Aligning Home Health Therapy Plan and Goals with Patient Outcomes and Satisfaction

EILEEN BACH, PT, DPT, COS-C, CHC

Course Description

Working in the Home Health Care setting can be immensely rewarding and professionally challenging. The Centers for Medicare and Medicaid Services (CMS) has increased scrutiny as well as revised standards and payment for Medicare part A home health services. The therapy professional needs to be able to demonstrate objective and measurable care. Patient engagement and patient centered care is a focus of publically reported quality measures, documentation and professional standards of care.

This lecture based webinar will provide the attendee with integrated processes, resources and case examples that connect the rehabilitation therapy plan of care and goals to delivery of services as see in patient outcomes and satisfaction. Medicare requirements are referenced and case examples are provided.

Your Speaker – Eileen Bach

I have worked in the home health setting for the past 33 years. In addition to field experience, I have served as a rehabilitation manager for both hospital based and non-profit community based agencies.

My roles have included managing and directing interdisciplinary staff, agency wide education and training, program development, quality and accreditation leadership. I am a certified OASIS clinical specialist and certified in Healthcare Compliance and currently work in Home Care Compliance.

Disclosure: I do not have a financial relationship with any commercial interest.

Objectives for this Webinar

1. Define Medicare Home Health standards for therapy plan of care and goals.

2. Identify 4 key components when writing patient goals to ensure that the therapy services are supported in documentation.

3. Compare 3 standardized tests used in evaluation and goal selection process to obtain measurable outcomes.

4. Explain the 5 key elements of patient satisfaction related to home health services.

This course covers:

Discuss Centers for Medicare & Medicaid Services Home Health requirements

Review Home Health Therapy - Plan of Care and goal requirements

Consider goal writing – a look at patient centric and defensible goals

Implement standardized tests and measures in your practice
from evaluation → plan → goals → outcomes

Connect patient centric care with current patient satisfaction measures

Review references and resources; Q and A

Centers for Medicare & Medicaid Services -CMS

Home health care is covered by CMS and other payers: home care agencies must become CMS certified to bill Medicare.
- Certified home health agency = CHHA

At the state level, home health is also regulated and agencies require state approval to operate.

Medicare covers home health care benefit under Part A
- There is no prior hospital stay required
- There is no length of stay limit as along as ALL Medicare criteria are met
- Care is provided in 60 days episodes

Medicare Home Health Criteria

Patient under a physician's care; agency care provided is:

Reasonable and Necessary

Skilled and Intermittent

and Patient is Homebound

All requirements are found in the Conditions of Participation

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf

Conditions of Participation (CoPs)

Expected January 2018, revised CMS CoPs Key changes-

Patient Rights - patient preferences; new Definition of patient representative; agency administrator name & phone# given to patient

Receipt of policy/procedure re: admission, transfer, discharge

Plan of care – with measurable goals, shared with patient

Documentation –

- shows progress; training & education provided to patient and/or caregivers
- Include date and time

Quality indicators QAPI – all staff participate, including contracted

Applying Medicare HC Criteria

Reasonable/necessary and Skilled/intermittent criteria are met based on clinician's plan of care and each visit's documentation.

Homebound was clarified by Medicare in 2013

Criteria 1 – individual must meet ONE

- Due to illness or injury, need for device (cane, walker, W/C), need for assist of a person, or need special transportation to leave the home
- **OR** - has condition where leaving home is medically contraindicated

Criteria 2 – individual must meet BOTH

- Must exist a normal inability to leave the home
- **AND** – leaving home must require considerable and taxing effort

Reference - Medicare Learning Network - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8444.pdf

Understanding Medicare

Many private and managed payers follow the Medicare established criteria for home health.

Medicare WANTS all providers to understand home health requirements and issues

Recommendation -bookmark - **www.cms.gov/center/hha.asp**

- This website provides multiple links to CMS reports, proposed changes, manuals, transmittals, billing information, home health compare and more

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Home Health - OASIS

Standardized assessment tool used at key time point such as Start of Care, Re-certification, Discharge..

Start of Care includes key items known as Process Measures as well as items covering Functional, Cognitive, Integumentary and other systems

OASIS is completed by one clinician; the clinician can discuss assessment elements with other team members

Home Health Reimbursement is based on key submitted OASIS data - a prospective payment system

CMS has reduced home health payments - for 2016 and 2017

A new 5 Star quality rating system and other quality reporting is required

Home Care Compare

https://www.medicare.gov/homehealthcompare/search.html

CMS uses standardized data that all home care agencies are required to submit [OASIS documentation].

