Medicare B Best Practice

Alden Management Services
Community Physical Therapy

Initiated September 2009
Revised September 2014
Revised January 2016
Revised December 2017
Revised September 2019
Revised August 2020
Revised January 2022

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Historical Perspective

The executive teams of Alden Management Services and Community Physical Therapy, as part of their routine examination of monthly statistics, noticed the amount of Medicare Part B services being provided in facilities with similar patient populations differed among locations.
In order to assess the situation in the most objective way possible and establish best practice for Med B patients, a committee was formed consisting of members of the CPT management team and Alden SNF therapy supervisors.
The Joiner 7 step method was used as a means to objectively and systematically guide this process and to record the actions and results.

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Step 1: Project

Goal: To identify the best practice for Med B patient selection, evaluation and treatment.

Output: To provide the optimal level of care for Med B patients in each facility based upon clinical needs.

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Step 2: Current Situation

Goal: To further focus the effort by gathering information on the current situation.

Output: Output will be in the same format as the attached charts regarding Med B potential and usage. This is as follows:

*Total/month trend data on Part B unit production per per patient per discipline

*Alden census numbers for Med B

*CPT Part B census numbers

Total Part B units per month, all Alden facilities, January – July 2014

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Step 3: Cause Analysis

Goal: Identify deep causes and confirm them with data in order to help ensure effective solutions.

Output: A site specific, ranked order of all causes.

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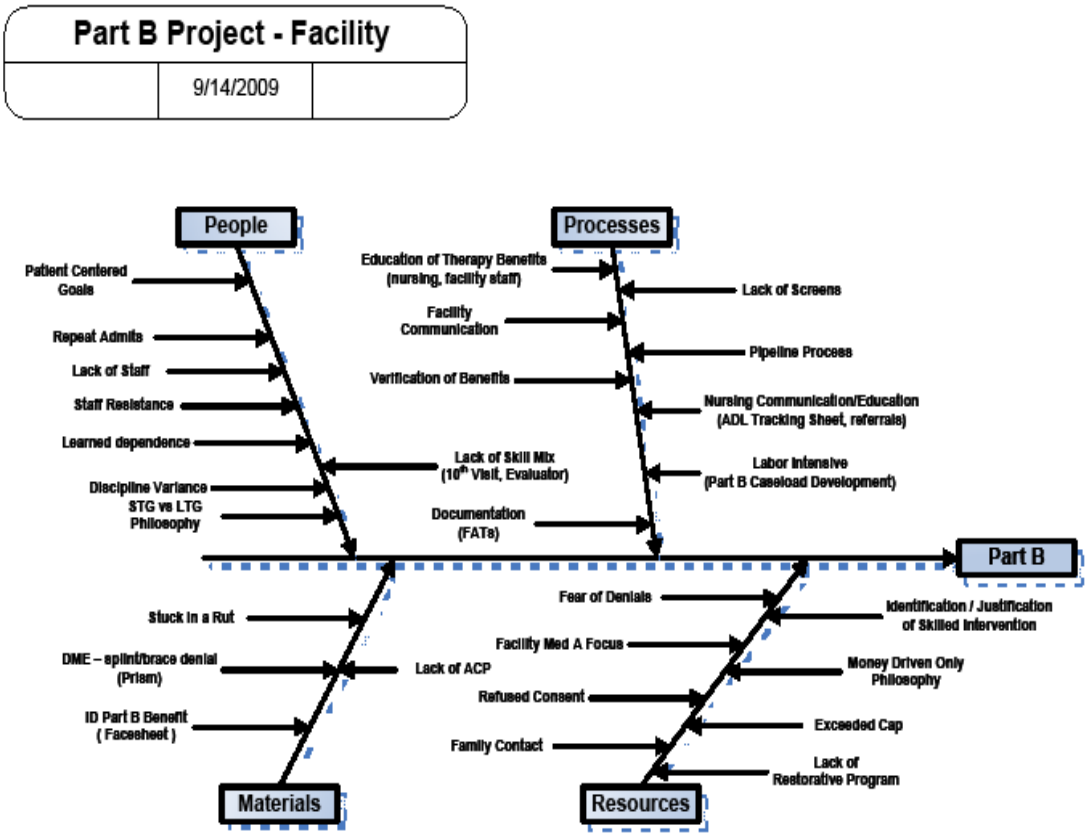
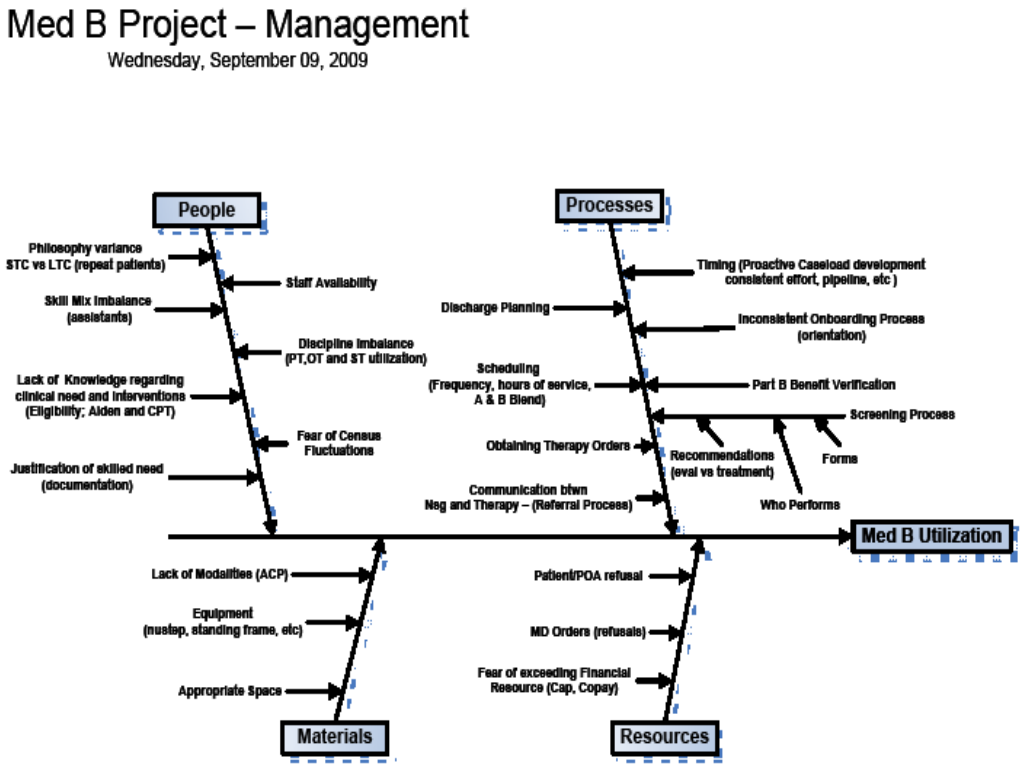
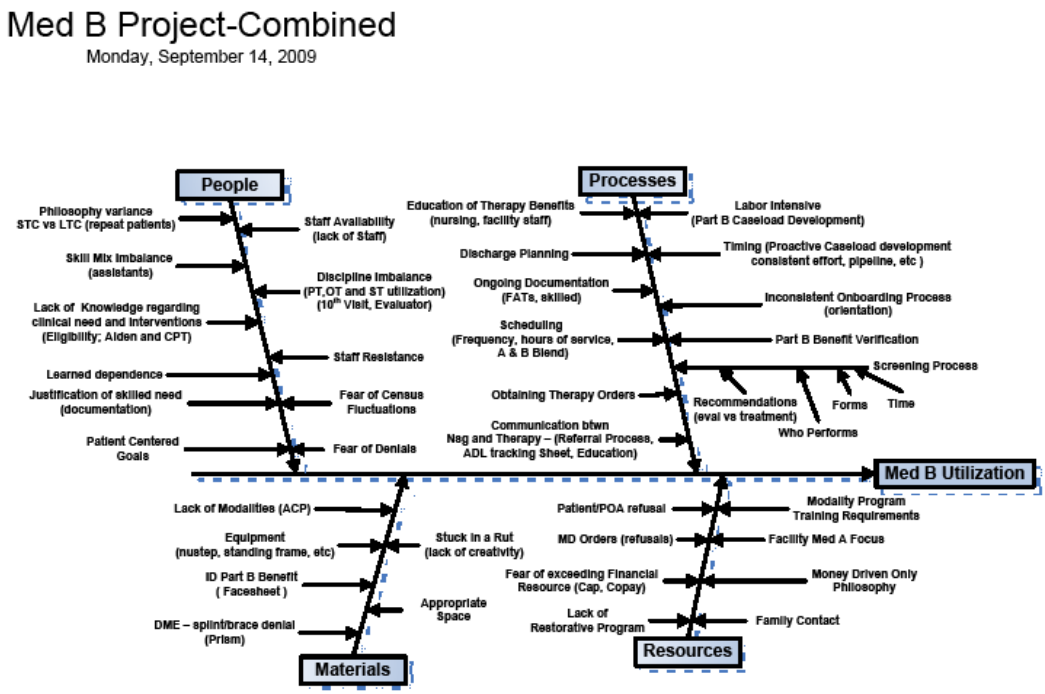
This fishbone diagram shows the factors that interfere with Med B case development as identified by a representative group of Alden facility rehab supervisors.





