Utilizing Therapy to Achieve Better Quality Measures

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Objectives

- Define reportable Skilled Nursing Quality Measures including their scope and intended purpose.
- Identify interdisciplinary team strategies to impact and improve facility-level Quality Measures.
- Describe clinical treatment approaches for clients with lower-level skills.

2

Background: Quality Measures (QM)

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CMS' Vision For SNF QRP Program

"We seek to promote higher quality and more efficient health care for Medicare beneficiaries, and our efforts are furthered by QRPs coupled with public reporting of that information."

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History

- IMPACT ACT of 2014
  - Through the use of standardized quality measures and standardized data, the intent of the Act was to access information for providers to facilitate coordinated care, improve outcomes, and appreciate overall quality comparisons

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2022 Short Stay Quality Measures

- Percent of Short-Stay Residents Who Were Re-Hospitalized after a Nursing Home Admission
- Percent of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit
- Percent of Residents Who Newly Received an Antipsychotic Medication
- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Percent of Residents Who Made Improvements in Function
- Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Who Received the Seasonal Influenza Vaccine*
- Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine*
- Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Residents Who Received the Pneumococcal Vaccine*
- Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine*

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2022 Long Stay Quality Measures

- Number of Hospitalizations per 1,000 Long-Stay Resident Days
- Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days
- Percent of Residents Who Received an Antipsychotic Medication
- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of High-Risk Residents with Pressure Ulcers
- Percent of Residents with a Urinary Tract Infection
- Percent of Residents who Have or Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents Whose Ability to Move Independently Worsened
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Who Received the Seasonal Influenza Vaccine*
- Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine*
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Residents Who Received the Pneumococcal Vaccine*
- Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine*
- Percent of Residents Who Were Physically Restrained
- Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
- Percent of Residents Who Lose Too Much Weight
- Percent of Residents Who Have Symptoms of Depression
- Percent of Residents Who Used Antianxiety or Hypnotic Medication

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Collecting Data

Data for the SNF QRP measures are collected and submitted through two methods:

- Minimum Data Set (MDS) 3.0
- Medicare Fee-For-Service Claims

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Why is SNF QRP Significant?

- The SNF QRP Data is publicly available
  - Could impact referral patterns
  - Marketplace dynamics
  - Used by hospitals and peers competitors to leverage partnerships as networks continue to narrow

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Risk Adjustment

Assessment-based quality measures are risk-adjusted

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Discharge Self-Care Score
- Discharge Mobility Score
- Change in Self-Care Score
- Change in Mobility Score

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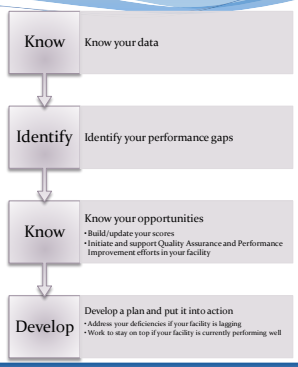
Knowledge is Power



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Improving QMs

- Enhance facility care delivery
  - Do the best for the residents in your care and your Quality Measures will improve organically

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Ways to Improve Your QMs with Therapy Initiatives

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SNF QRP Measure #1: Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

- Reports the percentage of Medicare where one or more falls with major injury were reported.
  - Major injuries are defined as bone fractures joint dislocations, closed head injuries with altered consciousness subdural hematoma reported during the SNF stay.

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J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding:
0. None
1. One
2. Two or more

↓ Enter Codes in Boxes

☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
☐	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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Percent of residents experiencing one or more falls with major injury (Long Stay):

- Therapists utilize standardized tools and clinical assessment to identify components of balance deficits.
- Therapists provide treatment interventions that address balance to reduce the risk of falls.

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Strategic Approach Falls

- Consider training therapy, restorative, recreation staff in Fall Prevention Programs
- Review use of alarms
- Review your pain management protocols
- Review individualized toileting programs
- Review hydration programs
- Perform a review of your recreation programming
- Strategically place work stations for CNAs in hallways near resident care or gathering areas

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Four Things to Prevent Falls in LTC Settings

- Begin an exercise program to improve their leg strength and balance
- Get an annual eye exam; Replace eyeglasses as needed
- Make their home safer
- Ask their doctor or pharmacist to review their medicines

- Source: ***https://www.cdc.gov/steadi/***

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Evidence-Based Fall Programs

- Fall prevention programs for can produce a net-cost savings of almost nine dollars for each dollar invested
- Programs designed to prevent falls can:
  - Save hospital admission and long-term care costs
  - Help older adults living in communities maintain their independence
  - Help older adults increase their leg strength and improve their balance

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Example: Otago Exercise program (OEP)?

