Transcript: January 2017 UP Network Webinar

The Value of Home & Community-Based Services:
Transforming the Healthcare System & Improving Patient Outcomes

Misty Kevech: Good afternoon, everyone. Thank you for joining us today for the HHQI Underserved Network webinar. Today's session is entitled Value of Home and Community-Based Services, Transforming the Healthcare System and Improving Patient Outcomes. That's a mouthful, but we have a lot of information that we think you'll find very valuable today. So, thank you for joining us. Also on the call today is some of our HHQI team. We have myself, Misty Kevech, an RN project Coordinator, as well as Cindy Sun, Crystal Welch and Sharon Miller that are all RN coordinators. Misty Dyke, our communication specialist; and Andrea Lefkay, also a specialist for us; and our director, Shanen Wright. So we thank you for joining us. Today we're going to be doing the presentation, and then we will entertain Q&As and if you will go ahead and enter any Q&As as we go along into the Q&A box or the chat box, we'll grab those from you and be able to ask those to our presenters.

But, we're excited and want to get started, so I'm going to ask for the next slide as I introduce our presenters for today. We have Tammy Rhoades, who has over 25 years of experience in the social service field and currently is serving as the Chief Executive Officer for Alleghenies United Cerebral Palsy since 2011. In this role, Ms. Rhoades ensures that the organization's fiscal operations, fundraising, marketing, human resources, technology, and program strategies are effectively implemented across all segments of the organization.

Ms. Rhoades also has a proven leadership track in medium to large non-profits including [serving as] the director of social service admissions for a local hospital center as well as a Lutheran home in that area. She has received her bachelors' degree in sociology from Saint Francis University and serves as the Vice President of the UCP of Pennsylvania Coalition.

Ms. Tina Trimbath has 32 years of experience as a nurse and has been working with the Alleghenies United Cerebral Palsy for the past two years. In this role, she is responsible for developing and compiling educational materials on specific diseases and conditions and consulting with service coordinators regarding the consumers' physical health conditions. She also assists with care planning review, including hospitalization documentation. They are also always doing ongoing research and networking with state's organizations to ensure the consumer quality of care. Prior to working with AUCP, she was a telemedicine development specialist with the Center for Excellence for remote and medically underserved areas and also served as a home health occupational therapist.

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So, we are very pleased to have both Tina and Tammy today, and I'm going to go ahead and turn the presentation over to them, and we'll talk about the nursing continuing education credits at the end. So, Tammy and Tina?

Tammy Rhoades: Thank you very much for this opportunity. So, to give everyone a little bit of history on our organization, and how it was developed. Alleghenies United Cerebral Palsy, as many of the organizations, was developed in 1955 by a group of parents who had children with cerebral palsy, and it was developed in order to assist them in getting services, so it is a 501C3. Our main office is in Johnstown, Pennsylvania. We serve as coordination providing in home care, case management to individuals with disabilities from 18 through the elderly and many times, it's individuals recovering from injuries or illness who are in need of assistance and want to remain in their home.

We have a seven member board, which represents us. We also actually worked as an independent enrollment broker from 2009 to 2010, when it became the Maximus organization. We currently serve a geographic location of 47 counties throughout Pennsylvania, which is about two thirds of the state. We are able to serve 67 counties, but Pennsylvania is a very large state, so we decided to limit our counties to 47 counties.

Through those counties, most of our people are in need of long-term support. Most of them have chronic conditions and it's been found with the Home and Community-Based Waivers that it is less expensive to assist individuals to remain in their home as compared to institutional care. And actually, the consumers, or the participants ... I was going to say that in the beginning, and please forgive me, we have two names we go by, consumers and participants. So, our participants actually can enjoy being in their homes and being as independent as possible and they can actually receive medical and personal care services and assistance with their daily living tasks. Some waivers actually permit our participants to have family members provide their care and they can receive payment in order to do that.

Just a little bit of history about the waivers themselves. They were actually developed in 1981, and they were developed by the centers of Medicare and Medicaid, and the waivers actually, or the waiver programs were actually given the name waiver because what it does is it's a waiver with the medical assistance roles, so that they're waiving institutional care so that they can remain in their own homes.

