CARE REDESIGN: VALUE BEYOND THE VISIT

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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 / HHVBP
- Home Health Payment Reform

Data Driven Decision Making

Objective Data Analysis

Subjective Opinions
CMS Focus on Alternative Payment Models

- Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

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 to reduce 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/o 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

Source: CMS Bundled Payment for Care Improvement Initiative Models 2-4: Year 2

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

Source: www.innovation.cms.gov

“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 anesthetic-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”

- Proficiency 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
Interception of “Best” Practice & Costs

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

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

- Intentional Interventions: Mobility
  - 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

Examination/Reexamination (cont'd):
- Perform integumentary integrity tests & measures including:
  - 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
The Benefits of Wound Care Provided by Physical Therapists in Home Health

Authored by: Michelle Abeln, PT, DPT, WCC and Jean D. Howard, PT, MS, WCC
Published in Quarterly Report, Fall 2014

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 of itself is not a physical therapy skill. The machine used is similar to using 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, as the physicians’ orders and dosing are dependent on the patient’s overall condition. Therefore, use of 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 of 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 for 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 of 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 fingerstick. 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, 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 trained specifically to remove staples. The training should include procedures for problem situations resulting from improper staple removal.

- The Board has received multiple inquiries as to whether staple 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 staples would fall under the same category as the removal of staples as indicated above.
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 staples 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
- Reduce severity by implementation of dietary & hydration interventions
- Decreased Constipation & Increased Quality of Life
- 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 that planned joint replacements BUT the concepts of bundling are expected to continue to expand beyond CJR.

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Thank you! Any Questions?

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