pursuing a post-masters certificate in nursing education. Now I'm going to pass it over to Barbara.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

Barbara Katz: Good afternoon, everybody. I represent, as Melissa said, VNA Community Healthcare and Hospice, which is a nonprofit Visiting Nurses Association located in South Central Connecticut. The agency has been in the community for 108 years and currently has an average daily census of about 1,400 patients. VNA Community Healthcare has focused on improvement of Triple Aim, we used to call it Triple Aim. Now we call it Quadruple Aim outcomes.

In the slide, I said 2012 but I'm mistaken. It was 2010 when the first hospital communities of care, which we sometimes call readmission collaboratives, were started by the QIN-QIO in partnership with the Connecticut Hospital Association. VNA Community Healthcare began its own internal improvement and best practices efforts at the same time, spurred on by the statewide effort and the support provided by the QIN-QIO.

Over the course of the last eight years, the QIN-QIO has provided resources that have supported our agency in improving chronic disease outcomes, reducing readmission rates, improving clinician expertise in patient self-management support and driving decisions with data.

One of the significant resources provided by the New England QIN-QIO has been the Leadership Academies. These are large one-day conferences that address tools and techniques for improved clinical outcomes and reduced readmissions. Someone from our agency has attended almost every one of these presentations. Topics have ranged from strategies for reducing readmissions for heart failure patients, the role of the pharmacist in clinical care and the opioid crisis, plus many other topics.

I was honored to do a presentation on motivational interviewing at one of these sessions. The Leadership Academies have been a source of new best practices and some very valuable tips and tricks from the experts who speak at the programs. They are also a wonderful professional networking opportunity and have allowed us to develop many fruitful relationships with people in other industry segments, including skilled nursing facilities and hospitals. Now I'm going to turn it over to Kristin Smith, who will tell you a little bit more about the community collaboratives.

Kristin Smith: Thanks, Barb. In 2010, the New England QIN-QIO partnered with the Connecticut Hospital Association and the goal was to reduce preventable readmissions of patients with heart failure. Initially, there were about 25 hospitals in Connecticut that had participated and now the program has expanded to include other settings such as home care, skilled nursing facilities, assistive living, there's some patient advisory council representatives, just to name a few. Currently, there are 15 communities throughout the state of Connecticut and really the goals of the collaboratives are to promote the transitions of care, community building and a culture of no blame. I currently co-

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

chair the Middletown collaborative with a representative. Her name is Becky DePiro from Middlesex Hospital. We meet monthly. We discuss patient safety stories, case study participation. We do cross organizational readmit debrief. We look into root cause analysis and cross organizational development of best practices. We've actually developed a cross organizational best practice for falls with that collaborative. We've also contributed to creating a COPD stoplight tool.

Also during the monthly meetings, we have an educational topic and those topics can range from something that's currently going on like the opioid crisis or anything that would be relevant to what we're talking about that month. We also have antimicrobial stewardship at the end of each month.

The New England QIN-QIO and participates in those meetings. They provide us updates. They give us data. They tell us what they're working on and how they think the community or Middlesex community could be involved in some of the projects that they have going on. The New England QIN-QIO utilizes the collaboratives to promote their own work as well.

We also partner in another community, the New Haven community. That community meets two times a month. We presented some case studies there and some of our best practice that we've done here with the QIN-QIO. I also participate in the New England QIN-QIO quarterly community leaders meeting. This is a meeting where all the communities come together with the QIN-QIO and we talk about data, readmissions, what we're doing in each of our collaboratives and we just talk about different ideas and projects that are going on and we share information with the communities and the QIN-QIO.

Okay, Barb.

Barbara Katz: The New England QIN-QIO has been instrumental in another way, and that is in implementing an evidence-based best practice program called Interact, which started with skilled nursing facilities in the state. Then the QIN decided to assemble a statewide home health task force to see if similar kinds of transition-related best practices could be developed for home care. VNA Community Healthcare has participated in this statewide coalition and helped to develop best practices. We participated in the development of physician home healthcare education materials and we have tested and implemented some of the tools endorsed by the task force.

