UTILIZING MAINTENANCE THERAPY IN YOUR AGENCY TO ELEVATE CLINICAL PROGRAMS

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- 30 year Home Health clinician/consultant
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MAINTENANCE THERAPY IN HOME HEALTH

HOME HEALTH LEGACY

- Hx of Rehabilitative (Restorative) Care
- Related “Improvement Standard”
- Hx of Maintenance Care (?)
- Jimmo vs. Sebelius
- Intent/Regulations/Analysis
- Developing Maintenance Care Programs
RELATED IMPROVEMENT STANDARD

• Care Directive until 2013; now “myth”
• Long-Standing Denial Reason
• Clinical Improvement Necessary
• Unsupported by Laws and Regulations
• Failed to Address Chronic Debilitation
• Challenged by ACA Reforms

HX OF MAINTENANCE CARE

• Historically Un-addressed by CMS
• Programmed via multiple acute programs
• Coverage Issue re Chronic Decline
• Associated Costs of Coverage Lapse
• Healthcare Evolution
• Prompted Jimmo vs Sebelius
JIMMO vs. SEBELIUS

- Lawsuit filed 1/18/11 Vermont Fed Court
- Challenged Improvement Standard
- Vermont Legal Aid – 5 pts/6 organizations
- Alzheimer's, MS, Para Vets, Park, UCP
- Settled 10/16/12
- Approved by Court 1/14/13

“The goal of this settlement is to ensure that claims are correctly adjudicated in accordance with existing Medicare policy so beneficiaries receive the full coverage to which they are entitled”
**JIMMO vs. SEBELIUS**

- No Coverage Expansion
- Reject Improvement Standard policy
- Clarifying “Rule of Thumb”
- G-Code Use
- Practical Application
- Concerns re Coverage

**Connection to Reform**

- PPACA
- ACO Population Health
- Integrated Health System
- Wellness-based Approach
- Multi-level Delivery Model
- Healthcare Cornerstone of the Future
HX OF RESTORATIVE CARE

- Requires Skill Level of Licensed Therapy
- Qualification Regulations
- POC/Care Requirements - Objective
- Potential to Improve
- Qualified Episode – HEP, Re-assess, etc
- Improvement as Qualification

Maintenance Care Programming

- Requires Qualified Therapist
- Customized to Patient
- Directly Related to Diagnosis/Illness
- Specific Guidelines & Limitations
- Instruction Component
- Periodic Re-evaluations
Maintenance Care

- Maint Programs tailored to Specific Pts
- Anticipated Decline Objectively ID’d
- Decline Prevention - Objective Program
- Acute vs. Chronic Contrast Required
- LOS approach expected – real-time use
- Frequency/Duration – Maintenance

Application to Rehab

- Patient Case Profile
- Skilled Rehab Care Progression
- Maintenance Care Determination
- Caregiver/Aide Requirement
- Program Establishment/Instruction
- Initial HH Provider Concerns
Examples re Application

• When does Acute become Chronic?
• Areas of Maintenance Opportunity
• Approaching Patients/Caregivers
• Areas of Maintenance Focus
• Establishment – Orders, G-codes
• Managing Frequency/Duration

MAINTENANCE THERAPY CLIENTS

• No Specific Diagnosis
• Ensuring Patient Safety or Program Effectiveness
• After Restorative – Maintain Function or Prevent Decline
• Without Restorative – Only when an Identified Danger Exists
MAINTENANCE THERAPY CLIENTS

- Re-Assessments must require skill of a Therapists
- Maintenance Activities taught to family or caregiver (not HHA)
- Skills requiring a Therapist delivery are covered
- Volume must be reasonable & necessary

DEVELOPING MAINTENANCE PROGRAM

- Example # 1 – 78 y/o male - Parkinson's
- Hx – Independent walker ambulator
- Lives w Daughter’s family
- Began to Fall due to exacerbation
- Hospital admission x 5 days
- Followed by Restorative Home Health
DEVELOPING MAINTENANCE PROGRAM

