Continuing Education

The planners and presenters of this activity disclose no relevant relationships with any commercial entity pertaining to the content.

- Nurse attendees may earn a maximum of 15.5 contact hours
- Accountant attendees can earn up to 18.9 CPEs

Accreditation Statement
NAHC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
NAHC is [also] approved by the California Board of Registered Nursing, provider #10810.

Commercial Support provided by Brightree, Excel Health Group, Healthcare Provider Solutions, and Simione Healthcare Consultants.
Learning Outcomes

• Understand the myths and the history contributing to current therapy utilization to stop the pendulum swing
• Know what to expect and where to access information for therapy ‘best practice’
• Use collaboration for most accurate OASIS data
• Shift therapy practice from volume to value

PDGM Therapy Utilization Myths

• “Medicare is no longer paying for therapy”
• “Therapists should no longer treat. Focus on teaching and no more than 3 visits”
• “This is the death knell for therapy in home health”
• What do you anticipate the impact will be at your agency?
NAHC Survey Results

How do you anticipate PDGM will impact therapy utilization in your agency?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay the same</td>
<td>34%</td>
</tr>
<tr>
<td>Decrease more than 10%</td>
<td>25%</td>
</tr>
<tr>
<td>Decrease less than 10%</td>
<td>23%</td>
</tr>
<tr>
<td>Unsure</td>
<td>2%</td>
</tr>
<tr>
<td>Increase</td>
<td>2%</td>
</tr>
</tbody>
</table>

485 Responses

What about therapy?

- We disagree that the PDGM diminishes or devalues the clinical importance of therapy. The musculoskeletal and neurological rehabilitation groups under the PDGM recognize the unique needs of patients with musculoskeletal or neurological conditions who require therapy as the primary reason for home health services.

- For the other clinical groups, we note that the 30-day base payment amount includes therapy services, even if the primary reason for home health is not for the provision of therapy. The functional impairment level adjustment in conjunction with the other case-mix adjusters under the PDGM, aligns payment with the costs of providing services, including therapy.
Therapy Track Record

<table>
<thead>
<tr>
<th>Pre PPS</th>
<th>Initial PPS</th>
<th>Revised PPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low Therapy Use Overall</td>
<td>• Therapy Use Increases</td>
<td>• Therapy Use Increases</td>
</tr>
<tr>
<td>• &lt; 10</td>
<td>• 10 - 13</td>
<td>• 14+ / 20+</td>
</tr>
</tbody>
</table>

Significant change in PDGM = Confirmation

Stop the Pendulum Swing

Pre PPS low therapy utilization

Current PPS high therapy utilization

Appropriate Therapy Utilization
Defining “Best Practice”

- APTA Guide to Practice
- Guidelines for the Provision of Physical Therapy in the Home
- AOTA Occupational Therapy Practice Guidelines
- Home Health: A Guide for Occupational Therapy Practice
- ASHA Scope of Practice in Speech-Language Pathology
- ASHA Practice Policy

Decision Making Today

Therapy frequency and duration in your agency currently is based on (select all that apply)
Therapy frequency and duration in your agency in PDGM will be based on (select all that apply):

- Office Based Care Coordination Recommendations
- Evidence Based Clinical Pathways
- Therapist Clinical Decision Making
- Clinical Grouping
- Functional Grouping

Multiple choice options:
- Unsure
- 14
- 194
- 224
- 224
- 224
- 154
- 225

<table>
<thead>
<tr>
<th>Functional OASIS Items</th>
<th>PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1800: Grooming</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>M1810: Current ability to dress upper</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M1820: Current ability to dress lower</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M1830: Bathing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M1840: Toilet Transferring</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M1850: Transferring</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M1860: Ambulation/Locomotion</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>M1033: Risk of Hospitalization</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
How do you anticipate PDGM will impact how therapists and nurses collaborate on OASIS data collection?

- Increase use of structured processes: 77%
- Unsure: 16%
- We do not use structured processes: 5%
- Decrease use of structured processes: 2%

OASIS Collaboration

Reconciling M and GG

(M1810) Current Ability to Dress Upper Body safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.

Enter Code

0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
1 Able to dress upper body without assistance if clothing is laid out or handed to the patient.
2 Someone must help the patient put on upper body clothing.
3 Patient depends entirely upon another person to dress the upper body.

F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
Thresholds Based on Clinical Grouping

<table>
<thead>
<tr>
<th>Clinical Grouping</th>
<th>Functional:</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMTA – Surgical Aftercare</td>
<td></td>
<td>0-24</td>
<td>25-37</td>
<td>38+</td>
</tr>
<tr>
<td>MMTA – Cardiac &amp; Circulatory</td>
<td></td>
<td>0-36</td>
<td>37-52</td>
<td>53+</td>
</tr>
<tr>
<td>MMTA – Endocrine</td>
<td></td>
<td>0-51</td>
<td>52-67</td>
<td>68+</td>
</tr>
<tr>
<td>MMTA – Gastrointestinal &amp; Genitourinary system</td>
<td></td>
<td>0-27</td>
<td>28-44</td>
<td>45+</td>
</tr>
<tr>
<td>MMTA - Infectious Disease, Neoplasms, Blood-Forming Diseases</td>
<td></td>
<td>0-32</td>
<td>33-49</td>
<td>50+</td>
</tr>
<tr>
<td>MMTA – Respiratory</td>
<td></td>
<td>0-29</td>
<td>30-43</td>
<td>44+</td>
</tr>
<tr>
<td>MMTA – Other</td>
<td></td>
<td>0-32</td>
<td>33-48</td>
<td>49+</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td>0-36</td>
<td>37-52</td>
<td>53+</td>
</tr>
<tr>
<td>Complex Nursing Interventions</td>
<td></td>
<td>0-38</td>
<td>39-58</td>
<td>59+</td>
</tr>
<tr>
<td>Musculoskeletal Rehabilitation</td>
<td></td>
<td>0-38</td>
<td>39-52</td>
<td>53+</td>
</tr>
<tr>
<td>Neuro Rehabilitation</td>
<td></td>
<td>0-44</td>
<td>45-60</td>
<td>61+</td>
</tr>
<tr>
<td>Wound</td>
<td></td>
<td>0-41</td>
<td>43-61</td>
<td>62+</td>
</tr>
</tbody>
</table>
Unacceptable Primary Diagnosis

9 of the top 50 primary diagnoses used from 2015 – 2017 are not on the acceptable list

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>M54.5</td>
<td>Low back pain</td>
</tr>
<tr>
<td>M62.81</td>
<td>Muscle weakness (generalized)</td>
</tr>
<tr>
<td>R26.2</td>
<td>Difficulty in walking, not elsewhere classified</td>
</tr>
<tr>
<td>R26.81</td>
<td>Unsteadiness on feet</td>
</tr>
<tr>
<td>R26.89</td>
<td>Other abnormalities of gait and mobility</td>
</tr>
<tr>
<td>R26.9</td>
<td>Unspecified abnormalities of gait and mobility</td>
</tr>
<tr>
<td>R29.6</td>
<td>Repeated falls</td>
</tr>
<tr>
<td>R53.1</td>
<td>Weakness</td>
</tr>
<tr>
<td>Z48.89</td>
<td>Encounter for other specified surgical aftercare</td>
</tr>
</tbody>
</table>

Source: SHP

Muscle Weakness (M62.81)

- CMS citing concern with this code since 2008
- One of the top 5 primary diagnoses in past several years
- CMS believes muscle wasting and atrophy codes *could* be more appropriate *if muscle weakness is the primary focus of therapy*
- Determine underlying cause for the muscle weakness
  **OR**
- Identify the true underlying reason for therapy
• Avoid limiting therapists to just the ‘Rehab’ categories.
• Consider appropriate therapy plans of care for the MMTA categories that can improve patients’ outcomes.

Therapy Strategies for Outcomes

- Managing medication *routines*
- Integrating diet into meal preparation
- Conserving energy as a lifestyle
- Incorporating physical activity into daily routines
- Self-monitoring as a lifestyle
- Problem solving (reducing hospitalizations)
Medication Management

- The single most important ADL
- Does not require that the therapist
  - Learn pharmaceuticals
  - Learn drug interaction
  - Provide medication instruction
- Does require that therapists recognize relationship between medications, medication administration and medication effects and safe, predictable performance of routine activities.

