2013 MAHC Annual Conference & Exhibition

There is an “I” in Team – Interdisciplinary Care Management

Presented by:
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There is an “I” in Team – Interdisciplinary Care Management

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Fazzi Associates, Inc.
President – Home Health Section APTA

How Much Time?

• OT plans on seeing a patient for a total of 5 visits:
  – 5 hours/1440 hours = 0.3% of total time
  – 1,435 hours with no direct intervention

• OT plans 5, PT plans 8, SN plans 6, and HHA plans 6:
  – 25 hours/1440 hours = 1.7% of total time
  – 5 times the opportunity to reinforce information

Diagnosis?

“A prescriptive definition of these sorts of conditions, such as a listing of specific disease states that provide subtext for these descriptions is impractical, as each patient’s recovery from illness is based on unique characteristics.”
Who Decides?

• “We believe that rehabilitation professionals, by virtue of their education and experience, are typically able to determine when a functional impairment could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities.”

• “We expect rehabilitation professionals to be able to recognize when their skills are appropriate to promote recovery.”

Therapy in 2012

• 0 to 5
  – 3.75% increase

• 14 to 15
  – 2.5% decrease

• 20 or more
  – 5% decrease

Incentive?

<table>
<thead>
<tr>
<th>Example 1</th>
<th>Example 2</th>
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<tbody>
<tr>
<td>M02200 = 19</td>
<td>M02200 = 19</td>
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<tr>
<td>Actual = 14</td>
<td>Actual = 19</td>
</tr>
<tr>
<td>Revenue = $2337 ($663 lower)</td>
<td>Revenue = $3000</td>
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<tr>
<td>Cost - $126 X 14 = $1764</td>
<td>Cost - $126 X 19 = $2394</td>
</tr>
<tr>
<td>Margin = $573</td>
<td>Margin = $606</td>
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Referral Expectations

63.2%
24.6%
53.1%

Source: Abt Associates Inc analysis of Home Health Datalink file

OASIS and Care Management

• Functionally Driven Items (M1800 series):
  – Grooming
  – Dressing
  – Bathing
  – Toileting
  – Toileting Hygiene
  – Transfers
  – Ambulation
  – Meal Preparation

• Focus on “why” the challenge exists.

OASIS and Referrals
Other OASIS Items to Consider

- Hospitalization Risk
- Living Situation
- Ability to Hear
- Ability to Understand Verbal Content
- Speech/Expression of Language
- Interfering Pain
- Pressure Ulcer Risk
- Dyspnea
- Incontinence
- Cognitive/Behavioral Issues
- Medication Management

The assessment for a 74 year old male reveals a past history of 2 hospitalizations in the last year, a fall 4 months ago without injury, a drug regimen of 6 medications and patient reports of more frequently not having the energy to do what he likes to do.

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

- Recent decline in mental, emotional, or behavioral status
- History of falls in the past 12 months
- History of falls or any fall with an injury in the past year
- Taking five or more medications
- Frailty, indicators, e.g., weight loss, self-reported exhaustion
- Other
- None of the above

In the professional judgment of the assessor, impact ability to remain safely in the home.

Recent decline = past year

Frailty can also include things like slower movements, declining function, etc.

M1300 Pressure Ulcer Assessment

SOC/ROC

(M1330) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?

- No assessment conducted (Go to M1339)
- Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- Yes, using a standardized tool, e.g., Braden, Norton, other

Assessment choices:
- Standardized tool = validated, scientifically tested, standardized responses
- Evaluation of clinical factors; evidence must be documented in record.
Therapists and Wound Care

- History Lesson:
  - Wound Care, Therapy and M0825/826/M2200

- State Practice Acts:
  - Lack of a consistent position for all states

- Involvement of therapy assistants:
  - Variation by practice setting and Practice Acts

“Skilled” Wound Care

- Routine dressing changes that could be done by a nurse would NOT stand alone as a skilled therapy visit.

- Routine dressing changes as part of a therapy visit reduce unnecessary nursing visits.

- Interventions specific to therapy for wound care (US, E Stim, sharps debridement) DO stand alone as a skilled therapy visit.

Therapy and Depression

- More interventions available than medications alone.

- Need to determine contributing factors:
  - Homebound
  - Self care = self esteem
  - Changing life roles
  - Loss of recreational activities

- Therapy can help!
Focus on Outcomes

• Care planning must be about more than visit numbers and physician orders.

• The intent is to improve the outcomes for the patient.

Home Health Compare

• Improvement in ambulation/locomotion
• Improvement in bathing
• Improvement of oral medications
• Improvement in transferring
• Improvement with pain interfering with activity
• Any emergent care provided
• Acute care hospitalizations
• Improvement in dyspnea
• Improvement in urinary incontinence
• Discharge to the community
• Improvement in the status of surgical wounds*
• Emergent care wound infections/deteriorating wound status*

“Improvement”

• Improvement is measured as scoring at a better level than at the start of the episode.

• Does not mean full recovery is the goal.
M1860 Ambulation

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, or on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (i.e., cane, single crutch, hemi-wheelchair), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a locomotion device (i.e., walker or rollator) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or uneven surfaces.
- 3 - Able to walk only, with the supervision or assistance of another person at all times.
- 4 - Chairlift, unable to ambulate but is able to wheel self independently.
- 5 - Chairlift, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

Care Planning - Ambulation

- Focus on surface and safety
- Accuracy of baseline data
- Contributing factors:
  - Medications
  - Cognition
  - Environment

M1910 Fall Risk Assessment

(M1910) Has the patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, falling frequency, general mobility/transfering impairment, environmental hazards)?

