Lay of the Land

- Affordable Care Act
- IMPACT Act
- Med PAC Recommendations
  - HH therapy utilization scrutinized
- Focus on Value and Quality
  - Bundled Payment Care Initiatives
  - Comprehensive Care for Joint Replacements
  - Home Health Compare / Stars / HHVBTP
- Home Health Payment Reform

Data Driven Decision Making

- Objective Data Analysis
- Subjective Opinions
CMS Focus on Alternative Payment Models

BPCI/CJR – How Did We Get Here?

- More than 400,000 Medicare beneficiaries with hip or knee replacement in 2014
  - Hospitalization cost was $7 billion

- Great deal of variability in these procedures
  - Complications up to 3x higher depending on the institution
  - Average cost ranges $16,500 to $33,000

- Triple Aim - Improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

A Quick Review of the Initiatives

BPCI: Voluntary

- Can linked payments for all providers in an episode of care costs while maintaining quality of care?
- Rewards cost-reducing practices
- Awardees held accountable for episode payments
- Choice of 4 payment models, 48 clinical episodes, 3 episode lengths & waiver options

CJR: Mandated MSAs

- Can we achieve better and more efficient care for Medicare beneficiaries undergoing the most common inpatient surgeries?
- Implemented in 67 geographic areas, defined by metropolitan statistical areas (MSAs).
- Core urban areas with population minimum of 50,000.

Source: www.innovation.cms.gov
BPCI Model 2 Successes

Lewin Group:
- BPCI episodes from Q4 2010-Q4 2013 show approximately a 10-15% savings in Model 2 Lower Extremity Joint Replacement (LEJR)

Utilization trends in LEJR include:
- Decreased IRF / SNF
- Increased Home Health


BPCI Model 2 Successes

Lewin Group – Early studies of episodes from Q4 2013-Q3 2014 initiators participating in BPCI joint replacement of the lower extremity (LEJR) show:
- Beneficiaries had greater improvement in 2 mobility measures vs. comparison hospital counterparts
  - Walk w/6/a rest; walk up & down 12 stairs
- Avg LOS with any SNF use was 1.3 days shorter vs. those discharged from comparison hospital counterparts
- Overall decline of $864 as compared to episodes initiated at comparison/non-BPCI hospitals
- Decreased Inpatient PAC utilization post-hospital


CJR – Hospital Driven Program

- Required for IPPS Hospitals in the selected MSAs
- Hospitals participating in other CMS models or programs such as the Shared Savings Program and other ACO initiatives are included in the CJR model if they are located in a selected MSA.
- Excluded: those participating in Model 1 or Models 2 or 4 of the BPCI initiative for LEJR episodes during the time of their involvement.
### Included Items and Services

- Physicians' services
- Inpatient hospital services (including hospital readmissions)
- Inpatient psychiatric facility (IPF) services
- Long-term care hospital (LTCH) services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs
- Hospice

### Comprehensive Care of Joint Replacement (CJR) Demonstration Project

- CJR is set-up virtually identically to BPCI Model 2 90-day risk period for DRGs 469 / 470
  - The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care.
  - Incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.
  - Period of time: admission to participant hospital + 90-days post (hospital) discharge = covers the complete period of beneficiary recovery.

### “Unrelated Services”

- Unrelated services are for:
  - Acute clinical conditions not arising from existing episode
  - Related chronic clinical conditions or complications of LEJR surgery
  - Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care.
  - The complete list of exclusions can be found on our website at https://innovation.cms.gov/initiatives/cjr, accompanied by the list of excluded MS-DRGs and ICD-10-CM diagnosis codes.
Collaborators

- Hospital is allowed to share with “CJR Collaborators”
- CJR Collaborators:
  - SNF
  - Home health agency
  - LTC Hospital
  - Inpatient rehabilitation facility
  - Physician
  - Nonphysician practitioner
  - Outpatient therapy provider
  - Physician group practice

Shift to Quality as the Focus

- 85% by end of 2016
- 90% by 2018

CJR and Quality Improvement

- The model adopts a quality first principle where hospitals must achieve a minimum level of episode quality before receiving reconciliation payments when episode spending is below the target price.
- The model incentivizes hospitals to avoid expensive and harmful events, which increase episode spending and reduce the opportunity for reconciliation payments.
Sharing Arrangements

- Sharing arrangements:
  - Must not induce a party to limit medically necessary services
  - Must not restrict Collaborator’s ability to make decisions in the best interests of its patients.