- Restorative Strengthening/Flexibility
- Restorative Gait w Walker/HEP
- Restorative DC Status – SBA w Walker
- DC Concern – Chronic Decline due to Dx
- Maintenance Program Considered
- Focus on Prevention of Functional Decline

DEVELOPING MAINTENANCE PROGRAM

- Identify Maintenance Potential
- Approve Program – Agency, MD, pt/family
- Establish Required Billing – G-codes, unit
- Develop Program (next slide)
- Establish Reassessment frequency
- Instruct patient/caregiver/family
DEVELOPING MAINTENANCE PROGRAM

• Strengthening – Establish obj baseline
• Develop program to prevent decline
• Outline Goals of successful program
• Instruct Family/Caregiver – performance
• Instruct Patient re Program Goals
• Document Specifics re SKILL content

DEVELOPING MAINTENANCE HEP

• Daily PRE’s – focused on specific areas
• Outline frequency – sets – reps – res
• Perform at establishment
• Reassessment Focus
• Assure Compliance – Results – Future
• Modification if Necessary
 DEVELOPING MAINTENANCE PROGRAM

- Example # 2 – 42 y/o female - MS
  - Hx – WC bound, safe transfers in home
  - Lives alone in accessible apartment
  - Begins to Fall during transfers
  - Incurring multiple bruises, injuries
  - Wants to remain independent in apt

 DEVELOPING MAINTENANCE PROGRAM

- Intermittent Caregivers – family, aide
  - Concerns - strength, gross motor, transfer
  - Want to prevent injury or decline
  - Identify Maintenance Potential
  - Approve Program – Agency, MD, pt/family
  - Establish Required Billing – G-codes, unit
DEVELOPING MAINTENANCE PROGRAM

- Develop Program re safety (see below)
- Establish Reassessment frequency
- Instruct patient/caregiver/family
- Program – Daily therex re MS, transfer tech, balance activities
- Caregiver instruction re disease process

DEVELOPING MAINTENANCE HEP

- Daily PRE’s – focused on specific areas
- Outline frequency – sets – reps – resist
- AVIOD FATIGUE!!!
- Perform at establishment/Reassessment Focus
- Assure Compliance – Results – Future
- Caregiver Instruction
MAINTENANCE PROGRAMMING

- Frequency – biweekly, monthly, weekly?
- Frequency - Reassessment Schedule
- Modify/Justify/Outline Success
- Skill Must be Identified Here
- Slowing Decline is Relevant
- Reasonable & Necessary

MAINTENANCE PROGRAMMING

- Maintenance – Assessment/Documentation
- Maintenance – Comparably Less Visits
- Therapists Delivery – Requires Therapist
- Elevated Documentation required
- Mandated by ACA
- Programming component of the Future
MAINTENANCE REASSESSMENTS

- Objective Measurements
- ROM/MS affects function
- Balance, assist, performance technique
- Future Expectations – Modification
- Reassessment Frequency Modification
- Agency information/Approval/Plan

G-CODES for MAINTENANCE CARE

- G0-159 – Services by a qualified PT in HH establishing or delivering a safe PT maintenance program – 15 minutes
- G0-160 – Services by a qualified OT in HH establishing or delivering a safe OT maintenance program – 15 minutes
- G0-161 – Services by a qualified SLP in HH establishing or delivering a safe SLP maintenance program – 15 minutes
CMS Reforms outline
New Care Landscape as
Volume to Value Transition Arrives
CMS Reforms slated for Value Implementation

• Impact Act Reforms (2014) – Post-Acute Care Transition
• Impact Act – eliminates silo approach quality measures
• PDGM, PCR, VBPM modification, Post-Acute PPS
• Redefines Quality Care - measured episodically (DRG 2.0)
• Basis of CMS Reforms is Volume to Value Care Shift
• PDGM prepares HH for place in new value model
• Pre-Claim Review assures qualified value-based SOC
• VBPM modifies for outcomes versus process measures
• Value-Based care production required for future
• HH Reforms focus on VOLUME-BASED HH LEGACY

