Managing Patient-Centered Care in a Changing Reimbursement World

2016 Combined Sections Meeting

Speaker(s): Mark Besch, BS-PT
Donna Diedrich, PT, DPT, GCS
Jaclyn Warshauer, PT

Session Type: Educational Sessions
Session Level: Intermediate

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Disclosure

We have commercial interests as salaried employees of the company, Aegis Therapies.

Employer: Aegis Therapies
- Mark Besch, VP Clinical Services
- Donna Diedrich, National Director of Clinical Services
- Jaclyn Warshauer, National Director of Clinical Services

Aegis Therapies is a contract therapy company providing physical therapy, occupational therapy and speech-language pathology services across the post-acute care continuum. Best practice and lessons learned are based on company experiences.
Session Learning Objectives

1. Compare/contrast care delivery models within the post-acute care realm, and be able to interpret the right patient, right plan, right setting philosophy.

2. Translate reimbursement of care from today’s practice patterns to future patterns of care including bundled services and ACO continuums.

3. Model best practices and apply care decisions based on lessons learned from pilots focused on value-based, patient-centered care.

MIPS - Clinical Practice Improvement Activities:

- Expanded Practice Access
  - Same day appointments for urgent needs
  - After hours clinician advice

- Population Management
  - Monitoring health conditions & providing timely intervention
  - Enrollment in a qualified clinical data registry

- Care Coordination
  - Timely communication of test results
  - Timely exchange of clinical information with patients AND providers
  - Use of remote monitoring
  - Use of telehealth

- Beneficiary Engagement
  - Establishing care plans for complex patients
  - Beneficiary self-management assessment & training
  - Employing shared decision making
Every Year (Through 2029)

3.5 Million

BOOMERS Turn 65

This means that approximately 10,000 new retirees will be added to the Social Security and Medicare rolls each day. Are you ready for how this will impact your patient mix?

The "Oldest Old" 85+

- The fastest-growing segment of the total population is the oldest old — those 80 and over.
- Their growth rate is two times the size of those 65 and over, and almost four times the size of the total population.
Where are the patients going after acute hospital stays?

Patient Type Based on DRGs

Table 4. First Site of PAC, Acute Hospital-Initiated Episodes, Overall and for Top 5 MS-DRGs by Volume of PAC Users, 2006-2008

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>N</th>
<th>% Discharged to PAC</th>
<th>% Discharged to LTCH</th>
<th>% Discharged to IRF</th>
<th>% Discharged to SNF</th>
<th>% Discharged to HHA</th>
<th>% Discharged to Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>All MS-DRGs 2008</td>
<td>653,549</td>
<td>35.7%</td>
<td>1.7%</td>
<td>8.6%</td>
<td>42.2%</td>
<td>37.4%</td>
<td>10.1%</td>
</tr>
<tr>
<td>470: Major joint replacement or reattachment of lower extremity w/o MCC</td>
<td>90,434</td>
<td>94.2%</td>
<td>0.1%</td>
<td>12.2%</td>
<td>37.4%</td>
<td>37.4%</td>
<td>12.9%</td>
</tr>
<tr>
<td>005: Intracranial hemorrhage or cerebral infarction w/ CC</td>
<td>13,892</td>
<td>75.0%</td>
<td>1.2%</td>
<td>37.0%</td>
<td>36.8%</td>
<td>17.3%</td>
<td>7.7%</td>
</tr>
<tr>
<td>481: Hip &amp; femur procedures except major joint w/ CC</td>
<td>13,704</td>
<td>55.4%</td>
<td>0.4%</td>
<td>22.1%</td>
<td>68.0%</td>
<td>7.7%</td>
<td>1.0%</td>
</tr>
<tr>
<td>294: Simple pneumonia &amp; pleurisy w/ CC</td>
<td>13,604</td>
<td>36.1%</td>
<td>0.9%</td>
<td>1.7%</td>
<td>51.1%</td>
<td>37.0%</td>
<td>8.5%</td>
</tr>
<tr>
<td>690: Kidney &amp; urinary tract infections w/o MCC</td>
<td>12,354</td>
<td>45.9%</td>
<td>0.4%</td>
<td>1.7%</td>
<td>58.3%</td>
<td>26.0%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

