Home Health: PDGM to COVID-19 Response

Recorded August 14th, 2020

Presenter: Scott Rushanan, MS, OTR/L, MBA

PhysicalTherapy.com Course #3801

- [Calista] Today's course is titled Home Health 2020 PDGM to COVID-19 and it is my pleasure to welcome back to fiscal therapy.com, Scott Rushanan. Scott has been the director of rehabilitation for the university of Pennsylvania's home health agency for the past eight years. He is pursuing his doctorate in occupational therapy at Columbia university with a focus on neurodegenerative and the ALS population. So thank you so much, Scott, for coming back to physical therapy.com and presenting for us. We are pleased to have you here with us today and at this time I'm gonna turn the microphone over to you.

- [Scott] Thank you, Calista, and thank you everyone for joining us today. Good afternoon or good morning depending on where you're calling in from and happy Friday. I'm really excited to present all of this or present this to you today. It's a little bit different because it's, there is literature and some best practice sprinkled throughout this lecture, but I really it's really just a recap of what I think we've all been going through throughout 2020 as home health clinicians. At the beginning we faced PDGM and I wanna tell you a little bit about what my agency did to respond to PDGM and some of the successes that we had in really utilizing therapy services to help drive PDGM.

And then what happened with us during the COVID-19 pandemic and what we're still doing to this day and tell you a little bit about, you know, how we handled it and the successes that we had, what we were thinking at the time 'cause it really evolved over you know, from March until now you know, in terms of, you know, even our response is continually evolving. So these are our disclosures for the presentation. And these are the learning outcomes. After this course, participants will be able to identify at least two ways of how the patient driven groupings model or PDGM affects home health reimbursement for therapy services. Identify at least two strategies on how home health agencies can benefit from PDGM changes to ensure both quality of care for

example, improve patient function, increase therapy utilization and have financial success. And identify at least three strategies on how to adapt to changes in healthcare in order to deliver effective and safe home health services. So this is a diagram that we often use at Penn Medicine Home Health to sort of describe how we transition patients from acute care in the hospital to the home. We are a very large academically based health system and we have the luxury of being a part of that model because as a home health agency, we are quite large and have become increasingly more and more responsible for the post acute care side of healthcare. We get the majority of our patients through our hospitals within our own health system about 80% of our patients come from our three downtown hospitals within the city of Philadelphia.

That's Penn Presbyterian hospital, hospital of the university of Pennsylvania and Pennsylvania hospital which is actually the nation's first hospital. And we do a lot of work with the acute care side working on transitioning patients from acute care to home care. And when they come to home care, we're actually during this transition, you could see the patients at the center of it and there's stakeholders engaged around the patient to ensure a safe discharge home with the physician to central intake when the referral comes into our home health agency, they process the referral, the home health schedulers play a big role in setting up home health services especially even according to different protocols and programs that we have.

We rely heavily on our home health schedulers and they have to be very knowledgeable about the clinical care that needs to come from each program and how to set that up. Obviously therapy services on the home health side as well as the acute care side are involved, case management in the hospital and then the home care social workers are also very much involved. So I'll move on to the next slide here. This is the geography that we cover. So for those of you not from Pennsylvania or even of those of you from the Northeast, this map might not make a lot of sense here so I'll try to explain it. This is our 10 geographical teams the ones in color are where we actually

have staffed teams, the teams 11 which you can't really see that 11, 12 and 13 are teams that we have set up for the future for future growth. There are no managers associated with it and we take patients on teams 11, 12, and 13 sort of like as needed basis like depends on the situation we may venture out in there but the primary care that we're providing is on teams one through 10 and teams one, two, three, eight and four, like right in this area right here, that's Philadelphia right here is the Delaware river, over here is New Jersey, Philadelphia is right in here and then you have the surrounding counties with Bucks County, Montgomery County, Delaware County and then Chester County out here in nine and 10. It's a very large territory. We are a very large home health agency, we do about 30,000 visits a month, all including therapies, nursing, social work and home health aid services.

Each of these teams carries about 300 to 350 patients and is staffed with about 40 team members and that's inclusive of all of our therapy disciplines and nursing and home health aid and social worker as well and each one of these 10 teams has a manager that oversees the care for those patients on that team. And in some cases our managers are therapists, in some cases managers are our nurses. And then those managers report to me as director of rehabilitation services and co-director of the home health agency and my colleague who is a nurse so it's very interdisciplinary.

And I would say also that the operations on all of these teams is the same if you're on team four or team nine despite the fact that that is, I don't know how many miles separates that, but it's a good bit, the operations is run out of two very small offices right outside of Philadelphia and the operations is the same no matter what team you're on. And this is just sort of shows the interdisciplinary team structure on these teams with the interdisciplinary team manager that I mentioned, one of those 10 team managers at the center and they, he or she coordinates care between all of these services. We do have a manager of rehabilitation services as well which helps oversee the operations and clinical practices of our speech, occupational and physical

therapists and then we also have a director of psychosocial services that helps with social work. It's sort of overlaps here with the LPN, it's not really supposed to do that it's just supposed to overlap with the MSW right there. I'm just going over this just to sort of set the stage as to what we did with PDGM and COVID-19 'cause it might give you a little bit better context in, you know, into those operations and those outcomes. We pay a lot of attention to 30 day unplanned readmissions and we have a lot of different programs and a lot of different protocols and different ways we engage patients and caregivers around the care that they are given.

When I, back in FY15, you could see that our 30 day unplanned readmission rate was about 13.3% back then and we've had a steady decline through FY20 quarter one which is 11.24%. And for the year, I wanna point out this slide is a little bit dated for FY20 for the entire year it was 11.26% so it wasn't too far off of that 11.24%. And we have implemented, as I mentioned, a lot of different services, therapy in particular really played a big role in helping us reduce these readmissions.

When I first got here back in FY as I guess I started in January of 2013, so that was FY14, we were vastly under staffed with therapy I don't think, you know, the agency really was able to keep up with the demand for therapy services in years prior so we were really starting with you know, out of a hole trying to recruit talented physical and occupational and speech therapists and we've pretty much more than doubled our therapy service personnel going from about 50 FTEs back in FY14 to now about 170 FTEs. So really robust therapy service line our, you know, our response to referrals and our timeliness of care has gotten much better over the years but the demand keeps growing so every time we feel like we've gotten enough staff, they keep moving the needle because as I mentioned, our health system keeps relying on us more and more for post acute care and coordinating pretty much all of post acute care. So now we're gonna get into patient driven groupings model. So for, I'm assuming most of you have an interest in this since there's 49 participants and I'm assuming most of you are from

home health and I'm sure you've all heard of this and I'm gonna sort of explain it, you know, as far as, you know, as I understand it and go through what, how we addressed it. So it was implemented in, you know, started in 2020, right at the beginning of this year and I'll add pre COVID times, it was a different world back then. The one thing that really stood out in terms of delivering therapy services were the number of therapy visits are no longer a determinant of pay. Under the old model if you remember, there were certain thresholds that if you reached a certain number of combined PT, OT, and speech visits, you would be paid, your agency would be paid a stipend for delivering those services and it was felt that therapy services were under utilized and not necessarily, you know, we didn't have enough services that there were, there are enough resources to provide those services I should say and so that's why they were paid higher.

There now is a higher emphasis on appropriate coding, and I have some data to show that no home health agency was coding correctly because we weren't paid for it so there's a lot of opportunity under PDGM just by getting the correct codes in there to make sure that you're sort of collecting enough reimbursement to cover the cost of supplying care to patients. There's an attempt under PDGM I mean, really the essence of PDGM, if you really step back and think about it, it's to promote value based care that meets patient needs.

Everything about the PDGM model is really geared towards getting good outcomes effectively and most importantly efficiently to the patient. Identifying what their needs are upfront, delivering the services and not having patients have a prolonged and unnecessary, I should say, unnecessarily prolonged home health episode. They want us to coordinate care better in our interdisciplinary teams which is really that's really what the essence is but unfortunately there must've been my agency did not do this, but from what I've been hearing from some colleagues, there must be some agencies out there that must have really taken advantage under the old program for therapy

visits and really relied on that extra reimbursement for delivering therapy services because when PDGM came in, a lot of agencies started furloughing and laying off therapy services which we really felt was the absolute wrong thing to do, we actually even doubled down on our therapy programs. And then they once, they wanna improve access to remote patient monitoring or having some element of telehealth in there and that's to really help manage the visit pattern. If you could reach patients in a more cost effective manner, they're not paying you extra for doing telehealth, but it doesn't cost you any more to do telehealth services, the cost of deploying a nurse or a therapist to do telehealth or I'm sorry to do an in person visit is gonna be a much higher cost than if you reach the patient by telehealth.

So you could have some balance between using telehealth services and in person visits to sort of help meet the patient's needs, help create positive behavior change, help make the patient more independent in managing their health. Unit of payment based on 30 days and no longer 60 days, that's actually important and that's what I'm getting at with efficiency. They want us to bring everything up towards more towards the beginning of the episode not let it linger on for 60 day episode. And it's a possible opportunity for therapists to shine.

As I mentioned, we doubled down on the use of therapy to meet patient's needs and continue to use them for quality outcomes and specific protocols to meet patient's needs. And I'll get into that towards the end of this lecture. I do wanna point out that because this is just more, you know, me speaking to, you know, our response to PDGM, what we were thinking at the time, giving you some outcomes that we got with our programs, if you do have a question, you can type it in to the chat and I will address it. It's a somewhat large group so I can't, you know, there's about 49 or 50 of you so I, you know, I mean we can't take the whole time to have a discussion, but I, it can be a little bit open so if you have a comment or question, don't hesitate, I'll get to it, you could type it in there. Patient driven grouping models. Major change in

reimbursement model for home health. As I said when in January 1st, 2020, the current model, the previous model had 153 case-mix groups in the way they sort of classified patients. Under PDGM, it went from 153 to 432 case-mix groups so that's a big difference from the previous reimbursement model. The current model, as I mentioned, had a 60 day period and then it went to a 30 day billing period. The episode length, I wanna point out, the episode stayed at 60 days so you would re-certify a patient under PDGM for 60 days but the billing cycle was every 30 days which actually makes a big difference because each 30 day billing cycle, you reimburse less and less under Medicare services for the care you're providing for patients.