- Providers are trying to save costs, but not by simply foregoing the provision of care. This is important to consider in the redesign of care for these patients. Need to have a rationale for care that is eliminated.

- ALL providers that receive gain sharing payments must be involved in the hospital’s CJR care redesign efforts.

CJR Beneficiary Protections

- CJR model does not restrict beneficiary’s ability to choose any Medicare provider or supplier

- CJR participating hospitals must inform beneficiaries of all Medicare participating post-acute providers in the relevant geographic area

- Hospitals must respect patient and family preferences when expressed

CJR and Compliance Programs

- The hospital AND each collaborator needs to have defined compliance activities specific to CJR
  - Financial Issues
  - Quality Measures
  - Involvement in Care Redesign

- Collaborators need to ask for reports from the hospital confirming key items:
  - Reconciliation Payments
  - Alignment Payments
  - Quality Measures
Why Partner with Home Health?

- Lower cost for care
  - 31% less expensive compared to SNF
  

- Similar outcomes for therapy
  

Comparative Study:
Outpt v. HH PT?

  - "Favored" direct referral to outpatient PT following hospitalization for TKA
  - Home Health Section of the APTA – Letter to the Editor (stay tuned!)

Care Redesign

- CJR sharing arrangements (as an example) must be solely related to the contributions of collaborators to care redesign that achieve quality and efficiency improvements.
Case Scenario: Mrs. K with L TKA

A tale of 2 joints...
- Initial replacement – 1998
- Anesthesia/post-op period
- CPM
- No therapy after 5PM
- Used wheelchair
- 4-day hospital stay
- Possible SNF, then HH post-acute course of care
- HH SOC on 2nd day home
- Last replacement – 2012
- Spinal + twilight meds
- Internal anlgesic-eluding joint bath (36hrs)
- NO CPM
- PT within 1 hour of return to room (6PM) + joint class
- No wheelchair
- < 36 hour hospital stay
- Directly home with SOC next day

What Makes Us Different

Inpatient Care
- 24/7 in person access to skilled care
- Direct control of the physical environment
- Focus is health care

Home Care
- Intermittent visits by skilled care
- Limited to no control of the physical environment
- Focus is on daily life

Home Health and Care Redesign

- Therapy Admissions – “they don’t want to”
- Therapy Frequency and Duration
- Intentional Interventions for Mobility and Self Care
- Pain Management
- Wound Care
- Medication Management
- PT/INR Monitoring
- DVT Monitoring
- Staple Removal
- Constipation Issues
PT Admissions – not “Optional”

Profiency must be confirmed:
- OASIS
- 485/Care Planning
- Drug Regimen Review
- Skin Assessment
- Coverage Criteria
- Homebound Status
- Policies and Procedures

Care Planning

What drives care planning?
- Staffing
- Geography
- Evidence

Best Practices for Home Health

Evidence-based care: "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research." – David Sackett
Intersection of “Best” Practice & Costs

Paradigm Shift Required:
- Move from “silo-approach” to practice to shared responsibility and accountability
- “What you measure will get managed.”

Value = Outcomes

EBP: Clinical Pillars for CJR

Systematic review of the literature
- Efficacious pre- and post-operative interventions
  - Preoperative pathways for co-morbidity risk management
  - Optimizing care coordination
  - Multimodal pain control
  - Optimizing VTED prophylaxis
  - Maximizing home resources/minimized PAC use


EBP Operationalization

Addressing “accelerated rehabilitation”:
- Timely admission process
- 7-days/week coverage
- Front-loading visits
- Education materials
  - Patient-centered
  - Health literacy considerations
EBP Operationalization

- Focused attention on management of re-hospitalization risk(s):
  - Falls prevention/risk mitigation
  - Pain control
  - Surgical wound management
  - Medication reconciliation
  - Anticoagulation management
  - DVT monitoring
  - Constipation

Fall Risk Management as a Team

- Consistent use of objective measurement in assessment, interventions and goals
  - ROM
  - 30 Second Chair Stand
  - 2-Minute Step Test
  - Gait Velocity
  - Timed Up and Go
Intentional Interventions: Self Care Issues

- Do not assume absence of self care issues for the CJR population.
  - "Do you want OT?"
- Must determine WHY assistance is needed and address in the plan of care.