Tina Trimbath: In addition, on that slide, I would just like to add that there's been a lot of studies done examining programs that are out there to improve outcomes and reduce the cost of care for patients with complex needs. And, one of the models that has been shown to be very effective is the multidisciplinary group model, and community health workers of course play a very important part in that

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multidisciplinary team, because they're in the homes for extended periods of time and they can assist with social and emotional aspects of care in addition to making sure that the physical conditions are also being addressed.

Tammy Rhoades: So, some new changes that have been happening for us in the home and community based field is that the state has decided to go with another model, which is the managed care model, or the community health choice model, as a delivery of the Medicaid-funded long-term care and support services. This was initially scheduled to begin on January 2017, and the second phase was to begin on January first, 2018, however, on December 15th of this year, the state decided that due to this being a huge undertaking with insurance companies having to learn the home and community based waivers, the home services, that it was a very big undertaking, so they changed that beginning phase one in the southwest region of the state will begin on January 2018, with the second part to be starting on July 2018 and then phase three and therefore after beginning January first, 2019.

So, why do they want to make this change which is a big change for us, for them and as well as for participants? But they decided to make the change because the NCOs are not required to include, well they decided to make the change, I'm sorry, they decided to make the change to become more efficient. To provide the medical as well as the home and community base and provide that in one package. So, what does this mean for us though? This means that the managed care organizations are not necessarily required to work with all Medicaid providers so, all supports coordination, they're not required to work with us. This may limit ... there may be limits placed on how many providers the NCOs decide to work with, and we must be included in their network and be willing to contract with them as well as them to contract with us.

Organizations who contract with the managed care organizations may be required on our ends to have different electronic medical records systems, billing systems in place and we may have to work with four or five different organizations as opposed to one system that we work with now. And we're also going to have to contract with them and negotiate for rates that they're willing to pay or organization, and they are telling us, if we're not part of the network then we may not be able to serve these individuals.

So, Alleghenies United Cerebral Palsy just to explain why our organization that supports coordination, organizations are so important to the participants. Our agency staff are going into their homes, they're understanding the importance of making our plans person centered and our main focus is on each participants care and how they would like to have that delivered in their homes. Service coordinators take the time, my staff takes the time to learn about the needs of the individuals. What are their strengths, what are their preferences, what are their life's goals to determine the best way to assist them to remain in their

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homes and to reach their own individual goals. And this is very important, if I think of it as, also for myself. What would I want if I were in this situation and I needed to be in my home, I would want to be able to direct my services and have them delivered in the way that I would want them delivered.

And another one of the things that goes unnoticed that the supports coordinators do on a daily basis is there are many of our individuals who have crisis situations on a daily basis. Whether that be financial, whether it be domestic, whether it be they become homeless. We manage all of those with our participants so that they become less of a crisis situation. We also have been noticing that we're getting an increased number of participants that have mental health diagnosis along with a physical disability of some sort.

Tina Trimbath: I would just like to reach out to the home health agencies also and just kind of explain where I'm coming from. Being, as I said, I health care for 30 years, in many different capacities, I thought I understood what a social worker did. But now that I work for this agency and I actually see what the service coordinators do and the things that, the way they can help when they go into the home, I think that we need to use them as a resource and realize that they're a very valuable part of the team and we'll discuss a little bit later in the presentation about the qualifications that they go through, they are professionals and sometimes I think because it's a home and community based program, people think they're non-medical, but that couldn't be further from the truth. They really do provide a very valuable service and their experience and credentials go a long way in the home care.

Tammy Rhoades: And our service coordination practices, we have qualified and experienced service coordinators already located throughout western and central Pennsylvania. We have our coordinators hired in the geographic locations and there's some reasons we do that. Financial literacy, we assist individuals to understand their financial choices, how to budget, how their behavior is going to affect their ability to remain in their home and how to reach the goals that they want to remain in their homes. Our staff has also built very effective partnerships and relationships within the community that they serve so they are able to develop a community resource guide for the individuals that we service.

Some of the other practices are with our agency, we have an emergency on call. We're available to our participants 24 hours a day. We report, we track any incidents, which include hospital visits, ER admissions, we want to know have they had a repeat admission, is this something that we could assist with health outcomes in order to improve or reduce future admissions. We track any behavioral health diagnosis, the medications and the treatments that they're receiving in order to assist the participants or the consumers with the continuum of care.