There's changes to the LUPA episode in PDGM. The previous model had four visits or less in a 60 day period. So you would collect under CMS payment, a full episode of reimbursement as long as you did four or more visits in 60 days for a patient. Now under PGM, it ranges. It depends on which grouping model the patient is in and it's one to five visits depending on those grouping models and it's in every 30 day period. So every 30 day period, you face the possibility of having a LUPA.

And for those of you who don't know, it's basically low utilization payment. It's if you're, it's sort of like a quality standard that CMS is saying, okay, you've accepted this patient onto your services, you're going to provide them with care to enable them to recover from a procedure or some illness that they have and we're not gonna pay you the full amount for the services you're saying you're going to provide if you're not providing the care and we're saying that you have to at least see the patient between one and five times, depending on what type of patient we're speaking of in order for you to collect full payment. I wanna point out patient driven groupings model is for the first time ever the word patient is used in it. So it is specifically included in this reimbursement model and it is, you know, in its essence, as it's intended, it is not perfect and we'll debate the ethics of PDGM in some upcoming slides but it is geared towards getting better outcomes for patients and holding home health agencies

accountable for that. So how does PDGM work? This diagram here breaks down the patients driven grouping model into its different categories. The first one is admission source and timing. It's sort of two elements of PDGM that come together. Where are your patients coming from? Are they coming from a ambulatory physician referral or are they coming from a hospital or a skilled nursing facility? And what's the timing of this? Did they have a home health episode immediately prior to them coming onto services? Or did they not have a home health episode. Then it's so we have that admission source right there, timing and then the clinical grouping, what clinic, which clinical grouping is the patient from? Are they neuro rehab like a CVA or brain injury patient? Do they have advanced wound care?

Do they just need a complex nursing interventions, musculoskeletal rehab, behavioral health, all of these different categories here have different, you know, reimbursements associated with them depending on which clinical grouping model they're in. With the admission sources and what the timing of the patient is. The next one is the functional impairment level from the OASIS. Are they low functioning, low functioning, medium functioning, or high functioning.

And it's sort of counterintuitive because low means they need low services meaning that they're fairly independent, medium they might need a little bit more advanced services and high if they reach that high category that means that on the OASIS we've identified this patient as being very, you know, very dependent with ADL and IADL and functional mobility and they're gonna require a lot of services, could be social work, PT, OT, or speech and nursing as well. And then what the comorbidity adjustment is for the patient. What secondary diagnosis does the patient have that may impact their recovery on home health and the amount of time that we're gonna see them? Do they have no comorbidities, a low amount or a high amount. And all of this calculates into a home health resourcing group based upon all of these five categories and there's 432 possible case-mix associated with all of these categories, all of them having a different

reimbursement code tied to it. So this is just sort of a summary slide. These are the characteristics which we just went into, better aligns patient needs with payments with a patient needs, better ensures that clinically complex and ill patients have adequate access to home health care so you'll be reimbursed more if you're taking on more clinically complex patients, patients that are not clinically complex from a medical standpoint, I do wanna point out, you know, this is really medical model driven so you could have a patient that is clinically not clinically complex, but their social history and different you know, things that they face in their context or situation might make their situation complex but from a medical standpoint, if they're not medically complex, they're reimbursed lower.

Clinical outcomes of low have always been and will always be critically important. This will not change and this is the same under PDGM and if you are focused on quality, you could certainly have financial success under this model as well. Care must continue to be highly coordinated, interdisciplinary and meaningfully planned. Agencies are no longer incentivized for higher number of therapy visits but that does not mean that therapy is not needed 'cause if you remember going back to the clinically complex patient, you're now reimbursed higher and getting higher levels of reimbursement will cover the cost for providing those extra therapy visits so what CMS is basically saying is we're not just gonna provide you for the quantity of therapy visits, but we will reimburse you more for the quality of visits including therapy that you have to provide for patients by reimbursing you a higher amount to cover your costs for providing those services. Change from payment of 60 day episodes to a payment of 30 day periods of episodes, cert period, as I said, will stay at 60 days, but the payment model, the payment billing cycle, the first 30 days will be one period the second 30 days will be another and every 30 days, the patient moves into a different category from early to late. And when you're in the late episode, you're reimbursed less and less. This is just sort of like to summarize is that architecture we just spoke about if you could review the slides, this is just a different way of looking at it. All right, start of care, resumption

of care source, institutional, or community and we're gonna break this down. So this is going at the source of your referral coming directly at, is it a, from an acute care or post acute care? Did the patient spend time in one of these facilities in the past 14 days prior to the home health admission? If that is the case 14 days prior to your home health admission the patient was either in a hospital or in a skilled nursing facility or some other post acute care facility, that would be an early episode. And these are what's listed as the post acute care facilities, it could be a skilled nursing facility, inpatient rehabilitation facility so you're in acute inpatient rehab, a longterm acute care hospital or LTACH or an inpatient psychiatric facility also applies to this.

The patient is considered community so not institutional, they're institutional if they spent time in one of these facilities 14 days prior, I think I might've got ahead of myself and said early it would be institutional if they were in there 14 days within 14 days of your home health admission, they're considered community if the patient was, had no acute or post acute care in the 14 days prior to the home health admission. So if the patient's coming from a referral from ambulatory physician and they were not in the hospital or rehab prior to the home health admission within 14 days, that would be community.

Also, if the patient may be was in a skilled nursing facility was discharged home without home health services, spent two weeks at home, then followed it up with their PCP and the PCP said you're not quite tuned up and you're, you know, I can see you're having difficulty walking, you're reporting that you're having difficulty with bathing, dressing and taking your medications, I would like you to have home health, he or she makes the referral to home health, that would be considered a community based referral. Timing. So that's also very important, timing as I mentioned about first 30 day period of the home health admission so they didn't, let's say a patient did not have a home health episode then it would be considered early, early institutional is the category that reimburses at the highest rate. Late is all other subsequent periods so

anything after 30 days, the patient is considered late. If a patient is discharged from home health and readmitted within 60 days to home health, it is considered a late episode. So once you dis, so it's almost like you have to make a decision you know, when you, are you gonna move the patient to a second 30 day period for which you're gonna be late, can you wrap everything up during that first 30 day period, if you move them to another 30 day period and let's say you discharge them, you better, you know, you should be sure that they're not gonna come back onto your service in another 60 days because you're then you're gonna start off again with a late episode. So it really is trying to make you accountable for the care you're providing the patients and really consider your discharges and consider how the episode is set up with the amount of services patients are receiving. You don't wanna wait until day 33 to decide, you know what, this patient needs speech therapy and they needed speech therapy all along so let's put in the speech therapy referral because that's just gonna prolong the home health episode. You wanna identify early on that the patient needs speech therapy services or any other service including home health aid. So this is how we looked at it, when we first got this information we started looking at, and we did some consulting with some different home health groups that work on these types of new payment structures and we were like, model this out for us you know, what, how do we look right now? And you could see and I'm gonna go to the middle here, it's a little blurry down here in this bottom. The one that's the most meaningful is in the middle so I'm gonna get my first time to get this pointer up for some reason here we go. So you could see here that the majority of our patients were actually late community and we took this to mean that we were holding patients on service for a longer period of time I mean, we do have patients that have pretty extraordinary comorbidities, and a lot of social situations that require us to stay in for longer periods of time. Early institutional was a good amount as well a third of our, you know, 31% of our patients were in this level so we felt pretty strong going into PDGM that we had a good referral source but there's probably a lot of opportunity we had in this late community to address the needs of those patients and then take on more early institutional. So episode timing

and source key points. You wanna provide patients with intensive home health services especially at the points in time when patients are most vulnerable for adverse events, improves, this will improve clinical outcomes. So you wanna start home health services early, you wanna begin additional disciplines quickly even if therapies are not on the referral, you want that admitting nurse to identify that therapy is needed and get services delivered quickly because we wanna get patients better quicker. If the patient has any missed visits, you really wanna work with the patient to engage them around the care that they need that's ordered by their physician and if visits are missed or the patient's canceling, instead of just having them fall to the very next visit which might be the following week, we really felt strongly that it was important to reschedule those missed visits and have patients make them up during the week that they were missed so that we're not prolonging care. And we wanna ensure that patients and caregivers are involved in the development of the plan of care to reduce refusal of additional disciplines. And we coached our nurses and therapists on how we're scheduling visits with patients and how we're connecting with them. And I mean, think about this in your own practice, what type of response do you typically get from patients when you say rather would you say, would you like me to have the therapist come out? A lot of times that's sort of putting the patient on, oh, you know, that's, I don't wanna bother them, I don't wanna be a bother to anyone, you know, don't bother sending anyone out, I don't think I really need that service. We wanted to be more directive and engage the patient around what's best for them by saying something like I noticed you were unsteady on your feet and you were holding onto the couch to steady yourself. I am going to have the therapist come out to show you ways to remain safe and steady and prevent you from having falls. And that way we get more buy in from the patient accepting of therapy services. It helps with the efficiency of our scheduling process and we get patients the services they need quicker and faster. So clinical groupings. Each 30 day period will be assigned to one of 12 clinical groups based upon the primary diagnosis. And I went through some of these earlier, each one of these has a different payment associated with them. Wounds get paid pretty high, neuro rehab gets

paid pretty high, musculoskeletal rehab is a little bit in the, you know, in the the middle and behavioral health is like one of the lower ones. So just to give that perspective in terms of which grouping models are paid higher. So this slide is a little bit blurry here, but I try to point out that our visit, the grouping model that we have the most staff is musculoskeletal rehab. We do like most home health agencies have a real robust orthopedic program for joint replacements, but Penn rehab and Penn ortho does a lot with elderly patients with hip fractures and ankle fractures so there's a big orthopedic component to it and that's what this one is here. And we I'll point that out, it's this one right here this is 19% that's our musculoskeletal rehab. We also do a lot with neurological rehab as well. I'm trying to find exactly where that's at surgical, cardiac, endocrine, GI. I thought it was around like 13% I'm trying to find it, but that just gives a percentage of our breakdown let's move on in terms of what our grouping models are. So comorbidity adjustment. As I mentioned, it's no comorbidity, low or high comorbidity. Traditionally home health agencies did not do spend a lot of time focusing on making sure that we had the correct amount of comorbidities in the chart 'cause we just weren't reimbursed for it. And you could see here in this slide here, this is our benchmarking here. You could see that most of our patients fell into the no comorbidity adjustment pre PDGM because we just weren't coding so because we weren't reimbursed for it we didn't spend a lot of resources in doing that so there was ample opportunity around getting our comorbidities in there. And this is our benchmarking from national and state averages. No comorbidities for Penn was 55%, national was 56 and the state was 54 so we were right on par with what other home health agencies were doing across the country and in the state. This is where we really saw ample opportunity for addressing patients' needs under PDGM. Our functional levels patients I gotta tell you, when we look at our clinical outcomes in terms of readmissions, we track TUG scores, timed up and go scores in terms of falls risk both at admission and discharge, we use the activity measure for post acute care in many of our protocols and look at functioning across from the beginning of their home health episode to the discharge and patients improve on our services functionally. However, we traditionally