Pain Management

- Completing the 0 – 10 pain scale is NOT pain management.
- Patient specific interventions include:
  - Medications
  - Modalities
  - Positioning
  - Activity Pacing

Wound Care

- Can therapists do wound care?
- Two separate issues:
  - Routine dressing changes
  - Therapy specific wound care interventions
Wounds & Physical Therapists

- APTA – Guide to Practice and outlining “minimal competence” for all clinicians

Guide to Physical Therapy Practice

- Outlines precise procedural interventions; stratification from prevention & risk reduction of integumentary disorders to superficial skin involvement; partial- and full-thickness wounds; scar formation
- Supports a defined role for the non-wound care PT on the interdisciplinary home health team
  - Reduce incidence and severity of wounds
  - Assist in accelerated wound closure

Minimum Competence – PT Grad

- Screening Expectation:
  - Conduct a systems review for screening of the integumentary system, the assessment of pliability (texture), presence of scar formation, skin color and skin integrity
  - Source Document: Minimum Required Skills of Physical Therapist Graduates At Entry-Level (BOD G11-05-20-49)
  - Def: foundational skills that are indispensable for a new graduate physical therapist to perform on patients/clients in a competent and coordinated manner
Minimum Competence – PT Grad

- Examination/Reexamination:
  - Perform integumentary integrity tests & measures including:
    - Activities, positioning, and postures that produce or relieve trauma to the skin
    - Assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment that may produce or relieve trauma to the skin
    - Skin characteristics, including blistering, continuity of skin color, dermatitis, hair growth, mobility, nail growth, sensation, temperature, texture and turgor

Minimum Competence – PT Grad (cont'd)

- Examination/Reexamination (cont'd):
  - Activities, positioning, and postures that aggravate the wound or scar or that produce or relieve trauma
  - Signs of infection
  - Wound characteristics: bleeding, depth, drainage, location, odor, size, and color
  - Wound scar tissue characteristics including banding, pliability, sensation, and texture

Baseline PT Wound assessment

- Components:
  - Measurement & documentation of the wound characteristics
  - Wound cleansing
  - Appropriate debridement
    - Sharp, selective
    - Mechanical
    - Autolytic
    - Enzymatic
    - Chemical
  - Recommendation & application of wound dressing
“Drug Regimen Review”

Identifies if a review of the patient’s medications indicated the presence of potential clinically significant problems.

The OASIS captures information for calculation of a process measure to identify best practices related to medications.

“Medication Management”

- This OASIS item is intended to identify the patient’s ability to take all medications reliably and safely at all times. These items address the patient’s ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management.
- Ability can be temporarily or permanently limited by:
  - physical impairments (for example, limited manual dexterity)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision, pain)
  - environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways)
Medication Management and Function

Includes assessment of the patient’s ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly), for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications, open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times.

Assessment areas:
- Ambulation
- Fall Risk
- Vision
- Fine Motor
- Balance

Safe & Consistent Administration

Knowledge:
- What?
- When?

Function:
- Where?
- How?

PT/INR Monitoring

- What is the role of the physical therapist in monitoring PT/INR with patients on anticoagulation therapy in your state?
PT & PT/INR: New Hampshire

Is it within the scope of practice for PT’s or PTAs to perform the testing procedure for monitoring a patient’s PT/INR (prothrombin time/international normalized ratio)?

- This type of testing is not a physical therapy skill. The machine used is similar to a blood sugar machine and the results are displayed in digital format. It is the understanding of the Board that the patient cannot do this testing and report the levels to their physician. The physicians will only accept results and orders from a licensed health care provider. It is also the understanding that the physical therapist cannot make recommendations regarding the levels of coumadin in the patient, and the patient must consult their physician for this.

- Using available technology and tools to assess the patient’s vital signs, is part of the definition of physical therapy as part of tests and measures. Therefore the Board reasoned that assessing vital signs specifically, the PT/INR finger stick testing for coumadin levels, would be allowed as a reasonable test and measure as part of the patient’s overall evaluation in preparation for physical therapy treatment.

- The ultimate responsibility rests with the licensed physical therapist or physical therapist assistant to be appropriately trained and competent in the technique. The Governing Board strongly recommends that appropriate training and competency be documented for those licensees prior to performing this specific task.