We've also used the QIN's videos Heart Talk and Lung Talk as part of our chronic disease best practices education for staff. One of the big things that the QIN does is data. VNA Community Healthcare and Hospice uses QIN-QIO state and local readmission data as part of our key performance indicator system and as a

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

benchmarking tool for our internal improvement efforts. QIN staff has been very responsive in terms of helping us obtain and interpret data.

VNA Community Healthcare has made use of HHQI published best practices as well to drive our own best practices. We've used HHQI resources in the design of staff training. I recently had the pleasure of co-presenting with a HHQI staff, Cindy and Misty at a QIN-QIO Connecticut Association for Healthcare at Home program process improvement techniques for the new QAPI COPS requirement.

Finally, just to summarize, the New England QIN-QIO has been a constant and reliable resource for home healthcare agencies like ours in the quest to improve quadruple aim outcomes. QIN-QIO staff have experience in our industry and understand our issues and capabilities. QIN-QIO staff are consistently available, supportive and responsive to our needs. I would urge any listener to take advantage of the many resources offered by your local QIN-QIO.

Melissa Gordon: Thank you, Barbara and Kristin, and now I'm going to pass it back over to Cindy.

Cindy Sun: Thank you all. I appreciate you. That's a lot of information, that's a lot of good information and I want to encourage each of you, even if you're not in Connecticut, start thinking about the different types of programs and if they would align on what's going on in your community. If you're not familiar with it, you're going to want to reach out and find out just to make sure you're not missing anything.

Now next, we're going to go into our next QIO and their collaborative partners. From Lake Superior QIN-QIO, I want to start with Barbra Link. Barbra's a license master level clinical social worker in the state of Michigan. She has over 20 years of experience in the field of aging and disability. She has worked in a variety of healthcare settings, from in home to hospital as a direct practitioner in an administrative position. She has worked for Lake Superior QIN-QIO for the past few years in their care coordination, behavioral health and immunization path. Barbra, Please introduce your team. Barbra, are you there? I'm not getting any audio.

Barbra Link: Can you hear me now?

Cindy Sun: Yes, thank you.

Barbra Link: Yes. Sorry about that. I wanted to thank Cindy and the HHQI for this opportunity today. We're very excited to be able to talk about our work with the home health agency workgroup that we've developed over the past two years and I'm also very excited to introduce my co-presenters as well as the dedicated home health agency workgroup members that we have speaking today. Erik Wilson is

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

the Director of Nursing and Quality for Optimal Care in Bingham Farms, Michigan. His clinical practice has included home health, behavioral health, emergency services and wound care. Erik earned his Master's degree in Nursing with a focus in quality and patient safety outcomes from the University of Michigan. He is certified as a professional in healthcare quality and credentials through the ANCC as a nurse executive advanced. He currently oversees the Optimal Care clinical team and quality programs.

Erik is actively involved in the community collaboratives in Southeast Michigan area and he has also been engaged in the continuing education of healthcare providers with special focus on safety, safe care transitions for patients into the community, and Salim Bhinderwala is the physical therapist by profession and for the past 12 years, has filled the role of administrator and CEO of T.O.N.E. Home Health Services, Inc. Salim has the privilege of leading a group of professionals who have led T.O.N.E. home healthcare for four and a half star ratings from CMS and apart from providing skilled home care services, T.O.N.E. also has created a robust population health management model that's led to reducing hospitalizations for many of its seniors and has resulted in increasing savings for accountable care organizations or ACOs in the area and because of the expertise and experience of its clinicians, T.O.N.E. has been recognized as an efficient partner in the acute and post-acute healthcare partners in this arena.