- Initiated in New Zealand and adopted by the Centers for Disease Control
- The program is individualized to address balance and strength
- The exercises are progressed over the course of a year and it includes a walking plan
- Clients are seen a minimum of 7 times with 7 telephone calls to encourage and monitor progress over a 12 month period
- Increasing evidence that interventions of longer durations and lower frequencies result in better outcomes

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Evaluation Process

- Should begin as soon as your community decides to implement a Fall program
- Must be part of program design and operation
- Must be part of the program activities

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Measuring Effectiveness

- Can be measured by outcomes, such as:
  - Improvements in functional abilities
  - Improved balance
  - Greater self-confidence
- Look at Process Measures
- Look at Outcome Measures

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SNF QRP Measure #3: Drug Regimen Review Conducted with Follow-Up for Identified Issues

- The facility conducted a drug regimen review on admission which resulted in one of the three following scenarios:
  - No potential or actual clinically significant medication issues were found during the review
  - Potential or actual clinically significant medication issues were found during the review and a physician (or physician-designee) was contacted and prescribed/recommended actions were completed by midnight of the next calendar day
  - The resident was not taking any medications

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SNF QRP Measure #3: Drug Regimen Review Conducted with Follow-Up for Identified Issues

- Appropriate follow-up occurred each time a potential or actual clinically significant medication issue was identified during the stay -- OR –
- No potential or actual clinically significant medication issues were identified since the admission or resident was not taking any medications

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The Medication Connection

- Polypharmacy is a risk factor for falls
- Studies have determined that taking ≥ 4 drugs is associated with increased falls and injuries
- Potentially Inappropriate Medications (PIM) for older people are listed in the latest edition of the Beers Criteria
- Source: ***Early, Fairman, Hagarty & Sclar, 2019***

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Polypharmacy and Falls

- Among the most common causes of increased fall risks in older people
- …usually among the easiest risk factors to change, when it comes to falls in older adults
- "And medication-based risks are often missed by busy regular doctors"
- Source: ***Kernisan, MD MPH, Geriatrician, 2019***

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Therapist's Role in DRR

- Within the scope of practice of a therapist to perform a patient screen in which medication issues are addressed.
- State practice acts may differ in their allowances for therapist's role in medication management.

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Strategies for Person-Centered Fall Risk Reduction

- Consider the risks specific from a person's medications
- Review medication lists of all residents
- Carefully monitor adverse effects per shift
- Discuss the risk vs. the benefit analyses with the client's physician
- Consider dose reduction as needed

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SNF QRP Measure #2: Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

- Reports percentage of Part A stays with admission and discharge functional assessment and at least one goal that addresses function
- Higher percentages are better

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Section GG: Functional Status

- Ten (10) items
- Points are assigned based on performance of each item
- "Resident refused," "Not applicable," "Not attempted due to medical condition or safety concerns" "not attempted due to environmental limitations" are grouped with "dependent"
- Additional response level to reflect residents who skip the walking assessment due to their inability to walk
- Multiple items are averaged together

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Section GG: Coding Tips and Definitions

- Residents should be allowed to perform activities as independently as possible
- Activities may be completed with or without assistive device(s)
- Code based on "usual performance"
- Not the most independent or dependent

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Section GG: Coding Tips and Definitions

- If a helper is required (i.e., resident is unsafe), only consider staff assistance when scoring
- A "helper" is facility staff who are direct employees and facility-contracted employees

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Section GG: Coding Tips and Definitions

- Residents with cognitive impairments may need physical or verbal assistance
- Code based on the resident's need for assistance to perform the activity

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Section GG: Activity Not Attempted

- 07, 09, 88, 10 should not be used if you did not directly assess the item during your evaluation
  - All attempts should be made to obtain the information from other sources
- 09 should be a rare score for eating, toileting, and bed mobility items
- Do not score dashes

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Supportive Nursing Documentation

- Reflects coordinated efforts between nursing and rehab
- Nursing documentation supports therapy services and may make impact claim payment

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Functional Outcome Measures

Change in Self-Care Score	Estimates the risk-adjusted mean change in self-care score between admission and discharge for Medicare Part A Type 1 SNF stays.
Change in Mobility Score	Estimates the risk-adjusted mean change in mobility score between admission and discharge for Medicare Part A Type 1 SNF stays.
Discharge Self-Care Score	Estimates the percentage of Medicare Part A Type 1 SNF stays that meet or exceed an expected discharge self-care score.
Discharge Mobility Score	Estimates the percentage of Medicare Part A Type 1 SNF stays that meet or exceed an expected discharge mobility score.