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We track any consumer wounds, participant wounds in an effort to assist them with proper care and to improve their overall health. We also track incidents or self-neglect or abuse because we need to address those and ensure the health and safety of our individuals. And in addition to doing that, we have to, we cannot do this alone. We do not have all of the expertise, so in addition to doing this, we're reaching out to our community providers, we're reaching out to the participant's PCP, we're reaching out to home health agencies because they have the PTOT, the nutritionist, the mental health. We're reaching out for all of those because they provide a continuum of care and we reach out to them to get them into the participants life for a resource.

We also, our service coordinators are in contact with ... and this is to show you how often we are touching their lives. We're contacting our participants monthly by phone. We're visiting them quarterly in their homes, to update on anything that's changing, any additional services. We develop a person centered plan with them, which includes identifying an emergency back up in the event that the agency or the provider is unable to go into the home to provide the care. We need to know that they're going to be safe when that's not happening. So we find unpaid caregivers. With track any medical services that are going into their homes, we get permission to speak with those agencies so that we can provide that continuum of care. And then, we also communicate monthly with medical agencies that may be in the home, it may be the PCP, it may be a skilled nursing agency or a home health agency going into the home, but we make the effort to reach out to them, to stay in contact.

We're also, and I don't know if anybody ... how much you know about this, but we work with Durable Medical Companies to obtain medical equipment for our participants. Many times, the insurance that they have will not cover a particular piece of equipment, so there is a, it's a lengthy process unfortunately, but we are able, in many cases, to get medical equipment that is needed for our individual.

We also are identifying risks that are going on in the home. We have many more than I like to say that are smoking and using oxygen while they're smoking. So we make an effort to review the dangers of smoking with oxygen and we do that with the Durable Medical Company, whoever's providing that oxygen, we make sure that they're aware that that person is smoking with oxygen and we have them go out on a every six month basis at least, to review the safety and what they should or should not be doing. We have an RN on staff that assists with critical incidence when our support coordinators or services coordinators identify that, they're reaching out to our RN to talk about what can we do, how can we keep this person safe?

Quality management checks are done quarterly and monthly to ensure our information is updated and accurate. And we create caseloads in a manner of

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knowing that the support coordinators of the geographic location that they know that area, that they're able to serve our participant quickly and they can get to their home.

And when we say home modifications, just to elaborate just a little bit, that could mean ramps, it could mean, and I didn't even talk about that, we do home modifications as well, so if it's going to ... we can't add new structures on, but if it's going to make their life easier, help them become more independent, we can do ramps, we can do door widening, we do a lot of bathroom modifications. We've done lifts within the homes. Occasionally, we've been able to do a kitchen, but it's gotta be something that we can show that we're making their lives better, more independent for that participant.

Also, we have policies and procedures in place to identify risks. We have risk assessment that we complete quarterly with our participants and we also address the risks that they have, both physical and environmental in their home. We educated our participants on identifying risks, we share this documentation with them and we work on mitigating strategies. Actually, individualized to that person. Our staff has monthly case conference with their supervisors and the service coordinators so that we're identifying and they're assigning if we're missing something, it gives us a second step to cover that.

We also have staff that are dedicated to a program called Nursing Home Transition. And that program was designed to identify individuals who are able to return home, who are in institutions and wish to return home, and then we work with them to identify any barriers that they have to returning home and we try to reduce those barriers to get them home so that they're living in the environment that they want.

Tina Trimbath: In addition, the agency has developed a reference library that the staff can use to help educate themselves maybe on a specific disease that they're not familiar with or the information is also developed at a level so that they can share it with the consumers or participants and educate them as well. When a consumer goes into the hospital or the emergency room, the coordinator will always follow up to determine if there was anything that could be done to prevent the hospitalization or the ER visit, and of course, we know some visits cannot be prevented, however, if after reviewing the case, it was determined that the visit could have been prevented, by a certain intervention, a mitigation strategy is put in place and the consumer is monitored to see if the strategy is effective. So all these things are really helping to keep these patients safe and healthy and able to stay in their homes.