The traditional payer for our services is shrinking every year as more and more potential patients need those services.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Episode Pattern</th>
<th>N</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AH</td>
<td>150,050</td>
<td>22.9</td>
<td>22.9</td>
</tr>
<tr>
<td>2</td>
<td>AS</td>
<td>91,928</td>
<td>13.9</td>
<td>36.8</td>
</tr>
<tr>
<td>3</td>
<td>ASH</td>
<td>56,661</td>
<td>8.6</td>
<td>45.4</td>
</tr>
<tr>
<td>4</td>
<td>AO</td>
<td>34,141</td>
<td>5.2</td>
<td>50.6</td>
</tr>
<tr>
<td>5</td>
<td>AHA</td>
<td>24,512</td>
<td>3.7</td>
<td>54.3</td>
</tr>
<tr>
<td>6</td>
<td>AT</td>
<td>18,485</td>
<td>2.8</td>
<td>57.1</td>
</tr>
<tr>
<td>7</td>
<td>ASO</td>
<td>17,931</td>
<td>2.7</td>
<td>59.8</td>
</tr>
<tr>
<td>8</td>
<td>AHI</td>
<td>14,900</td>
<td>2.3</td>
<td>62.1</td>
</tr>
<tr>
<td>9</td>
<td>ASAS</td>
<td>14,687</td>
<td>2.2</td>
<td>64.3</td>
</tr>
<tr>
<td>10</td>
<td>AHO</td>
<td>14,655</td>
<td>2.2</td>
<td>66.5</td>
</tr>
</tbody>
</table>

A = acute hospital, S = SNF, H = HHA, I = IRF, L = LTCH, O = outpatient department, T = independent therapist.
### Alternative Payment Models

#### Bundled Payments
- Target price for all services based on **episode of care**
- Shared risk between acute hospitals > group (physician) practices > PAC providers
- **All** working on outcomes based on quality, sharing same payment

#### Accountable Care Organization (ACO)
- All providers share responsibility for managing the total cost and quality based on a specified population (patients of the ACO)
- Some newer ACOs have population-based payments

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Four Pillars of Decreasing Rehospitalizations

1. Red Flag (S/S) Recognition
2. Medication Management (Self or Caregiver Understanding)
3. Transitions Notebook - Use of a Patient Health Record/Journal
4. Medical/Therapy Follow-Up (Nursing, MD or Rehabilitation Specialist)

Patient-Centered
Demonstrate Value
Collaborate

Does Care Transition Provide Value?

KEY FINDINGS: Five coordinated care models serving high-risk Medicare beneficiaries result in an ROI.

<table>
<thead>
<tr>
<th>Program Model</th>
<th>Annual Cost Per Enrollee</th>
<th>Annual Savings Per Enrollee</th>
<th>ROI Per Year</th>
<th>PMMA savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transition Intervention (Group Visit)</td>
<td>$678</td>
<td>$4,795</td>
<td>607.02%</td>
<td>$431.06</td>
</tr>
<tr>
<td>Transitional Care Model</td>
<td>$1,492</td>
<td>$5,534</td>
<td>267.48%</td>
<td>$520.14</td>
</tr>
<tr>
<td>Care Transition Intervention</td>
<td>$999</td>
<td>$2,311</td>
<td>131.3%</td>
<td>$109.34</td>
</tr>
<tr>
<td>GRACE</td>
<td>$2,201</td>
<td>$4,291</td>
<td>94.96%</td>
<td>$174.17</td>
</tr>
<tr>
<td>Project RED</td>
<td>$73</td>
<td>$493</td>
<td>32.37%</td>
<td>$10.65</td>
</tr>
</tbody>
</table>

Key takeaways:
- Per month, per member savings vary
- Integration of care and long-term care management
- Evidence-based care transition and coordination programs can result in positive ROI
- There was not a direct relationship between higher enrollee cost and better results
**Right Patient**

- Requires the skills of a therapist
  Example: Ask yourself, "Can this care be provided to this patient by others less skilled?"

- Example: Establish the plan of care based on skilled modalities and clinical judgment not passive applications* or habits.

**Right Plan**

*What Is Needed Now?*

[Diagram showing three concentric circles labeled "Concern," "Influence," and "Control"]
Patient-Centered  Demonstrate Value  Collaborate

What Am I Accountable for Now?