PT & PT/INR: Wisconsin

CAN A WISCONSIN PHYSICAL THERAPIST OR PHYSICAL THERAPIST ASSISTANT DO INR (INTERNATIONAL NORMALIZED RATIO) MONITORING?

- The scope of practice in physical therapy is defined by Wis. Stat. s. 448.50 (4) (a) 1-4 and (b). The Board considers any physical therapist or physical therapist assistant performing INR monitoring or Prothrombin Time testing to be acting outside the scope of their practice as stated in the Wisconsin Statutes. INR is used to monitor the effectiveness of blood thinning drugs. It involves collecting a blood sample by inserting a needle into a vein or from a finger stick. It is typically measured along with Prothrombin Time which is a lab test used to evaluate the ability of blood to clot properly. Prothrombin Time or Pro Time is commonly abbreviated as “PT” which can be a source of confusion if this is misunderstood to mean Physical Therapy.

DVT Monitoring

- Anticoagulation therapy
  - Aspirin — does the patient see this as a medication?

- Graduated compression stockings
  - Compliance?

- Screening Options
  - Homan’s Sign
  - Wells Index

Clinical Practice Guidelines: Role of PTs in the Management of Individuals at Risk for or Diagnosed with DVT. PTJ Vol 96:2. 2016
Staple Removal

What is the role of the physical therapist in staple removal in your state?

PT & Suture Removal: California

Is staple removal within the scope of practice of a physical therapist?

- The subject of staple removal was considered by the Practice Issues Committee of the Physical Therapy Board of California (Board) at their meeting of August 1995. The Practice Issues Committee opined that physical therapists may not perform invasive procedures, specifically in this instance, that of stapling a wound closed.

- The removal of staples, on the other hand, is a non-invasive procedure, which would ordinarily come under the heading of nursing services, and is not normally associated with the practice of physical therapy; however, physical therapists may provide any non-invasive physical rehabilitation procedure they have been adequately trained to perform. Should a facility elect to train physical therapists to do staple removal, the facility would need a written protocol to be included in their policies and procedures manual, and to be used in the training of each physical therapist who will perform this procedure.

- The training protocol must be sufficient to ensure the facility’s patients that the procedure is being done in a safe and efficient manner by personnel who are specifically trained to remove staples. The training should include procedures for problem situations resulting from removal of staples, for notification of proper medical personnel for problems, etc.

The Board has received multiple inquiries as to whether suture removal would be considered a non-invasive procedure such as staple removal. After consulting with a physical therapist expert consultant, it has been determined that the removal of sutures would fall under the same category as the removal of staples as indicated above.

<table>
<thead>
<tr>
<th>Two-level DVT Wells score</th>
<th>Clinical feature</th>
<th>Points</th>
<th>Patient score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active cancer (metastatic to lung or bony)</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Recent surgery within 6 months</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent chemotherapy</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent radiation therapy</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent infection at site</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent trauma to site</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent surgery at site</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent immobility</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent hospitalization</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent surgery &gt; 6 months</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent surgery &gt; 1 year</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent surgery &gt; 2 years</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent surgery &gt; 3 years</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Recent surgery &gt; 4 years</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

DVT deep: 2 points or more
DVT central: 1 point or less

Formula: Wells score + Clinical suspicion score

- Wells score:
  - DVT deep: 2 points or more
  - DVT central: 1 point or less

- Clinical suspicion score:
  - Active cancer (metastatic to lung or bony)
  - Recent surgery within 6 months
  - Recent chemotherapy
  - Recent radiation therapy
  - Recent infection at site
  - Recent trauma to site
  - Recent surgery at site
  - Recent immobility
  - Recent hospitalization
  - Recent surgery > 6 months
  - Recent surgery > 1 year
  - Recent surgery > 2 years
  - Recent surgery > 3 years
  - Recent surgery > 4 years

- Wells score:
  - DVT deep: 2 points or more
  - DVT central: 1 point or less

- Clinical suspicion score:
  - Active cancer (metastatic to lung or bony)
  - Recent surgery within 6 months
  - Recent chemotherapy
  - Recent radiation therapy
  - Recent infection at site
  - Recent trauma to site
  - Recent surgery at site
  - Recent immobility
  - Recent hospitalization
  - Recent surgery > 6 months
  - Recent surgery > 1 year
  - Recent surgery > 2 years
  - Recent surgery > 3 years
  - Recent surgery > 4 years

Formula: Wells score + Clinical suspicion score
PT & Suture Removal: Florida

This Order shall become effective upon filing with the Clerk of the Department of Health. DONE AND ORDERED, this 19 day of, November 2010.