Donna Filar has worked in the healthcare field for over 15 years, and for the last seven years, she has worked with Great Lakes Caring, covering home care, palliative care and hospice services, and our last but not least, Debbi Opalweski is a seasoned professional with many years of experience as a registered nurse and holds a national certification in infusion nursing. She has worked in a variety of healthcare settings, from hospital to home care and infusion specialty area as a direct practitioner and in management position. She's currently serving as the administrator of Harbor Home healthcare in Marine City, Michigan. She started her nursing career as a Navy nurse, and currently serves as a nurse consultant for the Michigan Vietnam Veterans Chapter 154.

Today, we're going to be talking specifically about our Southeast Michigan continuing care collaborative home health agency advisory and workgroup that was established and as New England mentioned and Cindy as well, we are part of a quality improvement organization. MPRO is part of the Lake Superior Quality Innovation Network and we serve in collaboration with Stratis Health of Minnesota and MetaStar of Wisconsin as the Lake Superior Quality Innovation Network. We assist CMS in improving healthcare for Medicare beneficiaries by convening and connecting providers to share knowledge and spread best practices and as you can see listed there, many of the same initiatives are part of our QIN-QIO as well as New England.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

Specifically through our work with our community care collaborative in our care coordination tasks, in Southeast Michigan, we have a collaborative that included many home health agencies and as we started our work specifically back in 2016, we found that including home health agencies in our work regarding reducing readmissions and admissions, improving coordination of care and increasing community tenure, they were just a linchpin in all of that work, and so we thought that we would reach out to some of our community partners in the home health agency world, ones that were directly affiliated with hospitals, ones that were their own private agencies, small home health agencies, large home health agencies and convene advisory workgroup. Through our first meetings, we did many of the same things that most workgroups do. We try to settle on some of the top priorities that focus on the top three bullets there and how we would move forward to meet some of those goals and through the Quality Innovation Network, we also wanted to provide data to support that and best practices and information and also just publications that would suit that mission as well. With that, I will send, let Erik talk about some of the things that we talk about at our collaboratives, at our larger collaboratives as well as some of the things that we work on within the group. Erik?

Erik Wilson: Thank you, Barb. Barb, can you confirm that you can hear me?

Barbra Link: Yes, I can hear you just fine, Erik.

Erik Wilson: A lot of our ongoing initiatives, we really started at a key time in home health just really came together and that was when preclaim review was really at the top of everybody's list in the rollout, and especially in the state of Michigan, we were going to be one of the top groups to roll that out. This group really came together and what we did as an advisory group between the 25 providers was come up with a preclaim letter that could go out to the physician and other care providers about what preclaim was, what home health agencies would need and we really had the support of our QIO/QIN behind us and that's who the letter was going to come from, and we actually still use this letter to our current practice because it's just so informative.

The actual need is to ensure that the safe transition of the patient occurs in the community, so it's something that's continually brought up in the overall Southeast Michigan collaborative about how that letter's working out and what the hospitals can do to assist us with certain things.

Another big initiative that we found was part of our operation community tenure and that was really, we had assessed a lot of the major health systems in the area as well as the home health providers and the data that we had had shown that patients who were eligible to come home to home healthcare really would benefit from home health were not receiving those services and a lot of those patients were later readmitted. Just from that, we were able to develop

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

as a group a community, an operation community tenure presentation, an educational initiative that we rolled out with one of the major health systems and their discharge planning team, specifically appropriateness for home health services, what home health provides, how home health works together to keep patients out of the hospital and reduce readmission as well as community resources available. We have a wide variety of resources here in the Detroit Metro area that many of the discharge planners or the hospitals or resident physicians or physicians are aware of that patients could qualify for, and so just getting that information out there for them really proved to be beneficial in our overall aim in getting patients aligned with the appropriate care that they needed.