Goal within my setting

Right Setting

Effective Placement: A Persistent Challenge

- Facility-specific capabilities underrepresented in discharge decision
- Proportion of Medicare patients placed in an avoidably high-cost setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>OP Therapy</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>14%</td>
<td>15%</td>
<td>5%</td>
<td>3%</td>
<td>31%</td>
</tr>
<tr>
<td>SNF</td>
<td></td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRF</td>
<td></td>
<td></td>
<td></td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>LTCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>42%</td>
</tr>
</tbody>
</table>

Evidence of Learning: Objective One

1) Compare/contrast care delivery models within the post-acute care realm, and be able to interpret the right patient, right plan, right setting philosophy.

- Q: What is the difference between payment under traditional Medicare (FFS) and CMS’s targeted projections for 2018 payment systems?
- Q: State the philosophy of: **Right Patient, Right Plan, Right Setting**

Objective Two

Translate reimbursement of care from today’s practice patterns to future patterns of care including bundled services and ACO continuums.

- Including documentation requirements supporting skilled care and outcomes
### Changing Reimbursement Landscape

**Better Care, Smarter Spending, Healthier People: Paying Providers for Value, Not Volume - Medicare**

Medicare’s goal:
- 30% of all Medicare fee-for-service payments made via alternative payment models by 2016
- 50% by 2018
- Shifting from volume to **value**

### Volume to Value

- This shift is now showing up in **rule-making**
  - Home Health Value-Based Purchasing Model
  - Comprehensive Care for Joint Replacements
  - Proposed Rule for Discharge Planning
    - May be final rule at the time of this presentation
  - IMPACT Act
**Value**

*Value = health outcomes achieved per dollar spent*


<table>
<thead>
<tr>
<th>Patient-Centered</th>
<th>Demonstrate Value</th>
<th>Collaborate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTCOMES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Degree of health or recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Functional level achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Pain level achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Extent of return to physical activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Ability to return to work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Time to recover and time to return to normal activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Time to return to physical activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Time to return to work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sustainability of health or recovery and nature of recurrences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Maintained functional level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Ability to live independently</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Porter NEJM 2010*
Patient-Centered Value

- Value for the patient is created by providers’ combined efforts over the full cycle of care. The benefits of any one intervention for ultimate outcomes will depend on the effectiveness of other interventions throughout the care cycle.

Porter. NEJM 2010

Therapy Settings as Partners

Initial Functional Decline ➔ Final Recovery Outcome

<table>
<thead>
<tr>
<th>Acute LTG</th>
<th>SNF LTG</th>
<th>OP LTG</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRF LTG</td>
<td>HH LTG</td>
<td></td>
</tr>
</tbody>
</table>
Awareness of Payer-Specific Coverage Guidelines

- Each third party payer has specific coverage guidelines
- Therapists should understand the various benefits, including those of the downstream settings

- Right patient
- Right plan
- Right setting

Rehabilitation Benefits

- Each benefit setting has specific requirements (in today’s world, but this is becoming more setting agnostic)
- All settings require that the services be reasonable and necessary in terms of:
  - Amount of services
  - Frequency
  - Duration
  - Setting appropriate to the patient’s needs/condition
Medicare Resource (Handout)

Medicare Therapy Coverage by Setting

- **RIGHT Patient**
- **RIGHT Time**
- **RIGHT Discipline**
- **RIGHT Setting**

### ACUTE CARE HOSPITAL and LONG TERM CARE HOSPITAL (LTCH/LTAC)  
### INPATIENT REHAB FACILITY (IRF)  
### SNF PART A (Including hospital Swing Bed)  
### HOME HEALTH  
### PART B - SNF Part A - (Including hospital Swing Bed)  

#### Reasonable & Necessary
All settings require that in order for therapy services to be billed to Medicare, the services must be reasonable and necessary:
- Safe and effective
- Not experimental or investigational
- Provided in accordance with accepted standards of practice
- Appropriate in frequency and duration

#### Coverage Requirements
- Must have Part A days left in the benefit period.
- The inpatient hospital setting.
- Requires multiple therapy disciplines.
- Requires intensive therapy generally defined as at least 3.
- At least 3 days qualifying hospital stay and Part A days left in the benefit period.
- Must be considered home bound.
- Must require skilled nursing (intermittent) or.
- Expected anticipated improvement attainable reasonable.