This fishbone diagram identifies factors that interfere with Med B case development as identified by the management team.

This fishbone diagram represents the combined input of both supervisors and management of factors that interfere with Med B case development.



Step 4: Solutions

Goal: Develop, try out, and implement solutions that address deep causes.

Output: Actions recommended as possible solutions to reduce or eliminate the impact of the causes identified in step three.

Cause and Effect Solutions

People

Cause:

Philosophy variance – how to treat STC vs LTC (also how to treat repeat patients)

Solutions:

- Identified decline in status or improved ability to participate noted regardless of frequency of previous therapy
- Supervisor screens patient
- FAT Utilization – do at eval and assess throughout Rx
- MDS support
- Two week trial encouraged
- Quarterly resident screening in line with MDS calendar
- Staff participation in weekly CMI meeting

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- ACP program to address current needs and provide opportunity for treatment
- Education of therapy staff and nursing

Cause:

Skill Mix Imbalance (therapists vs. assistants)

Solutions:

- Hire / recruit
- Improved scheduling and coordination
- Aide utilization for Medicare A

Cause:

Lack of Knowledge regarding clinical need and interventions (e.g. Eligibility – both Alden and CPT lack)

Solutions:

- Education and resource material; onsite and include in orientation process
- Inservice on capabilities - therapy and facility
- Include Physiatrist in treatment plan
- Second opinion

Cause:

Learned dependence by patients

Solutions:

- Educate staff - Nursing, aides
- Patient / family education
- Functional Maintenance programs prior to discharge

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Cause:

Justification of skilled need (lack documentation skills)

Solutions:

- Incorporating FATs to document skilled need
- Develop list of key phrases to utilize
- Goal writing
- Increase frequency of documentation – daily
- Documentation tutorial

Cause:

Lack of Patient Centered Goals

Solutions:

- Educate and encourage therapists to apply Patient Center focus to Part B patients
- Include Family/Nursing/CNA in goal identification
- Supervisor "modeling"
- OPN Resource for easy reference

Cause:

Staff Availability (lack of Staff)

Solutions:

- Hire/Recruit
- Improve coordination and scheduling of patients and therapy

Cause:

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Discipline Imbalance (PT,OT and ST utilization; 10th Visit Evaluator)

Solutions:

- Hire/Recruit Therapy evaluators; utilize prn
- Develop and Incorporate tracking tool to manage 10th visit
- Routinely incorporate weekly visit by therapist - OT and PT

Cause:

Staff Resistance

Solutions:

- Educate, Educate, Educate - at hire and ongoing
- Utilize management team and mentoring
- Establish Med B meeting - Peer/Patient Review
- Encourage continuing education - identify courses of benefit

Cause:

Fear of Census Fluctuations

Solutions:

- Scheduling and coordination
- Stable staff versus prn/float inconsistency
- Utilize 7 day week coverage
- Stay informed of sudden changes in census - plan ahead

Cause:

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Fear of Denials

Solutions:

- Timely and completed documentation
- Clinically appropriate language list
- Audits and chart reviews
- Education on functional goals - utilize training tools, mocked up practice charts
- Provide feedback about denials to individual therapists involved

Materials

Cause:

Lack of Modalities (ACP)

Solutions:

- Provide documentation for justification of ACP program

Cause:

Lack of Equipment (Nustep, standing frame, etc)

Solutions:

- Provide documentation for justification of identified equipment
- Identify portable options - requiring less space but providing appropriate solution (portable Nustep)

Cause:

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Unknown Part B Benefit (Face sheet)

Solutions:

- Obtain updated list from admissions
- Utilize eCare to identify Part B eligibility

Cause:

DME – splint/brace denial (Prism)

Solutions:

- Continue to coordinate efforts with Prism and use recommended products
- Obtain Prism catalog for each facility
- Coordinate common product stocking program with Prism to reduce denial and improve turn around time

Cause:

Stuck in a Rut (lack of creativity)

Solutions:

- Establish "Mentoring" program - at facility and across others
- Continuing Education
- Discuss with other CPT therapists in other buildings - develop network
- Rotate therapists providing patient treatment
- Utilize Journal club/ Evidence based intervention
- Utilize Case Study tools in P&P manual; develop additional tools

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- Establish "Lunch and Learn" program

Cause:

Lack of appropriate space

Solutions:

- Increase treatment hours; lunch hours
- Stagger staff
- Review current equipment utilization; rearrange department
- Champion/support remodel efforts
- Add/Increase storage space for department
- Appropriate scheduling
- Develop treatment "kits" to provide treatment at alternate locations

Resources

Cause:

Patient/POA refusal

Solutions:

- Education on benefit and treatment focus
- Get Social Service involved
- Get Physiatrist/MD involved

Cause:

MD Orders (e.g. refuse to sign)

Solutions:

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- Education on benefit and treatment focus
- Get Physiatrist involved to work with Primary MD
- Detailed clarification order before eval - use preprinted form?
- Get Patient or Family involved to discuss with Primary
- Nursing coordinate calls to MD - reduce multiple contacts
- Standing orders

Cause:

Fear of exceeding Financial Resource (Cap, Copay)

Solutions:

- Education and training on coding
- Exception process education
- Coordinate therapy services to patient's needs
- Comfortable in writing justification statement - develop resource list

Cause:

Modality Program Training Requirements

Solutions:

- Initiate one-on-one caseload development with ACP instructor

Cause:

Facility has a Med A Focus

Solutions:

- Hire labor resources to treat Med B patients

Cause:

Unable or difficult to contact family

Solutions:

- Involve social services and/or admissions to assist

Processes

Cause:

Education of Therapy Benefits (nursing, facility staff)
Provide inservicing

Cause:

Discharge Planning

Solutions:

- Educate as to appropriate goals since most patients are not returning home

Cause:

Ongoing Documentation (FAT's, skilled)

Solutions:

- Education on proper documentation
- List of functional tests and when to use

Cause:

Scheduling (Frequency, hours of service, A & B Blend)

Solutions:

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- Stagger treatment hours
- Hire adequate staff
- Stagger lunch times
- Extend treatment hours

Cause:

Difficulty obtaining therapy orders

Solutions:

- Education on benefit and treatment focus
- Get Physiatrist involved to work with Primary MD
- Detailed clarification order before eval - use preprinted form?
- Get Patient or Family involved to discuss with Primary
- Nursing coordinate calls to MD - reduce multiple contacts
- Standing orders

Cause:

Lack of communication between nursing and therapy – (Referral Process, ADL tracking Sheet, Education)

- Education

Cause:

Labor Intensive (Part B Caseload Development)

Solutions:

- Ensure adequate staffing

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Cause:

Timing (e.g. not enough time to build B caseload when A is low)

Solutions:

- Proactive Caseload development
- Consistent effort to develop Med B
- Adequate staff

Cause:

Inconsistent Onboarding Process (orientation)

Solutions:

- Develop standardized orientation process that includes Med B orientation

Cause:

Part B Benefit Verification

Solutions:

- Develop process for verification with Alden

Cause:

Inconsistent screening process

Solutions:

- Recommendations of eval vs treatment – know benefits of each
- Have a consistent person who screens
- Look at revising screening forms
- Educate as to benefits of Part B therapy

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Step 5: Results

Goal: Use data to evaluate both the solutions and the plans used to implement them.

Output: A before and after analysis of the improvement measure and a summary of the effectiveness of the actions.

Lessons learned:
As a result of going through this process, we learned that the original data we started the project with (see step 2), would not be enough to reach the outcome we desire. What we now know is that we need the following:

* A list of all patients who are either private pay or public aid as these patients may be eligible for the Med B benefit. Additionally, we will need to know patients who are Med B eligible but who have signed over benefits to a managed care insurer so that we do not erroneously bill Medicare.
* The list above will need to be verified by someone at CPT and verified on a quarterly basis. (QUESTION: is quarterly enough? Will status change possibly before that time?)
*Develop a process for understanding and education of dual eligible patients.

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Step 6: Standardization

Goal: Maintain the gains by standardizing work methods or processes.
Output: **Documentation of the new standardized method; training in the new method; a system for monitoring its consistent use and for checking the results.**

Evolution of screen process

Screens were completed.
New admits
Anyone we were notified that had orders
Referral from nursing when notes a decline on unit
When referred by mds coordinator after a pt declined on mds
When census was low
More passive process
Process: interview nurse and restorative nurse
Review chart for any decline in fx
Observe pt with CNA's
No guidance on what to look for was given on screen - no specifics as to what was done during the screen was given
Open ended form that simply stated from a review of chart and screen pt is or is not appropriate for therapy services

Revised form to give guidance on what areas in chart to assess to be sure therapists assessing all areas of concerns -

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joining with our educational initiatives including adding an interview with Pt and family re concerns and goals, incontinence, pain, etc
This did not increase the b to where we thought

We had independent staff from other sites or floats go to facilities to see if they were able to determine more pt's with theory that staff at site were in a rut
This however did not demonstrate a significant increase

Keep list of all LTR at sites - who had Med B etc
Who was screened, who was picked up and who was not picked up

We made the screen process a more active role.
Screening all long term residents at admission and quarterly in line with their MDS schedule in addition to previous process
Updated the form in line with the changes in the MDS
Due to the intensity and amount of things to address, the screens were quite lengthy in time leading to an increase in nonproductive time
Staff had to review multiple sections of one MDS and compare to the previous MDS as documented in software as well as reviewing nurses notes if any declines since last MDS all this required flipping thru multiple tabs. If a change was noted in one area we continued with the screen until the entire form was complete and then decided if eval was needed.
After the first 2 quarters were complete, we stream lined the process by having sups either meet directly with MDS

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RN and Restorative RN or attend the CMI meetings where changes in the MDS were already identified for us, nursing and restorative attended the mtg and had info from primary nurses on any recent declines.
The screen form could then be partially populated at the meetings.
If a change was identified in the meeting we would recommend eval
If no change was identified we would go to the next level of interviewing the pt &/or family. If that identified a concern then an eval would be triggered
If at any point in the screen process an issue or concern was identified, it triggered an eval.
This has allowed us to continue to be active in the screen process but not to the level that our productivity is affected in any significant manner.