Going forward, we're continuing to work on and have recently started a home health dashboard, so this is going to be a community dashboard where we can really measure how well patients are transitioning in the community and what some of those barriers are that we're seeing. For example, some of the top things that we're looking at is timeliness of care, appropriateness of medication supply in the home once they're discharged, and then taking that data and seeing where we can really impact quality outcome for patient measures. We know from the home health side that about 125,000 readmissions are associated with medication problems, so this is a huge opportunity for us as a community, specifically in the Southeast Michigan. We have probably one of the highest, if not the highest readmission rates in the country, to come together to really figure out how we can manage these patients going forward and what we can do from a community standpoint and really taking a look at that population focus.

This group in collaboration with the QIN, in collaboration with the hospitals and the skilled nursing and the assisted living in the area has really come together to start to develop initiatives, to start talking, to start measuring outcomes for the things that we've been doing. Current focus right now is really timeliness of care, barriers and successes from patients who are coming from the inpatient side to home health. Why aren't we getting there in time to see them? What are some of our more successful standpoints? The sepsis toolkit and the heart failure toolkit for this year are going to be one of our major rollouts as a collaborative. We're really looking to bridge that gap. Hospitals and skilled nursing are working really hard on sepsis as it's the number one re-admitter right now. Home health has been kind of pushed to the side for that and this community has really stepped forward to say, well, we need to start to standardize what we're doing in the community so that if we're looking at various criteria from a community standpoint, if we can initiate antibiotics sooner, if we can help assist with discharge assessments from the inpatient or skilled side to determine if the patient has an active infection.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

We're just really hitting the tip of that right now moving forward. Last but not least, as most of you know with the conditions of participation changing in January, the focus on care coordination in the community is a huge part of that. Right now, we're working pretty diligently with the health systems and the skilled nursing from our major collaborative side on the appropriateness of documentation or what we need from a home outside to ensure that the patient gets the care that is medically necessary in the community. Those are the initiatives that we've been working on and what we're doing going forward. It's really exciting work and it's kind of interesting to see the response that you get from the health systems from the standpoint of wow, home care is really coming together. You know, that once was such a competitive market but realizing the benefits of working for the entire population as opposed to just the agency specific outcome. Working with the QIN and the QIO has really bridged that gap and it's just a different feel in the community now, so it's been a great work over the past two years. Back to you, Barbra.

Barbra Link: Thank you, Erik. I thought Donna could talk a little bit more about our operation community tenure, how we develop that and a little bit of the efforts that she made to reach out to hospitals and the communications that she was able to develop and connections that she helped with. Donna, would you be willing to talk about that a little bit?

Donna Filar: Sure, thanks so much. Can you hear me?

Barbra Link: Yes, I can hear you.

Donna Filar: Great, thanks. I just want everybody to know, so like Erik said, it really was a great opportunity for us to really display to the entire community that this is just not wordsmith. We are actually working together very diligently to try to help the patients in the community. I think that was a really impressive standpoint for all the hospital systems to see that.

Our focus really was to go to some major hospital systems and we began with the head of discharge planning and case management and we would describe the objective of our group and the common objectives that we all have as home health agencies to really work on the post-acute care for their patients and all work towards the same goal of reducing re-hospitalization. We stress the importance of really looking at some additional training for them. We had put together a program where we had a CEU approved program where we're able to really talk about the discharge planning process and what happens when it reaches a home health agency and the different needs that we have on our end in order to carry forward the needs of a patient.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

Believe it or not, most of the discharge planners and the head of case management were very much in favor of us coming in and that was a good thing because it didn't matter the level of education of the discharge planner. All levels, whether they were tenured or if they were new discharge planner were able to benefit from our presentation because we really did talk about all aspects of a patient going home and our main focus was we wanted to make sure that no patient went home alone. In other words, we wanted to make sure that there was some level of service or resource provided for that patient upon discharge and explained to the case management team how home health agencies can work with that and if a patient was not qualified for home health, other resources that they could perhaps use to access the patient so that they can really provide that care for that patient.