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Patient-Centered  
Demonstrate Value  
Collaborate

**Medicare Payment Basics From MedPAC**

http://www.medpac.gov/-documents/payment-basics

**ACCOUNTABLE CARE ORGANIZATION PAYMENT SYSTEMS**

Accountable care organizations (ACOs) are groups of health care providers that include doctors, hospitals, and other health care professionals. ACOs have formed in 49 states; Washington, D.C. and Puerto Rico. They urban and rural areas, and serve mostly the largest number.

**HOME HEALTH CARE SERVICES PAYMENT SYSTEM**

Beneficiaries who go to their homes as a nurse, physical therapist on a part-time or full-time basis eligible to receive home health care. Home health personnel visit to provide services:
- Skilled nursing
- Physical therapy

**SKILLED NURSING FACILITY SERVICES PAYMENT SYSTEM**

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible for services.

The initial pay is to reflect the payment of the cost for the initial 20 days.
Focus on Value
Impact on Care Delivery

- Patients may pass through care settings faster
- Patients will need certain skills or abilities to transition to the next care setting
- Your care setting does not have to provide services to meet every possible rehab need

Communication and Dialogue

- Interdisciplinary and cross-setting communication will be key to success
  - Verbal
  - Medical record documentation
- Other interested parties will be asking questions
  - Therapists must be able to frequently and effectively communicate the status of our patients in terms of current complexity and barriers to transition to the next setting
<table>
<thead>
<tr>
<th>Patient-Centered</th>
<th>Demonstrate Value</th>
<th>Collaborate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication and Collaboration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Communicate with <strong>previous</strong> care setting in order to begin where they left off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Collaborate with the <strong>next</strong> care setting to know what the patient will need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Determine the transition plan <strong>within the first few days</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assess health literacy of <strong>patient/family</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identify subtle functional declines <strong>early</strong> (as we always have, but even <strong>more</strong> important now)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Follow up with patient <strong>after</strong> transitioning from this setting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient-Centered</th>
<th>Demonstrate Value</th>
<th>Collaborate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documenting Patient Complexity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Documentation must <strong>clearly convey the medical complexity</strong> of the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Explain the interaction of the comorbidities and complexities and how they influence:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The amount of treatment required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The setting for which the services must be provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Describe the <strong>rehab potential</strong> and the <strong>positive prognostic indicators</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Determine the Transition Point

- **Determine:**
  - What the patient needs to be able to do in the transition environment
  - What environmental or structural challenges exist in the transition environment
  - What adaptations to the transition environment need to be made; what adaptations to tasks must be made to allow transition
  - How much and what type of caregiver support is available
- **Document** the above findings

### Establish the Setting-Specific LTG

- Must know the transition setting
  - Including environmental factors and social support
- Must know the functional level needed for a safe and successful transition to the next setting
  - This is your setting-specific LTG
Set the Treatment Plan

- As always:
  - Obtain objective measures of PLOF and CLOF
  - Determine the underlying impairments that are causing the functional deficits
- Determine which functional deficits must be addressed in your setting in order to facilitate a safe and smooth transition to the next level of care
- Treatment plan should focus on these required transition functions

Skilled Services

- I am the value they are paying for
- Need to show the evidence of skill
Barriers to Transition

• At any given time the therapist should be able to answer, Why can’t the patient be transitioned to SNF/HH/OP therapy today? What is keeping him/her here? 
• These barriers to transition to the next care level must be updated frequently in the documentation
  – Progress reports

Discharge Summary

• Clearly describe the recommendations, instructions and precautions given to the patient and/or caregiver to ensure a safe and effective transition of care
  – The specific home exercise program provided and the patient/caregiver’s understanding
  – Family and caregiver training and their understanding
  – Recommendations for follow-up therapy in a different setting
  – Equipment provided
Managing Post-Acute Care in ACOs

• Some ACOs have partnered with **post-acute care continuum navigators**
  – naviHealth

• naviHealth provides decision support technology and a post-acute care analytics platform

**naviHealth**

• OPT (Outcome Prediction Tool)
  – Looks at function, comorbidities, living situation and diagnosis
  – Predicts functional recovery, readmission probability and burden of care
Patient-Centered  |  Demonstrate Value  |  Collaborate