SCREENING

A. ***NEW ADMITS*** – Screened within 1st week of admit
   1. Non-Skilled Beds
      a) Private Pay
      b) Public Aid
      c) VA
         *Can be recommended for Restorative Nursing
         *CANNOT receive skilled care, unless approved by VA, follow VA approval process
      d) Hospice
         *CANNOT receive skilled care unless approved by Hospice company, follow Hospice approval process
   2. Notification Methods of A NEW Admit
      a) Admission Board
      b) Face Sheet/Welcome Sheet in rehab mailbox
      c) Receptionist contacts therapy
      d) Admissions Coordinator
         (1) Always review the census form generated by the Admissions Coordinator to confirm the previous day's admits, DCs and room changes, confirm payer source for facility

B. **LONG TERM RESIDENTS** – *screened quarterly and as needed*

1. Non-skilled beds
   a. Private Pay
   b. Public Aid
   c. VA
      * Can be recommended for Restorative Nursing
      * CANNOT receive skilled care, unless approved by VA, follow VA approval process
   d. Hospice
      * CANNOT receive skilled care, unless approved by Hospice company, follow Hospice approval process
2. Notification Methods of a Resident to be Screened
   a) Medicare Meeting referral
   b) Nursing notices a decline - contacts therapy
   c) Therapy completes review of pts periodically between quarterly assessments as needed
   d) Quarterly MDS schedule is monitored, screen triggered 2-3 weeks prior to scheduled MDS completion date (ARD).
   e) Care Plan Coordinator notifies therapy department following Care Plan meeting due to concern raised in meeting by facility or family
   f) Following a fall: Aims Committee identifies pt and notifies therapy

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Screening Process: The following process has been identified as best practice to increase efficiency of the screen process. If at any time within the screen process a need is identified, there is no need to continue with the rest of the screen. Recommend the eval and move to the next screen.

1. Review pt's 1:1 with Rehab Coordinator or in CMI meeting with Alden Team. Timing is based on quarterly MDS/care plan calendar - initiate ~ 2 weeks prior to care plan date Bring screen form to meeting so can complete as much as possible during the meeting. Pt's with deficits, falls, or declines are discussed/identified. Supportive documentation is then verified in chart by therapy. If appropriate, recommend evaluation on form; no need to continue with screen process

2. Interview RN/C.N.A./Other Team members (Reported decline must be documented) If a need is identified, Supportive documentation is then verified in chart by therapy If appropriate, recommend evaluation on form; no need to continue with screen process

3. Interview pt and or family for any new concerns. If a need is identified, supportive documentation is then verified in chart by therapy. If appropriate, recommend evaluation; no need to continue with screen process

4. Visually assess patient performing functional skills with CNA. No physical contact allowed. If a need is identified, Supportive documentation is then verified in chart by therapy. If appropriate, recommend evaluation on form; no need to continue with screen process

5. Preview Chart for documented functional decline and lower prior level of function
    a) MDS - compare last 2 completed MDS's
    b) RN notes
    c) Restorative notes
    d) Fall/Incident Reports
    e) ADL tracking sheets
    f) Physician notes
    g) Hospital transfer records
    h) Previous therapy notes

    If at any point when reviewing documentation, a need is identified Recommend evaluation; no need to continue with screen process

6. Complete Screen Form; If nothing triggered eval, recommend any restorative services or no services.

7. File Screen in chart and copy to Rehab Coordinator

8. Add pt to screen tracking tool

9. If services recommended, Obtain / Ensure orders in chart for therapy to Eval and Tx

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10. Confirm Primary Insurance via E-care
    - Medicare
        - Consent Signed
        - Copy to Admissions to scan into PCC
        - Initiate Eval
    - Pvt Insurance
        - Verify/Obtain authorization via CPT office they in turn send auth to Alden Corp
        - Consent Signed
        - Copy to Admissions to scan into PCC
        - Initiate Eval
    - No Insurance / Authorization not received / Not appropriate to bill Insurance
        - Self Pay
            - Consent Signed
            - Copy to Admissions to scan into PCC and copy to Corporate
            - Initiate Eval
        - Administrator Authorizes Visits
            - Therapy Approval Form signed
            - Form sent to Corporate
            - Initiate Eval

11. At end of each month ensure the screen tracking tool is complete and email to Regional by the 3rd of the month at the latest.

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Screen Tracking Tool

Facility: Month:

CMI Meeting Frequency

Missed CMI mtgs/dates/reasons:

Screens

	Screen Findings							Results			Quarterly Screen Data				
Pt Name	screen trigger due to CMI? Y/N	no findings	Fall	Documented fxnl change	pt, family, nursing concern	Visually observed issues	LTC Discipline recommendation impairment category/ies	PT eval	OT eval	ST eval	CMI ARD	pt discussed at cmi mtg 1-2 wks prior? Y/N	support for therapy identified in CMI (best practice) Y/N	CMI Met	If not met why not?

Supervisor Screen Tracking Tool Process (Revised)

The new screen tracking tool is now an excel document located in the Shared drive on office.com
Best Practice is to add Patients to the Screen Tracking Tool as soon as it is completed
You can keep track of the entire year with each month having a separate tab
The first tab is an example on how to complete it and then there are tabs for each month
At the top of the page we are asking for information on your CMI meeting:

- The frequency you normally have meetings
- Any missed meetings with the dates and reason.
  **This is vital information for your Regional and we ask that there is a record of each missed meeting.

The remainder of the form is then completed for each screen that you do regardless of payer source.
Fill in the name of the pt in the first column.
The next group of columns provides information on the screen findings. Please check all that apply and be sure to include the impairment category that led to the disciplines chosen to evaluate the patient.
The next group of columns tracks which disciplines evaluated the pt
The last group of columns tracks information on quarterly screen data for CMI.

Rev 8/1/21

Part B progress made updates 6/20/17

What has worked:

In order to ensure we are providing the appropriate therapy services for all our Long-Term Residents, all sites have been directed to ***screen the entire facility for any need for therapy services. Not to wait for the facility to refer patients to them nor wait for their CMI meeting.***

The previous process was to wait for the CMI date prior to screening the residents. Also previously the goal was to only pick them up during their window. Often times we were asked not to pick them up until their window opened up. So the staff stopped screening patients outside the window so they would not identify patients that had a need and then not be able to pick them up. Further training now has occurred to ensure therapy and nursing both know that the dates can be moved in order to still meet the needs of the patient as well as assisting the facility in the CMI rate.

Expanded services with an Incontinence program: ACP incontinence training in conjunction with nursing has been initiated. Jennifer Fuller coordinated her team to be sure a member of the facility nursing staff has been identified for training on documentation needs. ACP also reviewing marketing with any other facility team members as available.

Regional attend CMI meeting and co-screen patients with Supervisor to ensure process is being followed correctly.

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Regionals providing second opinions when an Eval only occurs or disagreement occurs between facility IDT and therapy – promote 2 week trials as appropriate and medically necessary.

Regionals provide 1:1 mentoring to collaborate with the therapist regarding screens so residents can achieve their best ability to function.

Educating therapists in varying definitions of nursing assist levels. If a pt has remained at Extensive Assist they still may be able to improve within that Extensive Assist definition. Extensive assist is a broad term where as Therapy assist levels are broken out further.

There has been increased collaboration with the Alden team (Restorative RN and floor nurses) regarding long term residents and their long term needs outside the CMI meeting. They have received further training from Esther, Jennifer Fuller and her entire Medicare team resulting in improved therapy referrals of patients needing therapy services.

CPT Regionals and Alden Regionals attending CMI meeting together to reinforce the process and appropriate referrals to therapy.

CPT Regionals asking therapists to take a more proactive approach. When therapists are on the unit, if they notice a resident that may benefit from therapy, they would alert their supervisor immediately.

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CPT gave Jennifer access to CPT reports for pt census and review.

Calls (or emails) originally bi-weekly, now as needed between CPT Regionals and Jennifer Fuller and her team. Collaboration and Communication on CMI issues at each facility.

There has been improved access to documentation:
1. Worked with Rick Hoffman and Vanessa to increase our sups access to PCC.
We requested and then received additional PCC access for sups including
Access to the full MDS, previously they had limited access with most information being locked out (especially pain, falls and rehab potential)
Lab results
Care plan
Care plan focus Summary (some supervisors had access, some did not)
ADL significant change
ADL index report
Clinical Alerts

2. Supervisors had also been granted access to Care watch. This tool had several reports that were pertinent to therapy. It had ADL reports, MDS suggestions for patients that would benefit from therapy due to a trending change, etc. This was a very valuable and helpful tool. However Alden no longer uses Care Watch but has a different MDS monitoring report

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3. CPT now has access to the # of LTR that have a Med B benefit and have been able to adjust Med B report with those #'s.

