Shifting Therapy Practice from Volume to Value

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1

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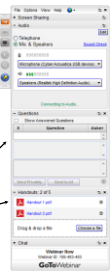

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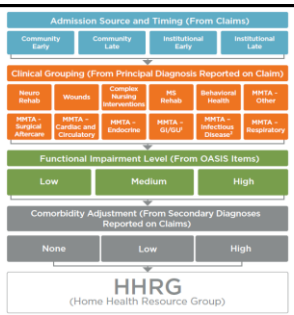
Absence of any domain grouping related to volume of visit count



HHRG determined entirely on characteristics of the patient

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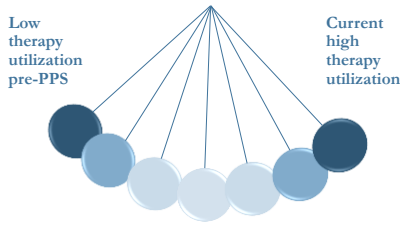

Without visits in the calculation, how does therapy add value to home health?

First, assist with accurate functional item OASIS scoring

Variable	Category	OASIS Items	Points
M1800: Grooming	1	2, 3	4
M1810: Dress upper body	1	2, 3	6
M1820: Dress lower body	1 2	2 3	5 11
M1830: Bathing	1 2 3	2 3, 4 5, 6	3 13 21
M1840: Toilet Transferring	1	2, 3, 4	4
M1850: Transferring	1 2	1 2, 3, 4, 5	4 8
M1860: Ambulation/ Locomotion	1 2 3	2 3 4, 5, 6	10 12 24
M1033: Hospitalization Risk	4 or more items	From 1-7	11

Collaborate on Accuracy of Functional Scores

Before data are locked and transmitted

Input from all who saw patient

Discuss discrepancies

Observation or interview?

Conditions present?

Reach consensus

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- Functional status is core to therapy evaluations
- Typically by therapist's observation, not interview
- Safety considerations key to performance
- Objective levels of assistance, cueing, supervision
- Function assessed in context of time and place
- Function assessed in context of habits and routines

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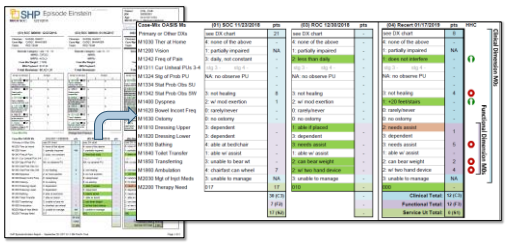
Episode Einstein℠ as a Collaboration Tool



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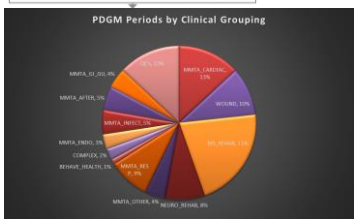
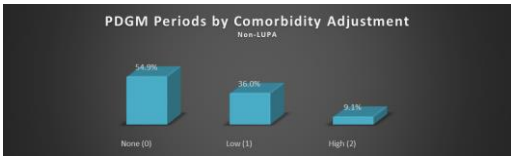
Clinical Grouping	Functional: Low	Medium	High
MMTA – Surgical Aftercare	0-24	25-37	38+
MMTA – Cardiac & Circulatory	0-36	37-52	53+
MMTA – Endocrine	0-51	52-67	68+
MMTA – Gastrointestinal & Genitourinary system	0-27	28-44	45+
MMTA - Neoplasms, Infectious & Blood-Forming Diseases	0-32	33-49	50+
MMTA – 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+

Note: Per CMS LDS 2018 data



Next, assist with painting the most accurate picture of the patient's clinical grouping….