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SNF QRP Measure #5: Change in Self-Care Score for Medical Rehabilitation Patients

- Estimates risk-adjusted mean change in self-care score between admission and discharge
- Calculated as the difference between the discharge and the admission self-care score
- Higher scores indicate greater independence

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Self-Care Assessment Items

GG0130A. Eating
GG0130B. Oral hygiene
GG0130C. Toileting hygiene
GG0130E. Shower/bathe self
GG0130F. Upper body dressing
GG0130G. Lower body dressing
GG0130H. Putting on/taking off footwear

Response codes include:
- 6-point rating scale.
- Activity not attempted codes.

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6-Point Rating Scale

06
- Independent
  - If the resident completes the activity by him/herself with no assistance from a helper

05
- Setup or clean-up assistance
  - If the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity.

04
- Supervision or touching assistance
  - If the helper provides VERBAL CUES or TOUCHING/STEADYING/CONTACT GUARD assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently

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6-Point Rating Scale

03
- Partial/ moderate assistance
  - If the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort

02
- Substantial/ maximal assistance
  - If the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01
- Dependent
  - If the helper does ALL of the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity.

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If Activity was Not Attempted

07
- Resident refused
  - If the resident refused to complete the activity

09
- Not applicable
  - If the resident did not perform this activity prior to the current illness, exacerbation, or injury

88
- Not attempted due to medical condition or safety concerns
  - If the activity was not attempted due to medical condition or safety concerns

10
- Not attempted due to environmental limitations
  - For example, lack or equipment or weather constraints

Do NOT code a dash (--)
This could affect the facility's annual payment update
2% reduction

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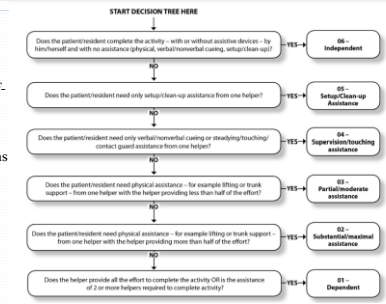
Coding Section GG Self-Care & Mobility Activities Included on the Post-Acute Care Item Sets: Key Questions to Consider When Coding



Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/GG-Self-Care-and-Mobility-Activities-Decision-Tree.pdf

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SNF QRP Measure #7: Discharge Self-Care Score for Medical Rehabilitation Patients

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Self-Care Assessment Items

GG0130A. Eating
GG0130B. Oral hygiene
GG0130C. Toileting hygiene
GG0130E. Shower/bathe self
GG0130F. Upper body dressing
GG0130G. Lower body dressing
GG0130H. Putting on/taking off footwear

Response codes include:
- 6-point rating scale.
- Activity not attempted codes.

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SNF QRP Measure #6: Change in Mobility Score for Medical Rehabilitation Patients

- Estimates risk-adjusted mean change in mobility score between admission and discharge
- Calculated as the difference between the discharge and the admission self-care score
- Higher scores indicate greater independence

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Mobility Assessment Items

GG0170A. Roll left and right	GG0170J. Walk 50 feet with two turns
GG0170B. Sit to lying	GG0170K. Walk 150 feet
GG0170C. Lying to sitting on side of bed	GG0170L. Walking 10 feet on uneven surfaces
GG0170D. Sit to stand	GG0170M. 1 step (curb)
GG0170E. Chair/bed - to - chair transfer	GG0170N. 4 steps
GG0170F. Toilet transfer	GG0170O. 12 steps
GG0170G. Car transfer	GG0170P. Picking up object
GG0170I. Walk 10 feet	

Response codes include:
- 6-point rating scale.
- Activity not attempted codes.