Navihealth- EXAMPLE

- OPT Report
  - Provides an estimated length of stay (ELOS)
  - Provides guidance for number of therapy minutes over the course of a week

<table>
<thead>
<tr>
<th>Number of days pt. should receive therapy during skilled stay</th>
<th>Low*</th>
<th>Medium</th>
<th>High*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cycle (days)</td>
<td>15.6</td>
<td>16.7</td>
<td>17.8</td>
</tr>
<tr>
<td>Hrs./Day</td>
<td>2.2</td>
<td>1.83</td>
<td>1.57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated therapy hours/day based on frequency</th>
<th>Hours if seen 5x/wk</th>
<th>Hours if seen 6x/wk</th>
<th>Hours if seen 7x/wk</th>
</tr>
</thead>
</table>

Objective Three

- Model best practices and apply care decisions based on lessons learned from pilots focused on value-based, patient-centered care.
Patient-Centered Demonstrate Value Collaborate

Expectations of Providers

- Greater focus on SNFs taking higher acuity patients
- Need for accepting patients on weekends and evenings
- Focus on reducing SNF length of stay
- Reduction in hospital readmission rates
- Greater use of clinical pathways to better sequence timing and delivery of services
- Compliance with ACO care protocols

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Care Paths (ACO Example)

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Assessment</th>
<th>Care Pathway</th>
<th>Evaluation</th>
<th>Outcome</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determines Plan Based on Evaluation of Patient Data</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
</tr>
<tr>
<td>Progression: Goal Setting</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
</tr>
<tr>
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</tr>
<tr>
<td>Progression: Goal Setting</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
<td>Pain Assessment</td>
</tr>
</tbody>
</table>

ACO example from Heartland Hospital, St Joseph, MO.
Expectations of Providers

- Initial new patient visit by attending MD within 48 hours
- Treat patients in place and attending MDs engaged in change of condition 24/7
- Better coordination with primary care physicians and home health agencies
- Identify and plan around barriers to return home (transition) earlier in stay
- Support ACO quality measures

Quality Measures (ACO)
Patient-Centered Demonstrate Value Collaborate

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medicare/All</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average length of stay (LOS) for Ortho patients/residents in SNF is ≤5 days</td>
<td>Medicare A patients discharged with MS-DRG 469 and MS-DRG 470</td>
<td>Number of Medicare A patients residents discharged with MS-DRG 469 and 470 who had LOS ≤ 5 days</td>
<td>Number of Medicare A patients residents discharged with MS-DRG 469 and 470 discharged from SNF</td>
<td>≤ 9 / 90%</td>
</tr>
<tr>
<td>Therapy (PT, OT, and/or SLP) started within 24 hours of admission to SNF</td>
<td>Medicare A patients including Ortho MS-DRG 469 and MS-DRG 470</td>
<td>Number of patients residents whose therapy (PT, OT, and/or SLP) started day minus admission day = 1 or less</td>
<td>Number of patients residents admitted to SNF from SFMC</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Therapy (PT, OT, and/or SLP) provided 5 (5) days a week for patients in RUG categories from RH through RU</td>
<td>Medicare A patients including Ortho MS-DRG 469 and MS-DRG 470</td>
<td>Number of patients residents who received therapy on (5) days a week for patients in RUG categories from RH through RU</td>
<td>Number of patients residents admitted to SNF from SFMC</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Therapy (PT, OT, and/or SLP) provided to Ortho patients twice a day seven (7) days a week</td>
<td>Medicare A patients discharged with MS-DRG 469 and 470</td>
<td>Number of Medicare A patients discharged with MS-DRG 469 and 470 who received PT and/or OT services twice a day 7 days a week</td>
<td>Number of Medicare A patients residents discharged with MS-DRG 469 and 470 admitted to SNF from SFMC</td>
<td>≥ 90%</td>
</tr>
</tbody>
</table>

Facility Preparation

- Value-based initiatives require acute and post-acute care personnel
- Establish an internal case management system to share information and coordinate care
- Understand that LOS will be reduced and the need may exist for greater infrastructure for admissions and social services for transitions of care
- Preparation to accept higher acuity patients
Facility Preparation

- Work across the acute and post-acute continuum and coordination outside of the facility walls
- Two-way data sharing capabilities with hospitals and other post-acute providers is critical
- Volume is maintained by avoiding network narrowing

