



"Situational Compliance"

- ❖ PT instructs patient to use a cane at all times when walking indoors and outdoors.
- ❖ Nursing instructs patient in orthostatic hypotension precautions and learns patient has not purchased pain med
- ❖ OT determines patient only needs help reaching her feet during showering.
- ❖ HHA Plan of Care for total assistance in shower
- ❖ Patient sees MD and increase dosage of pain med ordered

❖ *What is the patient supposed to do?*

Interdisciplinary Care



"The way a team plays as a whole determines its success. You may have the greatest bunch of individual stars in the world, but if they don't play together, the club won't be worth a dime."
– Babe Ruth

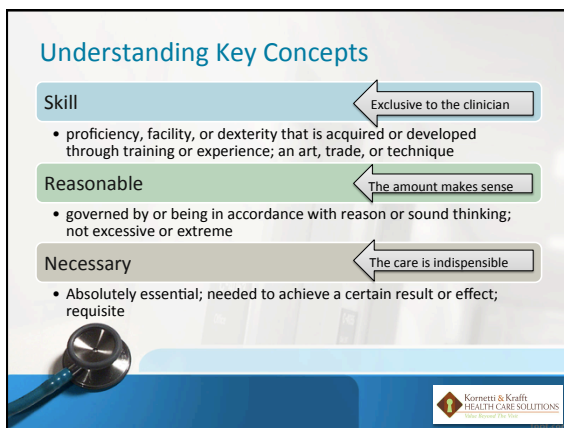



I'm a Good Clinician / I Hate Documentation











Does Every Home Health Patient Improve?

- Do NOT assume that the challenges of determining need for skilled care has diminished since the Jimmo decision.
- How deep does the addiction go in your agency?

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Home Based Care

Therapy Diagnoses?

- "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."
- *No assumptions can be made about the skilled need, reasonable and necessary status of a patient because they present with diagnoses that typically receive therapy*

Conditions for Coverage of Therapy Services

 <p>Skills of a qualified therapist are needed to restore function</p>	 <p>Patient's condition requires a qualified therapist to design or establish a maintenance program</p>	 <p>Skills of a qualified therapist are required to perform maintenance therapy</p>
Restorative	Maintenance	Maintenance




Anatomy of a Maintenance Program

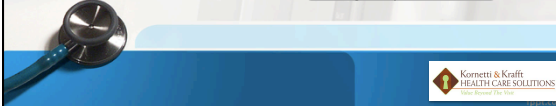




Knowledge Application


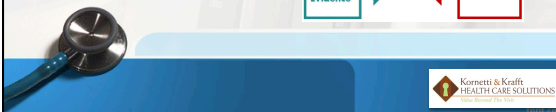
- Dementia patient with increased sedentary behaviors x 3 months
- Severe COPD with recurrent pneumonia, breathlessness with eating and airway clearance deficits
- Exacerbation of CHF with fluid overload/diuresis and recent ACH x 4 days

- Coverage Criteria 1 – Restorative Therapy
- Coverage Criteria 2 – Maintenance Program development and management
- Coverage Criteria 3 – Maintenance Therapy Program performance



Best Practices for Home Health

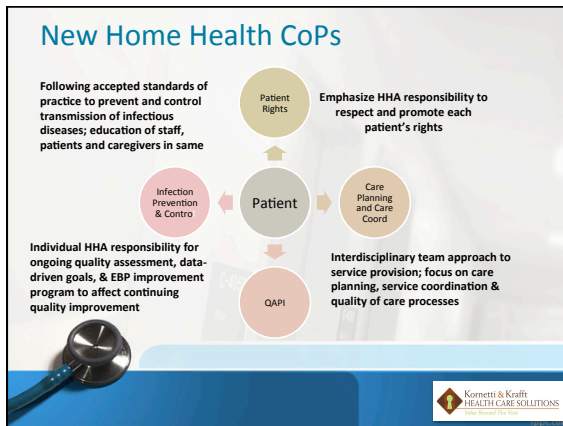
Evidence-based care — “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” — David Sackett