Note: Per CMS LDS 2018 data

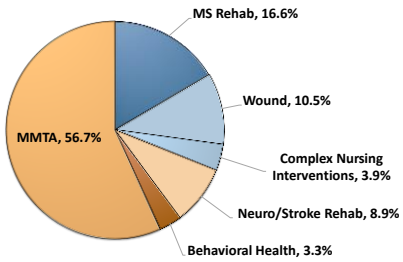


….and assist with capturing, confirming comorbidities

Collaborate on Primary Diagnosis & Comorbidities

- Consider the 'most intensive frequency' between on POC
- Reach consensus on primary reason for episode of care
- Share details for accurate coding
- Collaborate on change to primary diagnosis for 2nd 30 day payment period

Historical Breakdown by Clinical Grouping

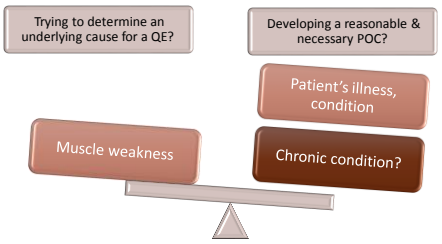


9 of the top 50 primary diagnoses used 2015 – 2017 are not on the acceptable list

Assist with avoiding questionable encounters. Contribute to the 'underlying cause'

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

Weigh the Difference Between….



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All of these strategies have focused on the value therapists can bring to the revenue side of the PDGM equation

However, there is great value therapy can bring to home health on the expense side, not to mention the quality side

Home health has to be re-programmed to quit thinking about therapy as 'ATM machines' based on volume of visits

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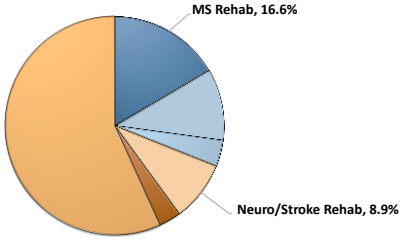
Therapists must re-program to not restrict themselves to stereotypical clinical groupings



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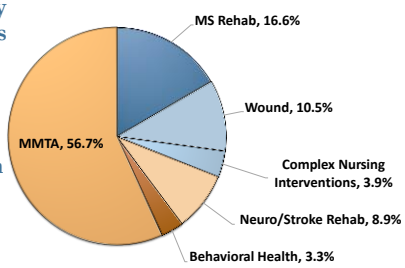
What therapy has to offer is 'reasonable & necessary' for many chronic conditions in the MMTA group



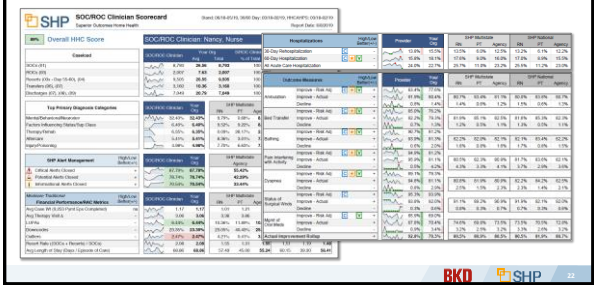
Chronic Condition Management

Medications	Identify routines to assist in taking as directed
Self-monitoring	Reinforce with tools for monitoring BP, glucose, skin, weight
Treatments	Routines to help with O2, nebulizer, insulin, pursed lip breathing
Diet	Practice meal prep watching glycemic index, sodium, potassium, fat
Physical Activity	Rather than an HEP? Familiar activity, use energy conservation
Health care encounters	Problem solving to attend & participate in encounters

The value therapy adds can be quantified by the outcomes achieved

How often patients got better at walking or moving around.
How often patients got better at getting in and out of bed.
How often patients got better at bathing.
How often patients had less pain when moving around
How often patients breathing improved.
How often HH began patients' care in a timely manner.
How often patients got better at taking their drugs by mouth.
How often the HH team checked patients' risk of falling.
How often the HH team checked patients for depression.
How often HH patients had to be admitted to the hospital.
Would patients recommend the agency to friends and family.