In addition, in order to ensure all sites have all the tools they need to provide all necessary services for our LTRs we sent them the following information:

1. Feeding Program – Additional service: Suggest Cognitive feeding tools adapt it into SNFs as successful at Courts of Aurora (See Appendix 1 at end of document)

2. Frailty Assessment (See Appendix 2)

3. Scope of Practice for PT, OT, ST (See Appendix 3)

4. A list of Reasons for a referral to therapy

- Updated the Nursing Unit Changes Indicating Need for Therapy form with additional reasons for therapy & submitted to facilities and often used during rounds to facilitate referrals to therapy (See Appendix 4)
- Created and Implemented to all sites use of Long-Term Resident Impairment and Discipline Recommendation Form. (See Appendix 5) This sets forth new policy that patients with specific issues are to be evaluated by multiple disciplines to assess if any underlying impairments causing the functional loss can be treated by those disciplines. Goal is to ensure all services needed to improve patient are addressed.

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To determine success, tracking # of residents with multiple discipline involvement month to month.

- Monthly tracking (reviewed by Regionals and Administrators – pg 27) of all screens by sups, # of pick-ups, Reasons why residents not picked up including Insurance limitations.

5. Able to obtain list of current residents with a Medicare # to help identify those with possible Medicare benefits – sent to all sups. Sups then meet with RCC and Restorative RN to identify residents that may need services

6. New Memory Support Program / Dining Program - Collaboration with Dr. Stelter on new Dementia program at SNFs for identifying Residents for Dementia Services. CEU approved program began education at specific sites with Dementia units. Goal to train all sites.

Sent out a step by step rewrite of the screen process to help in the understanding of the process
Being notified of falls in a timely manner at the daily meetings

Limitations:
Limitation of picking up all pts referred to us due to Insurance verification lag time. We can do the first 3 visits and the pt is in system as PA until we get the auth. Then we can change payer to B and continue beyond those 3 visits.

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Also limited in total # of visits for Ins patients due to limited visit approval or limited when facility does not have a contract with the Ins company to provide Part B services
Lkpk: Would like nursing to document declines and refer to therapy with more specific info and quicker
Some facilities have been identified as having a limitation in therapy availability due to an increase in Managed Care and Insurance as primary vs. Standard Medicare.

Added 08/2020

Strategies:

Screen the entire facility for any need for therapy services. Do not wait for the quarterly CMI screening date and do not wait for the facility to refer patients, take a proactive approach

Asking therapists to take a more proactive approach. When therapists are on the unit, if they notice a resident that may benefit from therapy, they would alert their supervisor immediately

Team Meetings: Add Med B to the topics discussed at team meetings – asking staff if they have noticed or heard of anyone needing therapy intervention, change in condition, etc while on nursing unit

Outside the CMI calendar or if CMI does not trigger an eval have multiple/varied team members screen patients to obtain a different / varied perspective of the patients.

Meeting with MDS for comprehensive review of all LTC residents

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Observe pts in varied environments: Room, dining room and activities to see if there are declines in one setting vs another

Increased collaboration with the Alden team (Restorative RN and floor nurses) regarding long term residents and their long-term needs outside the CMI meeting

Utilize Administrator' leadership to encourage an interactive team approach between Admin, MDS, Restorative, Nursing, C.N.A.s, Activities so all keep a watchful eye out for deficits and communicate those to therapy

Care Plan Meetings: Facility to use this contact with pt and families to discuss the benefits of therapy, especially for residents that are not currently on therapy so the pts/families understand if and when it is recommended.

If you see a pt with a decline and need supportive documentation – discuss with the RN, or bring up in Med mtg or whatever mtg LTC residents are discussed

Do not use caps to limit services, if a resident needs services they should be provided – good skilled documentation will support the clinical need.

Supervisors to identify and train their substitute sup to manage the screen process and ensure Med B best practices are properly followed when they are asked to step into the Sup role

Treating patients in their rooms during the covid pandemic has allowed therapy staff to keep a keener eye on non-therapy residents and allowing them to observe changes in

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condition of those pts. In addition, therapy staff are more visible to nursing and this has enhanced communication

Increased Regional involvement at various levels as needed

Daily calls and a daily list of screens provides Regionals with an increased and more timely opportunity to discuss screens and intercede especially with multiple discipline concerns or if no services have been recommended – ask probing questions to ensure a thorough screen

Regionals providing second opinions when an Eval only occurs or disagreement occurs between facility IDT and therapy – promote 2 week trials as appropriate and medically necessary

Regional increase interaction as needed including tracking of CMI calendar, attending CMI meeting, reviewing each pt to ensure referral to therapy is properly documented or work with the IDT to attain proper documentation, ensure each discipline screens thoroughly and evaluates timely, track if they make the CMI date and if not why not. Communicates with entire IDT on all pts meeting CMI date, any missed dates, and if days can be moved to capture the CMI on another.

Towards end of the quarter, Supervisor to ask RCC to print a list of all residents that includes their prior RUG and their projected RUG for the quarter. For all patients who have not met their prior RUG, therapy screens to determine if there is a need that can be addressed.

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Tools:

24-hour Summary Report (Appendix 8): Supervisor checks this facility form daily to assess any documented changes in condition on all patients as noted by nursing on each shift in the past 24 hrs– this report is accessed either on PCC or by checking manually on nursing units

The ADL Significant Change Analysis Report (appendix 6): This form in PCC identifies changes (declines & improvements) week to week in ADL scoring of residents in the facility allowing us to identify potential therapy need

Resident List Report-New (appendix 7): Report in PCC that provides a list of current residents with a Medicare # to help identify those with possible Medicare benefits. All sups have now been given access to this report in PCC

Monthly Screen tracking form (see pg 27): Completed by Supervisors to include a list of all screens, # of pick-ups and reasons why residents not picked up including Insurance limitations. To be reviewed by Regionals & Administrators monthly.

Long-Term Resident Impairment and Discipline Recommendation Form (appendix 5)– Ensure this document is strictly followed by all to ensure the decision for therapy intervention is based on an evaluation by each appropriate discipline vs making the decision based only on a screen or allowing another discipline to make that decision

Nursing Unit Changes Indicating Need for Therapy form (appendix 4): This form is for nursing units to identify

residents that have declined and in what area. It also can assist the nursing staff to know what areas therapy can address and help with. It can also be used by the therapy supervisor in the CMI meeting to prompt probing questions to ensure identification of any changes in condition from varied team members and varied shift members

Feeding Program (appendix 1): A program developed to ensure proper screening and identification of residents who are having difficulty with any stage of the feeding task which would lead to evaluation and treatment as necessary to maximize function.

Frailty Assessment (appendix 2): Tool to assess any resident for frailty/ risk for functional decline. Use this tool during an eval when considering an eval only

Task Tab (Appendix 9): Utilized to identify status for the past 30 days in all mobility areas: bed mobility, transfers, walking, locomotion (w/c propulsion), eating, bathing, dressing, personal hygiene, & toilet use. Then compare to Therapy DC summary status to identify declines

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Step 7: Future Plans

Goal: Anticipate future improvements and preserve the lessons from this effort.
Output: Completed documentation and communication of results, learnings, and recommendations for an effective Med B process and MMAI (dual eligible) process.

Medicaid is now being shifted to being managed by Private Insurance Companies.

Residents that qualify for Medicaid and Medicare are being called dual eligible. They will now have all their services (MC and Medicaid) managed by a Private Insurance company. This is being called an MMAI plan. The only way to keep their Medicare Benefits as they are is to opt out of the Insurance Company taking on the Medicare management.

If the Insurance Company is managing both PA and Medicare Benefits we will no longer be able to follow the Med B verification process but will need to get authorization from the Insurance Company and follow the private Insurance verification process. However the Med B billing rules still apply - G codes, 10th visits, etc.

If a pt opts out and the Insurance Company only manages PA, they remain Med B.

For patients who only have PA (no Medicare benefits), the process with the facility has not been finalized. Facility

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can not bill for the therapy services and be paid. It has always been a write off for the facility and it would remain that. However there is an opportunity for therapy services to be paid. The therapy suppliers can bill directly but then they have to have a contract with the Insurance plan, be in network with the Insurance plans, have NPI #'s, etc. Payment would be directly to the therapy supplier as well.

Potential Concerns:
The amount of Med B opportunity may dwindle under this system.
How will CPT be reimbursed - as Insurance or as Med B
Education needs to occur as to how these pts will be identified in the SNF and how will CPT identify them in the software.

Appendices

Appendix 1

Specialized Program for SNF: Feeding Program
Policy: Screen and Identify Residents who are having difficulty with any stage of the feeding task. Evaluate and Treat as necessary to maximize function. Complete a written FMP and complete education for resident, family and staff.