The Board understands the language in the above stated practice act to mean that physical therapists may use non invasive techniques for the treatment and prevention of injuries. The Board deems staple removal to be a type of non invasive, rehabilitative technique allowed under the physical therapist practice act as long as it is performed under the direction and specified order of a physician licensed in the State of Florida and the physical therapist receives adequate theoretical and clinical instruction before engaging in staple removal. Adequate instruction should be based on the current state of medical literature describing the proper removal of suture from the human body. Physical therapists providing staple removal services shall still be held to minimum standard found in Rule 64B17-6.001, Florida Administrative Code.

Constipation Issues

- Contributing factors:
  - Medications
  - Surgery
  - Immobility
  - Diet
  - Hydration

- Are ALL staff involved in management of this issue?

EBP Example: Constipation

- Constipation in the Elderly
  - Decreased Constipation & Increased Quality of Life

- Solution:
  - Reduce severity by implementation of dietary & hydration interventions

- Problem:
  - Nursing Sensitive Outcomes
Moving Beyond CJR

- Other “Bundles” currently proposed or up and running:
  - CHF
  - AMI
  - Cardiac dysrhythmia
  - Hip and Femur fracture
  - Stroke

- These populations and much less predictable than planned joint replacements BUT the concepts of bundling are expected to continue to expand beyond CJR.

Care Redesign and ICF

Disability and Functional are viewed as outcomes of interactions between health conditions and contextual factors.

HF and Preventing Re-hospitalization

- Daily Weights
- Monitored Activity
- Medication Management
- Vital Signs
- Dietary Restrictions
New York Heart Association

<table>
<thead>
<tr>
<th>Class</th>
<th>Patient Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I (Mild)</td>
<td>No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath).</td>
</tr>
<tr>
<td>Class II (Mild)</td>
<td>Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea.</td>
</tr>
<tr>
<td>Class III (Moderate)</td>
<td>Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea.</td>
</tr>
<tr>
<td>Class IV (Severe)</td>
<td>Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.</td>
</tr>
</tbody>
</table>

Use of Scale = ADL??

Compliance = Knowledge + Functional Ability

- Knowledge
  - When
  - How
  - Signs

- Functional Ability
  - Balance
  - Strength
  - Cognition

The Role of Exercise in Heart Failure

- Aerobic exercise produces significant improvements in functional capacity
- Exercise produces little or no improvement in cardiac performance
- Physiological changes that occur appear to be due to peripheral, rather than central adaptations
  - Improved aerobic metabolism
  - Improved autonomic regulation
  - Improved peripheral perfusion
  - Decreased local inflammation
  - Improved ventilatory control
  - Improved quality of life
  - Decreased hospital readmission and mortality
Defining Terminology

- **Progressive Resistance Training**
  - Exercise that requires muscles to generate force to move or resist weight, with the intensity increasing as physical capacity improves (e.g., strength training)

- **Aerobic Capacity/Endurance Training**
  - Exercise that involves repetitive motions, uses large muscle groups, increases heart rate for an extended period, and raises core body temperature (e.g., walking, dancing, swimming)

Exercise is Prescriptive

**Source:** American College of Sports Medicine (ACSM)

- **Key Components of an individualized prescription:**
  - **FITT-PRO**
    - Frequency – days per week
    - Intensity - % of maximum capacity
    - Type – mode of exercise
    - Time – duration on a given day
    - Progression – must ↑ over time to elicit cont'd improvements
  - Regularly updated
    - Cardiovascular
    - Muscular strengthening
    - Flexibility training

- **Modest modifications for special populations**

- **Source:**

**ACSM Exercise Prescription Principles**

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
<th>Intensity</th>
<th>Time</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>3-5 days/week</td>
<td>40/50-85% of HRR or VO₂:max</td>
<td>20-60 minutes</td>
<td>Large muscle mass, continuous, rhythmic</td>
</tr>
<tr>
<td>Muscle Strengthening</td>
<td>2 or 3 days/week</td>
<td>3- to 20RM range; typically 5-20RM</td>
<td>One set each of 6-10 exercises (≤ 1 hour)</td>
<td>Major muscle groups, full ROM, controlled speed</td>
</tr>
<tr>
<td>Flexibility</td>
<td>2 or 3 days/week</td>
<td>To point of tightness</td>
<td>15-30 sec for each of 3-4 reps</td>
<td>Static</td>
</tr>
</tbody>
</table>
**Exercise Prescription**  
Source: American College of Sports Medicine (ACSM)