Agencies are compared at state and national level.

Compare data is updated periodically.

Patient satisfaction data and quality ratings will be discussed later in this presentation

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Home Care Compare – Sample Data

Data collection period from October 1, 2015 through September 30, 2016

Managing Pain and Treating Symptoms	National Average
How often patients had less pain when moving around	73.6%
How often patients' breathing improved	72.1%
Managing Daily Activities	**National Average**
How often patients got better at walking or moving around	70.2%
How often patients got better at getting in and out of bed	67.1%
How often patients got better at bathing	73.6%

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Therapy Services – CMS Definition

Therapy care is designed to "materially improve" the patient's condition; this is **restorative care** and is the most frequent therapy service provided

OR –

Therapy care is necessary to establish a "safe and effective maintenance program"; **maintenance** requires the unique, specialized knowledge and judgment of a therapist.

CMS clarification of maintenance in 2013 is a result of a lawsuit
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf

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Improvement Standard: CMS Updated Guidance (effective 1/7/14) *note: CMS updated info due 9.2017*

Restorative/Rehabilitative therapy (i.e., whose goal and/or purpose is to reverse, in whole or in part, a previous loss of function), it would be entirely appropriate to consider the beneficiary's potential for improvement from the services.

Maintenance therapy. Even if no improvement is expected, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration and the services cannot be safely and effectively carried out by the beneficiary personally or with the assistance of non-therapists, including unskilled caregivers.

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CMS Statement 2017

CMS states in the Transmittal announcing the *Jimmo* Manual revisions:

No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims that require skilled care. Medicare has long recognized that even in situations where no improvement is possible, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly.

see http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf.

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Maintenance Therapy Includes:

Designing & setting up a safe and effective maintenance program to *maintain function* and/or *prevent regression* for specific illness/injury

Instructing patient, family and Home Health aides in the program (but not Home Health aide only)

Infrequently re-evaluating the program and/or the patient

A maintenance plan REQUIRES the specialized knowledge and judgment of the therapist (OT, PT, ST)

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Maintenance Therapy Example 1

A patient with a neurologic condition has increased tone in both lower extremities and is being managed by medication adjustments every 2 weeks. The therapist designs a maintenance exercise and mobility program and re-evaluates the program every 12-15 days to ensure maximal, safe functional ability.

- The patient's physical performance and abilities may vary based on the response to medication; the therapist is ensuring the maintenance plan matches patient capacity and is designed for maintaining maximal functional level.

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Maintenance Therapy Example 2

From CMS

"For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning."

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Maintenance is NOT

Personal Training – providing exercise and mobility "coaching" when patient is able to perform independently and no changes to program are needed

Unskilled therapy services – serving as companion, performing tasks that do not require a therapist's knowledge

Covered when patient and/or the family caregivers are capable of independently performing care activities

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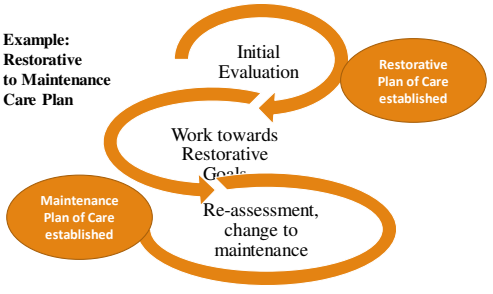
Example: Restorative to Maintenance Care Plan



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Examples of Managing the Therapy Plan

A patient with a joint replacement-
- What if patient independent in exercise, transfer and gait?
- What if there is a joint contracture is stable but no recent gain in range?

A patient after an acute stroke –
- What if patient plateaus quickly?
- What if family caregivers change?
- What if you are waiting on equipment approvals?

A patient with a chronic cardiopulmonary condition –
- What if exercise capacity is reduced and vital signs are variable?
- What if patient self-restricts activities and self-care abilities?

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Therapy Plan of Care

Agency start of care is conducted by a RN, PT or SLP and is a comprehensive assessment plus OASIS items in start of care.

The therapy plan of care is created by the qualified therapist following initial evaluation/assessment and is tied to the physician's orders. The plan is re-assessed at minimum every 30 days or as appropriate.
- Only a therapist can evaluate or re-assess

The plan of care describes the therapy treatment and is the foundation for the patient goals. Function should be assessed using objective measurements [which allows for comparison measurement to determine therapy effectiveness].