Tammy Rhoades: So you know that our staff, professional development, we've actually developed a very professional comprehensive training tool that we use with our staff. Some of the things that we do, we provide a significant portion of professional

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development training and in most cases, we use train the trainer model. Because this is such a fluently moving position, we feel that it is most effective to have our staff work with another staff member who has had that case or who is familiar with our process and developing it. It reduces our overall cost, but it also encourages lifelong learning and continuing education credits among our employees. It also strengthens employee to employee working relationship because then they are peer employees and they are able to serve as facilitators and new learning or changing service methodologies and government requirements, which change every day. Or, other industry related trends.

Our staff, we are trained on the home and community based waivers and the programs. It's important for them to know eligibility requirements and assessment forms. Home and community based enrollment and eligibility process is also very important, so that when they're out in the field, if they meet someone, they know how that person can become enrolled. Home and community based participant centered service planning development process is extremely important to us as well because we can go in and work with someone, but if we don't know how to act and how to get them doing their individual service plan, we're not gonna do the best job that we can. We also very aware of cultural sensitivity and cultural diversity, which is extremely important.

We also provide training on crisis management, on complaint management because it's important to know those things. Customer service and communication skills. One of the things that's become big in our field as well, even though we're considered non-medical is the HIPPA and the privacy and confidentiality. We have strict guidelines with that and we review that with our participants as well as with the staff.

With the nursing home transition, there's a program called Money Follows the Person, which is a program to provide funding back to the state as well, as an incentive to have people return home. We also are working with the department of human services, on person centered planning, and we also teach them on differing geographic locations, rural verses urban settings, which is extremely challenging for us because of many services that are available in the urban center are not available in the rural setting, and it's understanding also the different thought process of our participants as they're living in those different geographic locations.

Our staff ... let me see, I think I jumped ahead. I'm sorry. I'm gonna go back. If I can figure out how to do it. Also, too, for our staff, we have some very unique aspects of the Office of Longer Term Living, or DHS, with participant groups. The service needs associated with various types of disabilities and which waivers or programs to provide the services in, and the specific type of disability and the age group. And understanding in some of the waivers, to just give a little bit of

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explanation there, in some of the waivers, you cannot have home modifications in durable medical equipment, it isn't paid for. In some of them, such as one of our waivers, which strength called the over waiver, was specifically set up for children who were transitioning over and becoming adults at 18. So those are some of the things we train them on.

Understanding the services available, again, that's through each model. Collaboration and internal and external stakeholder groups involving enrollment, we must work with the independent enrollment broker. It's very important that we know our area agencies on aging, because they also do some of our assessments. The count assistance office which helps us with financial eligibility. Other service coordination agencies in the area. The link or ADRC entities throughout the state we work closely with and also with nursing home transition coordinators throughout the state. Understanding the role of mandated reporter as required by the older adult protective services has become huge. We have to know when we're supposed to report. And that doesn't limit us to that mandated reporter for adult protective, we also come across children in youth situations where we're requiring them to talk to those agencies as well.

Staffing requirements. Our staff are required to have a bachelors' degree in social work or an equivalent bachelors' degree. We prefer that they have two years of experience and a lot of times we're hiring them for geographic locations so that they know that area, they know the culture, they know the values, they're familiar with the resources within that community and they have field based experience as well.

Okay. Our staffing requirements, too. Confidentiality and sensitive information. Very important that they understand that we protect the confidentiality provider, our clients, our departmental records in compliance with the federal and state laws and regulations. We agree, AUCP agrees that any breach of this information is as a result of termination. All personal comply with the HIPPA regulations and we have a signed copy of that in every one of our participants files as it's important to our participants as well.

Our staffing requirements, not only do we require educational requirements, but we also do a comprehensive background checks, we check their child abuse, we do criminal records checks, we do the Federal Bureau of Investigation check, finger printing as well and we do Medicaid fraud checks and we actually do those on a monthly basis as a requirement for our agency.

Quality management plan. The importance of quality actually in our organization. We were tasked with ... this is a little bit of a challenge for me, but we were tasked with creating a quality management plan, as a tool for our agency to meet or exceed our participants expectations and to ensure that we

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were meeting the health and safety of each one of our participants. So we used the following methods to meet our standards. So with our quality management plan, the staff is actively achieving the agency's mission to assist children, youth and adults with disabilities in meeting their basic needs and enhancing their quality of life and promoting their independence. We do this by having a monthly binder and service note review to make sure that we're in compliance with the Office of Long Term Living regulations, we require monthly participant phone calls and quarterly home visits so we can keep a pulse on what's going on. We ensure participant satisfaction by giving annual surveys and we follow up with those surveys sometimes immediately to make sure that we're addressing needs and then other times, it's creating processes that we can improve.