did, I'll just say it a very poor job of making sure that we had accurate OASIS assessments and the literature shows that, you know, the validity and the utility and validity in using the OASIS, even from a multidisciplinary perspective inclusive of therapists, therapists were no better at doing OASIS functional assessments than nursing was. The OASIS, I don't know how it was designed but it's confusing, it really is. So we saw and this is reflective also in our five-star care measures, we had great patient feedback in our five star care measures on home health compare, but our functional levels made it look like patients were not improving even though we knew they were from other evidence it's just that the OASIS wasn't showing those improvement levels. We had found that in most cases you would read through the narrative which would describe a patient who is very medically complex, has multiple functional impairments and inability for mobility, ADL, IADL, transfers, bathing, dressing, all of those items on the OASIS but then when you looked at the scores, it sort of painted this picture on the OASIS like the patient was pretty much independent and then at discharge, the patient would come off services and there would be nowhere to go because they would either stay the same, which in measuring quality on OASIS is just as bad as the patient declining. So if you rank the patient as being a one and a one, meaning that they stayed the same from admission to discharge, that's just as bad as the patient declining or there was no room for them to get better because we rated them as independent at admission and now they're independent, or if it was more accurate at discharge and maybe we were saying, oh, they need a little bit of assistance so we're gonna score them as a one, it makes it look like they got worse and that was reflected in our scores. And I'll show you just how poorly we were and we saw this as really this was the gold nugget and for us in addressing PDGM along with providing more comprehensive, interdisciplinary care and, you know, keeping up with the coding correctly. So here's our functional level benchmarks. You could see the state averages over here, national is in the middle and we as Penn university of Pennsylvania here is on the left. Again, keeping in mind that high, the high level means that the patient is very impaired. These are patients who require a lot of services

because they're mostly deep ended. If you're in that high functional category in terms of PDGM, that means you have low functioning, you need high amounts of service as you fall into that. We were 17.18% of our patients were falling into the high functional category when nationally 32.3% of patients fell in there and at the state level, state of Pennsylvania, 33.3% fell into that category. So we were vastly under the national and state benchmarks. And I gotta tell you, the university of Pennsylvania, we really have some complex patients. I mean patients across the state and across the country seek out the services at this health system because it is so comprehensive in terms of like organ transplants and, you know, they are, a lot of our service lines are just ranked very highly, we attract a lot of, you know, a lot of talent, talented physicians, nurses, and therapists in our service line so we were like there was no way that our patients are any more healthy upon admission than national and state averages so we're obviously doing something wrong and we know from other evidence qualitative and quantitative that patients are fairly impaired when they come on our services. So I'm gonna, we'll come back to that in some upcoming slides, but I wanna talk about the low utilization payment. So remember I said that there's a separate threshold for low utilization payment adjustment, the LUPA adjustment. I just wanna put this into perspective that if you have a LUPA with a patient and I am not saying if you have a patient or you take on a services and all of a sudden they are so much better within two to three days and they're no longer home bound and they no longer require home health services and you only provided one to two visits, it is the ethical and right thing to do to discharge the patient. If you have to have a LUPA, we, I am not saying to avoid LUPA, you have to do that I mean, it's the right thing to do by the patient, but you're facing it twice now during a 60 day episode of care, the previous payment model was a 60 day certification episode period and you would only have to reach four visits to get the full utilization payment. If you have a LUPA of payment, it is substantially less but you only provided so many visits so the cost of providing those visits is, you know, one to two visits, you shouldn't be paid extra above and beyond for taking a patient under your agency if you only saw them a few times. So LUPA payment, it makes absolute sense,

but you face it twice now under PDGM. So as a patient's at day 29 moving on to date 30, you should review the patient's case and make sure that, you know, is there anything we could do to wrap this up during this first billing cycle because if you do go into another 30 day period, and we're only planning to do one more visit in that second 30 day period because we just have to do some more teaching or just do have like a family education day, we should do that prior to the 30 days expiring because otherwise you're, you know, you're just taking a low payment for providing that one visit or if it's two visits, you know, you might take a financial loss. CMS is saying to us, we want you to be efficient and really review the care you're providing for the patient and make sure there is value associated with those visits. Don't just do the visit to do the visit make sure that each visit holds value for the patient. And again, those thresholds for LUPA depend you know, it goes from one to five, depending on any number of the different scenarios and case mixes that patients could fall into fall into under this payment model. So some key points, what we looked at this, we just went back to what's best practice. What's best for the patient that will help us avoid unnecessary LUPAs. You're gonna have a certain percent where, hey, you know, you assessed the patient on a Saturday, they seemed like they really required a lot of care, they were really impaired and then by Tuesday, you know, they really turned around, they're looking a lot better and maybe they don't need the care that we, you know, we initially thought we were gonna provide and if it turns out to be a LUPA then we have to accept that but we wanna make it that we're not unnecessarily providing LUPAs for patients that require our services, we wanna make sure that we're doing our part to make sure the patients recover at home, that they were, they resume a healthy lifestyle as much as we possibly can, they don't have any negative outcomes, you know, recovering at home like a re-hospitalization or a flare up of whatever, you know, illness, you know, they've had or infection after a procedure or something like that. So front-loading visits, best practice shows that, you know, used by 64% of home health agencies that were the most successful at reducing hospitalizations. So front-loading your visits and making sure that patients get more care during the beginning part of

their episode and maybe trailing off that care towards the end of their episode is the right way to go. You wanna utilize your resources towards the level of care where patients are the most vulnerable when they first come onto your services and that's inclusive of therapy as well as nursing. It should be coordinated across all disciplines to ensure the most patient centered and efficient care delivery provided. So if the patient has difficulty with, you know, aspects of ADLs you should have that occupational go out there with their occupational therapist, go out and assess and treat the patient with their expertise in making sure that the patient is participating in their morning ADLs that's not just inclusive of bathing and dressing, but also, you know, healthy meal preparation, you know, cooking breakfast and lunch and dinner by adhering to the diet that's prescribed by the physician, that they're taking their medications as prescribed as part of a healthy ADL routine for the patient because OTs have knowledge around sort of organizing your life around these types of things and they should be included in those care plans so that the behavior change comes out of this and patients are adapting to a healthy lifestyle that will manage their health at home and they'll be independent with that and be less likely to have to seek out emergency room services or, you know, worst case scenario and back up in the hospital for an unplanned readmission. I spoke about rescheduling missed visits. If a patient missed a visit, misses a visit, we changed our operations, we were in the midst of doing this but we really focused on changing our operations to follow up with patients. We even implemented a system where patients can confirm or cancel their home health visits electronically. They get a text or a phone call, it defaults to texting as long as it's a mobile number where patients will then be able to respond yes to confirm, two to cancel and any patient who cancels they receive a phone call from our schedulers to try to reschedule that visit because maybe it's just the timing of the visit, maybe they're canceling it because they can no longer do the visit in the morning when it was originally scheduled for but is there any way, anything we could do to try to reschedule that for the afternoon so the patient doesn't miss their visit. That was one thing we did to address the missed visits. Again, we wanted to focus on decreasing refusal of care.

We wanted to build patient engagement and ensure that they understand that the services we're providing are they're physician ordered and it's designed to help them recover, it's for their benefit, they're entitled to this and we want them to be involved in this because we want them to be successful at home and try to make things better for them and help them recover from their medical, from whatever they're facing from a medical standpoint and from a social standpoint. So PDGM summary, it presents the opportunity to better match the patient's acuity, physical status, ability to safely interact with the environment and perform daily activities with payment. No longer is payment on a one size fits all approach. It's sort of designed to provide more services for patients who are more sick and more acutely ill. Interdisciplinary and well coordinated care ensures the most efficient care delivery and best patient outcomes under PDGM. Strong case management is essential and care planning must be informed by an accurate functional assessment. Function is very much at the center of PDGM and should be considered and patients engagement in ADL and IADL activities is, you know, a measurement of a patient's health status and therapy services always obviously play a very large role in that. Okay so I'm gonna move on to our response for PDGM. I just wanna take a moment, I don't see any questions in the box, but if anybody has any questions or comments, I can take some time to address it. It was a lot of information to go over and I thank you for sort of hanging in there with me as we went through that. Okay. I don't see anybody typing anything again, if you do, I will address it. So we will move on from here. So I went through our functional benchmarks I just wanted to come back to this slide because again, this really drove our response. You could see that 55% of our patients fell into that low functional level compared to national and state averages. So we were assessing our patients as being fairly independent upon coming to our services which, you know, I can attest to they were not. So function. Do we assess any significant patient data point by self report only? And that's a question to all of you I mean, that's just no like do we say to patients unless we're trying to work on having a patient monitor their own blood pressure level and we've sufficiently taught them how to do this and worked with them on

incorporating this into their ADL routine or I'm saying ADL routine 'cause it could be considered an ADL and we know we've observed them as being independent with doing this, would we ever under normal circumstances say to a patient, how is your blood pressure today? Especially after first meeting them? Well we would not do that. We would not say to them, hey, has your wound gotten any larger over the past week? We would assess them. We would physically look at it. We would take their blood pressure and we would, you know, inspect their wound. And would we, same thing with temperature, would we ever say, can you tell me your exact body temperature today? Unless you know, we've taught and worked with the patient and we are sure that they are absolutely independent with that, do not need any verbal cuing or assistance needed to perform those tasks, we wouldn't do that. So why would we assess function in the same fashion? So just think about that for a second. I'm gonna address a question from Janie Hopkins, she's writing, would you please do a quick review of the community institutional early, late? Yes, I can certainly do that. So this is slide 37 I'm gonna go back a little bit, 'cause it is a little confusing and I'll need my slides to sort of cue me on that. All right so there it was right there. Okay so community institution. All right. So community would be if the patient had not spent time in an acute care hospital or a rehab facility or a psychiatric unit within the last 14 days prior to your admission to home health. So if the patient has spent time, I'm sorry institutional would be that if the patient spent time in any of those facilities, it would be considered institutional in acute or post acute care in the last 14 days, that's considered institutional. If you admit the patient on, let's say they did spend time in a hospital, you're getting the referral source from the hospital and for some reason the referral came in late and you end up seeing the patient on day 15 after they were discharged from the hospital, that would be considered community. So there's two sources. Institutional, community, community would be day 15 or beyond after spending time in an acute care or acute rehab or psychiatric facility or a skilled nursing facility. If they never spent time in there, it would always be community. But if you're within 14 days of it, then it would be institutional. I think that should answer it. Let me