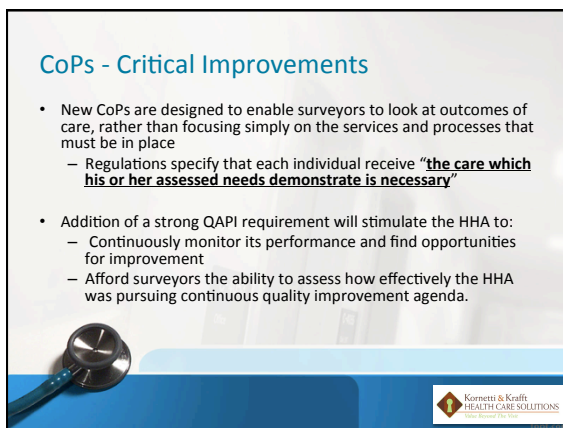



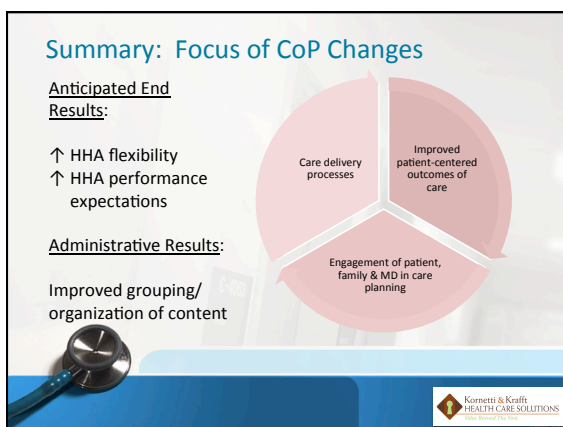
Intersection of “Best” Practice & Costs

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







Interdisciplinary Care: Components

Evidence in record or minutes of effective interchange, reporting and coordination of patient care.



Care Coordination

Agency is responsible for maintaining liaison with all personnel furnishing services to ensure efforts are effectively coordinated and support objectives outlined in plan of care.

Fluency of Multidisc. Documentation



Efficient visit utilization not just within individualized disciplines, but across disciplines.



One Beneficiary = One Care Plan



Reducing Re-Hospitalization



(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization?

- 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- 3 - Multiple hospitalizations (2 or more) in the past 6 months
- 4 - Multiple emergency department visits (2 or more) in the past 6 months
- 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- 7 - Currently taking six or more medications
- 8 - Currently reports exhaustion



M2001 Drug Regimen Review

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

Enter Code

- 0 No - No issues found during review [Go to M2010]
 1 Yes - Issues found during review
 9 NA - Patient is not taking any medications [Go to M2040]

- **Item Intent:** identify if **any potential clinically significant medication issues exist**
 - Defined as that in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest);
 - Includes an existing issue
- **Includes:** medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen (all medications prescribed & OTC, administered by any route)



Understanding Terminology

Adverse Drug Reaction

Adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment.

Side Effect

The term "side effect" is often used interchangeable with ADR, however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.



Examples of "Issues"

- **DUPLICATE THERAPY**
 - Patient taking generic + brand name of same medication
- **OMISSIONS**
 - Medications in patient's home don't match the hospital DC Summary
- **ADVERSE EVENT**
 - Patient has a visible rash
- **INEFFECTIVE DRUG THERAPY**
 - Proper use of medication without achieving desired pain management
- **DRUG INTERACTIONS**
 - Warning of severity of drug-drug interactions once medications entered into EMR



More Examples of "Issues"



- **DOSAGE ERRORS**
 - Patient taking 12.5mg and used to cut pill in half; now has pill = 12.5mg and didn't realize (still cutting in 1/2 = 6.25mg or unintentional underdosing)
- **NONADHERENCE**
 - Prescribed narcotic for pain, but patient did not fill prescription and states s/he will not take it because they don't want to get addicted




M2003 Medication Follow Up (& M2005)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code	0	No
<input type="checkbox"/>	1	Yes

- Item Intent:** where potentially significant medication issues identified through a medication review addressed with the physician by midnight of the next calendar day following their identification?
 - Contact with physician (def):** communication to physician/physician-designee through telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the patient status
- To enter Response 1 requires:**
 - 2-way communication, AND
 - Completion of the prescribed/recommended actions by midnight of next calendar day after issue identified



Oral Med Management


(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes 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 dosages are prepared in advance by another person; OR (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.



Safe & Consistent Administration

Knowledge:
What?
When?



Function:
Where?
How?