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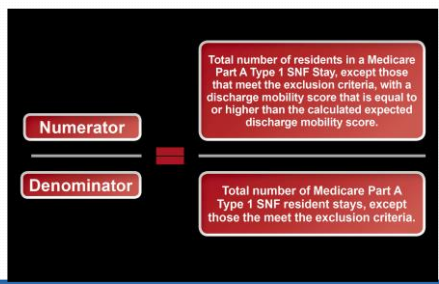
SNF QRP Measure #7: Discharge Self-Care Score for Medical Rehabilitation Patient



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Mobility Assessment Items

GG0170A. Roll left and right	GG0170J. Walk 50 feet with two turns
GG0170B. Sit to lying	GG0170K. Walk 150 feet
GG0170C. Lying to sitting on side of bed	GG0170L. Walking 10 feet on uneven surfaces
GG0170D. Sit to stand	GG0170M. 1 step (curb)
GG0170E. Chair/bed - to - chair transfer	GG0170N. 4 steps
GG0170F. Toilet transfer	GG0170O. 12 steps
GG0170G. Car transfer	GG0170P. Picking up object
GG0170I. Walk 10 feet	

Response codes include:
- 6-point rating scale.
- Activity not attempted codes.

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Calculations

- If the code is between 01 and 06, then use the code as the score
- If the code is 07, 09, 10, or 88, then recode to 01 and use this code as the score
- If the self - care item is skipped (^), dashed (-) or missing, recode to 01 and use this code as the score
- Sum the scores – scores can range from 15 to 90
- Higher scores indicate greater independence

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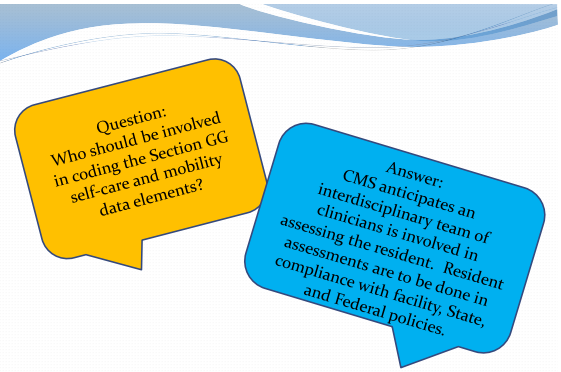

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What Can You Do?

- Audit documentation against GG scores/MDS data
- IDT communication for GG scores
- Educate all staff for appropriate coding
- Ensure nursing documentation captures GG data

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Want more Information?

- SNF QRP QM User's Manual
  - Access on the SNF QRP website in the Measures and Technical Information section page
  - Chapter 7 which outlines each QM and the numerator and denominator criteria for each of those measures

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SNF QRP Measure #4: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

Discharge assessment indicates one or more new or worsened Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, compared to admission.

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Wound Care Team

- Patient
- Physician
- Nurse
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Dietician

TEAM GOAL: Timely, cost-effective healing of wound

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Strategic Approach Pressure Injuries

- Educate all nurses who perform admission skin assessments:
  - On proper assessment and staging per RAI definitions
- Consider requiring skin assessments every shift for first 24 hours
- Consider having wound care nurse assess skin on admission
- Consider having wound care nurse assess the resident's skin the day after admission
- Consider having an RN assess the skin within 24 hours of admission
- Positioning and Mobility programs

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Advocacy for Clients with Wounds?

- Plan of care developed without consideration of whole person
- Clients feel disengaged in decision making regarding wound care
- Client should be at the center of treatment

56

Functional Limitations

- Clients with chronic wounds exeperience mobility problems, and their ability to perform activities of daily living is limited

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Research: Impact of Wounds on Functional Activities

- Study consisting of 88 patients with chronic leg ulcers, 75% reported difficulty performing basic housework (Roe et al., 1995)
- Study consisting of 50 clients with leg ulcers, 50% had problems getting on and off a bus and 30% had trouble climbing steps (Hyland et al.,1994)

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Therapy Functionally Based Treatment

- A functionally based treatment approach prepares the client for the specific activities and skill sets that they need to both successfully *transition* and *remain* in their discharge environment

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Determining the Best Approach

- Use standardized tests and measures to assess leisure and living skills * denotes free access
  - Kohlman Evaluation of Living Skills (KELS)
  - Preferences for Everyday Living (PELI)*
  - Modified Interest Checklist*
  - Role Checklist*
  - Assessment of Living Skills and Resources (ALSAR)
  - Canadian Occupational Performance Measure (COPM)

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What does Functionally Based Therapy Treatment Look Like?