Incident management is a very big part of our organization because our goal is to reduce the number of incidents and all of the above steps are in place to do that as well. And then, employee retention and satisfaction, this field is a very hard field to keep staff. I'm asking a lot of them to do every day. I'm asking them to be responsible for people's health and safety and be very cognizant of that. So, we're very aware of our employee retention and we try to meet their needs as well.

Quarterly and quality improvement committee meetings, we do that internally so that we have, our staff have a chance to be involved in that and to address the needs of our participants. We also do annual training on our quality management plan and it's actually a working document so it changes very fluently as we see if our agency's meeting that or needs to improve.

Data tracking. We recognize the importance of actually having data. In the first two years that I was here, we actually didn't have data, and then we decided that it was very useful because it gives us, shows us our quality of care and it drives us to have better outcomes. These efforts to assist the agency by providing important benchmarks as well, it gives us the ability to know have we improved on our incidents, do we have more people going to the hospital, do we have less people going to the hospital? Are we effectively communicating? Maybe you don't need to go to the emergency room all the time, maybe you can go to your PCP and get that addressed.

And it also gives us the ability to give other people that data as well. We've actually been able to identify the number and types of incidents that we have. Are we having people with the repeat incident actually for the same thing or do they have numerous hospitalizations and are they for different reasons? We're able to look at new conditions, new diagnosis. We can find decline in a participants condition or is there change? Do we need to add more hours in there, do we need to provide more care into the home? Our RN and our staff have developed a resource library that is phenomenal. They can provide our

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participants with educational materials on so here's your discharge plan and in addition to that ... and we can also with our direct care agencies that are going into the home, we can provide that information to them because they're there every day. They're seeing that person every day. So if they need to drink more, do they need changed more, do they need turned more? Are all these things in place so that we can make sure that they're getting the best care that they need?

We've also been able to, with the emergency rooms, we actually provided all of our participants, we look this up in the geographic location and we provided them with information on med wells or urgent cares in their areas to try to, if it's not a true emergency and you have a stomachache or you have the flu, go to your PCP or go to an urgent care, you don't always have to go to the emergency room.

The other thing that we've been able to do is based on people improving or changing with their individual or person centered planning, we can move around the services that they're receiving to say do you need more hours of personal care, do you need less hours of personal care, has there been medication changes that have been happening in the home, is there any contraindicated medications because a lot of times, we'll get a consumer that's overdosed when in fact maybe they haven't overdosed but there's some medications that need to be looked at. We offer the preventative measure tolls, we follow up phone calls with these participants, we do a visit if needed within 24 hours or 48 hours of them returning home.

We develop the individual action plan, maybe changing it up because they have something that's changed on there. We get consent to release of the information so that we can talk to the PCP, we can share information with them. If they have a home health agency or skilled agency going in, we can share information with them.

So overall, we've been able to reduce the number of hospitalization and actually reduce the number of ER visits as well. Just giving you an individual case that we ran into, we had an individual, this is how closely we monitor this individual, or all of our individuals. We have a particular individual who has, in addition to being a diabetic, she also has some very severe mental health diagnosis going on as well and a lot of times, we can monitor her, we've seen that when she stops taking her medication, or she's not eating properly, that she starts to decline and with the PAS agency or the direct care agency, we were able to identify when she starts to decline and from that, we have taken actually steps to know that she usually declines in December and what happens first is she stops paying her bills, then she stops taking her medication, then she stops going to her appointments. So we make a concerted effort that we know in

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November, we're going to start paying more attention, we're going to pay closer attention to that.

We had to have crisis involved in that. She has a psychiatrist that we talk with. She has the direct care agency that we talked with. So we're involved with all of those agencies to make sure that we're going to hit this in November, we know this is happening and we talk to her about it as well and knock on wood, we've been able to keep her, everything in control with her, with their help.