just catch up to myself on slide 37. We got time here so we should be okay. And this really is delayed so I'm advancing beyond where I was. Sorry about that. All right so again, getting back to function. Do we ever measure function by asking patients how, you know, they're performing, bathing or dressing? So what does the literature say on assessing function? The literature says, if you look at Don Brown and McGuigan, it's impossible to examine a person's functional abilities outside of the context in which they are living their lives, how they're living their lives in their home provides us the best opportunity to address a patient's level of function. And you cannot assess function, functional performance that is abstracted from the context of actually performing the activity. There are patient reported outcome measures that I do think add to the impact, the activity of measure for post acute care, the short forms used in outpatient are one that is, has been shown to be valid in assessing function. And I think the patient's own assessment or met, which we'll get into metacognition awareness of their own function is important and it's an important data point to go off of, but to exclusively measure function abstracted and removed from actually performing the activity we shouldn't do that, especially in home health. Home health is the only patient care setting which has the opportunity to examine the patient within the context with which they are living their lives and I don't just mean the physical context I'm not just talking about the steep staircase or the narrow hallways or the clutter or the throw rugs for which are all around our patients, I'm talking about the distractions, the phone ringing, the TV on in the background, the pets, the, even the relationships they have with family members and caregivers, you know, if they're, you know, they don't have a good relationship, maybe they it's contagious or I'm sorry, confrontational or sort of like a, you know, relationship they have with the person who's caring for them, it's not a good relationship between them and their spouse, that's going to affect their function. They could be distracted by that. They could be depressed by that. That's obviously going to decrease their ability to perform functional tasks within the context of their home health setting and that needs to be considered. All of that does, and home health nurses and therapists have the opportunity and obligation to accurately assess

function. What we were finding, I'm not suggesting you all are doing that, but even in, you know, which, you know, I think we're, I think we do a good job at Penn medicine but what we were finding is that in some cases upon admission, we were because of the volume that we were up against, nurses and therapists were not fully having the patient participate in an activity to measure their function. It was more of an interview type of question. So how are you doing? Are you getting yourself dressed? And the patient would say yes, but they haven't gotten themselves dressed in, you know, maybe six months or maybe they are getting themselves dressed but they're probably performing like 25% of that activity and they're getting, you know, 75% help from their son or daughter who comes over who you haven't even met yet and there you are grading the patient as independent based upon their own assessment or the patient doesn't believe they're fully independent they're just leaving out the fact that they're receiving help. All right. So what we wanted to do then is we developed an OASIS Mentoring Program, that's what we called it. And the goal of this program was to enhance functional assessments so that appropriate care plans can be established to return patients to the highest functional level possible. We wanted to get reengaged and it seems sort of strange when you're talking about physical, occupational and speech therapist it's like, well, of course we're focused on function but we really had to do a step back and think, are we coordinating care effectively around function? Are we really taking the patient's actual performance of these day to day activities into account when we're working with patients? You don't want a one off sort of like one session with an occupational therapist with maximum amounts of queuing and set up and, you know, under the most ideal of situations, they could work with a patient and get them through a certain level of independence with bathing and dressing, was the patient able to replicate that when we're no longer there, because often you'll see that with PTs and OTs, they'll say, oh, the patient was independent last time I was there with bathing and dressing, but not really taking responsibility, or I should say selling yourself short as a therapist by inaccurately grading the patient as independent and not taking fully into account that because you were there and with your advanced knowledge of

activity analysis, set the patient up for full success by having things within easy reach, by making sure that, you know, the throw rugs were removed or queuing the patient to properly reach for a grab bar or performing a shower chair transfer using the right technique for the patient given the physical constraints of that environment that the patient's in. We often do that and we set patients up for full success, meaning that they'll be independent and then we mark them on our assessment oh, they were independent, but they are not independent. They can't replicate that without us doing that and then we move on to the next patient and in some cases, discharge the patient possibly discharge the patient way too early and they don't incorporate that. They do not incorporate that in change behavior and incorporate that those activities into their routine at an independent level and then they're no longer independent. So we wanted to reengage our interdisciplinary staff around grooming, upper body dressing, lower body dressing, bathing, toileting, transferring, ambulating and ambulation locomotion and risk for hospitalization, the M question because these are the questions that drive quality outcomes under PDGM and just so happened to be associated with reimbursement. You know, we wanted to make sure we're not like out to you know, we just wanna make sure that we're being reimbursed adequately for the services that we're providing for patients, but more, most importantly, making sure that patients recover and have good outcomes under our service. So this was the design of our mentoring program. The mentors, so we took a certain number of staff some of them were nurses and some of them were therapists and they provided real time in home individualized shoulder to shoulder feedback and support with other clinicians as they're performing OASIS assessments looking at accurate for accuracy and excellence. We put these OASIS mentors through an advanced training program. We used some consultants to provide some of the education and we provided some in-home, we made use of our own educators, I took part in it, my colleague and co-director took part in it and we really worked with the staff and we showed them those data points that I just showed you all. We showed them that on paper, we appear that our patients are getting worse under our services functionally because of our

OASIS outcomes and we also look as though patients are coming on to our services at an independent state and we know that's not true. And we had some nurses and therapists give some, you know, stories and some narratives to support that talking about the patients that they last saw. We really had to take a hard look at this as an agency and sort of say, we're not doing too well with this you know, we think of ourselves as being so, you know, doing a great job and you know, we do, we're on other areas we're getting great outcomes but in terms of our OASIS outcomes, we're not very good at all and we had to look at it as an agency. So we put them through an advanced training and what we did was we lined up, sometimes in this program, we would line up a nurse with a therapist or a therapist with a nurse, we took discipline out of the context so you might have a nurse who was scheduled, a field nurse, a regular nurse who's not considered a mentor who didn't go part of the program and she would be, he or she would be scheduled to do two starts of care in the same day. That was all we were scheduling them for, for the purposes of this program, we would have one mentor who went through the advanced training go out with that nurse and he or she may be a nurse or a therapist who's the mentor and they would go out and they would demonstrate on the first start of care, even though the nurse would be taking credit for completing the visit. Let's say it's a therapist who went out with the nurse, they would demonstrate what we were calling a quote unquote, functional walk. We would engage the patient in things like toilet transfers, shower transfers, actually getting, making sure on that visit if we were gonna mark, we were gonna score them on that OASIS and we were saying how they were doing with bathing, we wanted to make sure if the patient was supposed to be getting into the bathtub or into the shower to bath and that was gonna factor into our scoring on bathing. Could the patient get in and out of that shower or bathtub and if it was deemed unsafe and they couldn't do it, then you had to mark the appropriate OASIS score which I believe is a three as like sort of that threshold. And you would mark them lower because what we would find is patients would say, yeah, I bathed myself and they might be bathing themselves at the sink but they're not, it's not considered fully like at the highest score on the OASIS. If the

patient's not getting into the shower, they're scored at a different level so we needed to capture that accurately. So that's just an example and then at the next visit, so they would do that first where the nurse or therapist who was the mentor would demonstrate how to do the functional walk with the patient and score the patient accurately then the nurse or therapist who was the field staff would score the patient on a separate sheet of paper and then they would talk afterwards and compare their scores. In many cases on that first visit, there wasn't a lot of agreement. You would find that the mentor was scoring the patient at a lower level than the mentee. They would discuss it, the mentor would talk with them about why they scored the patient lower and they would get, you know, look at what the differences were in their assessments. Then they would go on to the next start of care. At the next start of care the mentee took the lead. He or she would then do the functional walk with the patient and the mentor would score the patient separately and the mentee would score the patient and then afterwards they would compare their scores. And what we were looking for to pass this competency was that on that second visit, that there was inter-rater agreement between the mentor and the mentee of at least 80% on those M questions that I showed you earlier, you know, those, these questions right here, these ones in that blue box there like the M1800 through really pretty much the M1860, what was the percent agreement between the mentor and the mentee, we were looking for 80% of nurses and therapists to get that agreement with the mentor. And if they did, then they passed the competency for those who did not pass the competency, we gave them extra education and then they had to go through the process again. We really, during late December, around Christmas time and January and February really focused a lot of attention on this. It was, it came at a cost because we were basically taking two clinicians pretty much out of our scheduling ranks for that day because we were only assigning them two visits. It was just those two admissions and it was meant for them to take their time with it, to discuss it, talk about what they saw and you know, to impart this knowledge that the mentors had onto their mentees. I gotta tell you that we got a lot of positive feedback, from both parties, the mentees, the ones who were in

part of the mentor program said this was really eye opening and I did not realize that I was, you know, that I was doing this, I didn't realize I was so off on my assessments. So they, you know, they, you know, really saw value and the mentors saw a lot of value in it as well. They really liked connecting with their colleagues and really enjoyed getting out there to impart this knowledge that they've, this advanced knowledge that they have with with their colleagues so it really worked out well. And these were the results soon after, I mean well this is actually going back I took, we had good results right away, but it was a little skewed because under PDGM, remember everybody went initially right into that early episode because it was a new payment model so you actually caught a little bit of a bump in your either community early or institutional early patients because they were all new to the PGDM so it was a little bit skewed and plus then the pandemic started and that was a whole other thing with virtual visits that sort of skewed this information, but you could see the results that we were getting here, that lighter red not like that, not that crimson red or that like sort of like along the lines of it's not quite burgundy but there's a darker red and a lighter red, you could, that's the high functional impairments and you could see that. Remember we were at like, let me get my pointer here. We were at initially at benchmark before PDGM started Penn Medicine At Home was around like 17% at that high functional impairment level so I'm just gonna draw my line across. This is going across different time periods within July so very recent data just last month. So if I come across here with this pointer, that was the cutoff point as to where we were, you could see a large percent of our patients getting up towards 30% in many cases and in many cases over 30% were at that high functional level which is at pretty much just so happens to be at benchmark, you know, right around state national benchmark so that's pretty much what other home health agencies were getting on average. And remember there's gonna be on average, we were included in that average, you're gonna have some agencies that did this well and then some agencies that didn't do this well like us so that average sort of like levels off but we improved our average. We got more patients in that high functional impairment which is what we would have expected for the acuity of patients coming to our home