- Uses everyday materials and situations that provide opportunities to put therapy techniques into practice in fun and functional ways
- Can be used in any area within the center/facility, the therapy department, the client's room, the activities room, etc.
- A functionally based intervention can be made for just about any functional life activity

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Skilled Rehab Intervention

- A better approach would be to start with the patient.
- What is important to the patient? What would improve quality of life and be meaningful to the client?

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Medicare.gov/care-compare

- How nursing homes have performed on health and fire safety inspections
- How the nursing home is staffed with nurses and other healthcare providers
- How well nursing homes care for their residents – Quality Measures
- Nursing homes that have had issues related to preventing abuse
- Vaccination rates

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Importance of Communication Between Nursing and Therapy: Resident Identification

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Tips for Success

- Effective communication between nursing and therapy
- Regular meetings with restorative nursing staff
- Utilize a nursing referral form
- Ensure supportive documentation is present
- Provide in-services to the IDT
- Obtain information from variety of sources

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Tips for Success

- Review previous therapy and nursing documentation
- Complete a chart review
- Talk to nursing
- Observe in a functional setting
- Don't get trapped by "usual versus normal"
- Keep screening records

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Complete screens 2 weeks before care plan

Understand other disciplines and make referrals

Regular dining room/activities screen schedule

Regular room-bound screen schedule

Orient new staff to the role of therapy

Review discharged residents/RNA programs

Provide wellness in-services, open houses or "mini-clinics"

Tips for Success

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IDT Questions

- Have any residents changed (improved or declined) in any of the following areas:
- Turning in bed
- Getting out of bed
- Getting to the toilet
- Getting to the dining room
- Getting to activities
- Feeding self
- Dressing self

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Interdisciplinary Questions

Do any residents:

- Stay in their room more often?
- Want to stay in bed?
- Ask for more help than usual?
- Have more frequent bathroom accidents?
- Have difficulty self-feeding?
- Get "messy" during meals?
- Lean in the wheelchair?
- Demonstrate less participation in activities?

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IDT Questions

- Any documented changes in:
- ADL
- Falls/balance issues/functional mobility
- Skin integrity
- Swallowing or eating ability
- Ability to communicate wants/needs

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IDT Questions

Are residents:

- Eating in their usual area?
- Eating usual food preferences?
- Coughing/choking during meals?
- Losing weight?

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IDT Questions

Are any residents:

- More/less communicative?
- Discussing desire to leave the facility?
- Participating in fewer outings?
- Distressed about functional loss?
- Expressing desire to improve?
- Demonstrating inappropriate behavior?
- Having difficulty accepting a disability?
- Wanting to do more for themselves?
- Talking about what they used to be able to do?

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Facility "Lists"

Obtain facility lists for residents with:

- Orders for bed rest or who spend most of the day in their room
- Special positioning considerations
- Contractures
- Physical restraints
- Skin integrity issues
- Adaptive equipment needs
- High risk for contracture development

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Staff Interview and Focused Screens

Nursing/staff interview conducted in less than 5 minutes

- Weight loss in last 3 months?
- Fed by nursing staff?
- Using assistive devices for eating?
- Using restraints for positioning? Falls?
- Developed joint contractures?
- Decrease in ROM?
- Skin integrity issues?
- Hearing issues?
- Difficulty communicating basic needs?
- More assistance with ADL, toileting, hygiene?
- Change in bed mobility/transfers?
- Change in ambulation?
- Coughing or choking while eating?
- Cognitive changes?