Procedure:
1. Screen residents for:

- Having difficulty reaching food
- Drop a significant amount of food on themselves or the floor
- Have difficulty getting food from the plate to the mouth
- Have difficulty controlling food utensils
- Have difficulty eating food in designated/reasonable amount of time
- Have difficulty following directions
- Disruptive / uncooperative during meals

2. Recommend Eval for any of the above issues and obtain orders for Therapy
3. Complete therapy evaluation with focus on:

- Ability to use all meal utensils, straw, cup, glass
- Sitting balance and posture including
    - head control and positioning
    - trunk control
    - hip / knee alignment
- Ability to use or need for adaptive equipment:
    - Plate guard
    - Scoop dish
    - Built up utensils
    - Universal cuff
    - Weighted utensils
    - Straw
    - Adaptive cup
    - Other
- Cognitive and Behavioral status including:

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- Distractibility
- Initiation
- Following step by step commands
- Cooperation
- Safe swallow guidelines
- Neglect or visual field deficits
- Hearing loss

For Treatment the focus should be:

- Attempt different adaptive equipment or techniques in order to maximize function.
- Train nursing staff to use adaptive equipment with focus on allowing the patient to be as independent as possible, giving them the time to be successful
- Key words to ensure skilled documentation when developing a program should be used: design, establish, implement, teach, & train in functional maintenance program.

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Appendix 2

FRAILTY SCREEN INSTRUCTION GUIDE

Frailty is defined as a clinical syndrome in which 3 or more of the following criteria are present: unintentional weight loss (10 lbs in past year or 5% loss in body weight), self reported exhaustion, weakness (grip strength), slow walking speed, low physical activity and muscle wasting (sarcopenia). These criteria cause a loss of physiologic reserve that makes a person susceptible to disability from minor stressors, Other common features include frequent falls, immobility, exercise intolerance, incontinence and instability of chronic diseases,

Tools needed to complete screen: access to current and past body weight, stop watch or second hand, dynamometer, calculator, tape measure.

Weight Loss:

Calculate:

(last years body weight) - (current body weight) X 100 = _____%

(last years body weight)

Sign of frailty? yes no

Example: (175- 163) X 100 = 6.86%
175

Unintentional loss of at least •10 lbs or 5% of body weight since last year indicates a positive sign for frailty.

***If weight loss indicates a Sign of frailty conference with the RN, You may also need to conference with the MD, family, ST or dietician

---

Exhaustion: (ask the following two questions and circle response)

I . How often do you feel like everything you do Is an effort?

Response

0 = rarely or none of the time (<lday)
1 = some or little of the time (1*2dayg)
2 = moderate amount of the time (3-4days)
3 = most of the time (>4days)

2. How often do you feel like you cannot get going?

Response

0 = rarely or none of the time (<lday)
1 = some or little of the time (1-2days)
2 = moderate amount of the time (3-4days)
3 = most of the time (>4days)

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Subjects scoring 2 or 3 to either of the questions indicate a positive sign for frailty..... yes no

If exhaustion indicates a sign of frailty consider performing other tests: Physical Performance Test (PPT), Perceived Exertion Scale, Mini Mental Health.

Gait Speed:

Ask client to ambulate 15 feet jn one direction and time them. Timing starts in standing position,

Gender _____ Height _____ Time to walk 15 Feet_____

Men	Cutoff for time to walk 15 feet for frailty
height ≤ 5'8"	≥7 seconds
height > 5'8"	≥6 seconds

Gait Speed (continued)

Women	Cutoff for time to walk 15 feet for frailty
Height ≤5'4"	≥7 seconds
Height >5'4"	≥6 seconds

gait speed ≥ the cutoff times above indicates a + sign for frailty yes no

If gait speed indicates a sign of frailty consider performing other tests: Modified Falls Efficacy Scale, Timed Up and Go, Berg Balance, Tinetti Balance and Gait Measure, Dynamic Gait Index, Timed Movement Battery, Activity Balance Confidence Scale.

Grip Strength: (stratified by gender and body mass index (BMI) quartiles)

Body Mass Index Formula

$$BMI = \frac{.45 \times \text{pounds}}{(.0254 \times \text{inches})^2} = _____$$

Calculate Body Mass Index (BMI) $BMI = Kg/(m)^2$

1 inch = 2.54cm 1 meter = 100cm 1 pound = 0.4535kg

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Example: 5 ft 8 in = 68 in

68 in x 2.54 cm / in = 172.72 cm

172.72 cm 1.7272 m

and

139 lbs x 0.4535 kg / lb = 63.0494 kg

$$\frac{63.0494}{1.7272^2} = \frac{63.0494}{2.98} \approx 21.16$$

(use dynamometer)

Men	Cutoff for grip strength (Kg) criterion for frailty
BMI ≤24	≤ 29
BMI 24.1 -26	≤ 30
BMI 26.1 -28	≤ 30
BMI > 28	≤32
Women	
BMI ≤ 23	≤ 17
BMI 23.1 -26	≤ 17.3
BMI 26.1 -29	≤ 18
BMI > 29	≤21

Grip strength ≤ the cutoff values above indicate a positive sign for frailty yes no

If grip strength indicates a sign of frailty consider performing other tests: Manual Muscle Test, Barthel, Physical Performance Test (PPT).

Physical Activity:

Physical activity and energy expenditure is calculated in terms of Kcals or METS, A Kcal = 1000 calories. A MET is .0169 kcal per minute per kilogram. A MET is a unit used to estimate the metabolic cost of a physical activity. 1 MET = the uptake of 3.5 ml 0^2 per kg of weight per minute, An activity requiring 10 METS would expend approx. 70 kcals/hour (Oxford Handbook of Sports Medicine.)

$$\text{kcals/minute} = \frac{\text{METS x 3.5 x body weiaht in kg}}{200}$$

Men who expend <383 kcals per week on leisure activity are frail.

Women who expend <270 kcals per week on leisure activity are frail.

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Physical activity questions to determine frailty:

Men:

Do you do mild, active exercises (in a group or alone) at least 3x per week for 40 minutes? Yes no

Do you walk at a steady pace for at least 21 minutes every day? Yes no

Women:

Do you do mild, active exercises (in a group or alone) at least 3x per week for 30 minutes? Yes no

Do you walk at a steady pace for at least 15 minutes every day? Yes no

A no answer to either of the above questions indicates a positive sign for frailty .... yes no

If physical activity indicates a sign for frailty consider performing other tests: Activities Balance Confidence, Tinetti, Physical Performance Test, Berg Balance, Timed Up and Go, Dynamic Gait Index, Timed Movement Battery

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Appendix 3

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PHYSICAL THERAPY
SCOPE OF PRACTICE GRID
Place severity rating in box:
1. stand by 2. Mild 3. Mod 4. Severe
5. Profound

		Impact Rating on Function										
		Bed Mobility	Gait Level Surfaces	Gait Uneven Surfaces	Joint Mobility	Positioning	Sitting Balance	Skin Integrity	Stair Climbing	Standing Balance	Transfers	Wheelchair Mobility
UNDERLYING IMPAIRMENTS	**1. Cardiorespiratory**											
	a. Breathing pattern (diaphragmatic)											
	b. Chest excursion											
	c. Airway clearance ability											
	d. Aerobic capacity / endurance											
	e. Oxygen saturation											
	2. Skin / Tissue Health											
	a. Circulation											
	b. Edema											
	3. Nutrition											
	4. Neuro/Musculo/Skeletal											
	a. Postural alignment											
	b. Muscle tone											
	c. Range of motion											
	d. Gross strength											
	e. Weight bearing											
	f. Weight shifting											
	g. Postural control											
	h. Static balance											
	i. Dynamic Balance											
	j. Coordination / motor planning											
	k. Pain pattern											
	l. Quality of movement											
	m. Accessory motions											
	1. Joint motions											
	2. Muscular substitutions											
	n. Contractile tissue integrity											
	o. Non-contractile tissue integrity											
	p. Proprioception											
	q. Kinesthesia											
	r. Reflexes											
	5. Sensory											
	a. Tactile processing											
	b. Sensory awareness											
	c. Body scheme awareness											
	d. Vestibular status											
	e. Visual Acuity											
	f. Auditory discrimination											
	6. Cognition											
	a. Level of arousal											
	b. Orientation											
	c. Self-awareness											
	d. Safety awareness											
	e. Task sequencing											
	f. Problem solving											
	7. Psychosocial											
	a. Behavioral health											
	b. Motivation / cooperation											
	c. Family support											
	d. Caregiver support											
	e. Communication ability											
	f. Play/leisure ability											
	g. Health maintenance ability											

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OCCUPATIONAL THERAPY SCOPE OF PRACTICE GRID
Place severity rating in box:
1. stand by 2. Mild 3. Mod 4. Severe 5. Profound

		Impact Rating on Function														
		Bathing/ Showering	Bed Mobility	Community Activities	Dressing	Emerg. Resp./ Safety Proc.	Feeding	Functional Commun.	Grooming /Hygiene	Home Management	Joint Mobility	Leisure/ Productive Activ.	Meal Prep/ Cleanup	Medication Routine	Positioning	Toilet Hygiene
UNDERLYING IMPAIRMENTS	**1. Sensory**															
	a. sensory awareness															
	b. sensory processing															
	(1) tactile															
	(2) proprioceptive															
	(3) vestibular															
	(4) visual															
	(5) auditory															
	(6) gustatory															
	(7) olfactory															
	c. perceptual processing															
	(1) stereognosis															
	(2) kinesthesia															
	(3) pain response															
	(4) body scheme															
	(5) right - left discrimination															
	(6) form constancy															
	(7) position in space															
	(8) visual-closure															
	(9) figure ground															
	(10) depth perception															
	(11) spatial relations															
	(12) topographical orientation															
	2. Neuromusculoskeletal															
	a. reflex															
	b. range of motion															
	c. muscle tone															
	d. strength															
	e. endurance															
	f. postural control/balance															
	g. postural alignment															
	h. soft tissue integrity															
	i. gross coordination															
	j. crossing the midline															
	k. laterality															
	l. bilateral integration															
	m. motor control															
	n. praxis															
	o. fine coordination / dexterity															
	p. visual-motor integration															
	q. oral-motor control															
	r. edema															
	4. Cognitive Integration															
	a. level of arousal															
	b. orientation															
	c. recognition															
	d. attention span															
	e. initiation of activity															
	f. termination of activity															
	g. memory															
	h. sequencing															
	i. categorization															
	j. concept formation															
	k. spatial operations															
	l. problem solving															
	m. learning															
	n. generalization															
	o. safety awareness															
	5. Psycho/Social/Self-Expression															
	a. self-concept															
	b. role performance															
	c. social conduct															
	d. interpersonal skills															
	e. self-expression															
	f. coping skills															
	g. time management															
	h. self-control															
	6. Cardiorespiratory															
	a. breathing patterns (dysphn.)															

SPEECH-LANGUAGE PATHOLOGY

Scope of Practice

Place severity rating in box:
1. stand by 2. Mild 3. Mod 4. Severe 5. Profound

		Impact on Function				
		Expressive Language	Receptive Language	Cognition	Dyphagia	Speech/ Voice
UNDERLYING IMPAIRMENTS	**A. Auditory Comprehension**					
	1. word discrimination					
	2. response to phrases (Y/N, Wh-, personal ?'s, commands)					
	3. sentences					
	4. paragraph length materials					
	5. conversation					
	B. Speech Reading					
	1. visual discrimination tasks					
	2. auditory discrimination tasks					
	3. auditory closure					
	C. Cognitive Communication					
	1. attention: sustained, selective, divided, alternating					
	2. orientation: person, spatial, temporal, situation					
	3. memory: restrospective, incidental, prospective					
	4. sequencing: simple to complex					
	5. problem solving: math, money, time, verbal/visual					
	6. reasoning: deductive, inductive					
	7. judgment/safety awareness					
	8. executive function: initiation, organization, integration					
	9. error awareness					
	10. self-correction of errors					
	D. Pragmatics					
	1. initiation					
	2. turn-taking					
	3. topic maintenance					
	4. interpretation of tone of voice, facial expression, gestures					
	5. appropriateness					
	E. Reading Comprehension					
	1. visual tracking					
	2. matching forms, letters					
	3. word-object-picture matching					
	4. word/phrase comprehension					
	5. sentence/paragraph comprehension					
	6. multiple paragraph comprehension					
	7. functional reading (schedule, phone book, directions, etc.)					
	F. Graphic Expression					
	1. mechanics, imitation, copying					
	2. drawing					
	3. recall of written symbols					
	a. serial writing					
	b. dictation: letters, words, sentences					
	4. phrase/sentence formulation					
	5. paragraph formulation					
	6. functional correspondence (personal, business)					
	G. Oral and Non-oral Expression					
	1. imitation (sounds, words, phrases)					
	2. automatic/serial output					
	3. single word production					
	4. phrase production					
	5. sentence production					
	6. conversation production					
	H. Articulation/Speech/Voice					
	1. oral motor strength, ROM, and coordination					
	2. vocal quality (normal, nasal, breathy, harsh, hoarse)					
	3. rate, prosody, rhythm					
	4. pitch					
	5. volume					
	6. intelligibility: word, phrase, sentence, conversation					
	7. breath support (respiration/phonation coordination)					
	8. initiation of speech					
	I. Swallowing					
	1. oral muscular strength, ROM, and coordination					
	2. sensation: lips/oral cavity					
	3. sensation: oral pharynx					
	4. bolus manipulation					
	a. bolus formation					
	b. A-P propulsion of bolus					
	c. varied textures					
	d. hot/cold temperatures					
	5. swallow response: reflexive, volitional					
	6. appropriate posture					
	7. airway protection					

Appendix 4

Nursing Unit Changes Indicating Need for Therapy

Resident: _____ Date: _____

A change in any of the areas below on any shift can indicate a reason to screen or evaluate for therapy services. Change must be documented in medical chart. Please refer to therapy.

_____ mobility in bed

____ getting on / off bed

____ getting on / off chair

____ wheelchair mobility in room

____ wheelchair mobility in corridor

____ ambulation in room

____ ambulation in corridor

____ stability

____ use of assistive device

____ more assist in am or pm

____ complaint of shortness of breath

____ change in breathing pattern

____ Tires quicker

____ positioning / slouching in chair

____ fall has occurred

____ complaint of pain

____ skin condition changes

____ toileting

____ hygiene

____ feeding

____dressing

____ bathing

____ swelling in arm / leg

___ swallowing

____ coughing at meals

____ eating less of meal

____ pocketing food

____ dropping food

____ difficulty with meals

____speech clarity

____ weight loss

____ change in cognition

____ incontinence

____ visual changes

____ decreased ROM/possible new onset of joint contracture

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Appendix 5

If the resident has had any changes (improvement / declines) with the any of the functions listed below per patient screen, the following disciplines are recommended per the Scope of Practice for each discipline:

Functions	***Appropriate Disciplines***		
Speech clarity	ST		
Making Self understood	ST	OT	
Ability to understand others	ST		
Change in cognitive status	ST	OT	PT
Short term memory changes	ST	OT	
Long term memory changes	ST	OT	
Recall	ST	OT	PT
Cognitive skills/daily decision making	ST	OT	
Acute onset of mental status change	ST	OT	
Mood/Behavioral/Motivation/Coop	ST	OT	PT
Task sequencing	ST	OT	PT
Safety Awareness		OT	PT
ROM Joint mobility		OT	PT
Strength		OT	PT
Tone		OT	PT
Bed mobility		OT	PT
Transfers: Bed Toilet Chair		OT	PT
Posture: Sitting Standing Positioning		OT	PT
Walk in room		OT	PT
Walk in corridor			PT
Locomotion on unit (includes WC…)		OT	PT
Locomotion off unit (WC; gerichair…)		OT	PT
Stairs/UnevenSurface/Curb/ElevatorMngmt		OT	PT
Mobility / assistive devices (need, training, change)			PT
History of falls		OT	PT
Recent falls		OT	PT
Balance Instability		OT	PT
Coordination Proprioception		OT	PT
Vestibular		OT	PT
Visual Auditory	ST	OT	PT
Dressing		OT	PT
Toilet use		OT	PT
Personal Hygiene		OT	
Grooming		OT	PT
Bathing		OT	PT
Urinary Incontinence		OT	PT
Urinary toileting program		OT	PT
Pain		OT	PT
Orthostatic hypotension	ST		PT
Breathing pattern Chest excursion	ST	OT	PT

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Fatigues easily		OT	PT	
SOB	ST	OT	PT	
Increasing inactivity		OT	PT	
% Artificial Intake	ST			
Swallowing	ST			
Eating Chewing Pocketing	ST	OT		
Eating less	ST	OT		
Coughing Choking	ST			
Diet alteration	ST			
Feeding difficulty		OT	PT	(posture fine motor utensil/ cup use dropping food)
Weight loss	ST	OT	PT	
Pressure ulcer risk (skin integrity)		OT	PT	
Worsening pressure ulcer		OT	PT	
Circulation / edema		OT	PT	
Rehab potential ID by RN Restorative	ST	OT	PT	

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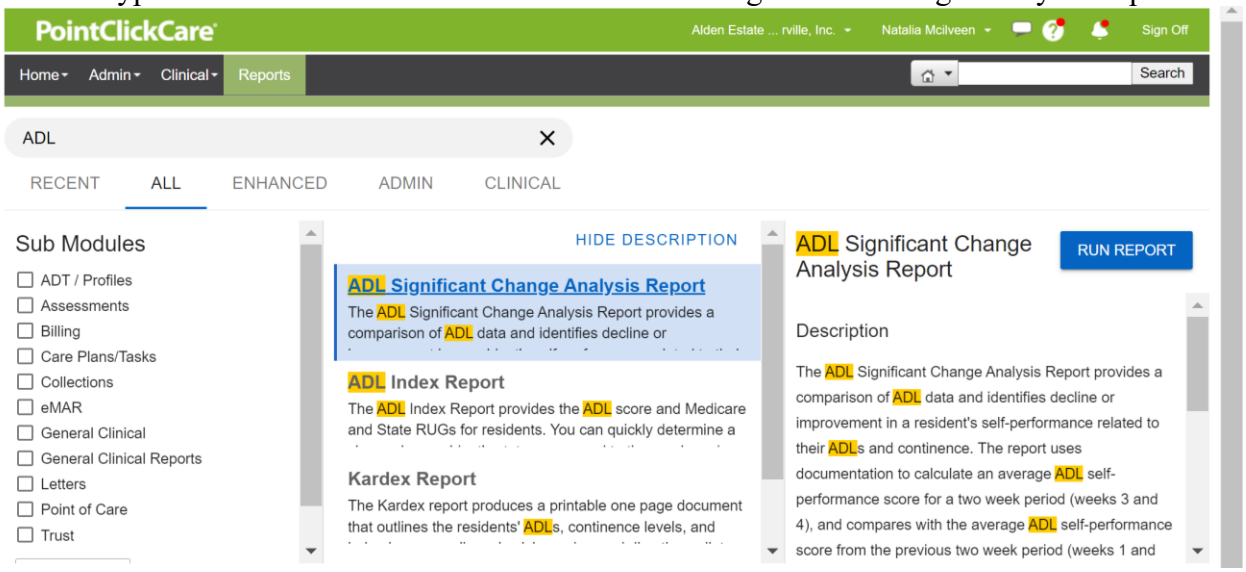
Appendix 6

HOW TO ACCESS: ADL SIGNIFICANT CHANGE REPORT

1. Click on REPORTS tab
2. Type in “ADL” in search bar: and click on ADL significant Change Analysis Report



3. Can search by individual Resident by typing in name into search bar

Facility #: ---
Alden Town Manor
Facility Code: 108
Date: May 12, 2020
ADL Significant Change Analysis Report
User: Joanne Metzger
Time: 11:35:21 CT
Page 7 of 21

Resident: All Unit: All Floor: All Status: Current Period Ending: 04/29/2020 - 05/12/2020
Comparison Period: 04/15/2020 - 04/28/2020 Payer: AARP M3 Plan, AARP Supplemental Insurance, ADR (MCA), ADR (MCB), Advantra Freedom MAP, Advocate MAP, Aetna, Aetna Better Health (PA) LTSS, Aetna Better Health (PN) LTSS, Aetna Better Health FHP (PA), Aetna Better Health FHP (PN), Aetna Better Health Managed Care Oxygen, Aetna Better Health Managed Care Part B, Aetna Better Health P .....see last page

Resident	Period	ADL Index	Bed Mobility	Transfer	Walking In Room	Walking In Corridor	Locomotion on Unit	Locomotion off Unit	Dressing / Grooming	Eating	Toilet Use	Personal Hygiene	Bathing	Urinary Continence	Bowel Continence	Urinary Continence	Bowel Continence
[redacted]	Week 1	6.71	2.40	2.70	1.00	-	1.90	1.00	2.70	1.00	2.20	3.00	2.50	2.00	2.00	3.00	2.80
	Week 2	3.86															
	Week 3	4.86	2.90	2.90	1.00	-	2.50	2.60	3.00	1.00	2.60	3.00	3.40	2.30	2.00	2.40	2.50
	Week 4	6.00															
	Difference		-0.50	-0.20	0.00	-	-0.60	-1.60	-0.30	0.00	-0.40	0.00	-0.90	-0.30	0.00	+0.60	+0.30
	Category		Decline	Decline	Same	Same	Decline	Decline	Decline	Same	Decline	Same	Decline	Decline	Same	Improve	Improve
[redacted]	Week 1	4.00	3.00	1.60	-	-	1.00	1.00	1.00	1.00	3.00	1.00	1.00	1.90	0.90	3.00	2.70
	Week 2	5.14															
	Week 3	4.00	3.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	3.00	1.00	1.00	2.20	1.10	3.00	3.00
	Week 4	4.00															
	Difference		0.00	+0.60	-	-	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-0.30	-0.20	0.00	-0.30
	Category		Same	Improve	Same	Same	Same	Same	Same	Same	Same	Same	Same	Decline	Decline	Same	Decline
[redacted]	Week 1	0.00	-	-	-	-	-	-	-	1.00	-	-	-	0.00	0.00	3.00	3.00
	Week 2	0.00															
	Week 3	0.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.00	0.00	3.00	3.00
	Week 4	0.00															
	Difference		-	-	-	-	-	-	-	0.00	-	-	-	0.00	0.00	0.00	0.00
	Category		Same	Same	Same	Same	Same	Same	Same	Same	Same	Same	Same	Same	Same	Same	Same
	Week 1	8.00	3.00	2.90	1.50	1.50	1.50	1.00	3.00	1.00	3.00	3.00	1.60	2.50	2.50	3.00	2.90
	Week 2	7.29															
	Week 3	6.57	2.90	2.90	1.40	1.70	1.00	1.00	3.00	1.00	3.00	3.00	3.50	2.50	3.00	3.00	3.00
	Week 4	7.43															
	Difference		+0.10	0.00	+0.10	-0.20	+0.50	0.00	0.00	0.00	0.00	0.00	-1.90	0.00	-0.50	0.00	0.00
	Category		Improve	Same	Improve	Decline	Improve	Same	Same	Same	Same	Same	Decline	Same	Decline		
	Week 1	12.43	3.50	4.00	-	-	4.00	4.00	3.50	3.20	3.40	4.00	4.00	1.80	3.00		
	Week 2	11.71															
	Week 3	12.29	3.40	4.00	-	-	4.00	4.00	4.00	3.00	4.00	4.00	4.00	3.00	3.00		
	Week 4	12.43															
	Difference		+0.10	0.00	-	-	0.00	0.00	-0.50	+0.20	-0.60	0.00	0.00	-1.20	0.00		
	Category		Improve	Same	Same	Same	Same	Same	Decline	Improve	Decline	Same	Same	Decline	Same		

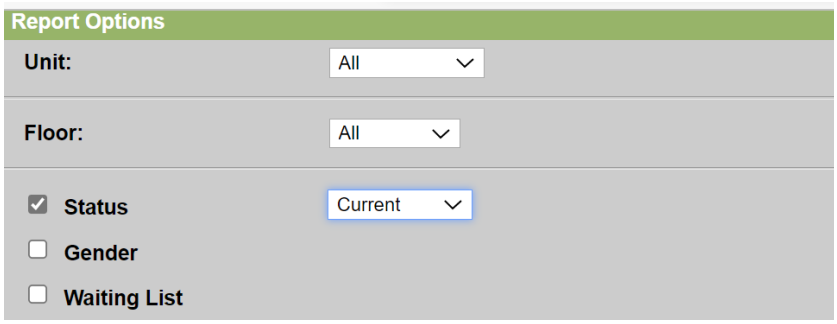
Appendix 7

HOW TO ACCESS: RESIDENT LIST REPORT *NEW

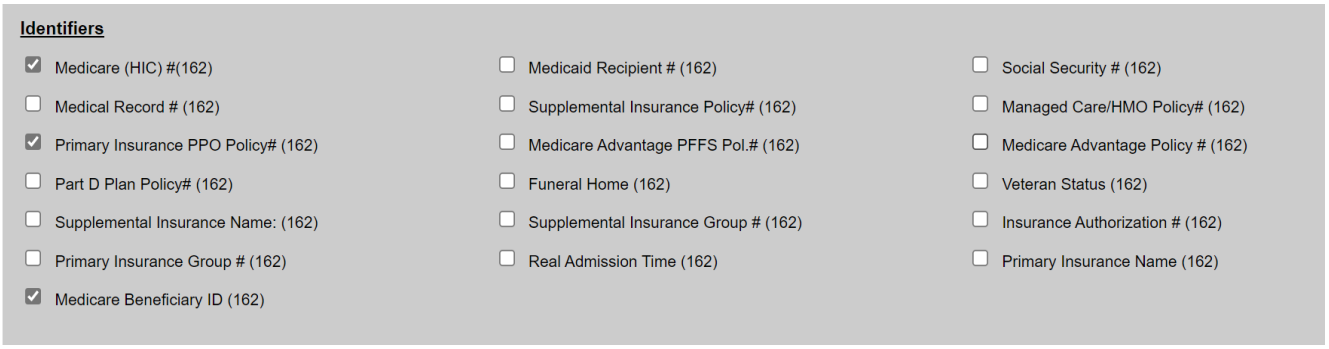
All CPT supervisors now have access to a report in PCC called **"Resident List report-*NEW*"**

This report allows for you to pull a list of residents in your facility and identify if they may have Medicare B, Managed care B, or public aide benefits. This report does not replace the process of insurance verification. However, it does allow for you to identify if residents may have benefits. Residents that have both a PPO# and Medicare # are likely managed care B, and those with a Medicare # only likely have traditional B benefits, and those with no #s may be public aide.

To run this report, choose the following criteria:
1. Click on "Status" a box will pop up- choose "current"



2. Scroll Down to "Identifiers"
Click on:
-Med HIC#
-Primary Insurance PPO Policy #
-Med Beneficiary ID



Please be aware that it is only as accurate as the last time the patient's information was updated into the system by the facility, so it is not error-proof.

Also, as always… this list is just a reference, decisions as to whether a patient requires therapy is ALWAYS based on clinical needs- refer to scope of practice for each discipline.

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EXAMPLE:

Date: Jan 25, 2022
Time: 19:59:20 CT
User: Joanne Metzger

Alden-Valley Ridge Rehab. and Health Care Center, Inc.
Resident Listing Report

Facility #

Page # 1

Resident: All , Unit: All , Floor: All , Status: Current

Name	Age	Location (Fl Un Rm Bd)	Admission Date	Status	Medicare (HIC) #	Primary Insurance PPO Policy#	Medicare Beneficiary ID
[redacted]	63	2 Floor Yorkshire 201 A	12/8/2021	Active			
	74	3 Floor Middleton 317 B	7/24/2020	Active			5UW8HE2VV52
	86	1 Floor Georgetown 108 C	1/3/2022	Active			1EV1FE0MQ27
	80	2 Floor Yorkbridge 214 A	9/17/2021	Active			2V38WE6NH57
	68	2 Floor Yorkshire 207 A	2/8/2019	Active			4UX5QE4GT51
	68	1 Floor Williamsburg 117 B	1/10/2022	Active		XOH832144601	
	85	1 Floor Williamsburg 123 A	1/13/2022	Active			4AC2JK6YR13
	88	3 Floor Wellington 325 A	5/19/2019	Active			7P66XP0TN74
	83	3 Floor Middleton 311 B	10/13/2017	Active	4PE7EH3FD54		4PE7EH3FD54
	93	3 Floor Manchester 303 B	7/6/2020	Active	3CY6DC2QM47		3CY6DC2QM47
	78	3 Floor Wellington 327 A	6/19/2018	Active	3HM0TX7QJ05		3HM0TX7QJ05
	69	1 Floor Georgetown 108 A	1/30/2011	Active		979761221	4AH5C64UR98
	74	1 Floor Georgetown 107 C	10/20/2020	Active	3AW4XT5MD80		3AW4XT5MD80
	71	3 Floor Manchester 306 B	11/6/2021	Active	423649174A	963951278	2R91K30UM97
	64	1 Floor Williamsburg 115 B	6/5/2021	Active			

PPO# and Medicare # are likely managed care B

Medicare # only likely have traditional B benefits

NO #s may be public aide.

Appendix 8

HOW TO ACCESS: PCC 24 HR REPORT

1. click "REPORTS" tab

2. click "24 Hour Summary"
3. System will default to date you are running report
4. Scroll down to "Summary Interval" Choose "last 24 hours" or "last 72 hrs"
5. Click Blue "RUN NOW" in upper right-hand corner
6. Items to look for in this report- note this is all information in the time frame you selected (24/72 hrs):
    - Admissions
    -Discharges
    -Residents on Leave
    - Resident Summary reports:
        Scan for: pain, Nurse Practioner, MD, Physiatrist notes for any information relating to therapy, "Post-Occurrence Documentation" notes- reporting falls, injuries, etc:

Weights and Vitals current in this shift	
Weight	None Entered
Respiration	16.0
BP	129 / 75 (Lying r/arm)
Temperature	96.9 (Forehead (non-contact))
Pulse	70.0 (Regular)
Blood Sugar	None Entered
Height	None Entered
O2 sats	96.0 (Room Air)
Pain Level	0 (Numerical)

Progress notes
1/23/2022 06:15 - Post Occurrence Documentation
Vital Signs: BP 119/81 - 1/23/2022 06:45 Position: Sitting r/arm T 97.5 - 1/23/2022 06:45 Route: Forehead (non-contact) P 89 - 1/23/2022 06:45 Pulse Type: Regular R 18.0 - 1/23/2022 06:45
Day & Shift of Occurrence: Initial, Night Shift
Complete Body Check Done Y/N: Yes
If No, Why:
Are there any Injuries: No,
Details of any findings:
Description of occurrence: (If initial) This writer was called into resident's bathroom. Resident was sitting on the floor between toilet and wall. Gripper socks was on feet. Resident was continent of B and B. No c/o's pain/discomfort. Resident denies hitting head. No injuries noted. Resident stated, "I was getting up and my arm got caught in bar and my foot got caught up and I slid down. Assessment was completed with no injuries noted. Neuro checks initiated. Assisted resident up

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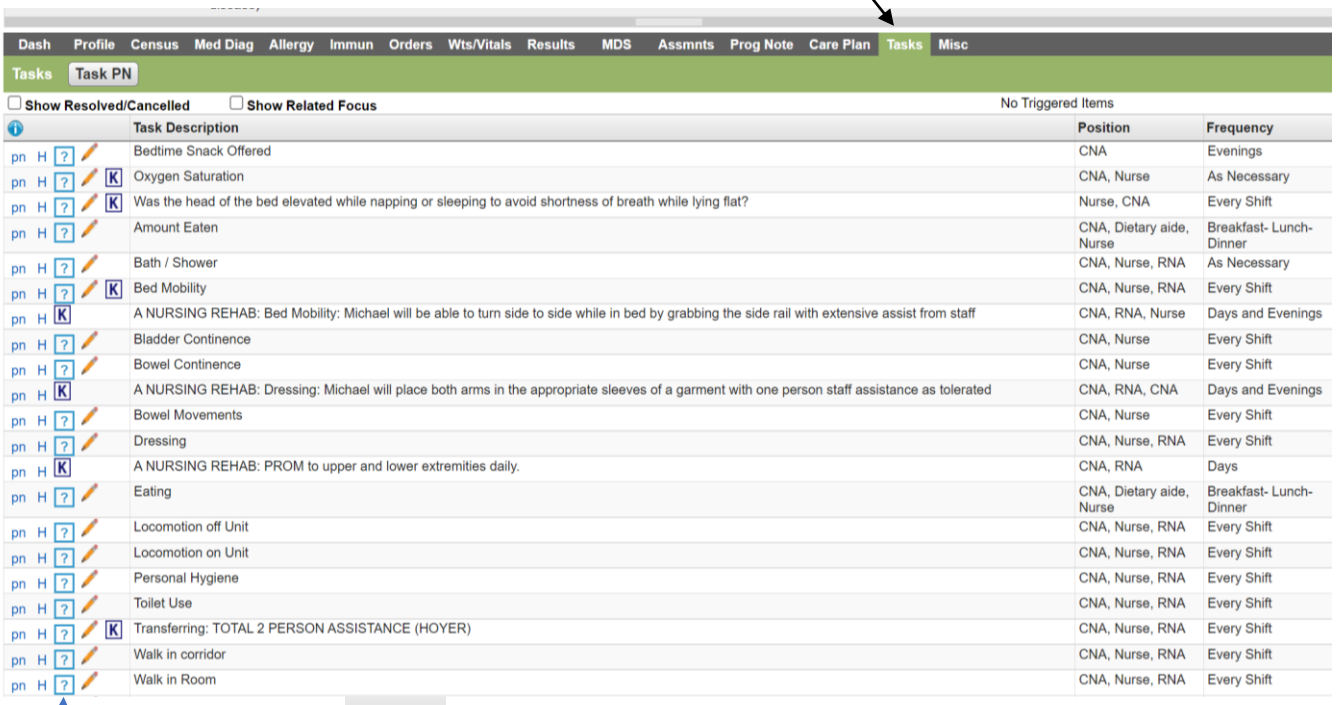
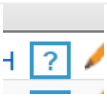
Appendix 9

HOW TO ACCESS: Task Tab

Task Tab is located on the tool bar for each patient's clinical page



Task Description	Position	Frequency
Bedtime Snack Offered	CNA	Evenings
Oxygen Saturation	CNA, Nurse	As Necessary
Was the head of the bed elevated while napping or sleeping to avoid shortness of breath while lying flat?	Nurse, CNA	Every Shift
Amount Eaten	CNA, Dietary aide, Nurse	Breakfast- Lunch-Dinner
Bath / Shower	CNA, Nurse, RNA	As Necessary
Bed Mobility	CNA, Nurse, RNA	Every Shift
A NURSING REHAB: Bed Mobility: Michael will be able to turn side to side while in bed by grabbing the side rail with extensive assist from staff	CNA, RNA, Nurse	Days and Evenings
Bladder Continence	CNA, Nurse	Every Shift
Bowel Continence	CNA, Nurse	Every Shift
A NURSING REHAB: Dressing: Michael will place both arms in the appropriate sleeves of a garment with one person staff assistance as tolerated	CNA, RNA, CNA	Days and Evenings
Bowel Movements	CNA, Nurse	Every Shift
Dressing	CNA, Nurse, RNA	Every Shift
A NURSING REHAB: PROM to upper and lower extremities daily.	CNA, RNA	Days
Eating	CNA, Dietary aide, Nurse	Breakfast- Lunch-Dinner
Locomotion off Unit	CNA, Nurse, RNA	Every Shift
Locomotion on Unit	CNA, Nurse, RNA	Every Shift
Personal Hygiene	CNA, Nurse, RNA	Every Shift
Toilet Use	CNA, Nurse, RNA	Every Shift
Transferring: TOTAL 2 PERSON ASSISTANCE (HOYER)	CNA, Nurse, RNA	Every Shift
Walk in corridor	CNA, Nurse, RNA	Every Shift
Walk in Room	CNA, Nurse, RNA	Every Shift

To the left of each task is a 

Click on the

Daily status per C.N.A. Shift is identified

.K IN ROOM: SELF PERFORMANCE - How resident walks between locations in his/her room

	INDEPENDENT - No help or staff oversight at any time	SUPERVISION - Oversight, encouragement or cueing	LIMITED ASSISTANCE - Resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance	EXTENSIVE ASSISTANCE - Resident involved in activity; staff provide weight-bearing support	TOTAL DEPENDENCE - Full staff performance	Resident Not Available	Resident Refused	Not Applicable
/2022								
07:40		✔						
18:45		✔						
/2022								
00:51		✔						
07:29		✔						
18:49		✔						
23:07		✔						
/2022								
07:22		✔						
16:39		✔						
/2022								
03:01								✔
07:33		✔						
22:59		✔						

Gait Speed:

Ask client to ambulate 15 feet in one direction and time them. Timing starts in standing position.

Gender _____ Height _____ Time to walk 15 Feet _____

Men	Cutoff for time to walk 15 feet for frailty
height ≤ 5'8"	≥7 seconds
> 5'8"	≥6 seconds