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30 Day Therapy Re-assessment

CMS requires that on or before the 30th day of therapy services, the qualified therapist completes a re-assessment. *From CMS – "at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient".*

The re-assessment would be documented in the clinical record to show:
- How Treatment is within accepted standards of clinical practice
- Function is assessed via objective measurements enabling comparison measurements to determine effectiveness of therapy goals.

Documentation shows progress towards goals or explains lack of progress.

The qualified therapist should update the plan and the goals based on the re-assessment findings.

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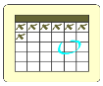
Tips for managing 30 day re-assessments

The start date is the date of the FIRST therapy visit.

Each therapist providing care must complete 30 day re-assessments.

Days are calendar days not business days.



Best practice is to schedule visit between days 21-27.

- This ensures there is still time to "re-schedule" in case patient not home, visit is cancelled or other unexpected occurrence takes place.

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Therapy Reassessment Continued

Example: PT visits 2x per week

Month Year

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		Therapy visit 1		Visit 2		
		Visit 3		Visit 4		
	Visit 5		Visit 6			
	Schedule re-assessment & complete in next 3 visits					
				30th day		

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Therapy Plan of Care [Recap]

Considered accepted professional practice

Specific, safe and effective treatment for patient condition

Necessary (medically justified)

Plan is documented against with objective evidence

- The evidence shows improvement OR shows prevention of decline/ stabilization in patient condition [restorative or maintenance]

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Therapy Goals are written to:

Identify the therapist's and patient's expectations of therapy care
- May be structured as short and long term

Include functional assessment data and objective measurements to show the effect of therapy care

Show variable factors that influence condition or affect response to treatment
- Examples - Co-morbidities, psychosocial elements, environmental issue in home

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Goals should be:

Patient focused

Clear and concise

Observable and measurable

Time Limited

Realistic/Achievable

Eileen's Recommendation: Document using the patient's own words what is the patient's goal/expectation of therapy
- Useful to create agreement and validate the patient's expectations

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Therapy Goal Template

Impairment	Measure Used	Relevance	Rationale/ Evidence	Time
Sit to Stand Transfer	•5 time sit-stand test •Assistance needed– **be specific** [i.e. level of therapist assist,verbal or tactile cues…]	•Increase self-care ability •Decrease pain and fatigue	•Safety •Compare to age or other norms	4 visits
Specific	*Named*	*To Patient function*	*Reflect Skill and needs*	*When will goal be met?*

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Goal Examples

Patient will transfer sit to stand with standby assistance and verbal cues to increase participation in grooming self-care in 4 visits.

OR

Patient will improve sit to stand transfer ability and safety as measured by completing the 5 Time Sit-to-Stand test in 15 seconds or less in 5 visits.

Reference for 5 time sit to stand test:
http://www.rehabmeasures.org/Lists/RehabMeasures/DispForm.aspx?ID=1015

Person Centered Care

The IOM (Institute of Medicine) defines **patient-centered care** as: "Providing **care** that is respectful of and responsive to individual **patient** preferences, needs, and values, and ensuring that **patient** values guide all clinical decisions."

Current preferred terminology = person centered care

A key element in quality care; Correlated with:

- ~ teamwork
- ~ shared knowledge and information
- ~ transparency
- ~ inclusion of patient and family/friends
- ~ safety
- ~ individualized, customized care

Goals Reflecting Person Centered Care

Person Centered Care reflects patient needs, values and decisions

Goals written using this care framework reflect that by:

- Identifying the specific devices client wants to use
- Specifying assistance level client decides on
- Noting client desired performance rather than overall "possible" performance

Note: Assumption is safety needs have been determined for any goal

Defensible Goal Documentation

Bottom line – show evidence that therapy services were appropriate and beneficial to the patient

Write goals that have:

1. Objective measureable data
2. Reflect meaningfulness for patient and therapy level
3. Support short and long term therapy plan
4. Specific not general information; patient and therapists' actions
5. Clearly written clinical judgment/decision making/rationale

Include in Your Documentation

1. Current measurements or objective data – i.e. measure gait speed/gait pattern, not simply distance walked
2. Specific therapist actions – hands on, tactile cues, verbal cues, etc not just with therapist or with "assist"
3. Specify patient actions – avoid vague terms such as "tired", "unsteady", "fatigue". Measure vital signs, use objective balance measurements or functional capacity tests
4. Education and be sure to add return demonstration/teach back for any education provided – teach back can take place in subsequent visits as well
5. Any adjustment, modification, change should have rationale and how it is appropriate to the therapy plan
6. Issues that are a factor in therapy as environment, lack of equipment, psychosocial issues with patient and/or family