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Screening Observe Residents Who Have:

- Had a fall
- Abnormal posture
- Poor head, neck or trunk control
- Contractures
- Problems with edema
- Decreased safety awareness
- Decreased transfer ability

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Screening Observe Residents Who Have:

- Decreased ability to self-propel wheelchair
- Difficulty breathing
- Decreased socialization due to poor position
- Difficulty maneuvering wheelchair in environment
- Difficulty using motorized wheelchair or scooter

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Screening Observe Residents Who Have:

- A restraint
- Difficulty keeping feet on foot rests
- Leg length discrepancy in sitting
- Broken equipment in wheelchair
- Worn/stretched seat or back rest in wheelchair
- Difficulty positioning due to orthotic/prosthetic device

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Nursing Communication to Physical Therapy

- Decreased coordination
- Decreased endurance
- Decreased lower body ROM
- Decreased lower body strength
- Falls or slips forward/side
- Poor neck control
- Poor safety awareness

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Nursing Communication to Physical Therapy

- Gait, shuffled, unsteady
- Lower body contractures
- Has shortness of breath
- Leg splint causing redness
- Needs assistance with transfers
- Needs assistance with walking
- Pain in lower extremities

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Nursing Communication to Physical Therapy

- Frequent falls
- Poor sitting/standing balance
- Restraints
- Tremors
- Skin breakdown
- Swelling
- Unable to get in/out of bed/wheelchair

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Nursing Communication to Occupational Therapy

- Cannot lift utensils
- Decreased upper body ROM
- Decreased upper body strength
- Difficulty dressing
- Difficulty feeding self
- Difficulty grooming and hygiene
- Does not look right/left

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Nursing Communication to Occupational Therapy

- Hand/wrist splints do not fit
- Has shortness of breath
- Poor neck control
- Poor problem-solving skills
- Poor safety awareness
- Unable to cut food
- Unable to follow directions

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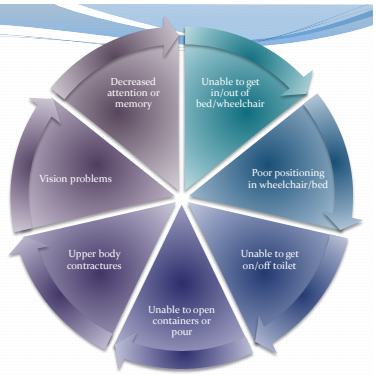
Nursing Communication to Occupational Therapy



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Nursing Communication to Speech Therapy

- Cannot or will not chew
- Dehydration
- Difficulty speaking
- Food/liquid coming out of nose
- Wet, gurgly voice

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Nursing Communication to Speech Therapy

- Food falls out of mouth
- Frequently asks speaker to repeat
- Heartburn
- Increased mucous or phlegm
- Lack of dentition
- Non-oral feedings
- Pockets food in cheeks

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Nursing Communication to Speech Therapy

- Poor lip closure
- Recurrent pneumonia
- Recurrent temperature spikes
- Significant weight loss
- Unable to communicate wants/needs
- Vomiting during or after meals

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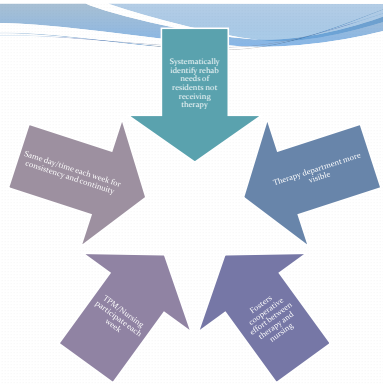
Grand Rounds



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Grand Rounds

- Topics include
  - Dining Rounds
  - Seated Positioning Rounds
  - Activity Rounds
  - Bed Positioning, Skin & Contracture Rounds

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What Does this Mean for Us?

- Address transfers, locomotion, walking in corridor
- Relate to highest self-performance in ADL and mobility
  - For a facility to achieve a high quality rating, **entire IDT** must be prepared to emphasize these elements during care
- Prepare client for successful discharge

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What Can You Do?

- Transfer and Mobility Programs
  - Identify residents with a change in function and notify therapy
  - Therapy screen and evaluation
    - Discharge planning for carryover
  - Restorative programming
  - Consider skilled maintenance

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Importance of Discharge Planning

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Preparing for Successful Discharge

- ADL Programs to ensure highest level of function
  - OT, nursing, and restorative
- Medication management and understanding
- Caregiver training
  - Ensure return demonstration
- Home programs
- Home assessment (consider technology)

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Impacts Percentage of residents who are successfully discharged to the community

- Proactive discharge planning are imperative and therapy departments can help to ensure a patient is ready to be discharge.
- Therapy may address cognitive issues, determine the supervision level required for specific tasks, and identify abilities for medication self-management.
- Patient satisfaction and therapists provide the one-on-one patient attention to increase these outcomes.

