Home Health Roadmap

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- 30 years Medicare Care Continuum
- 30 year Home Health clinician/contractor
- Home Health consultant & speaker
- Progressive clinical delivery/management
- ACO Post-Acute Bundling Consultant – Vanguard Health Systems – DMC Pioneer
  ACO Grant Awardee
- Model 2 Bundling Awardee – DMC 10/9/12

Dombi’s Thoughts on the Future

“Ten years from now, homecare will still be around but it will be different; it will not be what we see today, it will be a much, much bigger realm of homecare services; it may not even be called Home Health anymore.”
Dombi’s Thoughts on the Future

“It’s not just price per visit, it’s outcomes. If I’m an ACO, I don’t want you because you’re cheaper. I want you because you cost less in a dynamic way: less re-hospitalizations, better management of patients, better integration, etc. We have the skill set and the infrastructure, we just have to adapt.”

Dombi’s Thoughts on the Future

“Budget some of your energy and resources towards keeping the ship afloat, dealing with current care, the proposed cuts, etc., while devoting energies as well to those new opportunities that are out there. If you don’t, somebody else is, and they will be the one who succeeds.”

Home Health Value

- Start of Care within 24 hours or less
- Shift care focus - care dependence to self-care determination
- Proven ability to clearly define clinical vulnerabilities
- OASIS Accuracy – Utilization Review of Assessment
- Better communication and coordination
- Data integration
- Outcomes measurement/reporting – transparency
- Professional Staff – management, productivity, control
- Ability to manage Rehab Care – volume, intensity
- Provide expertise in Accountable Care strategy
  - ED to home care
  - Readmission Reduction
  - Population Health Management
Post-Acute Benefits to Accountable Care

- **Pre-PPACA:**
  - Reduce LOS
  - Follow hospital/physician treatment plan
  - Volume-based payments
  - Minimal transparency

- **Post-PPACA:**
  - Improve continuity of care and quality
  - Improve patient experience
  - Decrease post-acute care costs
  - Decrease avoidable readmissions
  - Value-based payments (bundling and quality)
  - Increase transparency

HEALTHCARE OF THE FUTURE

Healthcare of the Future
- Evidence-based, Best Practice
- Wellness-based, Episodic Care
- Value-based Delivery
- Hospital Redefinition
- Acute Admissions for Critical Care
- Affordable Care Approach to Episodes
- Value Based Care Delivery
The Centers for Medicare and Medicaid Services (CMS) released a clearer definition of homebound to be used when deciding if patients are eligible for home health services under Medicare.

CMS Homebound Clarification

- Requires Aid of Supportive devices, OR
- Requires assistance of another person to leave home, OR
- Medically Restricted from Leaving Home
- Also Must Meet Following Requirements:
  - Normal Inability to Leave Home
  - Considerable and Taxing Effort
CMS Homebound Ramifications

- Thoughts on Application
- Over-Application of Homebound Status
- Under-Application of Homebound Status
- Issues Re: Non-Homebound Cases
- Homebound Status vs. New Care Models
- Clarified to Foster Compliance

Skilled Rehab Documentation

Documentation of rehab Evaluations, Care Plans, routine visit notes, and discharge documentation is paramount to the qualification, focus, and efficiency of a Home Health program. Payment and coverage integrity may be directly related to documentation content.
Skilled Rehab Documentation
- State Medical Necessity
- Describe Functional Deficits/Care Affect
- State Skill Involved
- State Why the Skill is Needed
- State Why Only A Skilled Professional
- State Progress to date/Maintenance Program Validation

Skilled Rehab Documentation
- Clear and Concise
- Identify What you mean to Convey
- Use objective Data
- Focus on Goals: Care Plan & Patient goals
- Patient Subjective Response - Perspective
- Prompt Compliance w HEP use/progress

MAINTENANCE REHAB FOR HOME HEALTH
Rehab Maintenance Documentation

- Justification of Maintenance Programming
- Maintain Function at Highest Level
- Identify why Skilled Professional Required
- Identify Caregiver Instruction
- Identify Caregiver Compliance
- Update Program Routinely and Objectively

ACUTE CARE HOSPITAL READMISSIONS

Hospital Readmissions

- Symptom of expensive/uncoordinated system
- Hospitals benefit fiscally from readmits
- 2 million-30 day readmits - $17.5 billion
- 71% of hospitals penalized 2012 - $280 mil
- Penalties double 10/13 increase again 10/14
- Make admissions less toxic
- Promote safe patient passage from acute care
Post – Hospital Syndrome

An acquired, transient period of vulnerability and risk in the critical first 30 days after discharge (DC). This period of clinical risk is connected as much to the stresses of the inpatient admission as it is connected to lingering effects of the original illness. Patients are not only recovering from their illness, but they are also in a phase of generalized risk for a series of adverse events.