- **Strength Training**
  - Skeletal muscles adapt or improve in size and strength when an overload principle is applied.
  - Accomplished through:
    - Increased intensity (resistance, weight)
    - Intensity determined via the # of repetitions until fatigue.
    - Increased duration (# of sets performed)
    - Dependent on number of exercises & sets performed
    - Increased frequency (# of workouts)
    - Recommended 2-3x/week with at least 48 hours of recovery time between workouts.

- **Aerobic/Endurance Training**
  - One that stimulates a substantial, sustained increase in oxygen consumption; requires use of a large amount of muscle mass that is continuous and rhythmic.
  - Accomplished through:
    - Increased intensity
    - Prescribe by heart rate (HR)
    - Prescribe by perceived exertion
    - Prescribe by workload
    - Increased frequency & duration
    - Increase total volume of exercise by 10% per week.

**Heart Rate**

- Heart rate (HR) varies in a linear manner with oxygen consumption during aerobic exercise.
- Dehydration, altitude, heat, and humidity can increase HR.
- Therefore, by monitoring HR you can get a good idea about oxygen consumption — this is your ultimate goal of aerobic exercise.
- Most accurate measure is heart rate reserve (%HRR) for an individually tailored exercise prescription.
- Difference between resting and maximal heart rate
- \( THR = (\text{Intensity fraction})(HR_{max} - HR_{rest}) + HR_{rest} \)
Borg Rating of Perceived Exertion

- Optimum training target zone for a healthy adult is 12-16 on the scale.
- Approximates an exertion of 60-80% of target HR using the Karvonen Heart Rate Reserve method.
- Allows most cardio-respiratory benefit from exercise.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>No exertion at all</td>
</tr>
<tr>
<td>7</td>
<td>Extremely light</td>
</tr>
<tr>
<td>8</td>
<td>Very light</td>
</tr>
<tr>
<td>9</td>
<td>Light</td>
</tr>
<tr>
<td>10</td>
<td>Somewhat hard</td>
</tr>
<tr>
<td>11</td>
<td>Hard</td>
</tr>
<tr>
<td>12</td>
<td>Very hard</td>
</tr>
<tr>
<td>13</td>
<td>Very, very hard</td>
</tr>
<tr>
<td>14</td>
<td>Exhaustion</td>
</tr>
</tbody>
</table>

Rate of Perceived Exertion & Work Load

<table>
<thead>
<tr>
<th>Modified Scale</th>
<th>Ordinal Scale</th>
<th>Percent Work</th>
<th>Perceived Work Load</th>
<th>Talk Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>0%</td>
<td>Very, very light</td>
<td>In bed</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>20%</td>
<td>Very light</td>
<td>Starts walking or &quot;hearing&quot;</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>40%</td>
<td>Fairly light</td>
<td>Brisk walking, able to carry on a conversation</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>60%</td>
<td>Hard</td>
<td>They lose walking pace, must take a breath between 4-5 words</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>80%</td>
<td>Very hard</td>
<td>Unable to talk and keep pace</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>100%</td>
<td>Exhaustion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Workload – Metabolic Equivalent (MET) Levels

- A coding scheme linking specific activities performed in a variety of settings to their respective metabolic equivalent intensity levels.
- Settings include home activities, home repair, inactivity, lawn and garden, outdoor exercise including running, bicycling, etc.
- Examples: making bed = 2.0; carrying groceries upstairs = 7.5

Summary of Key Points...

- Exercise is prescriptive, like medication
  - Appropriate dosing is required
  - Monitoring by professional required
  - Education in intent and expected outcome needed
- Strengthening requires overloading the muscle
- Aerobic/Endurance training requires sustained increase in oxygen consumption over a period of time
- Professional skill, knowledge and judgment come into play with development of an individualized program – FITT-PRO

Maintenance Therapy?
Management and Evaluation?

Care Redesign and M&E

- Skilled nursing visits for management and evaluation of a patient’s care plan are reasonable and necessary when underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose.