I think what Erik said, it was a really good opportunity. We had some great feedback from a lot of the state hospital systems who let us come in there and talk to them and it was a really nice moment for us to all be standing there in front of the group and I know they were personally kind of surprised to see people that are typically in competition to be working together on the same initiative and it was a really good feeling to the community to see that. Barbra, go ahead. I give it back to you.

Barbra Link: Thank you, Donna. Thanks. Next, I thought Salim and Debbi could just speak a little bit about our monthly meetings that we have with the home health workgroup and sort of some of the things that we focus there and how we share ideas and that sort of thing. Maybe Salim, would you like to go first?

Salim Bhinderwala: Thank you, Ms. Barb. I hope everyone can hear me. I'm a physical therapist and currently in the role of administrator of T.O.N.E. home health services in Farmington Hills, Michigan. With our monthly meetings, like when MPRO started these monthly meetings with our care like with the QIO, it gave us an opportunity to see other home health agencies in our area not as competitors but as colleagues, colleagues facing the exact same challenges, exact same issues that I face in office daily. Suddenly, I'm not the only one having the task to come up with all the solutions. I had found many problem solvers, many great minds coming on the table and helping us resolve issues.

One such problem was the timeliness of care, being able to see the patient and do a start of care within the stipulated 24 to 48 hours of being discharged from the inpatient facility. What we did at the monthly meetings was discussed about our challenges and obstacles in providing the timely care. We collected data from multiple agencies and shortlisted our top reasons. Like Erik and Donna mentioned earlier, when we had the services of the case managers, we discussed the top issues that we had in doing a timely start of care. Those were like not having the proper contact information on the referral from the hospital or skilled nursing facility. Another one was patients were not being informed by

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

the discharge planner about the scope of services being provided by the home care team and patient either were delaying or refusing home care staff to make the initial visit.

After discussing these issues, MPRO along with multiple home health partners coordinated in-services and CEU hospital case managers, wherein we emphasized the importance of accurate contact information to be present on discharge paperwork and also explained to them the range of and scope of what we do as a home health agency. This did wonders for us, resulting in better transition of care processes between a hospital and a home health agency and being able to provide care in a timely manner. These actions at times might be too challenging for an individual home health agency and thus, working with QIN-QIO, in this case, the MPRO helped us to make it more effective and efficient moving forward.

When we meet as a group on these monthly meetings, we don't merely stick our conversation to sepsis or CHF toolkit or some things like that. We discuss any and every concern that we have as a home health agency. In other words, it gives all agencies a voice, no matter how big or small we are, and in process of finding solutions to these common questions or concerns, we end up creating a better workflow or a better process within our agency that makes us more effective and efficient. Really, I cannot be thankful enough for MPRO to get us together and starting to have a more coordinated effort of moving forward.

It's not my problem alone. We all work towards it together now and I cannot emphasize the importance of HHQI that they've given us over the past so many years with all the free resources that they keep giving, we use them on a regular basis. Thank you, and I'll let Debbi talk.

Deborah Opalewski: Are you able to hear me?

Salim Bhinderwala: Yes.

Barbra Link: Yeah, we can hear you. Debbi.

Deborah Opalewski: Great. I'll just well kind of make a synopsis in regards to what my other three colleagues have addressed. The importance at the MPRO meeting is to be able to network with other agencies. Having been in home care for quite some time, I've seen the more welcome change of home care agencies that were in competition now working together to do what's best for our home care patients. I have the opportunity to not only share with the MPRO and quality group that we meet on our monthly meetings, but I also have the opportunity to sit on committees at the Michigan Home Health Association at the state level, where we can collaborate and speak with issues from other home care agencies,

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

so that the sharing of that information can be brought back to either both meetings, again to focus on what the better patient outcomes might be in regards to providing optimal care to our home care patient.

It's quite the opportunity to be able to sit down at the table with home care agencies to not be so to speak reinventing the wheel, being able to collaborate and contribute from the many, many years of knowledge that are brought to the table on a monthly basis. We so appreciate each other's expert knowledge in different areas that we provide to our home care patients and we're very thankful that MPRO can facilitate the collaboration of all these home care agencies. Barb, I'll send it back to you.