health services. So we felt that this program was very beneficial and just to sort of summarize it, I think even as therapists, we really have to keep in mind not only with just OASIS outcomes but just as you're doing your assessments with any single patient, like really take credit for everything you're doing with your patients, you know, the amount of queuing, the amount of setup, even if it's just a gestural cue for the patient to remember you know, use your walker in the correct way, don't get too far away from it, pay attention to, you know, that obstacle coming up where there's a toy on the ground or you know, your dog is now, you know, out, what do you do when your dog is running up to greet you and you're walking and you're unsteady? Like those types of things that we give education to patients, we have to make sure that they're not just hearing what we're telling us, but there's an actual behavior change and that they're utilizing the strategies that we worked on with them in real time, in their real life, in the context of their homes when we're with them and when we're not with them and the best way to tell that is, are, do we have to cue them? Do we have to point these things out to them? If there's a specific strategy for even bed mobility like where you want the patient to roll to their side, bring their legs over and then sit up, are they doing that when you're there or do you have to cue them through those steps? Because if you do have to cue them, remember they're not independent. I do have a question question here, asks is PDGM really working? I have seen a significant impact on therapists, pre COVID being furloughed, reduced hours, I have seen the home health companies reducing visits to patients regardless of patient's need to balance financial losses. Yes, Mark, you are absolutely right about that. And I think what happened is I think I neglected to say is there were unfortunately some home health agencies that budgeted when they were talking about looking at their finances, they would budget that they would receive a certain amount of payment for extra therapy visits and unfortunately they chased those thresholds and it's the wrong thing to do. Like they really should not have been doing that and they relied on that and yeah and then when PDGM came, they weren't set up to utilize the program as it was meant to be and they ended up just going to furloughing therapists. And I also think there might've been a

certain level of misinformation there being presumptive about it, you have to remember that, you know, as therapists and I'm really stating this to all of you like we really have to be leaders in healthcare and we're gonna get into a little bit about the ethics around PDGM. It might come off, I do not want anyone to misperceive me as saying like, PDGM is great or I completely agree with it or this is like some sort of advertisement for PDGM, I'm just saying this is what we did and how we addressed it and this is, you know, the success that we had in working within the constraints of PDGM. But and I will say like, you know, we've had issues too like it isn't all, you know, bright and shiny on the, on, at my agency side I mean, we've, there's some things going on that we're trying to diagnose from a financial standpoint why we're not quite meeting budget now when in years past we were, I don't think it's just because of the therapy thresholds I really don't. I think there's some other things embedded in here that we need to look at as an agency but we need to be leaders in healthcare, we need to take on positions where we are on boards not just that like discipline specific like AOTA, APTA, we have to be involved in legislation, we have to take on jobs and really stretch our assignments so that we are directors and not just like directors of therapy departments and managing directors, but really take on positions where we're managing systems in health systems. And a lot of these positions end up going to business people or, you know, nursing and I think that with our advanced education, I think we need to get degrees like MBAs and other things that allow us to take on these more leadership type positions so that our voice is heard and we're considering this especially as these new payment models come out. And we'll get into the ethics around PDGM, that's an excellent transition. All right so ethics of PDGM. So post acute care recovery from an illness or a procedure can cause occupational disruption. Occupational disruption and I'm speaking like don't like interpret just because I'm saying using the term occupational that this is geared towards occupational therapy, occupational disruption, occupational justice, which I'll talk about is a term we all can use as you know, nurses, therapists, you know, business people, we all face it. We all, I mean, even during the pandemic when you're talking about occupational justice, I for one was over employed

when you're talking about from an employment standpoint and I'll talk about this in a few more slides. You know, I ended up being over employed, meaning from the standpoint that we were pretty much working like what felt like 24/7, it was seven days a week. We were doing this sometimes 12 hours a day and then even answering texts and emails later at night and even having phone calls into the evening when unfortunately in other areas of the economy, people in the service industry, like bartenders, waitresses, waiters, you know, even some construction workers, things like that, where they were laid off. There were therapists that were laid off, not in my agency because we were still utilizing them but you know, people then were underemployed and I'm talking about occupational, like part of occupational justice, which I'll talk about is the ability to engage in activities that are mentally stimulating and that you want to engage in that has meaning in your life and it's seen as positive. Well, our jobs, like I'm an occupational therapist, I'm a director at a home health agency and yes, I do get pleasure out of doing that and that is stimulating to me, but you know, eight, nine, 10 hours a day, okay you know, five days a week, I wanna do that but when you're talking about seven days a week, 12 hours a day, no, that was an imbalance in my life I had no time for my own personal life, I had no time to recharge and that had its effect on me so when I'm saying over employed, I don't mean from a standpoint of salary because well, you know, it's, you're, when you're salaried you're not obviously paid more but I'm just talking about from a work life balance that was over employment for me. So patients as they're recovering from an illness or a procedure, they face occupational disruption. They're not able to engage always in activities that are meaningful to them. If you have a knee replacement surgery and you are a tennis player or a golfer, you're not gonna be able to do that for a period of time obviously you have to get back to that, you have to work towards getting that and but, you know even you know that going into the surgery, there could be periods of time where you have pain and you know, that's depressing to you and that just exasperates your pain and that exasperates the effects of the surgery and it could impact other level areas of your life, you facing that occupational disruption, not having that outlet, you know, to

engage in tennis or golfing, or you know, even just get yourself bathed and dressed on your own in an adequate amount of time without taking extra time to do those things, it could affect your relationship with your spouse or your friends so but it's usually temporary and it's transient, it's a temporary or transient reduction in the engagement of occupations so occupational disruption is one thing usually happens when you're recovering from an illness or an injury. And PDGM does provide resources to address impairments in day to day activity resulting from an illness or procedure. And I really wanna point out the term, the words, illness, or procedure. So most of our patients when they have a procedure at the hospital, they face occupational disruption. Under PDGM it assumes that if you provide nursing, PT, OT, or speech therapy services, home health aid, social workers, that patients will improve, it has so you could say it has some ethical value from that standpoint, but again, it's transient, it's only looking at the medical model of things. How many of our patients face other like there's bias or injustice or, you know, even just in these times right now when we're looking at you know, those types of things like, you know, political bias or financial, economic bias, bias, you know, being in a situation where, you know, you're from a socioeconomic standpoint you grew up in an area and in a household where you did not have opportunities that other people had, couldn't go to college or if you went to college, you could only afford, you know, a two year degree versus a four year degree, you know, going on to be getting a masters, a doctorate in physical or occupational therapy that takes a lot of time, it takes a lot of, you know, financial resources and not everybody's afforded those opportunities to do what we're able to do. And but when you're in those so low socioeconomic status and it could affect your health as well because you don't have knowledge, you don't have time, you're taking on jobs that don't have access to health care, when we live in this world where your job is tied to the health care that you're receiving and you have a waitressing job and yeah, you could pay your rent with it, you could pay your car payment, you can go on vacation but they're not providing you health benefits and those health benefits are expensive to pay for on your own, you're not following up with your PCP and all of a sudden what

one thing, one health issue that, you know, could have been taken care of with one PCP visit, a blood test, and then maybe some medication or some therapy takes care of something or change in lifestyle that you need to be aware of that you need to change you don't do and then all of a sudden what starts off as a minimal health issue becomes a major health issue and then it requires even more services then you can't work, then you don't even have the money to pay for the health insurance that you might've been able to get then, you know, it just exasperates itself and our patients often face that and that's part of the reason why they require home health services and to truly fix the structural institutional issues that patients face, which is leading to poor health it's more than just recovering from transient or a, you know, a temporary reduction in function. It's more than just recovering from a hip or knee replacement. Patients who have diabetes or heart failure or like they didn't just get there overnight, it took years for them to develop that disease and for us to address their function from a standpoint of taking on some exercises or using some strategies to help them with basic ATLs, that's not enough we need more time with patients to truly, to truly address the issues that they have. So from that standpoint, you know, we shouldn't just consider ourselves as therapists to be so aligned with the medical model. The medical model is one way of looking at patient care, there are so many other models that relate to health and wellbeing and quality of life that are more socially and institutional and structural in society that we need to be involved with as physical and occupational therapists. So I mean that's part of, you know, the ethics around PDGM that I don't agree with at all like it's just medical model driven. So let's look at it from a utilitarian perspective. Utilitarianism was developed by Jeremy Bentham. It's an old model, actually I don't even know when it dates back to, I should have put that on there, this is taken from a 1957 resource so you can tell it's at least, you know, that old, it focuses on actions that maximize utility. So it's looking at decision making and the effects of that decision, does it maximize utility for everyone affected by that decision. And utility is defined as happiness, pleasure and wellbeing. It's meant to minimize pain and misfortune. And the decision that's made when you're looking at how we're measuring

happiness, pleasure and wellbeing and minimizing misfortune, it's really that how does it affect humans, animals, everyone affected by the decision. So PDGM from a utilitarian perspective. As therapists, we want to improve health and function for all patients. We want to maximize beneficence and that's actually in, I know it's in PT, I think it's, yeah, I know it's in OT as well in our code of ethics. If you look that up, beneficence is actually called out there. We wanna maximize beneficence and we want to minimize maleficence. So maleficence is minimizing harm to our patients. We want fairness. So from a utilitarian perspective, is PDGM, does it maximize health and wellbeing for all patients? Does it maximize beneficence? Does PDGM minimize maleficence? Was PDGM designed and implemented fairly? You know, those are questions which I think, you know, the last question sort of, you know, got to and I would say that, you know, going back to this, going along the lines of it being so aligned with the medical model, being transient, short term duration home health services, there's a restriction there and you know, there's a financial component to it that where you have home health agencies then as a result of PDGM, you know, as the other person pointed out furloughing and laying off therapists, reducing access to therapy services and even if it's not PDGM is set up, even if home health agencies like mine, we didn't lay off therapists, it's almost like finite, there's a finite amount that we can do. Now I'm not saying that we have the capacity even within my agency to address all of the issues for which patients fall into a state of, you know, poor health but we certainly, it puts us at a disadvantage of addressing any issues outside of the medical issues patients are facing when you're locked into these 30 day periods, it's gonna take longer, you know, we need more access to social work, more access to community services, more money for community services to address things like food insecurity, financial resources and issues, food deserts that patients have so that they have access to better food and they're not just ordering out, you know, Chinese food and having high sodium intake when, you know, a patient has heart failure but they live in an area where they just don't have access to fresh food so what else are they going to do? And to adequately address that from a PT, OT, social work, nursing perspective,

we need more time with patients, we need more resources and PDGM doesn't offer that. All right, ethics from an occupational justice perspective. So I talked about occupational justice before. That's your perspective on your ability to engage in activities that you find mentally stimulating, physically stimulating, provide value to your life and it really it's a balance because there might be activities like I pointed out like our jobs where yeah we find them stimulating where you're all here on a, you know, a Friday afternoon, you know, listening to my lecture on this so obviously you're dedicated to your, to your career choice as being a physical therapist and me as an occupational therapist but do we wanna do that 24/7? No, we have other activities we wanna engage in where, you know, we have relationships with other people, we have friends, we have family, we have loved ones, we have other activities we like to engage in, we like to, you know, exercise, go to the gym, we like to go to shopping, we like to try out new restaurants, unfortunately the times we're living in is really restricting us from being able to do those things so you face occupational apartheid. Occupational apartheid is a type of occupational injustice where some individuals are afforded opportunities to participate in occupation but others are restricted from these opportunities based on race, disability, gender, age, nationality and social status. And I do wanna point out that occupational apartheid is not short term in duration and it's not by choice like for example someone who lives in Miami or someone who lives in I don't know if there's skiing in Mexico or something like that, but I'm trying to picture someplace really hot where you might live and there isn't skiing readily available but you want to participate in skiing but you choose to live there, that's by choice. You know you could travel to a place to learn how to ski or you can move and live in a place where skiing is more relevant and there's more access to it, but that's not occupational apartheid it's more at the structural level. You don't have a choice in this you're really disadvantaged because of those items that I just went over, race, disability, things like that, it restricts home health services. PDGM does restrict home health services when you think about this. PDGM restricts home health services based on socioeconomic status, their ability to pay, you would have had to pay into Medicare

and be eligible for Medicare, you have to be 65 years of age so it discriminates based on age and disability can have functional impairments without an acute medical condition. PDGM requires the patient to have a medical condition for which patients are required you know, that a physician signs off on as being medically necessary for patients to receive physical and occupational therapy services. But some patients might not have a disability that's related to a medical condition you know they, maybe they, they have adequate strength, but it's not to their, to their liking and they want to engage in more exercises so they could take on other activities or maybe they have a developmental delay and otherwise they're healthy, but they're still not participating to their highest level of functioning, maybe there's cognitive deficits that were there upon birth and they need more access, more assistance, more community resources, more access to OT or speech or in physical therapy to address some of their needs but they don't have an acute medical condition and maybe they can't travel to an outpatient clinic but they're restricted from home health services 'cause they're not necessarily home bound but they can't drive themselves. So it does restrict home health services PDGM defines function in terms of ADL and IADL status. We went through those M questions. What does it look at? Those M questions that we focused our mentoring program on, they were focused on completion of bathing and dressing, just basic transfers, locomotion and ambulation, those are the types of things that the OASIS measures in terms of function so it defines function. But do you think that our patients wanna be relegated to a life where the only thing they have to look forward to is to get themselves washed and dressed and be able to walk around their house? I mean, no, like who wants to, I certainly don't wanna like that's not all I look forward to when I wake up on a day to day basis, like we wanna be able to socialize with others, we wanna be able to get out into the community, we wanna be able to go to a restaurant, we wanna be able to go golfing. I wanna be able to go to back to my gym of course I can't at this point because I think it's unsafe but that's what, you know, our, even our patients, even our elderly patients, they that's what they wanna do they wanna feel like they're, you know, they're part of something, they're part of society and we should look

at like, so what about social functioning? Like that's not included in there. That's, you know, one of the main things that our patients wanna, elderly patients wanna feel like they're a part of but it's so commonly unaddressed even in occupational and physical therapy. As an occupational therapist, we're supposed to be looking at leisure and socialization as part of function in a holistic fashion. But what do we focus on? When do we get called into cases? When patients can't bathe and dress themselves and you know, I think that's important but we need to take it further and there's a lot of cognitive functioning that comes along with that. And when I'm saying cognitive function, I'm talking about the motor component of it as well because think about it when you're mobilizing yourself in community mobility, there's a lot of planning that goes into that, how are you gonna get from point A to point B, how are you gonna navigate a subway system, other public transportation, driving yourself, but that's not covered under PDGM. So it does restrict, it provides, you know there's a certain level of occupational injustice associated with PDGM that makes it not, you know, not ethical I think. So we can debate that all day long and talk about that, I'm gonna a pause there. Does anybody have anything else to add to that before we go into the last, like probably 25 minutes of our presentation here, I'll tell you a little bit in the upcoming slides about a program we implemented post PDGM that's working for us. Still I wish I had some financial data on the program to share with you as well 'cause I do think that's important and I don't, however I could go over into clinical data with you for our CVA Home Recovery Program. If anybody has a question, you can type it in here. I am going to just pause myself, okay. So CVA recovery home recovery program, we are currently in the process of working with one of our large downtown hospitals on a recovery program for patients who have mild stroke or brain injury. And the program came up because we had found as a health system, we were sending more and more of our patients to inpatient rehab after having a stroke. We actually got low scores for this on US News and World Report, which affected our neuroscience neurology service line ratings. So we're trying to, you know, identify some sort of like low hanging fruit, some patients who are mild in nature who would have otherwise, meaning mild

impairments, who would have otherwise gone to inpatient rehab but instead having them sent to home health. One of the concerns was the amount of therapy services that they would receive under home health, there was a lot of misperceptions, oh under home health they only get seen two times a week. That's not true. We could see patients up to daily. Oh under home health it takes a while to get PT and OT in there, there are staffing constraint because of the referral volume and the staffing that they have. I'm not saying like most home health agencies, we don't, aren't staffing constrained and currently, you know, during this pandemic, our referral volume is high and it's hard to address it but we can get patients into this program. So starting in the end of June going to through July, we enrolled 13 patients into this program and it was really geared towards the protocol pretty much was five straight days of physical and occupational therapy including weekends and it would also be a 24 hour start time, 24 hour response from, to home health admission from hospital discharge. So we put 13 patients into the program, actually two patients despite our best efforts declined the program even though originally agreeing to go into it so ended up only having 11 patients in there. For home health admission within 24 hours, 85% of the patients were seen within 24 hours for a home health admission by either the nurse or physical therapist. The two outliers who weren't seen within 24 hours were not the two patients who declined services, they were two patients who initially declined the initial visit by the nurse and the physical therapist but then were subsequently seen the next day by either one of those disciplines for home health admission, they just wouldn't take us within 24 hours. So if you took out those two outliers, all, there were nine patients that were seen within 24 hours. And the great thing because of the pandemic which I think is completely appropriate, is that a physical or an occupational therapist to do a home health admission regardless of nursing is on the referral CMS lifted those guidelines and we've taken advantage of that. Currently most of the patients were admitted by a physical therapist, although I would really love to have an OT do the admission for some of these patients, it just would require us to do a little bit more like just, you know, education with the OTs prior to them doing the visits so they would be a little bit

more involved in it so we just didn't schedule that as of yet, but I'm looking to do that in the future. The average time from hospital discharge to the first visit regardless of if it was an initial evaluation or an admission visit was 1.27 days PT. Again, they did the majority of the admission so they have the lowest. 1.8 days for nursing. We actually usually had nursing come in within 48 hours and then OT was either there within 24 hours or the following day. So 1.6 days for the OT visit. We looked at because these patients were mild in nature we originally set off to do, you know, five straight days of physical and occupational therapy services but the issue that we ran into were the patients were mild, had mild impairments so they didn't always need five straight days of PT and OT, in fact some of the patients on day four were community ambulators, they were, you know, they were completely independent and really should have been going to if anything, should have been going to outpatient so we ended up discharging them. So that's why they did not complete the full five straight days. No one completed actually some patients did, but most got at least four. And you could see 75% of the patients got four straight, at least four straight days of PT and 88% got at least four straight days of OT. I think OT was used a little bit more heavily because the patients from a mobility standpoint were fairly independent even upon admission but it was more higher level cognitive function when engaging in like meal prep, financial finances, financial management and also things like medication management. So the OTs typically did one or two more visits than the PTs with this specific subset of patients. We did give some of the patients telehealth. We do have a very robust telehealth and what we call virtual case management. Virtual case management is a, which I'm gonna get to in a slide or two is actually a, we consider it a discipline and it's a discipline that isn't usually a nurse although we're looking to hire some therapists into these roles that sort of captain or, or they reach out and engage patients from a distance, they don't make in-person visits. They do video chats with patients. They summarize the home health plan of care with patients from a video standpoint, they follow up on things that happened during the in person visits by reading the charts and they reassess the patients after hours or in not so much after hours I shouldn't say

sometimes after hours, but on days when the patients aren't getting in person visits to sort of supplement the in person visits we're doing and keep patients engaged in the home health program. We've gotten a lot of success out of it and I think that's one thing that's helped drive down our readmissions over the last five years. And three of these patients did get social work as well. I'm gonna address a question here by Marie going back to PDGM. She writes if PDGM creates such an ethical dilemma, how is it that it has completely changed how patients are classified and seen? That's a good question. I think that you know, in future payment models, there's some elements of PDGM that I think are trying to get at outcomes and offer value for the care that we provide but I do think, you know, look, home health, let's face it, whether you're, no matter how you line this up, however which angle you look at it, it is the cheapest way to provide healthcare services to patients. It is other than I guess them going into a clinic but when you consider, you know, the rental of space, the efficiency of having a brick and mortar clinic, there's a lot of costs associated with that as well but home health offers an opportunity to provide very, you know, cost-effective care to patients and I think that needs to be considered, I think home health services need to be expanded. I think telehealth visits as I just spoke about, virtual case management visits, they need to be covered and reimbursed and I think we need to get the patient's perspective in here I mean, how many patients participated in this? How many physical and occupational therapists participated in the panels that led to this? Personally I think, you know, I think politicians need to be involved because they do the legislation and set the rules and laws but you need to have real medical professionals that is encompassing of an entire medical team not just physicians, inclusive of therapists and nurses, but I really wanna point out therapists because I do think that we probably are the last to be invited to these types of things and social workers to talk about issues that patients have and what we can do from our service line perspectives because I think there's some misperceptions as to what we do for patients and a lack of understanding of the real benefit of physical and occupational therapy. So I think that's the problem with PDGM. I'm not exactly sure I could have done I guess, more research

for this lecture as to how it was developed but that's my thought on that question, that's just basically an opinion piece on it. But we could do our part and I do think that's why it's important to get accurate assessments. I really, that's why I was imparting on you to all to pursue, you know, different, even small and large leadership opportunities, participating on quality outcomes at your health agencies and within your hospitals, program development, folk a real focus on outcomes and accurate assessments and evidence based interventions that will help. I think in the longterm those little things we do that will help. So CVA home recovery program, these are clinical outcomes so we had zero readmissions for those 11 patients. Well actually nine because the two declined services, two emergency room visits. Luckily they did not result in a readmission and these are our clinical outcomes. So we do activity measure for post acute care and the inpatient side, they used the six click model. We use the, for those of you familiar with the AMPAC, we use the short forms in an acute care, I'm sorry in rehab, or I'm sorry in home health, we use the short forms and the scores are right there in initial evaluation and discharge. These are just the averages, it's just a simple average of the scores. On admission patients needed from an ADL perspective, needed assistance with ADL at discharge, they were independent with ADL and needed some assistance with IADL. our mobility AMPAC, they were independent indoors at initial evaluation. I did not have adequate discharge data. The therapists on my team just weren't doing the discharge AMPAC probably because they were already independent indoors but I would imagine that 60.22 would have been at a higher level which would be indicative of independence outdoors ambulation. Our TUG scores, you could see these are fairly mild patients, 15.8 seconds at initial evaluation, 10.4 seconds at discharge so improvements there. The Barthel went from 84 moderate dependence to 90 slight dependence so increase there from these are FIM scores, supervision at initial evaluation and discharge independence. And one of our OTs was very, we did the competency with this and some of our OTs are very good with doing Allen's cognitive levels. For those of you who aren't familiar with that, it's a leasing instrument which gives perspective on how much cuing patients might need or how much, you know,

assistance they might need with higher level IADL activities from a cognitive perspective and two patients who got the Allen's cognitive level at discharge, which the OT used to set up a level of you know, first looking at caregiver education and a system of cuing to make caregivers aware that they should not just presume that this patient is independent with IADL specifically, she called out medication management and money management that the patient would need assistance with this moving forward so she did do that assessment. So what does all of this mean in terms of PDGM? For one thing these patients had us did not on most of them did not have a long length of stay on home health. We gave them very intensive therapy services upfront. We addressed a lot of their needs upfront and I think under normal circumstances in our normal pattern of scheduling patients, these patients probably would have been seen one or two times a week and the episode of home health would have gone on for multiple weeks, possibly going into multiple billing periods and maybe a full episode of care, which from a cost perspective, I think would have been higher for us. I don't have the financial data, but we addressed these patients' needs early on when they were most vulnerable after their acute care stay and hospital admission, they were seen within 24 hours for the first five days they had intensive therapy services and many of them were then discharged after that first week, they didn't have ongoing home health needs. We got them to a higher level of function. They started to participate in higher level IADL activities and they started to access the community. So from that perspective, from a PDGM perspective, it met the quality points for those patients. Now mind you, there could have been more we could have done for these patients like for example that patient that, you know, needed help with money management or medication management, maybe there's more we could have done for that patient had she still been home bound or if the home bound requirement wasn't still required for that patient, she might've needed more followup but nonetheless, you know, this is a program that shows how you could be successful in this program utilizing a lot of therapy services as well. Any questions about our CVA home recovery program? Okay. All right. So then last 10 minutes here, COVID-19

response, then early March pandemic hits. We, I gotta be honest, this evolved over time. It's like, you know, like all of you, we were in the thick of it getting information on the amount, the way it's transmitted early on there was a lot of thought that, you know, you were hearing things like the virus can live on surfaces for, you know, long periods of time that that was a route of transmission, everything needed to be wiped down and everything did need to be wiped down. And then there was a lot of, is it droplet precautions? Is it airborne precautions? You know, there was a lot of talk about the masks that we were wearing and are they effective at stopping the transmission of the virus because the virus is so many microns large and the masks allow so many microns through and N95 versus surgical mass, the lack of PPE, are we gonna burn through all of our PPE? So early on what did we do? We really our health system had the luxury of having a supply chain management which gave us an abundance of PPE. We started early on monitoring body temperatures for our staff, they actually got a text message every day where they had to report their body temperature for that morning and anybody who did not, they were followed up with immediately by the nine o'clock hour there was like, you know, we would follow up with anybody who did not. We have a staff that's like 400 plus clinicians on any given day now, there might be three people who don't report their body temperature that we have to follow up with meaning, you know, the vast majority of our therapists and nurses are reporting their body temperatures. I do have to say there hasn't been one instance that I'm aware of where we've identified that a patient has, or I'm sorry that, or an employee has a fever and they're unable to work for the day so I don't know how beneficial that was but nonetheless we're doing it. And then that became testing with our patients and testing with our staff. At the time what we were doing at the beginning of March where we started monitoring patients only for to see if they, you know, they screened positive do they have symptoms of COVID-19? Shortness of breath, chest pain, fever and any patient who reported that then we would wear PPE with those patients. But what we were finding was we were only wearing PPE with patients who were symptomatic which in some cases turned out to be COVID-19 and some cases where it didn't, but it

was still out there in the community you know, it was all around like our therapists, our nurses they're going into convenience stores in between patients, they're coming into contact with people, people aren't wearing masks, not everything is shut down and when patients and staff members needed to be tested, it was a long turnaround for tests which was, it meant nothing to be honest with you. If you tested someone and it took a week for those test results to come back I mean, like if it came back positive it was like, great now we have to, you know, we quarantined this, this therapist for a week now we have to go back to everybody they came in contact with, make them aware they have to be quarantined and it was just massive like operational chaos but what happened?

So what happened was our PPE supplies got better. Our testing results within our own health system, got to the point where we would have a 12 hour turnaround for testing, which was like, it revolutionized our operations. So what we did is we went to full PPE therapists are to wear PPE, meaning face shields, goggles, or goggles but we wanted them to use face shields. So face shields first and foremost once we got a supply of them, gloves, surgical masks with every patient, surgical masks whenever they are out in public and not just in their cars. What we ended up seeing when we did, once we did that we were not seeing staff infecting patients. We were not seeing patients who then tested positive infecting staff and we still monitored every single referral that came through and I'll show you how robust we were with monitoring those referrals. We keep every single day and it used to be twice a day including weekends, the management and leadership team would get together and review every single referral, touch base with every single staff member who was maybe going to see a patient. We would set positive patients up with telehealth services and not do in person visits and then we would monitor them for a period of 14 days through telehealth. Once the patient was asymptomatic meaning fever free and no coughing, shortness of breath for a period of three straight days from 14 days of testing positive, or I'm sorry, if a patient was symptom free for three straight days and from 14 days of symptom onset, we would

consider them free of COVID and recovered and then we would resume in person visits wearing an N95 mask at least for the first week and then going back to what we called normal PPE, which was our face shield, surgical mask and gloves. Obviously with the N95 you would still wear the face shield and the gloves and if necessary gown with the patient as well. And I'll show you the matrix we came up with for PPE wearing with different patients in different scenarios. So we got a large and you know, our turnaround, what we started finding that even with symptoms, when symptoms would come up because everyone was wearing PPE, even staff that had symptoms when we get them tested it turned out to be something else, it wasn't COVID-19 related. And even when patients were positive and then it turned out that we tested them and they were positive because staff were seeing them wearing at the very least face shield, surgical mask and gloves, they were not getting infected. If they came into contact with a patient that we then found out was positive because they were wearing that PPE they were not then testing positive.

This is our matrix and I'm gonna just, I don't know if you, on your end if you could see this, I have it blown up a little bit on my end, but on the left hand column it shows the patient status. If a patient screens negative as I mentioned, they get the gloves, face shield and the surgical mask, if a patient screens negative, but they have a high risk medication treatment, meaning that they have a nebulizer or a C-PAP or BiPAP that's being used in the home, you would wear gloves, a face shield and then when using goggles place surgical mask over an N95 mask and discard that after each visit. So we wanted our therapists and nurses to use an N95 in addition to the surgical mask whenever any type of aerosol medication was being used with a patient regardless if the patient screened positive or was negative for COVID-19. If they screen positive we would get them tested and we wouldn't see them but you know, anybody who was using nebulizers or aerosol medications, we included an N95 with those patients because that has been shown to be a high level of transmission with aerosols, the virus and then it becomes like airborne precautions not just droplet precautions. Technically

yes, I know there's been a lot of talk about the micron of the virus and the, you know, the surgical mask and can the virus fit through the bottom line is that virus is held in droplet particles. So the droplets don't get through the mask, the virus doesn't get through the mask and there's no rate of infection, or there's a, I should say there's a decreased transmission of infection. So for patients then who either we are testing for COVID-19 and it's pending again, we got that down to 12 hours or you're caring for a known positive COVID-19 patient you have two choices, you either use the N95 mask or a PAPR they're both equally effective, none is better than the other. The PAPR is more comfortable, it allows you to breathe much easier, it's got a battery operated air, you know, movement in, within the mask, it's sort of like a, like a helmet type of thing you would use and it looks like it's, it makes you feel safer because it's a bigger apparatus, but it's no more effective than an N95.

They would use that, a face shield and a gown, you have the opportunity to use the N95 if you're not using the PAPR or you could use the PAPR and if you're doing testing on a patient or if the patient is positive, you also use the cap if you're just using an N95 and shoe coverings are optional. It really all depends on the situation. If you're concerned that, you know, for bodily fluids getting on you or something like that and you could use shoe coverings. So that was our matrix for PPE. Jeffrey asks, it would be interesting to have had the ability to track start a care and discharge functional status for the patients who refused services to see if the patients simply improved regardless of rehab interventions verse in response to those interventions. Yes. You know, a clinical trial like that would be interesting to do and that would be the highest level of clinical trial and if we could go back to those patients to see what their status was without our interventions, that would be one way of doing that, yes.