- The complexity of the necessary un-skilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient’s recovery and medical safety in view of the beneficiary’s overall condition.
Time Limitations?

- Management and evaluation is not intended to serve as the primary mechanism for providing long-term care.
- However, there are no time restrictions for carrying out this skill.

M&E Checklist

- Briefly document the complicating factors resulting in a high potential for complication or for ensuring that essential non-skilled services are achieving its purpose to promote the beneficiary’s recovery and safety.
- Skilled management and evaluation involves finding that recovery and safety cannot be assured unless the total care, skilled or not, is planned and managed by a registered nurse.
- Skilled management and evaluation should be a specific order when it is the only skilled nursing service rendered.
- MUST be RNs only – no LPNs

Care Redesign and Maintenance

- Skills of a qualified therapist are needed to restore function
- Patient’s condition requires a qualified therapist to design or establish a maintenance program
- Skills of a qualified therapist are required to perform maintenance therapy
- Restorative Maintenance Maintenance
Condition #1: Restorative

Must be reasonable and necessary for the treatment of the patient’s illness or injury.

To the restoration or maintenance of function affected by the patient’s illness or injury within the context of the patient’s unique medical condition.

Must be inherently complex = safely and/or effectively performed only by or under general supervision of a skilled therapist.

Must be consistent with the nature and severity of the illness/injury and patient’s particular medical needs.

Must be considered specific, safe, and effective treatment for the patient’s condition.

Ref:
PFS-2011 Final Rule
§40.2 – Skilled Therapy Services (Rev. 1, 10-01-03)
A3-3118.2, HHA-205.2

Condition #2: Maintenance

Patient is responding to therapy and can meet the goals in a predictable period of time.

The maintenance program must be established by a qualified therapist (and not an assistant).

The unique clinical condition of a patient may require the specialized skills, knowledge, and judgment of a qualified therapist to design or establish a safe and effective maintenance program required in connection with the patient’s specific illness or injury.

Must include the program design, instruction of the beneficiary, family, or home health aides, and the necessary periodic reevaluations of the beneficiary and the program to the degree that the specialized knowledge and judgment of a PT, SLP, or OT is required.

Ref:
PFS-2011 Final Rule:
§§§ 409.44(c)(2)(H)(4)

Condition #3: Maintenance

Where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involve the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant), or

The clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient’s safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.

Ref:
PFS-2011 Final Rule
§§§ 409.44(c)(2)(H)(4)
What About the Caregiver?

- The presence or absence of a caregiver DOES NOT define the intervention provided as “skilled”
- IF someone OTHER THAN a therapist can do the intervention THEN it would NOT be considered “skilled”

Anatomy of a Maintenance Program

- Complexity requiring qualified therapist
- Skills: knowledge, judgment
- Safe & effective Program design related to disease
- Periodic reevaluation
- Prevention of decline

Knowledge Application Exercise

- Match the therapy service to the correct coverage criteria

- Dementia patient with increased sedentary behaviors x 3 months
- Severe COPD with recurrent pneumonia, breathlessness with eating and airway clearance deficits
- Exacerbation of CHF with fluid overload/diuresis and recent ACH x 4 days

Coverage Criteria 1 – Restorative Therapy

Coverage Criteria 2 – Maintenance Program development and management

Coverage Criteria 3 – Maintenance Therapy Program performance
Making a Decision

Key: Clinical Decision-Making

- Requires the therapist (1) know what chronic conditions are present, and (2) where the beneficiary is in the course of the disease(s)
  - i.e., CHF - NYHA Classification – The Stages of Heart Failure
  - Relates symptoms to everyday activities and quality of life
  - i.e., COPD – GOLD grading system
  - Defines the disease according to its severity; serves as a guide for initial approach to treatment
### GOLD Spirometric Criteria for COPD Severity

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>FEV1/FVC &lt; 0.7</th>
<th>FEV1 &gt; or = 80% predicted</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Mild COPD</td>
<td></td>
<td></td>
<td>patient is probably unaware that lung function is starting to decline.</td>
</tr>
<tr>
<td>II. Moderate COPD</td>
<td></td>
<td></td>
<td>Symptoms progress, with shortness of breath developing upon exertion.</td>
</tr>
<tr>
<td>III. Severe COPD</td>
<td></td>
<td></td>
<td>Shortness of breath worsens and COPD exacerbations are common.</td>
</tr>
<tr>
<td>IV. Very Severe COPD</td>
<td></td>
<td></td>
<td>Quality of life at this stage is gravely impaired. COPD exacerbations can be life threatening.</td>
</tr>
</tbody>
</table>