VBPM
VALUE–BASED PURCHASING MODEL
Home Health Reform Expansion
VBPM Expansion Implementation Expected

- VBPM – Value-Based Purchasing Model since 2016
- Connects care quality to payment improve outcomes
- Currently in AZ, FL, IA, MD, MA, NC, NB, TN, WA
- 24 HH quality measures in achievement/improvement
- Employs data from OASIS, HHCAPS, Claims, Creates Score
- 3% Current VBPM adjustment, 2022 increase to 8%
- 2019 HH Proposed Rule outlines changes for value reforms
- 2019 VBPM changes focus on patient improvement
- Removes flu and pneumonia vaccination from VBPM
- Installs Bed Transfers, Bathing & Ambulation Improvement
- 2019 changes - precursor to VPBM national expansion

PDGM
PATIENT DRIVEN GROUPER MODEL
Home Health Reform
Value Structure
PDGM Slated for 2020 Implementation

- 1/1/20 Proposed PDGM Implementation (2019 Prop Rule)
- Replaces 60-day episode with two 30-day units
- Decreases Community Referral patient payments (20%)?
- PDGM based on 12 Clinical Groups by Primary Diagnosis
- Significant Coding Role in PDGM Primary Dx/Comorbidities
- Number of Case – Mix Weights increase from 153 to 432
- Significant LUPA Modifications – 2-6 visit LUPAs based on dx
- Eliminates RAP payments for new HH Providers (1/1/19)
- Shifts HH episode composition - clinical to administrative

PDGM Slated for 2020 Implementation

- Removes rehab visit totals as primary payment factor
- ADL Functional Levels (Low, Med, High) denote rehab $$
- Each Functional level expected as 30% of HH population
- Functional levels associated with rehab program funding
- Functional scoring changes per episode based on dx
- OASIS ADL accuracy required for rehab placement
- PDGM Rehab challenge – match level w skilled value content
- Required Rehab content produces value-based outcomes
- Rehab Culture change must be addressed pro-actively
UNIFIED PPS

POST – ACUTE PPS BUNDLE

Home Health Reform Expansion

Post-Acute PPS Care Continuum 2021 Trial

- Post–Acute PPS – 30 Post-Acute Bundle for ALL diagnoses
- Acute Care Hospital serves as Bundle Convener in all cases
- Convener paid all PAC PPS costs – acute, IRF, SNF, HH, Opt
- Average LOS 34-day Bundle reduces acute phase to 11%
- PAC PPS – considered DRG 2.0 – Providers linked in episode
- PAC PPS – 30+ day episode managed via acute care model
- PAC PPS Rewiring – significant HH growth opportunity
- Value Identity (Cost vs. Outcomes) - favor HH after reforms
- HHSM – MI Pioneer ACO PAC PPS Trial 2016 – 2017
- HHSM PAC PPS Trial – LOS decreases SNF>60% - HH>20%
- HH’s Value failure in future - creates 3rd party opportunities
Why Value Programming Works for the Home Health of Tomorrow

Why Value Programming works for Home Health

- Improves Care Quality/Results for HH Patients
- Offers a quality HH response to Reforms and Cuts
- Assures Optimal Payment and Quality HH Outcomes
- Directly addresses Star Ratings Quality concerns
- Addresses Care Reform Focus – ER visits, Re-admits
- Manages care on an IN-AGENCY basis – SOC to DC
- Rewires Volume model for front-line clinical staff
- Provides program integrity for CMS beneficiaries
- Care platform for future Value Reform Models
- PDGM – PCR – VBP – Post-Acute PPS
Home Health Program Analysis for Value Era Preparation
(What are they looking for?)