Barbra Link: Thank you so much. Debbie, I would like to thank all four of you. I think you've really provided the spirit and the reason why we have the home health workgroup and advisory group.

I just wanted to show this last slide to show that this is just one example of the use of data that we have here. We do share this with the regional collaborative when we get everyone together and it's just to show that over time, the readmission percentage has slowly trended downward for the Southeast Michigan area, and I do believe that that's something to celebrate. We are able to show the difference in stay between readmissions to one hospital in the region to readmissions to all the partner hospitals in the area and I think that that also enhances and helps us to tailor the work that we're doing, but we use a variety of different data to support the work that we're doing, as Erik mentioned about how we started to targets sepsis with some of the data that we have from the hospital, as well as the CHF work that we're doing as well.

I just thought I would end it with just showing one example of that but also, I just wanted to summarize by saying the importance of having all of the various home health agencies come together for the workgroup. It's just been a wonderful experience. I think there's been a level of trust and dedication that's happened over the past two years that just really enhances the quality of work that all of the home health agencies are providing in the area as all of our speakers referenced so I really appreciate that they were able to come and present with me today and the ongoing work that they do for quality improvement and helping all the patients in Southeast Michigan and the state of Michigan as well.

All right, Cindy, I'll pass it back to you then.

Cindy Sun: Thank you. I thank all of you. I think you provided an amazing amount of information in just a short period of time and I'm hoping that giving a taste of the differences as well as the similarities across the state, this is something that

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

we each experience and each QIN-QIO has a general idea of what CMS is wanting as far as the focus goes that as you can see, the collaboration between, you heard the home health agencies for Michigan came to the QIN-QIO with an issue in regards to the preclaim reviews. This is not something that maybe the QIN had in mind to focus on but seeing that this can be a collaboration and a joint effort to make a better situation so that all of the citizens, especially the Medicare beneficiaries will benefit from it.

I just wanted to give you a couple ideas. As you are formulating your questions, make sure to go ahead and put them into the q&a box and into the chat and/or the chat and we'll get to them but I wanted to show a couple more resources for you. As HHQI participants, you can find this information, this is an interactive map that you can find under the local QI support under networking. Under interactive, you can click on the map and it will take you directly to the web page of your QIN-QIO based on your state, territory or city.

The other thing is if you want to know who to contact directly at your QIN-QIO, this is part of my own personal objective for you today. If you go to this list, it's available not only under the About Us tab on the blue toolbar across the top of the main page of HHQI and then partners and then network, HHQI Network Coordinators, you'll find this list and it is a constantly changing list. We update it with new network coordinators that come about but it will give you access to who in the QIN-QIO to directly reach out to. This is the same list. I know some of you are familiar with it under the data resources on the data site. That is the same list that will give you who at the QIN-QIO is the best person to contact. If you reach out to them and somehow, maybe it's going into their spam or you're not hearing back from them, definitely reach out to me and I can do an introduction for you.

QINs want to work with you. You can hear that I think in presentations today, the presenters, but at the same time, you don't have a lot of time to reach out and hear about this, so we want to help you foster that relationship, at least know what's available in your area. Okay, so let's get to a few questions real quickly here and I had a few come in privately, so let's start with there were a couple questions that had to do with the same thing so I'm going to ask most of you as far as QINs and agencies go. When you're talking about the data, when you're talking about the different resources such as the preclaims review letter, is that available to everyone in the state or just the agencies in the collaborative?

Maybe Melissa and company in New England, I'll toss it to you first about the data. Does the data report that you create, I think that person is asking, does that include just the collaborative agencies or all the agencies in the state?

Melissa Gordon: No, it's statewide. Each state has their data and it is statewide.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

Cindy Sun: Okay and the preclaim review, I think that was mentioned by Michigan in Lake Superior. Is that available, are those resources available to all the agencies or just the ones in the collaboration?