Facility Admission Process

- Increase admission readiness (evenings, weekends)
- Increase admission awareness by all — concierge attitude (“We’ve been expecting you.” vs. “Find a way to meet your needs.”)
- Increase communication prior to admission — choose the right admission and plan transitions early
- Increase teamwork to ensure focus on one priority: the patient’s goal
Rehab Department

- Trends towards shorter LOS
- Creates need for increased rehab hours during day and across more days of the week
- Greater need to perform initial evaluations ASAP
- Greater need to accommodate late arriving new patients
- Days of Monday through Friday rehab going away, if not gone already. New normal is seven days per week.

Transition Environment Determination

- Early planning for transition setting is critical
- Information about potential setting can be obtained in new multiple ways
  - Physical home visit with the patient
  - Virtual home visit (aide)
  - Virtual home visit (family, caregiver)
  - Checklists, questionnaires
- Be willing to adjust the plan (setting) if indicated
Challenges

- Coordination of care takes time and personnel
- Identification of patients important — bundling, ACOs
  - PatientPing is an example of a system to identify ACO patients. It links providers wherever a patient receives care.
- Programs to reduce readmissions and treat more patients in place may require more diagnostic or monitoring equipment in SNFs

Key Drivers of Success

- Patient identification
- Care redesign
  - Requires both clinical changes and philosophical changes
  - Requires significant and continued focus
- Active case management
- Safe, effective transitions
- Improved patient activation
Reducing SNF LOS and rehospitalization percentage will be primary drivers in reducing post-acute costs.

Our Results

<table>
<thead>
<tr>
<th>Costs</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>70.4%</td>
</tr>
<tr>
<td>Readmit to Acute</td>
<td>12.2%</td>
</tr>
<tr>
<td>Carrier</td>
<td>8.0%</td>
</tr>
<tr>
<td>Home Health</td>
<td>5.8%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>2.6%</td>
</tr>
<tr>
<td>DME</td>
<td>.8%</td>
</tr>
<tr>
<td>LTCH</td>
<td>.8%</td>
</tr>
</tbody>
</table>
Patient-Centered  Demonstrate Value  Collaborate

Lessons Learned

• Collaboration with hospitals and MDs takes staff time and significant effort
• Reducing readmissions is a team sport
• Emergency departments may be difficult relative to engagement and changing practice patterns
• Need to actively monitor your data and react quickly when course corrections are needed
• Dedicated staff — this is not a part-time project

How Can You Transition to the New World?

• Know your environment — don’t wait
• Maintain constant pulse on changing regulatory and reimbursement environment
  – Mandatory CJR Bundled Payment Pilot
• Track outcomes by diagnostic groups or populations
• Know LOS by diagnostic groups/populations
• Have marketing tools to communicate your outcomes
• The reimbursement world expects this
Questions?

Thank you for all you do to work together for quality patient care in these changing times!

THANKS,
Donna, Jaclyn and Mark

References:


Outcome Prediction Tool (OPT) © 2013CareManagement,naviHealth,Inc.


Medicare Therapy Coverage by Setting

<table>
<thead>
<tr>
<th>Right Patient</th>
<th>Right Plan</th>
<th>Right Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE CARE HOSPITAL and LONG TERM CARE HOSPITAL (LTCH/LTAC)</td>
<td>INPATIENT REHAB FACILITY (IRF)</td>
<td>SNF PART A (Including hospital Swing Bed)</td>
</tr>
</tbody>
</table>

### Reasonable & Necessary

All settings require that in order for therapy services to be billed to Medicare, the services must be reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. The services must be:

- Safe and effective
- Not experimental or investigational
- Provided in accordance with accepted standards of practice
- Appropriate in frequency and duration
- Furnished in a setting appropriate to the patient’s medical needs and condition
- Provided by qualified personnel
- Meets, but does not exceed, the patient’s medical need

### Skilled Services

All settings require that in order for therapy services to be billed to Medicare, the services must require the skills of a therapist. Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed **only** by a qualified therapist or therapy assistant under the supervision of a therapist.