Measure the Value to the Agency's Outcomes



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Med Management – Most Important ADL

- Does ***not*** require that the therapist
  - Learn pharmaceuticals
  - Learn drug interaction
  - Provide medication instruction
- ***Does*** require that therapists recognize relationship between medication administration, medication effects and safe, predictable performance of routine activities
- Ineffective medication management is the ***biggest*** contributor to hospitalizations

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Medication Management in Therapy POC

- Gather information about the whole routine of a day (a good day & a bad day), inquire about the difference
- Determine where medications are kept in relation to when they are taken
- Identify which medications are more often being missed and help identify reasons
- Assess barriers or interruptions to the usual routine based on recent events

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Dietary Adherence into Daily Routines

- Assess willingness for compromise versus the 'deal breakers' about diet restrictions and problem solve
- Problem solve adherence barriers , i.e obtaining food
- Analyze the component skills required for the task of preparation (cognition, fine/gross motor coordination, strength, balance, etc.), address/remove barriers
- Identify and implement compensatory strategies
- Practice alternative menu items

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Physical Activity into Daily Routines

- Analysis of amount and type of physical activity
- Incorporate physical activity into daily routines
- Analysis of avocational or leisure ***preferences***
- Identify long term options to sustain physical activity and capacities
- Increasing daily activity ***rather than*** a home exercise program (HEP) for specific extremity muscle strengthening

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Conserving Energy as a Lifestyle

- Analyze 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)
- 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)

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
- Integrate condition-specific self-monitoring tasks into daily routines, problem solve strategies to barriers
- Identify compensatory strategies or needs for caregiving/supervision to support self-monitoring

Problem Solving

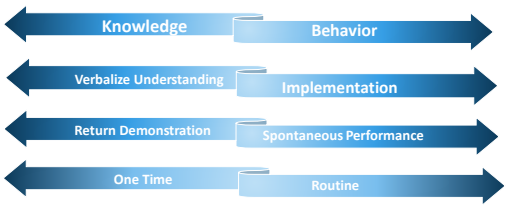
- Analysis of performance in context to identify and problem solve to reduce risk and promote consistent performance
- Promote patient and caregiver problem recognition and problem solving
- Focus on “what to do” to identify an emerging need, problem, risk at earliest possible stage

Return Demonstration not Enough

- Actual performance in context (location/time of day) shifts teach-back from words to actions
- 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…

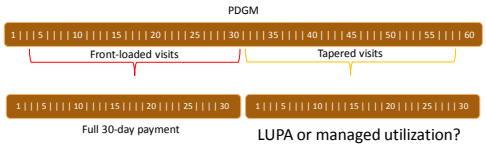


Effective & Efficient Visit Frequency

Coordinate POC & visits	Coordinate monitoring parameters	Taper frequency to allow self management
Engage patient for 'in between visit' progress toward outcomes		Adjust frequency to patient progress

Spread visits over time to manage utilization and reduce risk of LUPAs

Managing LUPAs, Utilization with Tapered Frequency



Full 30-day payment

LUPA or managed utilization?

Visit Utilization Benchmarks

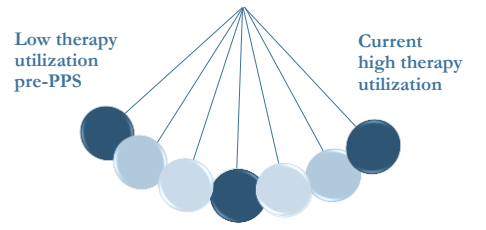
SHP Provider Scorecard
Superior Outcomes Ventura

Stand: 02/18-01/19, 30/60 Day: 11/17-10/18, HHCAHPS: 11/17-10/18
Report Date: 2/28/2019

Page 2 — Provider: (9999) Superior Outcomes Ventura

Medicare Traditional Average Visits per Episode by Type	Therapy Visits PT	OT	ST	All Therapy	Non-Therapy Visits SN	MSW	HHA	All Visits
Provider	2.94	0.63	0.02	3.58	7.20	0.23	0.00	11.01
Your Org	4.56	1.50	0.16	6.23	6.26	0.18	0.50	13.16
SHP Multistate	5.43	2.06	0.44	7.92	7.18	0.14	1.06	16.30
SHP National	5.64	1.91	0.41	7.96	7.18	0.16	1.07	16.36

- Currently shows visits per payment episode – New PDGM reporting will look at 30-day Periods and Episodes of Care "Stays"



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