Okay. Mental health, again, I just did talk a little bit about this, but since it's been a huge issue with us, our staff's actually gotten training on this as well, we're able to identify the participant risk, current treatments, medications, professional services. We watch and get other agencies involved as well within the home and in the waivers. We watch for interruption of waiver services and we collaborate with other agencies as well.

Wound identification. One of the things we found is that a majority of our participants because of the medical diagnosis that they have, they're also at risk for wounds or skin integrity issues. So we've created a way to identify individuals at risk through their individual service plan. We work in collaboration with the medical professionals, getting them into the home, to insure that there's a plan of care, and that the wound is being treated. We work with the participant to insure treatment, and again, we're getting the consent to releases, monthly reports. We have our RN reviewing that and working with the participants to insure that the treatment is being followed. And if they refuse treatment, which they absolutely have the right to do that, we work with them on doing that as well and figure out other ways or we concede and that's what they want to do and we just monitor it.

Consumer satisfaction, again, we're doing the annual surveys, we're looking at the core indicators for home and community based services, and over the last two years, we've been able to have about a 40% return rate from our individuals. We've been able to create quality of care from this. We follow up with the participants, we do the monthly calls, we have the complaint process and we're tracking all the complaints for resolutions. One of the biggest issues that still remains for all of our participants is transportation. Especially in the rural areas, and one of the things the waivers can do is we're actually able to add nonmedical transportation within the waiver services so that they can have someone drive them to and from their appointments, so that is huge. And then we're also looking at employment because that's a big push right now is to be able to have our participants find and get to employment.

Information technology, again, as with everyone else, we're required to know the HCSIS system which is the state system, a SAMS system which is Social Security, or Social Administration and the provider reimbursement where we

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also look with promise to do all of those things so we're staying current on what we need to do there as well.

We also have access to COMPASS, and I don't know if everyone's aware of that, but COMPASS is a system that was actually set up by the state of Pennsylvania so that providers can, or participants can actually access social service agencies online and be able to see who is a provider in your area. The client information, it gives us the ability to look at food stamps, Medicaid, who's eligible, SSI, those types of systems. And then we agree that we have to meet all of our, the standards and regulations to be part of that network.

Okay, I mean, those are mainly ... these are questions that we have to help determine if there's quality of care within the organization. If you're looking for that, what's the mission? What's the agency's accreditation. We're working now on getting an accreditation that's recently been offered to our organization. You know, the agency, a qualified provider and the staff, I mean, in the state and if they're not, why aren't they and are you comfortable with that? What safety measures do they do to assure that the agency protects our participants in their rights. Do we have a qualified staff, does an agency have the qualified staff and are they maintaining that highest quality standards? Is the agency respected in the community that is served?

What connections do they have with other agencies within the community? Does the agency have a 24 hours on call policy? Are they looking at the health and safety? What's the case management, how many are on a caseload? Are the consumers satisfied or do we monitor that? Does the agency monitor that and how do they monitor that? Those are all questions that you want to have of an organization, even if you're looking for the services for a family member or you're recommending an agency. They should be looking at all that.

The success of our agency stems actually from the expertise delivering high quality, compassionate, person centered planning and management of our services. But the other thing that makes us successful is is that we're striving to reach out to the medical field to our community agencies to try to provide collaborative care, to make it a continuum of care, I cannot stress this enough, our agency has worked over the last two years to strive to reach out to agencies that are in the homes of our participants because it's so important that we provide the continuum of care and we go in daily, we have services that are in there every single day so if there's something that our agencies can be doing, we want to do what the PCP wants us to do, what the skilled agencies think that would work best with the people. PT, OT, we do range of motion. All of that is extremely important to keeping our individuals independent in the community and we need all of these agencies to do that.

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So we create these positive relationships with our participants, we work with all of you, or other agencies to try to provide that and we want to be educated on what's going on. We want to keep our people healthy and out of the hospital and the ERs, and that's our goal. That's what we're doing, we're striving to provider overall quality of life for the individuals that we serve.

And I really appreciate the opportunity to present to all of you and definitely looking forward to any questions that you might have.