NO MISTAKES ALLOWED





Documentation – Med Impact

Effectiveness	<ul style="list-style-type: none"> • Vital Signs (+ Pain) • Blood Sugar Levels
New Symptoms	<ul style="list-style-type: none"> • Side Effects • Adverse Reactions
Compliance	<ul style="list-style-type: none"> • Willingness • Ability





Documentation - Planning


Impact of Meds	<ul style="list-style-type: none"> • Monitoring Vitals in Plan • Plan for Next Visit
Function	<ul style="list-style-type: none"> • Connection to Goals • Patient Specific Care Plan
Communication	<ul style="list-style-type: none"> • Within the Agency • With the Physician

Bottom Line on Med Management



- The management of medications in the home is:
 - Interdisciplinary care issue
 - Patient safety issue
 - Patient-centered, individualized care planning expectation




**One Beneficiary –
One Care Plan**

What are the key elements a CHF patient needs to focus on to prevent re-hospitalization?

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Overview of Heart Failure

A Right-sided heart failure
(Back-ups in the area that collects "used" blood)

B Left-sided heart failure
(Failure to properly pump out blood to the body)

C Congestive heart failure
(Fluid collects around the heart)

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New York Heart Association



Class	Patient Symptoms
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath).
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea.
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea.
Class IV (Severe)	Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

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Use of Scale = ADL??



Compliance = Knowledge + Functional Ability

- Knowledge
 - When
 - How
 - Signs
- Functional Ability
 - Balance
 - Strength
 - Cognition



The Role of Exercise in Heart Failure

- Aerobic exercise produces significant improvements in functional capacity
- Exercise produces little or no improvement in cardiac performance
- Physiological changes that occur appear to be due to peripheral, rather than central adaptations
 - Improved aerobic metabolism
 - Improved autonomic regulation
 - Improved peripheral perfusion
 - Decreased local inflammation
 - Improved ventilatory control
 - Improved quality of life
 - Decreased hospital readmission and mortality

Key Points about Exercise

- Exercise is prescriptive, like medication
 - Appropriate dosing is required
 - Monitoring by professional required
 - Education in intent and expected outcome needed
- Strengthening requires overloading the muscle
- Aerobic/Endurance training requires sustained increase in oxygen consumption over a period of time
- Professional skill, knowledge and judgment come into play with development of an individualized program





• What are the key elements a patient with a fall risk must focus on to prevent re-hospitalization?







Fall "Prevention"??






- ✓ Determine PATIENT SPECIFIC risk factors
- ✓ Use of MAHC 10 / Timed Up and Go
- ✓ Use of Tinetti-POMA
- ✓ "No falls during episode of care"
- ✓ Role of Maintenance Therapy / Skilled Management and Evaluation

One Beneficiary – One Care Plan

What are the key elements a diabetic patient needs to focus on to prevent re-hospitalization?

Injectable Medication Management

- Knowledge
 - When
 - How
 - Signs
- Functional Ability
 - Fine Motor
 - Accessibility
 - Cognition



Compliance =
Knowledge +
Functional Ability




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Blood Glucose Control and Exercise

- There are a few ways that exercise lowers blood glucose:
 - Insulin sensitivity is increased, so your cells are better able to use any available insulin to take up glucose during and after activity.
 - When your muscles contract during activity, it stimulates another mechanism that is completely separate of insulin. This mechanism allows your cells to take up glucose and use it for energy whether insulin is available or not.
- This is how exercise can help lower blood glucose in the short term. And when you are active on a regular basis, it can also lower your A1C
- See more at: <http://www.diabetes.org/food-and-fitness/fitness/get-started-safely/blood-glucose-control-and-exercise.html#sthash.kV2Xo8xO.dpuf>

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One Beneficiary – One Care Plan

What are the key elements a COPD patient needs to focus on to prevent re-hospitalization?

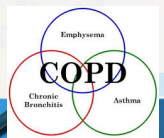
Airway Clearance

Vital Signs

Breathing Techniques

Aerobic Activity

Medication Management



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GOLD Spirometric Criteria for COPD Severity		
I. Mild COPD	*FEV1/FVC < 0.7 * FEV1 > or = 80% predicted	patient is probably unaware that lung function is starting to decline
II. Moderate COPD	*FEV1/FVC < 0.7 *FEV1 50-79% predicted	Symptoms progress, with shortness of breath developing upon exertion.
III. Severe COPD	*FEV1/FVC < 0.7 *FEV1 30-49% predicted	Shortness of breath worsens and COPD exacerbations are common
IV. Very Severe COPD	*FEV1/FVC < 0.7 *FEV1 < 30% predicted or < 50% predicted with chronic respiratory failure	Quality of life at this stage is gravely impaired. COPD exacerbations can be life threatening.