● How do we affect change in this area?
● Replicating the programs of the past?
● Evidence-based, best practice focus
● Accurate assessment of condition
● OASIS/Care Tool?
● Focus on illness/Post-Hospital Syndrome
● Residential vs Care Acuity Programming
Hospital Readmissions
- Assess current delivery system
- Focus on CHF, AMI, and Pneumonia
- Identify Opportunities to create/modify
- Retrain workforce to strategic focus
- Retrain for improvement and communication
- Evaluate performance for opportunities
- Track outcomes for reinforcement

Hospital Readmissions
- Readmission rates fluctuate per diagnosis
- 2011 levels from chart/episode review
  - Heart failure - 37%
  - Pneumonia - 29%
  - COPD - 36%
- Generic factors – sleep, nourishment, pain, meds, deconditioning, etc.
- Develop strategies to mitigate risk

UR Orientation
- Process Identification
- UR-based Care
- Clinical Management
- Live Demo
- Staff Assessment and Data Collection
Utilization Management

- Establish Concession
- Staff Composition
- Patient-focused
- PPS-compliant
- Care Responsibility

UR OASIS Training

- Mandatory SOC staff
- Case-mix Focus
- Care Drivers
- OASIS Answer Review
- Common Mistakes

UR Installation

- Kick-off Date
- All New Start of Care Assessments
- Virtual Open Process – UR Control
- UR-dictated care
- Dovetails Patient/Program Focus
UR Management
- Identify SOC performance
- Per discipline performance
- Identify Fire-Starters by Discipline
- Address Stragglers
- Reinforce Participation

Documentation Training
- All Disciplines
- Skilled Care Approach
- Compliance, Caregiver, HP
- New Outcome Focus
- Precursor to Discharge Management

SOC Documentation
- For Accuracy of Case-Mix (Focus)
- Care Trends
- Live from Home
- Discipline Inclusion
- Under-Performance Often Seen
Nursing Care Plans
- Contemporary Content
- SOC Outcomes
- Fresh Staffing
- PRN Management
- Post-acute vs Cert Period Programs

Quality Assurance Management
- Establish QA Concession
- In-episode Control
- Audit Process
- ALL Care Programs
- All Disciplines

Chart Reviews
- Connection to SOC
- Utilization Management
- Peer Review Exposure
- Audit/Denial Protection
- Survey Preparation
Discharge/Outcomes

• Elevation of Outcomes
• Targeted Care Delivery
• Per Clinician Profile
• ID Strengths/Weaknesses
• Value for New Care Models

Financial Analysis

• Identify Improved Results
• Deviations from SOC plan
• Connect PPS Care/Earnings
• Analyze Individual Cases
• Connect to Savings Models

Quality Improvement

• Improve Care
• Address Reform Efforts
• Modify Delivery
• Advance Staff Skill
• Reinforce Performance
• Mock Survey
ACO Care Plan Production

- Clinical Replaces LOS-based POC
- Faster is Better!!
- Orient Agency/Support Staff/RN/Rehab
- Change the Culture
- Utilization Review for POC Approval

Skilled Episode Delivery

- Baseline Relevant HEP First Visit
- Full Performance HEP Each Visit
- Capture Progression Each Visit
- Seek/Reinforce Progress
- Move Program Forward Each Visit

Goal Production/Management

- Safety/Function is the ONLY Focus
- Distance as Gait Goal Prompts Denials
- Possess Skilled Rehab Visit Approach
- Better Therapists = Faster Results
- Utilize a Sense of Urgency
WHAT IF THE PATIENT WAS YOUR AUNT?

Home Health Strategic Management
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