Misty Kevech: Thank you so much Tammy and Tina. So if you do have some questions, please put them into the Q and A box or into the chat box and I'll kind of get some things started as we go along. Today's presentation, which I probably should have said at the very beginning, you know, is an example of a high quality organization that you can look for in your own state or in your local communities. We tend to use home and community services as our last ditch effort unfortunately. In home health, we tend to make referrals kind of late, there's a long application, waiting list, so we need to start thinking well in advanced and not only getting involved with them sooner, but also because of the whole change in health care, with the focus on quality and for home care, we know the new QAPI requirements came out in January, so we are all about the focus of quality and so do we not want to be partnering with other organizations including home and community based services that have the same goals, the same type of experience or strive for high quality.

And are they doing tracking and data? That was one of the things that really excited us when we talked with Tammy and Tina months and months ago is that they're doing data tracking that isn't necessarily required, although the rules continue to change just like in home care, their changing for all of the services providers and looking more at data driven, quality focus formal processes and this is a great organization that is doing wonderful things and if ... I'm going to see if ... there we go. I have control. I'm going to go back to ... I'm going to back here to a slide. I had asked Tammy and Tina to create the slide 33 for you, these are questions, these are some things to help you jump start what you should ask about. What are you working on? What are your quality indicators? Are you working on hospitalizations? Do you live in a community that has high incidents of mental health? Are they skilled? We've heard from Tammy that not only do they acknowledge they are data tracking some of those diagnosis, they're doing education and training with all of their clinicians.

So those are the kind of things that you could start in having a dialogue about and then being selective with which providers you're working with, it's only going to improve your own outcome.

I am going to check for some Q and A and we has some questions about the PowerPoint and if you look in the chat box, the link is provided in the chat box,

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where you can go to get the slides, and let's see, as well as you can also download the slides at the top of our WebEx screen under file and you're able to click on save as and then you can save the slides that way as well.

I'm going to go and ahead, Tammy and Tina, we're gonna come back to you in a few minutes and I have some more comments, but I'm going to go ahead and actually go ahead through the rest of the resource slides and then we'll come back to some more Q&A. Actually, I've got a question for you right now, so please speak more to the interaction with family care givers and assessment of family care giver resilience.

Tammy Rhoades: So when we ... at the beginning of our services with a participant, there is a lengthy assessment that we complete asking about the informal supports or the family and we're extremely cognizant of how important the family is, so every single time we meet with an individual participant, we'll ask them if they would like to have a family member present. We have a huge number of parents that care for our individual participants. We have siblings that will care for our individuals. So overall, what we do is from the very beginning, we pull them in and we ask about the dynamic, we look at the dynamic at the beginning and we actively involved family if the participant allows us to contact them and have them involved so they are very important and we discuss that at the beginning and every year and at our quarterly visits about the family and the interaction there because they're extremely important within the whole quality of care.

Misty Kevech: Wonderful. And I have gotten another comment in too just to say this was really good information. It gives me more insight out to work with the service coordinators, and you would be the experts then to tell us what we can and cannot do for patients in those waiver programs, such as with ramps, et cetera, so this is very valuable.

Tammy Rhoades: Thank you.

Misty Kevech: All right, well then I'm going to let you continue to put in any other questions and I'm just going to show you a very resources and go over the continuing education and then we'll come back to Q and A. Two resources that were provided of our best practices intervention packages are the underserved population best practice package, which really address population. We know from home health, this is our dual eligible patients, our patients with disabilities, as well as behavioral health. So there's lots in this best practice package that's for the underserved. And also, our fundamentals for reduction hospitalization BPIP, that Tammy talked about the work that they've been doing in hospitalizations and really that is a cross setting initiative, so there is a good practice.

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Now, in the underserved population BPIP, there was really one resource I wanted to highlight because it's so much aligned with what Tammy and Tina were going to talk about today. And this is just some simple tips for creating health care collaboration, which could be hospitals, could be skilled facilities, but it also could be your home and community based providers. But just some simple tips and points. I really would suggest that you sit down, think about what you want to do, and open up dialogue. I would set up a meeting with each of your providers individually and start dialoguing. Find out what ... know more about their organization, what they're doing, not just covering their patients, but these are our providers that are going to continue after we discharge our patients, to keep them in the community. And we could be better coordinators or collaborators.