M1400 Shortness of Breath

(M1400) When is the patient dyspneic 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 (for example: while dressing, using commode or bedpan, walking distances less than 20 feet)

☐ 3 - With minimal exertion (for example: while eating, talking, or performing other ADLs) or with agitation

☐ 4 - At rest (during day or night)

➤ If the patient uses oxygen continuously, select the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, mark the response based on the patient's shortness of breath **WITHOUT** the use of oxygen.

➤ The response is based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.

M1410 Respiratory Treatments

(M1410) **Respiratory Treatments** utilized at home: (Mark all that apply.)

☐ 1 - Oxygen (intermittent or continuous)

☐ 2 - Ventilator (continually or at night)

☐ 3 - Continuous / Bi-level positive airway pressure

☐ 4 - None of the above

➤ Identifies any of the listed respiratory treatments being used by this patient in the home.

➤ Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers).

Exercise Prescription

Source: American College of Sports Medicine (ACSM)

- Aerobic/Endurance Training
 - One that stimulates a substantial, sustained increase in oxygen consumption; requires use of a large amount of muscle mass that is continuous and rhythmic
 - Accomplished through:
 - ↑ intensity
 - Prescribe by heart rate (HR)
 - Prescribe by perceived exertion
 - Prescribe by workload
 - ↑ frequency & duration
 - Increase total volume of exercise by 10% per week



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Borg Rating of Perceived Exertion

- Optimum training target zone for a healthy adult is 12-16 on the scale
- Approximates an exertion of 60-80% of target HR using the Karvonen Heart Rate Reserve method
- Allows most cardio-respiratory benefit from exercise

6	no exertion at all
7	extremely light
8	
9	very light
10	
11	light
12	
13	somewhat hard
14	
15	hard
16	
17	very hard
18	
19	very, very hard
20	



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Is it “skilled” or isn’t it?



- Instructing patient in individual exercise program
 - **What isn’t:** completion of program if able to train lay (unskilled) individual to carry out
- Walking for increasing (progressive) distances
 - **What is:** development of a walking program for aerobic capacity rebuilding abiding by ACSM guidelines for patient population
- Determination of 1RM for appropriate resistances
 - **What isn’t:** increasing number of reps/sets in an established exercise program



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Is it “*reasonable & necessary*” or isn’t it?

- Development and instruction in an individualized maintenance program for a frail elder who lives alone
 - **What isn’t:** generic program for UE/LE exercises
- Home exercise program “instruction” on multiple visits without program changes (advances, modifications, etc.)
 - **What is:** Education in delayed onset muscle soreness (DOMS) and muscle fatigue/overload principle for strengthening
- UE/LE strengthening program . . .
 - **What isn’t:** for < 5/5 MMT scores that don’t contribute to a functional impairment for the patient



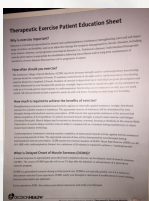
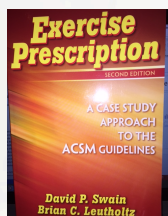
A Litmus Test for Your Agency



- ✓ Have you audited for **exercise prescription** in therapy documentation?
- ✓ Do therapists outline **prescriptive parameters** of exercise programs?
- ✓ Is there evidence of **teaching and education** by therapist?
- ✓ Are there **objective measures** (i.e., target heart rate, perceived exertion) associated with exercise programs?
- ✓ Are prescribed programs **modified/advanced** based on patient response?



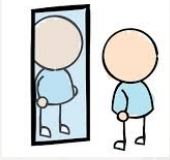
Resource Materials




www.exerciseismedicine.org




So Now What?




- Every single home health visit **MUST** advance the overall plan of care.
- Collaboration is critical and includes the physician.
- Defensible documentation is not optional



Answering Your Questions



- Please use the **Q&A box** to type in any questions you have about today's topic.





Are you concerned about protecting the revenue you have earned from providing therapy services?



Kornetti & Krafft Health Care Solutions, physical therapists with over 70 years of clinical, management and ownership experience, is a consulting company with proven home health care solutions in interdisciplinary, patient-centered care management to fortify your agency's fiscal security.




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