


Can't See The Forest For The Trees?

Lynda Laff
Laff Associates



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**Where Is CMS Going...
Will You Be There When THEY Get There?**



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A Look Back...

- Cost Reimbursement 1999**
 - ✔ High visit utilization by home health agencies
- ~~PPS~~ **2000 – 2003**
- Home Health Compare – 2003**
 - ✔ Incentives to report outcomes
- Deficit Reduction Act of 2005**
 - ✔ Authorized CMS to develop a healthcare VBP plan
 - ✔ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
 - ✔ Post Acute Care (PAC) Reform

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Fast Forward...

- CMS Report To Congress 2007
- Public reporting of hospital consumer satisfaction begins in 2008
- Home Care PPS refinement in 2008
- VBP Plan for **hospital** implementation in 2009
- RAC and ZPIC audits – 2009
- OASIS – C – process measures – 2010
- Process measure reporting - 2010

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And Now...

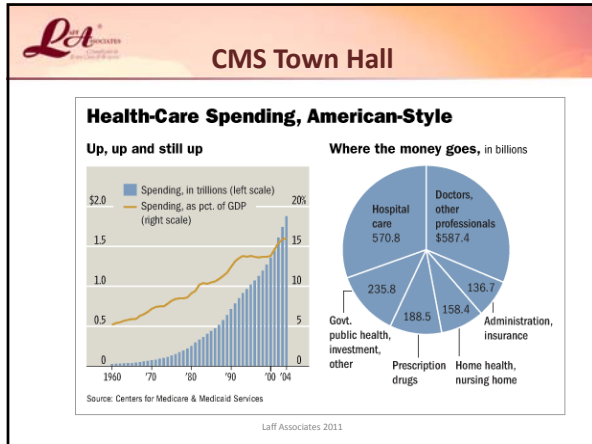
- Billing code changes - G Code additions – 2011
 - More specific visit codes
- New** Home Health Survey Protocols 2011
- Diagnosis coding – ICD-10 – 2013
 - More specificity of DX
- PPS Refinement 2013? 2014?
 - Will be based on “levels” of care
 - Will be based on “level” of discipline providing care
 - Will be based on OUTCOMES
- Value Based Purchasing – 2013?
 - Incentive based payment

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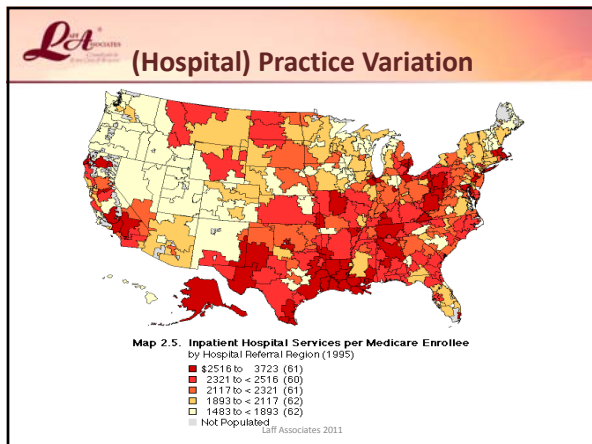
CHANGE Across The Continuum

- Patient Safety
- Promotion of Evidence Based Best Practices
- Focus on Error Prevention
 - “Your Mistake, Your Problem”, *Modern Healthcare*, Jennifer Lubell, August 20, 2007
 - “Present on Admission” – concern over time spent documenting presence of problem at the time of admission
- “Coding is the keystone to reimbursement, it all comes down to documentation”, Alan Rosenstein, MD, VP and Medical Director of the Voluntary Hospital Association, West Coast.