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Preparing for Successful Discharge

Protocols!

- Full team including SW, nursing, therapy
- To ensure that all critical elements are addressed
- Addressing high risk re-admissions (e.g., AMI, COPD, CHF)

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	Day 7 – 13	Day 13 - 20
Re- assessment	• Progress toward short, long term and patient goals and discharge plan with treatment plan modifications as indicated ○ Nursing ○ Physical Therapy ○ Occupational Therapy ○ Social Work/Discharge Planner	• Ongoing re-assessment of status in relationship to the discharge plan ○ Nursing ○ Physical Therapy ○ Occupational Therapy ○ Social Work/Discharge Planner
Medical Management	• Vital signs • Skin integrity • Nutrition/diet • Bowel and bladder management • Medication management • Lab values	• Vital signs • Skin integrity • Nutrition/diet • Bowel and bladder management • Medication management • Lab values
Symptom Management	• Dyspnea • Edema/swelling • Positioning • Lower extremity pain management	• Dyspnea • Edema/swelling • Positioning • Lower extremity pain management
Cardio/ Pulmonary Status	• Precautions • BP/Respiratory rate • Endurance/exertion (Borg Scale) • O2 saturation • Heart rate/pulse • Any comorbidity complications	• Precautions • BP/Respiratory rate • Endurance/exertion (Borg Scale) • O2 saturation • Heart rate/pulse • Any comorbidity complications
Safety/ Precautions	• Energy conservation • Safety precautions • Activity restrictions • Other precautions	• Energy conservation • Safety precautions • Activity restrictions • Other precautions as prescribed by physician

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Education	• Breathing exercises • Adaptive equipment/DME • Medication use and administration • Activity restrictions • Family education • Risk factors/lifestyle modification • Medication management • Symptom management • Exercise program to be performed with cues or independently • Caregiver competency with ADL/mobility program • Train patient to monitor vital signs • Energy conservation with functional tasks • Progress home program activities and exercises • Discuss progress toward goals • Signs and symptoms of acute cardiac event	• Home program • Exercise program to be performed independently • Breathing exercises • Adaptive equipment/Durable medical equipment • Medication use and administration • Activity restrictions • Family education and integration into treatment • Risk factors/lifestyle modification • Medication management • Symptom management • Caregiver competency with ADL/mobility program • Train patient to monitor vital signs • Progress home program activities and exercises
Discharge Planning	• Conduct home assessment, if required • Contact follow-up services • Order necessary adaptive equipment/DME • Conduct a family conference with the team to discuss discharge plans and handle any patient/family concerns	• Determine continued community based rehabilitation needs and make referrals including scheduling first appointment • Give final instructions on day of discharge

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Preparing for Successful Discharge

- Engage the resident and family in a partnership to create the POC
  - Assess desires and understanding of the POC
  - Reconcile the care plan developed collaboratively with the resident and family caregivers

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Early DC Planning with IDT

Discharge Planning Worksheet

PHYSICAL THERAPY

Functional Status: Check all that apply and include assistance level and any specialized instructions for each

	Activity	Current Assistance Level	Goal	Specialized Instructions (e.g., set-up instructions, cues needed, etc.)
☐	Bed Mobility			
☐	Transfers			
☐	Ambulation			
☐	Stairs			
☐	Curbs/Ramps			
☐	HEP			
☐				
☐				
☐				

Recommended Assistive Devices: Check all that apply

☐	Walker	☐	Straight cane
☐	Front wheeled walker	☐	Quad cane
☐	Wheelchair	☐	Wheelchair cushion
☐		☐	
☐			

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Prevent Readmissions Post-DC

- How can/will you continue to work with the client after discharge?
  - Client advocate for the episode of care
- How can you make technology work for you?
  - Web-based home programs, exercises, vital sign monitoring

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Prevent Readmissions Post-DC

- Who addresses the "social" side of discharge?
  - Were medications delivered timely?
  - Is DME/AE in place?
  - Did the client see MD for follow up?
- One person to coordinate and place phone calls

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Summary

- CMS uses quality measures that include quality improvement, pay for reporting, and public reporting
- Quality measure reporting involves everyone who works in a long-term care facility
- Therapists can address and assist in improving QMs
- Efficient and accurate communication is required for quality health care and is linked to improved QMs

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Thank You

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