### Coverage Requirements

- **Must have Part A days left in the benefit period.**
- **The inpatient hospital setting does not define setting specific therapy coverage guidelines.**
- **Requires multiple therapy disciplines (PT, OT, SLP, P/O) - one of which must be PT or OT**
- **Therapy program generally consists of at least 3 hours of therapy day at least 5 days/week. In certain well-documented cases, therapy might instead consist of at least 15 hours of therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.**
- **At least a 3 day qualifying hospital stay and Part A days left in the benefit period**
- **Admission to SNF within 30 days of hospital discharge or within 30 days of discharge from a SNF level of care**
- **Must have a need for and receive skilled services on a “daily” basis**
- **Services can only be provided on an inpatient basis – as a practical matter**
- **Must be considered home bound**
- **Must require skilled nursing or PT or SLP to initially skill the case. OT can stand alone to continue the skilled need**
- **All services are generally provided on an “intermittent” basis**
- **Expectation that the patient’s condition will improve materially in a reasonable and generally predictable period of time;**
- **Expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time; If an individual’s expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary**
- **If the skills of a therapist are required, establishment or**
- Expected to make measurable improvement in a prescribed period of time as a result of therapy
- Improvement must be ongoing, sustainable and of practical value to improve functional capacity or adaptation to impairments
- Requires interdisciplinary team meetings weekly

- Frequent or prolonged periods away from the SNF may cause question for need for a SNF inpatient level of care
- Skilled therapy services needed for a medical condition that was either a hospital-related medical condition or a condition that started while the patient was getting care in the SNF for a hospital-related medical condition
- Expectation that the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment or performance of a skilled maintenance program

- Defines specific documentation requirements, including what must be documented in the initial evaluation and in the progress reports
- Therapist must treat the patient at least once every 10 treatment visits
- Requires Functional Limitation Reporting (G-codes)