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- ### Numbers Don't Lie
- **Costs escalate with little improvement in outcomes**
 - **Major variations in the cost of care delivery vs. patient outcomes**
 - High numbers of patient re-hospitalizations
 - Medical errors
 - Medication mismanagement
 - Increasing number of pressure ulcers
 - Diabetic foot ulcers
 - Falls
 - Depression in the elderly
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Let **Method To the Madness...**

- *Where is CMS going and will YOU be there when they get there?*
 - ☑ Cost Reimbursement 1999
 - ☑ PPS 2000
 - ☑ Home Health Compare - 2003
 - ☑ PPS Refinement 2008
 - ☑ RAC and ZPIC audits – 2009
 - ☑ OASIS – C – process measures - 2010
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 - ☑ Value Based Purchasing – 2013?




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Let **Vision for PAC**

Facilitate care transitions across the continuum to;

- Optimize choice and control of services
- Ensure that decisions are based on patient needs
- Provide coordinated, high quality care with seamless transitions between settings
- Reward excellence by payment for quality measures
- Recognize role of family care giving
- Utilize health information technology



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Let **Best Moves ?**

- Efficiency
 - Less care?
 - Fewer staff?
 - No education?
- Focus on **Patient Care = Outcomes**
- How to deliver good patient care?
 - "Right-size"
 - Invest in people
 - Invest in education



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Get Focused!


- **Clinical Management Information**
 - Key Indicators
 - Routine Reports
- **Education**
 - Clinical assessment
 - OASIS Accuracy
- **Supervision & Oversight**
 - Documentation Timeliness
 - Care Plan Development
- **Continuity**
 - Case management
 - Clinical model
- **Accountability/ Responsibility**
 - Reward / incentive
 - Corrective Action



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Education and Validation


- Education without validation and reinforcement is **Money down the drain!**
 - How do you know?
 - What checks are in place?
 - How long does it take?
 - Who is validating what?
 - Were the suggested corrections actually made?
 - What "tools" do you use?
 - Are there repeated errors? **IF SO - WHY?**
 - Repeated errors cost money



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Accountability

- Primary clinician – with F2F contact
- May be RN or PT
 - Must be accountable for patient and financial outcomes
 - Accurate assessment
 - Appropriate care plan
 - Constant knowledge of;
 - Goals of care
 - Projected visits vs. actual
 - Team performance – Therapists must be included in the team
 - Patient response to care
 - Need for change in plan



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LCA **Diagnosis Coding – Outsource?**

- Requirements
 - Assessing clinician MUST complete initial diagnosis sequencing
 - Assessing clinician MUST complete final codes on the OASIS document
 - Access to History & Physical information
 - Validation from MD for diagnosis specificity
 - **Cannot code by medication list** – can be a guide to ask questions
 - Must follow coding conventions

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LCA **Diagnosis Coding – Outsource?**


You Must Consider This...

- Communication requirements
 - Clinician to coder
 - Clinician to MD
 - Supervisor to coder
 - Coder to MD?
- Volume of OASES
- Number of clinicians completing OASES
 - SOC
 - ROC
 - Re-certifications

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LCA **Diagnosis Coding – Outsource?**


- Timeframe for process completion
- Access to database
 - Electronic
 - Mail
 - Scanning and e-mail
- Method of communication
 - E-mail
 - Telephone
 - Fax
- Who is accountable?



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Diagnosis Coding – Outsource?

- **Best Solution – Make or Buy?**
- **Make**
 - **Develop Expert Coding Staff... (Oh yes you can...)**




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OASIS Review – Outsource?

You Must Consider This...


- **Communication requirements**
 - Clinician to reviewer
 - Supervisor to clinician
- **Volume of OASES**
- **Number of clinicians completing OASES**
- **Process for OASIS corrections**
 - Should be done by clinician
 - Measurement of OASIS errors and error rates by clinician
 - Repeat errors



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Communication Conundrum


- Intake information
- History & Physical
- Clinician summary
- Completion of SOC documentation
- Supervisor conference
- Timeframe for communication
- Volume of admissions
- Identification of errors



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Laff Associates **OASIS Review – Outsource?**

- Best Solution – Make or Buy?
- **Make + OASIS Scrubbing Tool**
 - Educate RN(s) for OASIS review
 - COS-C
 - Educate clinicians about their errors
 - Corrections by **clinicians** – if there is no consequence to constant error...there will be no error reduction!