### Example: Therapy Utilization Redesign

- Maintenance program development and instruction
  - 1 x for evaluation and program development
  - 1-3 x for training/instruction of person(s) completing program
- Follow up on instruction/training; determine program efficacy and need for modification(s)
  - 1-3 x for follow up on program completion and need for modification
  - Can be PRN visits
- Reevaluation of patient and current program
  - 1 x for reevaluation
  - Time period for reevaluation completion – every 30 days

### The Future of Care Redesign

- Home Health cannot risk being late to the table.
- Limiting therapy services by “improvement” impedes care redesign.
- Utilize evidence based practice
- Think outside the box Home Health has been kept in.
Practical Considerations

- Home health needs to get into partnership arrangements!
- Want to be part of care redesign.
- What can you offer?
- How can the hospital change its processes in light of home health for post-discharge care?
  - Earlier discharge?
  - Earlier home health involvement?
  - Redesign discharge/referral process to allow for better/faster communication?
  - Less need for post discharge follow up?
- What about non-Medicare patients?
  - Can you handle the post-discharge follow up at a lower cost?
  - Provide same care/outcomes for non-Medicare patients?

What is an Episode Initiator Looking For in a Partner?

- Success in BPCI happens when clinical decision making drives the care
- Quality Conveners/Hospitals are not looking for the “cheapest” provider
- Conveners/Hospitals are looking for partners with:
  - Exceptional Communication
  - Clinical decisioning to avoid readmissions
  - Ability to manage urgent issues without ED utilization (whenever possible)
  - Fiscally responsible providers

Episode Initiators Don’t Know What They Don’t Know

- Hospitals are aware of inpatient practices, but lack the knowledge of post-acute providers
- In earliest conversations, most time was spent educating Conveners/Episode Initiators (EI) on Home Health Billing and practices
- Erroneous assumptions by Conveners/EIs included believing:
  - # of days impacts total cost
  - HH agencies added nursing for additional revenue
  - Home health aide and social work increase cost
  - LUPAs were best practices
Practical Considerations

- Be prepared to make your case
  - Begin putting together a gain sharing explanation that shows how home health can align financially with hospitals, emphasize how home health can drastically improve outcomes and reduce costs.
  - Demonstrating you understand this model is important.
  - Speak their language.
  - Know your data!!! Be prepared to explain how your outcomes related to post-discharge joint replacement patients relate to local and national outcomes.
  - Show them that your agency can better help them to achieve their goals.

The Future. Third party payors are likely to adopt this model as well. Be prepared to address those projects.

Pitfalls – What to Avoid

- Over promising / Under delivering
  - Avoid discussions regarding specific numbers of visits
    - Remember, we are required to develop individualized care plans which are reasonable and necessary
    - We can establish "best practices" and "protocols", but care must be individualized
  - Communication
    - Episode initiators want to be kept in the loop for things outside the "norm"
    - Ensure process and expectations for communications are established

Pitfalls – What to Avoid (cont’d)

- Ensure HH staff are educated
  - Don’t assume that clinicians, clinical supervisors are aware of agreements leadership has made
  - Ensure that an appropriate amount of time is spent in training that includes:
    - What is the CJR program?
    - How to identify CJR patients at an agency level
    - Expectations for clinicians including protocols, best practices and communication processes
    - Early identification of complications and actions to avoid readmissions – what are agencies procedures?
The Future of Home Health

CMS Website Resources

- https://innovation.cms.gov/initiatives/cjr

Evidence-Based Practice Resources

- Medication Management and Physical Therapists
  - Source: APTA, 2013. Advocacy@apta.org
  - Provided
- The Role of Physical Therapists in Wound Management: An Update
- Role of Physical Therapists in the Management of Individuals at Risk for or Diagnosed With Venous Thromboembolism: Evidence-Based Clinical Practice Guideline
- Two-level Wells score: templates for DVT and PE
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Kornetti & Kraft Health Care Solutions, physical therapists with over 70 years of clinical, management and ownership experience, is a consulting company with proven home health care solutions in interdisciplinary, patient-centered care management to fortify your agency’s fiscal security.

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