Goals of Value Programming in Home Health

• Star Ratings – 4 or greater Value Score
• Good HHCAPS scores re patient satisfaction
• Specific attention to 30-day re-admit, ER visit%
• HH LOS focus – address culture of recertification
• Provider support for Care Transitions mgmt.
• 24 hour Start of Care capability
• Missed visits, use of caregivers, compliance
• Value-Based Clinical program production & delivery
• DC with goals met – focus on rapid clinical outcomes
How to Assess your Home Health Agency for Value Potential

Assessing your HH Agency for UR Value Potential

- A culture of crisis management for essential tasks?
- Examples: OASIS timepoints, DC audits, recerts, audits?
- Are you seeking recertifications in your agency?
- Are Star Ratings 4 or less? Scheduling an ongoing struggle?
- Are SN visit totals > 5 per episode? Staff Productivity?
- Are LUPAs/NTUCs greater than 5%? Approval required?
- What is your Potentially Avoidable Events level - >20%?
- What are HHCAHPS ratings? Do they match Star Ratings?
- HH LOS >30 days? Self-scheduling? Missed Visit totals?
- Do your clinicians create/manage their care programs?
- Are you threatened by loss of clinical staff?
Home Health PPS Operational Targets for Value Era Reforms

- Intake Management - Referral Integrity for rapid SOC (24 hr)
- OASIS Accuracy – Clinical education not the solution
- Clinical Profile for Plan of Care - accuracy/global POC
- Traditional 60-day certification period belies value model
- Front-line Clinical Management unseen other CMS Providers
- Clinical Frequency/Duration order control – Safety-Based freq
- Lack of Scripting for patient-centered and standardized care
- Lack of CMS-Qualified care & CMS-Required documentation
- Resultantly, lack of required in-episode clinical content
- Volume-Based HH Care – excessive costs/time to DC/Stars
- Compromised clinical goals, care costs, and margins result
Relation of Clinical to Fiscal Factors in Home Health Programming Model

HH PPS Model Review for Clinical & Fiscal Identity

- HH 60-Day Certification Period – *up to* 60 days of care
- Acuity-based Case-Mix creates Cost-based HHRG rate
- OASIS Admission Assessment – cornerstone of HH PPS
- OASIS - Multi-System/Discipline global assessment
- HH POC – reflective of OASIS clinical profile declines
- HH Clinical disciplines – Evals - Objective POC - Program
- Skilled HH Episode – thru CMS-required HH content
- HHRG Service Score – based on rehab visit totals
- Episode DC or Recertify – Goals met or Another 60-Days
HH PPS Model Review for Clinical & Fiscal Identity

- HH PPS incorporates both CLINICAL & FISCAL elements
- Clinical Factor is the primary driver in HHRG care model
- Clinical component is based on patient acuity level
- Patient acuity established via accurate OASIS admit
- Clinical Acuity connects to Fiscal Identity (HHRG)
- Clinical acuity & Therapy volume determine CMI-HHRG
- Higher Acuity patients = Higher Case-Mix & HHRG rate
- Relates to value of accurate OASIS SOC data

How Volume Approach & Operational Inefficiencies relate to Value-Based Programs
How Volume & In-Efficiency affect Home Health Value

- **Volume** – 60-Day Cert Period approach – Post-Acute Care
- **Volume** – Lack of timely interventions – SOC, Evals, Visits
- **Volume** – Lack of Global Program, clinical schedule model
- **Volume** – Lack of Safety-Based frequency limits acuity
- **In-Efficiency** – Inaccurate OASIS, Admit POC development
- **In-Efficiency** – Decreased content focus – audit issues
- **In-Efficiency** – Lack of content increases volume to goals
- **In–Efficiency** – Lack of DC Control leaves uncovered care

Operational Areas in Home Health Model that Compromise Clinical Acuity
Home Health Operational Areas affecting Acuity ID