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Laff Associates **Medical Supplies – Outsource?**

You Must Consider This...

- Costs
 - Current practice for purchasing supplies
 - Volume purchasing contract
- Use of formulary
- Warehousing – inventory
- Management of inventory
- Clinician as delivery tech? \$\$\$
 - Time lost – fewer patient visits
 - Mileage \$\$\$




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Laff Associates **Medical Supply – Outsource?**

You Must Consider This...

- Accountability – who is responsible for medical supplies?
 - Inventory
 - Controls – distribution (eliminate “shoppers!”)
 - Purchasing




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Medical Supply – Outsource?

- Best Solution Make or Buy?



- Buy!!!
 - Negotiate volume contract, develop limited formulary with alerts for orders over X dollars, patient specific delivery by the vendor, and direct electronic reporting into billing system.


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Payroll – Outsource?

Consider, *if you have a choice!*

- Costs
 - Current practice of accumulating payroll data for:
 - Each pay period including overtime, PDOs earned, used and balance available, oncall, weekends
 - Quarterly and Year-end tax returns and 1099s
 - Use of payroll software, costs of processing, including those if not utilizing direct deposit
 - Personnel




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Payroll – Outsource?

- Best Solution Make or Buy?

- Buy!!!
 - Negotiate contract with specialized firm to handle servicing, including direct deposit that either interfaces with or replaces payroll software (or billing software for per visit pay).




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When IS Enough Enough?

- How do you know????
- It depends.....
 - Clinical Model
 - Agency Size and Scope
 - Geography
 - Volume
 - Paper or Point of Care
 - Clerical versus Clinical Function





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Realistic Expectations

- Number of visits per day is dependent upon clinical model
 - Do your field nurses case manage a census of patients”
 - If so – is the number consistent among your staff?
- Do you have admission nurses?
- Do you use a point of care documentation system?
- How many miles does a clinician average per day/week?





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When IS Enough Enough?

- The Clinical Director comes to you and says “I don’t have enough nurses to see all these new patients. What’s the first thing you do?”
 - a. Call a temp agency
 - b. Put an add in the paper
 - c. Review statistics



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When is Enough Enough?

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What Statistics?


- Look at the number of ACTIVE patients on your census list
 - “Clean” census list
 - All discharges removed at least weekly
 - Identify why “old” patients remain
- Review your expectations for staff productivity
 - Visits per day, per week
- Look at actual performance of staff – how many **actual** visits per day did they perform last week?
- Identify “weakest links” and investigate why....

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What Statistics?

- Are your expectations per clinician met?
 - Are they reasonable?
- Are your expectations **standardized**?
- Do you monitor and enforce the expectations?
 - Are you using the “warm body approach?”
- Is there a consequence for non-performance?




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What Statistics?

- A review of operations and records indicate presence of one or all of the following;
 - Many OASIS item inconsistencies
 - DX Coding errors
 - Low EOE case weight
 - High LUPA rate
 - Higher than average therapy utilization
 - LOS average over 60 days



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What Statistics?

- Who is reviewing the OASIS?
 - Is that a **primary function**?
 - Is that individual **qualified**?
- Manual or Scrubber?
- Duplicative functions
- Corrections versus consequence....
- Management oversight


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Statistics to Live By

- Case Weight
 - Case weight variance – SOC to EOE
 - EOE case weight
- Re-certifications and LOS
- Visit Utilization Averages
 - Ratio nursing/therapy
- Actual Revenue versus Anticipated Revenues
- Timeliness of RAP Submission
- % of Therapy Visits per Threshold
- Average visits per episode
- Productivity by discipline - *Actual*
- Cases **Managed** per Clinician – **WHO IS REALLY MANAGING THE PATIENT?**

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 **Statistics to Live By**

- VBP Statistics
 - OASIS Errors by Clinician
 - OASIS Corrections Completed
 - Outcomes Improvement
 - Patient Declines
 - Potentially Avoidable Events
 - Have you audited each of them?
 - What did you do to prevent them in the future?

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