<table>
<thead>
<tr>
<th></th>
<th>ACUTE CARE HOSPITAL and LONG TERM CARE HOSPITAL (LTCH/LTAC)</th>
<th>INPATIENT REHAB FACILITY</th>
<th>SNF PART A (Including hospital Swing Bed)</th>
<th>HOME HEALTH</th>
<th>PART B – (SNF Part B, Rehab Agency, CORF, HH Part B, Private Practice, OP Hosp.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Maintenance Therapy</td>
<td>Covered</td>
<td>Not covered</td>
<td>Covered. May be provided by a therapist or an assistant</td>
<td>Covered. May only be provided by a therapist</td>
<td>Covered. May only be provided by a therapist</td>
</tr>
<tr>
<td>Patient's Therapy Frequency Need</td>
<td>As needed based on patient's individualized assessment</td>
<td>• Based on individualized assessment findings, the patient must require at least 5x/wk&lt;br&gt; • Therapy must start within 36 hours of midnight of the day of admission</td>
<td>• Based upon patient's individualized assessment, there must be a need for “daily” skill defined as either 7 days per week for nursing or at least 5x/wk if therapy is skilling the patient&lt;br&gt; • Therapy at least 3x/wk for at least 45 min would qualify for a RUG payment level if the patient is actively receiving 2 restorative nursing programs 6x/wk</td>
<td>• As needed based on patient’s individualized assessment&lt;br&gt; • Start of Care Admission assessment must be held within 48 hrs of referral or return home, unless a specific start date is specified in the physician order</td>
<td>As needed based on patient's individualized assessment</td>
</tr>
<tr>
<td>&quot;Medicare Week&quot;</td>
<td>May be defined by the hospital</td>
<td>Rolling week starting with the day of admission</td>
<td>Defined by the SNF. May be a rolling week or a calendar week. Must be consistently applied.</td>
<td>Agency defines the Medicare Week - typically is a calendar week with the Agency defining</td>
<td>Defined by the Facility/Provider/Practice. May be a rolling week or a calendar</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th><strong>Orders Required</strong></th>
<th><strong>ACUTE CARE HOSPITAL and LONG TERM CARE HOSPITAL (LTCH/LTAC)</strong></th>
<th><strong>INPATIENT REHAB FACILITY</strong></th>
<th><strong>SNF PART A</strong> (Including hospital Swing Bed)</th>
<th><strong>HOME HEALTH</strong></th>
<th><strong>PART B – (SNF Part B, Rehab Agency, CORF, HH Part B, Private Practice, OP Hosp.)</strong></th>
</tr>
</thead>
</table>
|                     | Orders required by physician or physician extender prior to therapy evaluation | Initial orders signed by the physician. Subsequent orders may be signed by physician or NPP* | • Orders required by physician. Verbal Orders must be obtained to approve the therapy plan of care before treatment, beyond what is in the initial order, is initiated  
• Orders must include: specific procedures and modalities and the amount, frequency and duration | • The physician (doctor of medicine, osteopathy or podiatric medicine) develops the overall plan of care and must certify the need for services and that the patient is homebound  
• A face-to-face visit by the physician or NPP*** must occur no more than 90 days prior to the HH SOC date or within 30 days after the SOC | Orders may be required per company policy or per State Practice Act |
| **Certification Required** | Physician certifies the hospital stay | Physician's overall plan of care must include:  
• anticipated therapies  
• expected intensity (# of hours/day)  
• expected frequency  
• expected duration  
• functional outcomes detail  
• discharge destination from the IRF | Physician or NPP* certifies the SNF stay and the services required | **Physician (doctor of medicine, osteopathy, or podiatric medicine) or NPP* must certify the POC / UPOC***. Certification period is based on treatment duration, not to exceed 90 days.  
(****CORF – The rehab plan of treatment is written by the physician in consultation with the therapist. The rehab plan must be established and signed prior to commencement of treatment.) | |
<p>| <strong>Group Therapy</strong> | No specific guidelines | Should be primarily 1:1. If Group Therapy better meets the patient's needs on a limited basis, the situation/rationale for Group should be documented. Group therapy is recorded when the therapist/asst is dividing his/her attention between 2-6 patients at the same time who are performing the same or similar activities. | Group therapy is recorded when a therapist/asst is dividing his/her attention between 4 residents who are performing the same or similar activities | NA | Group therapy is billed whenever the therapist/asst is dividing his/her attention between patients (does not apply when supervised modalities are provided) |
| <strong>Concurrent Therapy</strong> | NA | Concurrent therapy is recorded when the therapist/asst is dividing his/her attention between 2 patients at the same time. | Concurrent therapy is recorded when the therapist/asst is dividing his/her attention between 2 residents that are not the start day of the week. Must be consistently applied. Orders must be specific to the defined Medicare Week | Not addressed in regulations | If the therapist/asst is dividing his/her attention between patients at the same time, the time is billed as Group Therapy |</p>
<table>
<thead>
<tr>
<th>Co-Treatment (2 clinicians from different disciplines treating 1 patient)</th>
<th>ACUTE CARE HOSPITAL and LONG TERM CARE HOSPITAL (LTCH/LTAC)</th>
<th>INPATIENT REHAB FACILITY</th>
<th>SNF PART A (Including hospital Swing Bed)</th>
<th>HOME HEALTH</th>
<th>PART B – (SNF Part B, Rehab Agency, CORF, HH Part B, Private Practice, OP Hosp.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No specific guidelines</td>
<td>Co-treatment minutes are counted in full by both disciplines. Co-treatment must be clinically appropriate and provided solely for the benefit of the patient. Co-treatment may not be used for the accommodation of staffing schedules. The specific benefit to the patient of the co-treatment must be well-documented in the IRF medical record</td>
<td>All Co-Treatment minutes are recorded in full by each discipline involved</td>
<td>No specific guidelines in the CMS regulations for co-treatments. If an entire visit was Co-treatment, this would be atypical and would only count as 1 visit per APTA interpretation of payment structure</td>
<td>Co-treatment minutes are split between the disciplines involved when billing</td>
<td></td>
</tr>
</tbody>
</table>

**Specificity for Recording Therapy Minutes**

| No specific guidelines. Not reimbursed by the minute. | Therapy minutes cannot be rounded for the purposes of documenting therapy provided in an IRF | Record the actual minutes of therapy. Do not round therapy minutes (e.g., reporting) to the nearest 5th minute | No specific guidelines. Not reimbursed by the minute. (Industry standard to record Time In and Time Out) | Report...the time actually spent in the delivery of the modality requiring constant attendance and therapy services. The time counted is the time the patient is treated |

*NPP – Non-physician Practitioner where allowed by State law (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist)***NPP for Home Health Face-to-face Encounter - Non-physician Practitioner where allowed by State law (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife)