404. PDGM – Therapy

FINANCIAL MANAGEMENT CONFERENCE & EXPO

HOMECARE & HOSPICE
National Association for Home Care & Hospice

HHFMA
Home Care & Hospice
Financial Managers Association

PDGM - Therapy

7/15/2019

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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

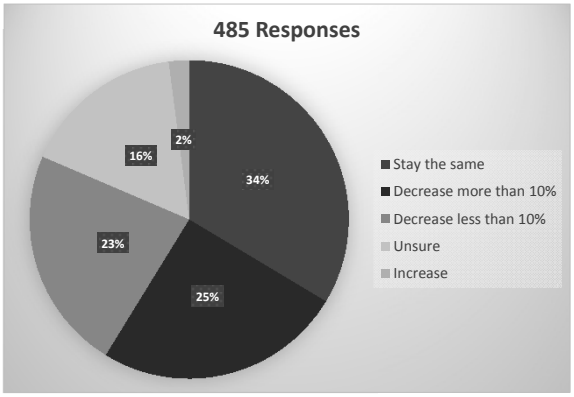
- Understand the myths and the history contributing to current therapy utilization to stop the pendulum swing
- Know what to expect and where to access information for therapy 'best practice'
- Use collaboration for most accurate OASIS data
- Shift therapy practice from volume to value

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?



What Does CMS Say?

PPS 2019 Final Rule

- *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.*

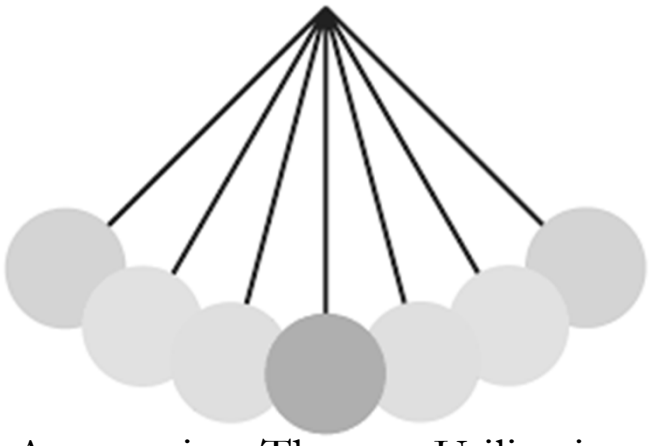
Therapy Track Record

Pre PPS	Initial PPS	Revised PPS
• Low Therapy Use Overall • < 10	• Therapy Use Increases • 10 - 13	• Therapy Use Increases • 14+ / 20+

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

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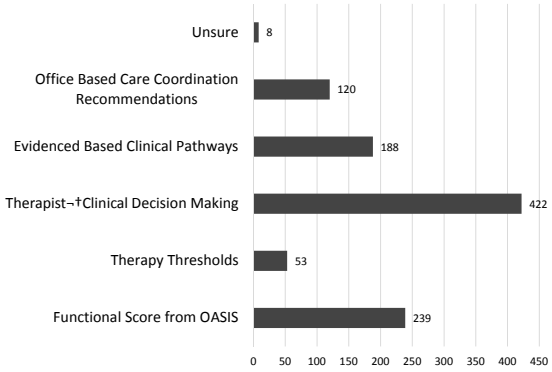
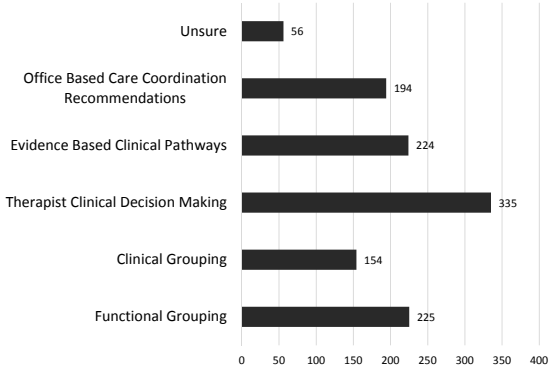
Decision Making Today

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



Decision Making in PDGM

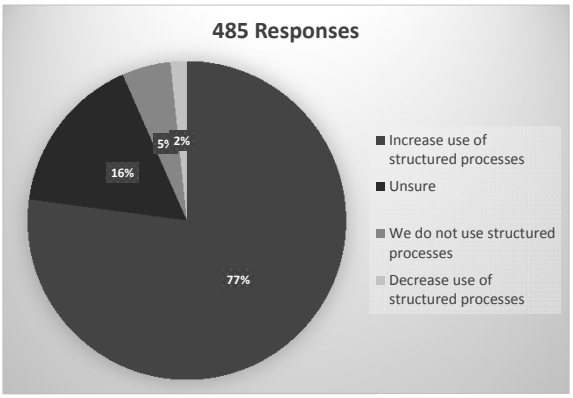
Therapy frequency and duration in your agency in PDGM will be based on (select all that apply):



Functional OASIS Items	PPS	PDGM
M1800: Grooming	No	Yes
M1810: Current ability to dress upper	Yes	Yes
M1820: Current ability to dress lower	Yes	Yes
M1830: Bathing	Yes	Yes
M1840: Toilet Transferring	Yes	Yes
M1850: Transferring	Yes	Yes
M1860: Ambulation/Locomotion	Yes	Yes
M1033: Risk of Hospitalization	No	Yes

OASIS Collaboration

How do you anticipate PDGM will impact how therapist and nurses collaborate on OASIS data collection?



Repositioning Moved 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.

M

GG

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**
Enter Code ☐	0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6 Unable to participate effectively in bathing and is bathed totally by another person.

M

GG

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower

Thresholds Based on Clinical Grouping

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

Unacceptable Primary Diagnosis

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

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

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

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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

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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

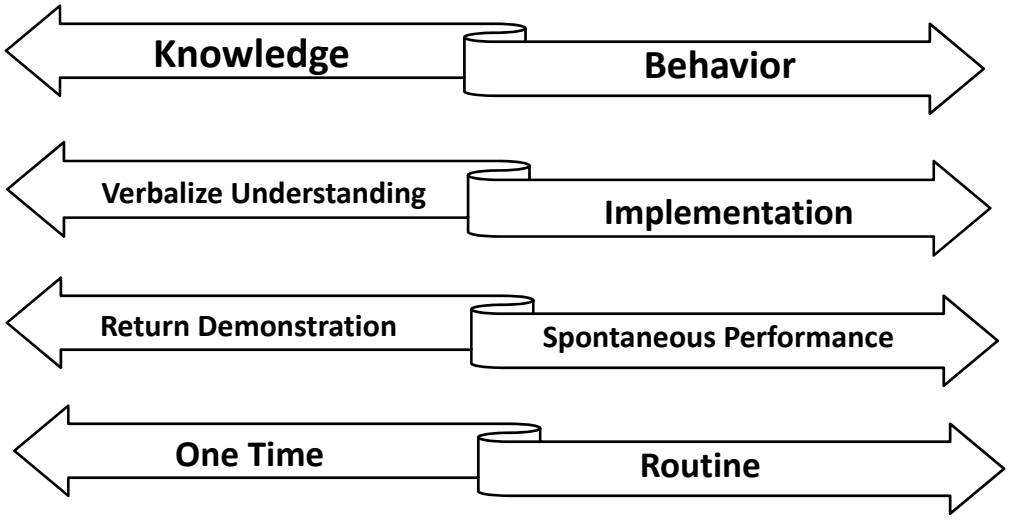
- Actual performance in context (location/time of day) shifts teach-back from words to actions
- Analysis of performance in context to identify and problem solve to reduce risk and promote consistent performance
- Promote patient and caregiver problem recognition and problem solving
- Focus on "what 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

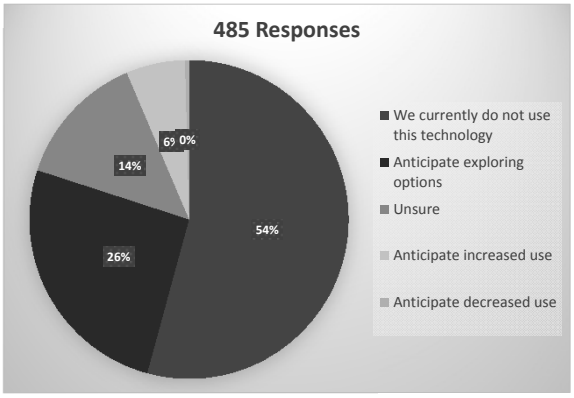


Value to Agency Outcomes

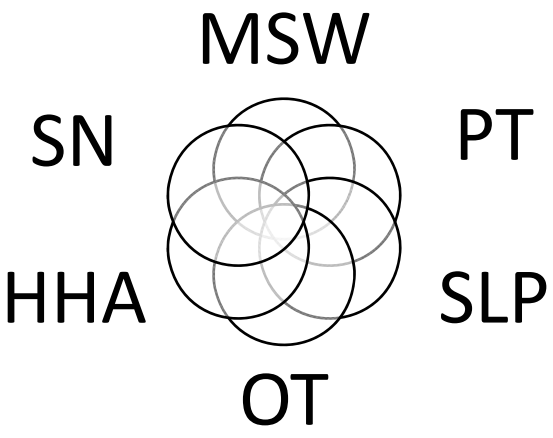
Measure	HHA	State	Nat'l
How often patients got better at walking or moving around.	72.3%	76.5%	75.6%
How often patients got better at getting in and out of bed.	76.9%	75.3%	74.8%
How often patients got better at bathing.	77.1%	80.7%	77.9%
How often patients had less pain when moving around	67.8%	79.9%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

Exploring "New" Options

How will PDGM impact agency use of telehealth technology specific to therapy (remote exercise interface activity trackers Speech Therapy Telepractice)?



Do You Have A Functioning Team?



Clinician Checklist

Clinician Name:

Discipline:

Key Area	Currently Proficient	Willing to Learn	Plan to Address
OASIS	Y/N	Y/N	
Comprehensive Assessment	Y/N	Y/N	
Medication Management	Y/N	Y/N	
Patient Centered Care Planning	Y/N	Y/N	
Care Coordination	Y/N	Y/N	
Collaboration	Y/N	Y/N	
Communication	Y/N	Y/N	
Documentation	Y/N	Y/N	

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