More on Documentation – SOAP format

If you or Home Care your agency uses a SOAP note format, document tips include:

S – Subjective so that you clearly capture the patient's thinking or feeling about the therapy care; include any relevant family discussion

O – Objective so that all activities, interventions, observations and actions by both patient and therapist are captured

A – Assessment so progress/level is noted, objective data captured, factors related to therapy identified and therapist's clinical reasoning is entered

P – Plan so the intended service for upcoming visit/week is noted, to adjust any intervention and/or goal, to spell out any limitation such as weight bearing and to identify the discharge plan including time frame

What Not to Document in SOAP

S – "I really don't like that hospital"

O- Patient ambulated 30 feet with walker and moderate assist

… or - Patient performed "therex" UE, LE

A – Patient tolerated treatment well

P - Continue therapy … or – Continue treatment

Enhanced CMS Guidance - Skilled Care Documentation

"the Home Health clinical notes must document as appropriate

History and physical exam pertinent to care (including response or changes to behavior from previously provided skilled services)

Skilled services provided on current visit

Patient/caregiver immediate response to skilled services on current visit

Plan for next visit based on rationale of prior results

Detailed rationale explaining the need for skilled services in light of patient overall medical condition and experiences

Complexity of the service performed

Any pertinent characteristics of the beneficiary or the home"

CMS Guidance Documentation - continued

"Clinical notes should be written to adequately describe the reaction of a patient to skilled care. Clinical notes should also provide a clear picture if the treatment as well as next steps to be taken. Vague or subjective descriptions of the patient's care should not be used. Examples of insufficient terminology to describe need for skilled care – "Patient tolerated treatment well"; "Continue with POC"; "Caregiver instructed in medication management".

"Objective measurements of physical outcomes of treatment should be provided and clear descriptions of changed behaviors due to education programs provided should be recorded so all concerned can follow the results of the applied services."

Documentation – Open Note "Narrative" Type

Notes should address (based on plan of care):

- Current patient clinical status with objective measures
- Treatment (interventions) actually provided
- Patient [family] response and interactions with treatment
- Patient need for continued services
- Progress towards Goals
- Teaching provided – patient, family, caregivers; teach back received
- Specific plan for next visit/next contact; changes to plan recommended

Care is skilled, reasonable and outcome based

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Gathering Case Information - Interviewing Strategies

Summarize what you hear the client saying

Use transitional statements

Confirm past medical history; as well family, social & patient profile history

Effectively close the interview

Use of Motivational Interviewing

- Set of specific skills to elicit discussion, explore importance and confidence, reflectively listen, help balance decision making and enhance self-efficacy
- Learn more - https://www.centerforebp.case.edu/practices/mi

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Consider Using SBAR

S – Situation

B – Background

A – Assessment

R – Recommendation

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Home Health Care – Use Standardized Measures

Requirement to use standardized tools can be seen in OASIS documentation as an effort to ensure evidence based data.

- Example -Some Process measures in Start of Care require use of a valid, reliable standardized tool include screening items for-
  - Depression
  - Falls risk
  - Pressure Ulcer Risk
  - Pain

Each agency can select which tools are used as long as valid and reliable

Other process measures do not require a standard measure such as screening for heart failure, but do reflect best clinical practice standards.

Standardized Tests and Measures

Resources available to know what is available to use [not proprietary as well as what are norms or cut-offs for each measurement

Professional organizations – AOTA, APTA

http://www.rehabmeasures.org/Lists/RehabMeasures/Admin.aspx

https://www.qualitymeasures.ahrq.gov/content.aspx?id=27468

http://www.rehabmeasures.org/rehabweb/links.aspx (link to sites with tests and measures

http://geriatrictoolkit.missouri.edu/

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Tests and Measures Easy to Use in Home Health

Pain – Visual analogue scale, Wong Baker FACES scale, Pain AD

Pressure Ulcer Risk – Braden

Sensation – Monofilaments, use of standard anatomical test points

Cognition – Clock draw, MMSE [mini-mental], MoCA

Functional screens – quick-DASH, Katz ADL, Barthel…

Cardiopulmonary related – 2 minute walk test/6 minute walk test; vital signs before & after activity, orthostatic screening….