And I might be actually be able to, to do that because those patients did come on our service, they did accept nursing so that would be an interesting thing. Good, good. Very good comment, Jeffrey. Then we have another, I guess there's another Jeffery,

right? Are these your current PPE protocols, are these consistent with CDC guidelines or more proactive? Our office seems to read the CD guidelines very differently. This is a little bit above and beyond CDC guidelines. The use of the N95 and the PAPR is beyond CDC guidelines. In our hospitals for example, even with COVID positive patients, they're just using the surgical masks. We, because the home environment is less controlled and you don't know who's coming in and out we in the presence of suspected or known COVID-19 patients, we would use the PAPR and the N95 with even coverings and you know, things like that. We're a little bit above CDC guidelines because of, because of those issues with home care providing such an uncontrolled environment if you will. I'm gonna try to, we only have a little bit of time here so I'm gonna not rushed, but sort of pick up the pace here. So clinical treatment of COVID-19, we would do an in person admission with a PAPR to get the telehealth delivered. We would do a combination of in-person and telehealth visits by PT, OT, RN and speech therapy during the first 14 to 21 days, the patient is on service, really depending on upon when the patient's symptoms of COVID started and then we would monitor them as I mentioned looking for three straight days of being afebrile without using any type of medication that would control their fever and as long as they reached those three straight days and it was 14 to 21 days of symptom onset, we would then start to resume more in person visits and reduce the telehealth visits that we were doing with patients.

So we started actually doing a very robust amount of telehealth visits with not only COVID positive patients, but we in March and April and the beginning of May actually switched over our entire agency to doing majority telehealth visits with patients. I will add this was completely non-reimbursable. We were caring for patients and providing care for patients that we essentially did not accept under like from a CMS, from an insurance standpoint, take under our care from a billable standpoint, we were just providing this care free of charge. And we monitored anybody coming on to service. As I mentioned with these two time daily manager director huddle calls with infection, we

had an infectious disease doctor who is one of the health systems CMOs. We tracked all patients who screened or tested positive. Those who screened positive, we would get them tested and then we would make a decision as to what to do with their home health and set them up with telehealth equipment so that we can monitor their vitals and do video visits from afar, including PT, OT and nursing as per protocol, part of their COVID recovery program with telehealth. This is our dashboard. You could see as of this is going back to June, we had 158 patients that we were monitoring. We had 102 patients who were active positive on our services. In total, there were 750 positive patients that we had cared for that were some resolved. We had 376 patients that we screened presumed positive but then ended up being negative. And like this is how we managed this and we went patient by patient, each team reporting out on this, and then each manager would follow up with the therapist and nurses involved in that case giving them instruction on when they should do in person visits, what PPE they should wear and when we should be doing telehealth visits. For our telehealth visits we quickly from a therapy standpoint, we did not do this.

We did not have therapists who were doing telehealth visits prior to COVID-19 so we were like, we need a contact type. We need documentation. We need assessments embedded in these contact types so that we could get accurate information and have a consistent method of engaging patients in this program so that we could get accurate assessments and do interventions that were meaningful for patients whether they were COVID positive patients or just patients who were generally referred to us who were fearful about having us come into our homes and quite frankly, at the time, we did not want to go out and subject them to it. We did not want our staff out in the community so we went to full on telehealth for a good period of time, a good two months we were doing this. So we looked at how could we do this? So we looked at elements of cognitive rehabilitation.

This is based in neuropsychology and it's focused on retraining cognitive processes. You know, something like, you know, if you have someone who has a short term memory deficit or an attention deficit that the thought processes that you would engage them in activities that would focus on memory or focus them to attend to something in a method that's almost like building that skill or building that strength up, building that cognitive function up, hoping, or with thought that it would transfer to function that by engaging in a game that focuses you on attention and like the memory game or something that somehow that's going to translate into memory with functional context or function within the context of the patient's home. We don't believe in that, this is not always shown to be effective, this is not the type of treatment that you would wanna do with patients. What we wanted to do with our telehealth visits is to use more of a metacognitive strategy. We wanted to use patient driven goals. The therapist, we saw them as coaches guiding patients and changing their patient's behavior with the standpoint that all bodily systems interact with the environment and adapt in response to new learning and environmental change using plan, do, check, act as a co-op strategy and that's one of these metacognitive cognitive strategies we wanted to employ. It was a lot of having the patients self-assess like we would walk through, like tell me about how you're doing with getting out of bed. Tell me how you're doing with getting dressed. And there were very specific questions we were asking patients, do you feel fearful of falling? And if possible on the video having them demonstrate activities for us. There were a lot of questions that we would ask of patients that were open-ended like what it's working, what's not working? When do you feel pain? Why do you think that's happening? Why do you think that you're having difficulty with showering?

Why do you think you need help from your daughter? And really just engaging the patients every step of the way to sort of develop strategies based upon their own awareness level of how they're doing. Having patients be more sort of aware of their own thought processes and unaware of their own strategies to try to overcome their

deficits and then working with them to employ methods that might make more sense that might have the chance of being more meaningful and we followed up with them regularly. We saw them daily almost with these telehealth visits and the feedback, I don't have data to report, but the feedback from the therapists and even some of the patients were that they really liked this and they felt like they were making progress and I think the frequent touch points that our therapists were having with these patients were making a lot of difference. Therapists said to me, I think I'm making more progress in some ways through these telehealth visits with certain patients than I was if I would be seeing them in person one to two times a week and we used patient reported outcome measures like AMPAC, the Canadian occupational performance measure, taking Borg and RPE scale measurements during these visits. All in all we ended up doing from a PT perspective from March 1st and I believe this went through probably July 1st, a total of 5,145 physical therapy virtual visits, 1,849 occupational therapy visits and 352 speech therapy visits. And that's like the amount of virtual visit that we ended up providing during this timeframe. You know, I think I'd have, we'd have to go back and run some reports to get some clinical data out of this to see what type of progress we made and, you know, really we're in the midst of really looking back and reflecting on this, what did we learn? How can virtual visits be a part of our home health program even from a therapy perspective going forward so that under this PDGM model where maybe the cost of providing in-person visits is high, how do we sprinkle in, or like add in this element of a virtual followup with patients, will that make sense so that we could get better outcomes with patients while being more cost effective with how we're, you know, we're utilizing our services under this PGM model.

So that's the future for us of telehealth visits and we're looking into ways to do that. And there's software systems out there that do this very well, we actually employed, I can't mention it, but a patient education platform that allows you to build exercises and activities and share patient education on your screen with patients, we deployed that as well to better engage patients. You could show videos and things like that. And

there's more of these types of softwares coming out there that, you know, will this is the future I think that in, you know, in the future, PT and OT have a role in virtual visits and I think that that's just, I think it's good for the profession, but we have to think of ways that we can engage with patients and how we better 'cause being hands on in biomechanical isn't gonna be the answer in some of these situations.

So, all right, going on to questions. Jennifer asks how many COVID positive patients were too sick to participate in telehealth or in person visits. That is a very good question, we would get this. We would have patients that would say I do not feel well. The amount of like what we tried to focus on was we really focused on having the patients be able to use our telehealth equipment to take their vitals. All of our COVID positive patients got telehealth equipment so they can monitor their vitals. We wanted their respiration rate to stay at normal levels, we really, we took their heart rate and with, you know, we wanted to work with patients so that they were within normal levels or at least no like high increase of vital capacity while engaging in activities so for example, oxygen saturation with activity we wanted to keep it at 93%. Part of our interventions were deploying energy conservation strategies to patients and helping them utilize those strategies during day to day tasks so that they kept their oxygen levels at or above 93% while still being able to participate without overly exerting themselves. A lot of the education that we worked on with patients were utilizing their supplemental oxygen appropriately and titrating that oxygen appropriately so that there were, they realized that, hey, I'm gonna engage in an activity here that's gonna have a higher require a higher output from me so I have to turn my oxygen, titrate my oxygen higher so that I could wash the dishes so I don't get so short of breath or sit down while I do that. And we did have some patients who it was hard to get them to engage because they were so tired. I don't have numbers on the actual numbers who refused though, but we did have that. Jeffrey asks, are you comparing patient outcomes for the exclusive telehealth patient self-reported assessments, rehab versus your actual onsite rehab?

I think I could probably do that within the reporting of our EMR, I just have not had the opportunity to go back and look at that but that would be an interesting study Jeffrey. And then someone else says is Jeffery another Jeffrey asks, it sounds like you are talking the past tense. Are you still doing these telehealth calls, if not, what did you transition to? Also, how can, so I'll just take it right there. We went back to in person visits, we went full on in person, even patients who are COVID positive, we are now doing in person visits with that. We are confident enough in our PPE structure that we can provide care to patients even when they're COVID positive. We do some in some cases, some telehealth with therapy visits and we still continue to do remote patient monitoring and telehealth because we've always had that for patients who need ongoing monitoring of vitals either COVID or non COVID related. So we do sprinkle in some telehealth visits but we have resumed much more in person visits. How can smaller companies perform similar actions when such action might demand volunteer work, or maybe this will be paid in the future? Yes, we did have the luxury of being able to provide this level of care because we had the financial backing and it wasn't easy even, you know, from our perspective, this was something that, you know, was not easy to do from a financial perspective. I think in the future some of the work that we did will lead to some of these services being covered, they should be covered I think there was value in these services and it just not covering them just restricts healthcare and that's unethical to do and you can provide quality care without being in person with the patient. It just doesn't make sense not to do that and you know this is one pandemic we might face you know, we're still in it, there could be a second wave, there most probably will be a second wave in the fall and then what's the next thing to come down the line because even when we make it through COVID-19, these things happen and they're gonna continue to happen and we have to be prepared for them.

I don't know if that fully answers your question, but that's at least my thoughts on it. I think grant funding, engaging other resources for finances, that's what smaller

companies should do. We have to have more funding available and more, it starts with legislation and having a really strong I think, federal response to these types of pandemics that has funding available for prevention and response and healthcare during these times, these trying times and we did not have that and that's what we need going forward. I don't see any other questions coming in and I wanna thank you for hanging in there with me for these two hours, this was a long period of time to have to listen to me so God bless you all for doing that and hanging in there. I hope I really hope that you enjoyed this and got something from it. You know, if you have any questions, my information's up there, you could always reach out to me, in the meantime I will answer your questions via email, but that will conclude our presentation today. Thank you.

- [Calista] Thank you so much, Scott, for once again sharing your expertise with us today and we're gonna go ahead and close out today's course. Have a great day everyone.