I also want to tell you about our next UP networking event, which we're very excited about. It's Patient Safety: All in a Day's Work, and it will be first steps to meet the new home health conditions of participation. We know that there are safety and infection control as well as regular QAPI that is included into those COPs, but Tina Hilmas and her team at the Center for Patient Safety, are going to really talk about and kind of treat this as a workshop or as a bootcamp, and it's going to be a two hour, which is longer than we normally do, but there's going to be work projects that you're going to do throughout the webinar to help you jumpstart in getting pieces into place for your COP. They really focus on the culture of organization improvement, so we're gonna learn a lot and be able to do a lot in these two hours, so save the date, April the 20th from 2:00 to 4:00 p.m. eastern, and there is a link within the presentation that you can go ahead and sign up for as well.

Now, for the continuing ed for this course, for today's course, for nursing, there are 1.25 hours of free nursing CEs that come through the American Nurses Credential Center, and you just needed to watch this session and obviously if you are watching live, you've done that. If not, you'll be able to watch the recording. But you do need to register for the course. You just have to register in our HHQI University and complete a couple items and I'll show you those on the next slide.

So you go into HHQI University and there's a specific link, and you will be directed there after this live presentation. You just need to create a registration one time, it's different than HHQI's general site, so you just have ... because you need to put in a little bit specifics for your CE part, I think four or five questions. If you're not sure you've already registered, contact us in our mailbox at HHQI@qualityinsights.org and we'll have that on another slide because we'll check for you so you don't have two. We want to keep you so all of your certificates are in one registration. So that's what you'll need to do first. If you've already registered then just log in and if you forgot your password, there is a forgotten password feature.

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Then you're going to need to go to the underserved population course catalog and that's where you're going to find this course of value of home and community based services. And click on the little apple just to enroll and then go ahead and click on my account that's gonna pop up and you can go ahead, click the little green box that will come up in the view column and it sounds more complicated than it is, just using the apple, hit enrolled, hit the little book to get started and go ahead and start into your first lesson. And actually, there is only one lesson, it's the evaluation and the reflective questions all built in. You know, you can just quickly see what your requirements are, take the evaluation and answer the reflective question and you can finish off of that. When you're done, you go to the my account area and it's in the black menu bar and your certificate will be listed on the left side that you'll be able to download, either print or electronically save.

So that's how to do CEs. If you have any questions, please contact us through our mailbox. And, let's see if there's any additional questions in the mailbox.

Okay. There's also another comment. This provides a lot of feedback on staffers I should consider when pruning community relationships for my health ministry as well. So that's an excellent comment, thank you very much. We do not provide social workers CEs for this webinar, we do have one other webinar that does provide social work CEs that is in our HHQI University and that is the long term effects of negative effects of trauma if you're interested in CEs for that. And Misty Dyke, I'm going to ask if I have missed anything, I'm thinking I've got most of the questions.

Misty Dyke: Yeah, I'm not seeing any additional questions on my end.

Misty Kevech: Okay, thank you. I always like to have someone else take a look. So as we kind of close out, I want to thank Tammy and Tina so much for providing us an insight. It's kind of like pushing the curtain past and looking at the insides of a high functioning quality organization. The terms for your state may vary, the different programs, we know there are most changes to be coming with improving and reducing cost and being more efficient for our Medicaid population, especially our dual eligible, as well as improving outcomes related to hospitalization, med management, and this is just such a beautiful marriage for home health, but we need to take a more active role rather than just being a one way making a referral and then it's off of our radar. We need to be working with high quality players. We need to be seeing what we both can do that we're not doing duplicate services and can save up money and be able to work collaboratively for better patient outcome.

I'm going to come back to Tammy, do you or Tina have one final statement that you would like to provide?

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Tammy Rhoades: I think for me, it's just understanding the importance of the continuum of care, that home and community based services coordination agencies may not be considered medical, but the non-medical care that we do, the social aspect is part of the medical aspect and collaborating the whole picture gives us continuum of care and just working together just gives us so much more quality and so much more that we can give to our participants if we're working together.

Misty Kevech: Well, again, we thank the two of you very much for sharing today, we'd also like to thank everybody for your time. This session is recorded and will be posted by tomorrow and the CEs will also be available for nursing at that time as well. Thank you very much.

Tammy Rhoades: Thank you.

Tina Trimbath: Thank you.

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