- 0 - No multi-factor fall risk assessment conducted.
- 1 - Yes, and it does not indicate a risk for falls.
- 2 - Yes, and it indicates a risk for falls.

Select 0 and 1 carefully
Fall Prevention Checklist

- Assess usefulness of “incident report” data collection tool.
- Risk assessment tool:
  - Does it point in the right direction?
- Referral triggers.
- Structured interventions.
- Measurable outcomes.

M2020 Management of Oral Meds

M2020 Management of Oral Medications. Patients current ability to prepare and take all oral medications safely, including administration of the correct dosage at the appropriate times/intervals. *Exclude* injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

- 0: Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times
- 1: Able to take medication(s) at the correct times if:
  - (a) individual is prepared in advance by another person;
  - (b) another person develops a drug diary or chart
- 2: Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3: Unable to take medication unless administered by another person.
- NA: No oral medications prescribed.

*Alert!* If ability varies from med to med, select the response for the medication needing the most assistance!

Reminders by a device, chart or diary that a patient can independently manage are not considered assistance or reminders. Score as independent.

Care Planning – Medication Management

- Assessment and management is a patient safety issue.
- Functional components cannot be overlooked.
- All members of the care team must be involved.
M2000 Drug Regimen Review SOC/ROC

M2000 Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- 0 - Not assessed/reviewed [Go to M0090]
- 1 - No problems found during review [Go to M0010]
- 2 - Problems found during review
- NA - Patient is not taking any medications [Go to M0090]

**Includes all meds, prescribed and over the counter, administered by any route.**

**Alert!** Office based staff may collaborate and must communicate findings to the assessor:

- May change M0090 assessment completed date

**Potentially clinically significant “problems”:**

- Adverse reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, noncompliance (intentional or accidental) MCR COP 484.55

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**Drug Regimen Review COP**

G337 – The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance with drug therapy.

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**CMS Comments**

“Medication management and education: Physical therapists are more than capable of completing the drug regimen review item. It is within the scope of the physical therapist to perform a patient screen in which medication issues are assessed even if the physical therapist does not perform the specific care needed to address the medication issue.”
M1830 Bathing

M1830 Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  a. For intermittent supervision or encouragement or reminders.
  b. To get in and out of the shower or tub.
  c. For washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.

Care Planning - Bathing

- OT and/or HHA?
- Keep in mind “improvement.”
- Don’t overlook safety of the transfer!

M1850 Transferring

M1850 Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is infirm.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

Response 1
Someone OR Something
Care Planning - Transfers

Assessment and intervention specific to the transfers in OASIS:
- In/out of tub/shower
- Bed to chair
- On/off toilet in bathroom

M1242 Frequency of Pain Interfering

- Pain assessment expanded beyond rating pain 1–10
- Consistency of information across disciplines
- Impact on plan of care and goals
M1400 When Noticeably Short of Breath

(M1400) When is the patient dyspeptic or noticeably Short of Breath?
- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - All day (during day or night)

Care Planning - Dyspnea

- Medication management:
  - Remember Oxygen

- "Energy Conservation":
  - Standards of Care

- Consistency across disciplines

M1615 When Urinary Incontinence Occurs

(M1615) When does Urinary Incontinence occur?
- 0 - Timed-voiding prevents incontinence
- 1 - Occasional stress incontinence
- 2 - During the night only
- 3 - During the day only
- 4 - During the day and night

• Response 0:
  - Schedules toileting to prevent episodes of incontinence and it works.
• Response 1:
  - Inability to prevent the escape of urine during stress (laughing, coughing, sudden movement, lifting, etc.).
• Select 2, 3 or 4 if incontinence happens with regularity or for reasons other than "stress."
Care Planning - Incontinence

- Timed voiding programs
- Pelvic floor interventions
- Cognitive interventions
- Addressing mobility issues
- Equipment and environmental issues

M2250 Plan of Care Synopsis SOC/ROC

<table>
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<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>a. Patient-specific parameters for identifying patient-specific pain parameters for this patient.</td>
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<tr>
<td>b. Diabetic foot care including monitoring for the presence of ulcer, wound, or foot ulcer, and education on proper foot care.</td>
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<tr>
<td>c. Falls prevention interventions</td>
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<tr>
<td>d. Depression intervention(s) that are relevant to the patient, or a monitoring plan for current treatment.</td>
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<tr>
<td>e. Intervention(s) to monitor and mitigate pain</td>
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<tr>
<td>f. Intervention(s) to prevent pressure sores</td>
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<tr>
<td>g. Pressure ulcer treatment based on principles of minimal wound healing</td>
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<tr>
<td>h. Patient has no pressure ulcers with need for minimal wound healing</td>
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Documentation Tools

- Tools need to facilitate good documentation.
- Paper versus electronic???
- The responsibility will always remain with the therapy professional.
Helpful Resources

- American Physical Therapy Association:
  - www.apta.org:
    - Home Health Section
    - State Level Associations

- American Occupational Therapy Association:
  - www.aota.org

- American Speech and Hearing Association:
  - www.asha.org

- National Association of Home Care
- State Home Care Associations

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