- **Intake Integrity** – Incomplete intake data limits timely SOC
- **OASIS Admit** – Inaccurate Case-Mix clinical data profile
- **POC Development** – Inaccurate OASIS data, non-global
- **Scheduling Control** – Managed by front-line staff, MV
- **Documentation Review** – Unqualified Evaluations, Visit notes
- **In-Episode Management** – Assures rapid, skilled progress
- **Rapid Outcomes** – Timely goal resolution vs. increased LOS
- **Discharge for Outcomes** – Independent DCs, dovetail DC

Management of Home Health Operational Areas for Value Results
Home Health Operational Management for Value

- **Intake** – Scripting for complete referral for 24-hour SOC
- **OASIS-Collaborative SOC** – Accurate profile, functional walk
- **POC Development** – Global POC (30 day) by decline depth
- **Add-on Disciplines** – 48 hour addn disciplines, connect to SOC
- **Scheduling Control** – Safety-Based Frequencies – MV mgmt
- **Documentation Review** – Unqualified Evals, routine visit notes
- **In-Episode Management** – Weekly clinical rounds – Rx to date
- **Discharge for Outcomes** – Rapid outcomes, Post-DC HP

Value Era Programming for HH Reforms
Value Programming Installation for Home Health

- Assessment of current HH Provider status
- Case-Mix, OASIS accuracy, Star Ratings, HHCAPS
- Avg LOS, Post-Acute %, Per Discipline Visit Totals, LUPAs
- Eval only %, Missed Visits, Required Documentation
- Focus on ER Visits/Hosp Readmissions (Medical Error)
- Orientation to HH Clinical Staff for interactive intro
- Initiative for 100% CMS-required clinical documentation
- Value-targeted OASIS Training – Case-Mix OASIS areas

Value Programming Installation for Home Health

- Case Manager Training – role modification, pt. Mgmt
- Intake/Scheduling – for timely SOC and discipline evals
- SOC Collaboration – assure OASIS walk, OASIS Manuel
- Assures patient POC inclusion, global PPS Mgmt
- In-Episode Mgmt (IEM) – weekly clinical rounds
- IEMS employ (reinforce) documentation for coverage
- Star Ratings/HHCAPS – addressed at SOC/DC
- Focus on qualification, CGVR, Compliance, DC planning
Value results for Home Health - Readmissions

- **Health Care Management** – Wyomissing, PA
  - January 2018 - 30 Day Rehospitalization – 8.7%
  - July 2018 ------ 30 Day Rehospitalization – 6.5%

- **VNA Home Health** – Albany, NY
  - April 2018 ------ 30 Day ER w/o Hosp – 9.7

- **Maine Health Care at Home** – Saco, ME
  - May 2017 ------ 30 Day Rehospitalization – 5.6%
  - March 2017 ------ 30 Day Rehospitalization – 9.3%

- **VNA Spectrum Health North** – Grand Rapids, MI
  - October 2017 ------ 30 Day Rehospitalization – 7.5%
  - August 2017 ------ 30 Day Rehospitalization – 3.8%

- **VNA Spectrum Health South** – Grand Rapids MI
  - April 2017 ------ 30 Day Rehospitalization – 7.1%
  - September 2017 ------ 30 Day Rehospitalization – 7.1%

- **Harbors Home Health & Hospice** – Hoquiam, WA
  - May 2017 ------ 30 Day Rehospitalization – 9.5%
  - April 2017 ------ 30 Day Rehospitalization – 7.5%
Summary of Operational Approach to Value-Based Home Health Care

- HH Volume era is over - change requires HH belief shift
- Staff education essential for insight into value programs
- Value Reform success requires an agency-wide reboot
- Operationalize managerial shift in care management
- Address Coding changes in care episode production
- Begin Care production changes as soon as possible
- Assure in-agency support staff ID’d and activated
- Focus on OASIS accuracy & aligned POC – Value areas
- Standardized schedule control – productivity, MV
- Embrace the Value path for Reform era success
Home Health Strategic Management

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