Medication Management

- Gather information about the whole routine of a day (a good day & a bad day)
- Identify when the isolated tasks your are assessing occur throughout the day
- Determine where medications are kept in relation to when they are taken
- Assess barriers or interruptions to the usual routine based on recent events
Dietary Adherence into Daily Routine

- Focus on the task and the routine
  - Within scope of therapy
  - Not medication teaching
- Analysis of the component skills required
- Identification and implementation of appropriate compensatory strategies
- Integration of medication management into daily habits and routines

Conserving Energy as a Lifestyle

- Analysis of existing routines and habits in relation to energy demands and capacities
- Pacing and planning to balance demands to capacities
- Self-monitoring energy and energy expenditure
- Adapting routines
- Specific techniques (controlled breathing, relaxation, etc.)
- Use of pulse oximetry as a measure of effectiveness of interventions
Energy Conservation

• Not a technique, but a principle that must be incorporated into every activity every day
• Learning how to budget time & energy to accomplish high priority needs embedded in daily routine
• Recognition that endurance (activity tolerance) is the limiting factor, not strength (or weakness)

Physical Activity into Daily Routines

• Analysis of overall daily physical activity
• Incorporate physical activity into daily activity
• Analysis of avocational or leisure preferences
• Identification of long term options to sustain physical activity and physical activity capacities
• Increasing daily activity rather than a home exercise program (HEP) for specific extremity muscle strengthening
Self Monitoring as a Lifestyle

• Analyze skills and capacities relative to demands of the task the patient is expected to perform
  – Blood pressure
  – Blood glucose
  – Skin integrity
• Integration of condition-specific self-monitoring tasks into daily routines
• Identification of compensatory strategies or needs for caregiving/supervision to support self-monitoring

Problem Solving

• Actual performance in context (location/time of day) shifts teach-back from words to actions
• Analysis of performance in context to identify and problem solve to reduce risk and promote consistent performance
• Promote patient and caregiver problem recognition and problem solving
• Focus on “what to do” to identify an emerging need, problem, risk at earliest possible stage
Return Demonstration is Not Enough

• Simply observing a patient giving a return demonstration of any activity
  – While being cued/supervised
  – In a place where it won’t typically be done
  – At a time when it won’t typically be done

provides little or no information about the patient’s ability to perform the activity routinely, consistently and effectively

Don’t Confuse

Knowledge Verbalize Understanding Return Demonstration One Time Behavior Implementation Spontaneous Performance Routine

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Value to Agency Outcomes

<table>
<thead>
<tr>
<th>Measure</th>
<th>HHA</th>
<th>State</th>
<th>Nat’l</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often patients got better at walking or moving around.</td>
<td>72.3%</td>
<td>76.5%</td>
<td>75.6%</td>
</tr>
<tr>
<td>How often patients got better at getting in and out of bed.</td>
<td>76.9%</td>
<td>75.3%</td>
<td>74.8%</td>
</tr>
<tr>
<td>How often patients got better at bathing.</td>
<td>77.1%</td>
<td>80.7%</td>
<td>77.9%</td>
</tr>
<tr>
<td>How often patients had less pain when moving around</td>
<td>67.8%</td>
<td>79.9%</td>
<td>78.6%</td>
</tr>
<tr>
<td>How often patients breathing improved.</td>
<td>82.4%</td>
<td>75.8%</td>
<td>77.8%</td>
</tr>
<tr>
<td>How often HH began patients’ care in a timely manner.</td>
<td>96.5%</td>
<td>96.8%</td>
<td>94.3%</td>
</tr>
<tr>
<td>How often patients got better at taking their drugs by mouth.</td>
<td>59.0%</td>
<td>70.2%</td>
<td>66.7%</td>
</tr>
<tr>
<td>How often the HH team checked patients’ risk of falling.</td>
<td>100.0%</td>
<td>99.6%</td>
<td>99.6%</td>
</tr>
<tr>
<td>How often the HH team checked patients for depression.</td>
<td>99.4%</td>
<td>97.8%</td>
<td>97.6%</td>
</tr>
<tr>
<td>How often HH patients had to be admitted to the hospital.</td>
<td>17.8%</td>
<td>16.1%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Would patients recommend the agency to friends and family.</td>
<td>79.0%</td>
<td>83.0%</td>
<td>78.0%</td>
</tr>
</tbody>
</table>

Exploring “New” Options

- We currently do not use this technology: 54%
- Anticipate increased use: 26%
- Anticipate decreased use: 14%
- We currently do not use this technology: 0%
- Unsure: 14%
# Do You Have A Functioning Team?

MSW  
SN  
HHA  
PT  
SLP  
OT

---

## Clinician Checklist

**Clinician Name:**

**Discipline:**

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Currently Proficient</th>
<th>Willing to Learn</th>
<th>Plan to Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Assessment</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Patient Centered Care Planning</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
</tr>
</tbody>
</table>
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