Barbra Link: That resource is available to any agency that's interested and they can go to the Lake Superior QIN website and go under care coordination and find that resource and after the presentation, I can send that information to Cindy so it's accessible as well.

Cindy Sun: That's wonderful. Thank you, so anybody that is interested in that, especially for those of you, I know not everybody is because preclaim review's only for a few states but if you are in one of those states and interested in it, contact us, either me directly or through HHQI Info and we'll be sure to get that to you.

The next question had to do with the Home Health Association. Are the home health associations active in the collaborative?

Melissa Gordon: Hi, this is Melissa from the New England QIN. Yes, our association and actually all the associations within the New England states are very active in our initiatives.

Cindy Sun: That's wonderful. How about in Michigan?

Barbra Link: I would say the same for Michigan. Our Hospital Association and our Home Health Association has representatives I think in almost all our collaborative and with a statewide group that we have working as well.

Cindy Sun: That sounds great. One other question was, I think this is more of a comment than a question, so forgive me, whoever wrote if I'm getting this incorrect, correct me, talking about the united front. It's interesting how providing a united front is something that is so difficult in home health with the competition and yet it is so powerful.

I think that's what both of you have shown that you've done, both of the organizations that a collaborations that you've done have demonstrated that it is interesting how home health as a healthcare setting is perceived by the other healthcare providers in the community and that demonstrating that something so simple is making such an impact.

Erik Wilson: Cindy?

Cindy Sun: Yes, hello there.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

Erik Wilson: This is Erik and I just wanted to add something in the Michigan community. Well, one of those ways of creating that united front and comfort levels, when we have our monthly meetings, we actually rotate between agencies and so we go to different agencies and have the meetings there, meet their staff, things like that so that you can really kind of conduct with each other on that non-compete level.

Cindy Sun: Thank you for that Erik and I think this is really good information, especially for those who are starting to reach out to their QINs and to realize what else is going on. All right, I'm seeing no other questions right now coming in and I'll give everybody one more minute, literally 60 seconds.

Salim Bhinderwala: In the meanwhile, I was just saying thinking about the same terms of the united front, some agencies might have created some processes for the like the timely initiation of care and later when we will go into these different agencies every month, like some agencies were very good at medication reconciliation process and we were freely sharing that information across and it's for the greater good and I cannot agree more with the comment that was put in.

Cindy Sun: Thanks, Salim. All right, so if we're hearing no more questions, I'm just going to give you a couple final thoughts and a couple announcements before we close out this session.

Of course, we want to mention to you the next Thursday event will be on April 19, which is the underserved population learning action network and as you know, all of these events of HHQI are open to everyone. I want to just put a bug in your ear. For those of you that are interested in wounds, the wound BPIP, I had the privilege of having a peek at an early draft of it. Misty Kevech here is the primary author of all of the BPIPs but this one is a good one, and it's coming out in May. Keep that in mind if you are focusing on wounds or even if you're not sure if your current wound program is as current as you would like it to be. This will be available to you in May and it is a primary BPIP, so it will be a beast, and it will contain multiple tools and resources and it's another collaboration from multiple sources from around the country and it's really good.

The next CardioLAN is going to be on June 23, everything is on the third Thursday so we encourage you to come back. We hope that you do or listen to the archived recording and that's all for the announcements for today. I'd like to thank all of our presenters, you guys for sharing your expertise, sharing your experiences. We really appreciate it. Hopefully this will move home health and the agencies, let them know at least that there is another resource that may not be tapped into. For those of you that are in the audience, if you're not familiar with your QIN-QIO or you'd like to have an introduction to them, please let me know. I'll be glad to do that. We want to take advantage of these quality

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818

improvement experts as well as home health experts that are available and wanting and willing to work with anybody, especially our home health agencies.

With that, I will say have a great day everyone and we will see you next month. Bye bye.

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication number 11SOW-WV-HH-MMD-031818