Gait, balance, mobility related – TUG, Functional Reach, Single Leg stance, Sit-to-Stand, 4 Step Square test, Romberg, Step test……

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Standardized Measures = Link Outcomes & Goals

Use standardized tools at key time points especially initial visit, 30 day re-assessments and final visit – this data will quantify progress and patient abilities

Perform measure exactly each time; note variances or related issues if needed/appropriate

Link measurement to the function, not just the task (this should also be seen in the written goals)

Plan of Care & Goals → Patient Satisfaction

Key elements of satisfaction with health care services point to several areas that can be part of every day clinical practice

1. Communication, transparency
2. Efforts to engage and involve
3. Competency = knowing what to do, knowing how to do it
4. Coordination, especially with transitional care
5. Respect and cultural competency

CMS Quality Strategy

Better health care
Healthier People
Smarter Spending

Source - MLN Connects IMPACT Act Presentation 2.4.2016

Goals

~Make care safer
~Strengthen person & family centered care
~Promote effective communication & care coordination
~Promote effective prevention & treatment
~Promote best practice for healthy living
~Make care affordable

Patient Experience: Quality of Care

Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) is a standardized survey set for all HC patients

HHCAHPS is designed to:

Provide data on the patient's perspective that can be compared in objective and meaningful ways between home health agencies

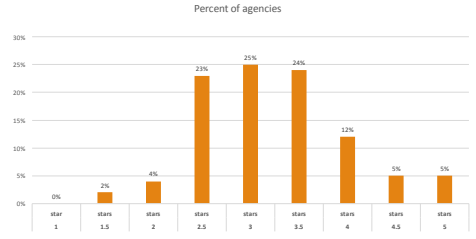
Provide public reporting of results as an incentive for home care agencies to improve care quality

Enhance transparency of health care quality and increase accountability across care providers

Quality of Care Patient Star Ratings (scoring on scale of 1-5):

1. OASIS Process Measures –
   - Timely Initiation of Care, Drug Education on all Medications provided to patient/caregiver, Influenza Immunization [current flu season]
2. OASIS Outcomes Measures –
   - Improvement in Ambulation, Bed Transferring, Bathing, Pain Interfering with Activity, Dyspnea and Acute Care Hospitalization
3. Patient Experience [HHCAHPS Survey] Measures –
   - Care related items, Communication between Providers & Patient and Overall Rating of Care Provided

Star Ratings All US Agencies 10/2015-9/2016



Home Care Compare – Sample Quality Data

Data collection period from October, 2015 through September, 2016

Patient Survey results	National Average
How often the home health team gave care in a professional way	88.0%
How well *did* the home health team communicate with patients	85.0%
Did the home health team discuss medicines, pain, and home safety with patients	83.0%
How do patients rate the overall care from the home health agency	84.0%
Would patients recommend the home health agency to friends and family	78.0%

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Client Expectations of Care

Care is coordinated- all key information is pulled together to make the best care decisions

Care is managed – each clinician manages care; all clinicians collaborate

Desire to have the highest quality, safest and most effective care

Even with a designed person as "care manager", clients do not want to communicate with 1 person only - every clinician should be interacting

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Supporting Client Self-Management

Behavioral skills that increase ability to manage the disease/condition and support the best possible quality of life are:

Learning about condition(s)

Problem solving

Decision making

Good use of Resources

Create/maintain partnership with clinician(s)

► Taking action to manage

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Patient Centered Care Strategies

Develop awareness of patient quality of life and autonomy concerns

Express knowledge of what other HC team members are working on

Check on environmental issues and physical concerns, especially pain

Probe need for and provide emotional support; address anxiety & fears

Involve family and friends unless patient directs you not to

Create and discuss a transition plan well before the final therapy visits

Show respect and kindness, honor dignity – verbally and non-verbally

Home Health Care

Increasing demand
- Aging population, preference for care at home

Need for and use of technology
- Agency – variation, cost as well as Adoption and use by older adults clients

New Models of care – value based, bundled care, etc

Capacity – qualified staff at all levels
- More Caregivers, professional and support, needed for older population

Implementing Evidence based care

Increasing payment reductions, audits, regulation

Productivity concerns

Additional Resources

https://www.cdc.gov/steadi/index.html Falls related

http://www.homehealthquality.org/Education/Best-Practices.aspx

https://homehealthcahps.org/ Home Care patient surveys, analysis links

http://www.cdc.gov/hrqol/ Health related quality of life, more data links

http://www.ahrq.gov/research/findings/index.html


THANK
YOU!