Home Care Delivery Tips for LSVT BIG®

I. Establish that you have met criteria set forth by The Centers for Medicare and Medicaid Services (CMS):

A. Establish a functional need

1. Skilled care requires documented decline in function and/or potential for decline in functional status in order to qualify as "skilled need"
2. Start of Care (SOC) Outcome and Assessment Information Set (OASIS) must establish Reasonable and Necessary requirements based on M1810 –1860 scores of greater than or equal to 2

B. Document multidisciplinary collaboration

1. Comprehensive SOC must document multidisciplinary collaboration on the patient's plan of care reflecting functional needs, with special attention needed to match GG scoring items with M1800's to prevent denials.
2. The focus with GG items is on the patient's clinical presentation and anticipated resource needs.

II. Establish a reasonable frequency based on benchmarking and staffing roles:

A. Consider a PT/OT "split" of 2x4 each

1. Comprehensive home care approach for ambulation, transfers, bathing, dressing deficit, treatment approaches, based on deficits identified at SOC
2. Built-in opportunities for coordination of care
3. Reduced staffing burdens for valuable field staff
4. Added value in quality approach for team training, patient is in a win-win situation for recalibration in functional carryover tasks

B. Remember that frequent coordination of care, progress updates, sharing of carryover tasks/feedback are essential!

III. Document your assessments and re-assessments using "home-care-friendly" standardized measures:

A. Pay attention to standardized assessments recommended by PD EDGE as the "gold standard" and for coordination of care across the continuum

1. PD EDGE Recommendations for Parkinson's by Hoehn and Yahr Stage: http://www.neuropt.org/docs/default-source/parkinson-edge/pdedge-all-documents-combined.pdf?sfvrsn=bccd4f43_2 (There are many to choose from!)
2. Grouped also by categories of Body Structure and Function, Activity, and Participation.
3. More info about many standardized tests can be found on the Shirley Ryan Ability Lab website: https://www.sralab.org/rehabilitation-measures/database

IV. Document your skill in LSVT BIG training tasks:

A. Never just take a “picture” of the patient, always “put yourself in the picture”
   1. Never just list Maximal Daily Tasks completed
   2. Always document what you did to train, cue, facilitate Maximal Daily Task training and shaping for self-cueing and recalibration

B. Always document the patient’s Hierarchy Task goals in the Assessment portion – it is your focus of care! Note this under “Patient’s Rehab Goal” in Assessment

C. Always document Functional Component Tasks identified and implemented each session. Coordinate this with your PT/OT partner for continuity of care

D. See Documentation examples in binder to illustrate these points

V. Screen patients for LSVT BIG stimulability and participation (PD and Atypical Parkinsonisms, CVA, MS, Dementia)

A. If the deficits are documented, you have established Reasonable and Necessary for your skilled services using this evidence-based treatment approach
   1. Never provide LSVT BIG to your patients with ALS or Myasthenia Gravis to avoid acceleration of damage to muscle tissue
   2. Use task pacing and avoid over-heating with your MS patients. Avoid training in LSVT BIG during an MS exacerbation

B. Remember that patients with more advanced Parkinson’s Disease can still be candidates for full LSVT BIG protocol
   1. Remember that competency and safety with functional tasks become increasingly important
   2. Daily exercises and cued BIG functional movement may become your “goal” in people with greater disease severity
   3. Caregiver competency in cueing BIG for bed and ADL mobility safety may be your goal

C. Reduces caregiver burden, reduces transition to extended care facility. Activating your “advanced” or “end-stage” patients in-home can be a stepping- stone to discharge to outpatient treatment and community re-entry with support!

D. Co-morbidities and acute conditions are very real issues in home care.
   1. Remember that these patients are still candidates for full LSVT BIG protocol!
   2. Adaptations to positions and movements is acceptable and may be necessary for safety and quality of movement
   3. Reduced repetition of Maximal Daily Exercises may be necessary at first, but do not otherwise modify the protocol.

4. They may need even more repetition of practice for learning and generalization and may need more than 16 total sessions.

E. Fall risk, problems in functional transfers and mobility can exacerbate chronic medical conditions

1. Their homebound status will prevent them from participating in LSVT BIG in outpatient settings
2. A two-week trial is appropriate and evidence-based for use of stimulability testing, pilot assessment of patient and caregiver's "compliance" for an intensive in-home approach

VI. LSVT BIG can be bridged across practice settings

A. LSVT BIG patients started in home health may progress to the point of no longer being homebound and can be transitioned to outpatient practice to finish the protocol. Be proactive in searching for other LSVT BIG providers in the area if the patient is progressing quickly.

B. LSVT BIG can be "finished" in home health when the patient started LSVT BIG in a SNF, Inpatient Rehab or Hospital Setting. Evaluation and SOC OASIS still required, but communication with the referring therapist will help to provide a more seamless transition.

VII. How will Patient Driven Groupings Model payment in 2020 affect my treatment using LSVT BIG in the home health setting?

A. Medicare payment initiatives will drive providers to coordinate evidence-based clinical programs, such as LSVT BIG, across a patient's continuum of care in order to assure quality outcomes

B. Connect with community SNF and Outpatient LSVT BIG certified providers to create network opportunities and templates for effective communication. Consider creation of local networks that advocate for our patients in need of LSVT BIG. Consider inclusion of physicians, managed care organizations, and community PD organizations in your network

C. Clinical Groupings are used in determining Medicare payment thresholds, but your appropriate patients may be designated with any clinical grouping or from community or inpatient referral sources. You are NOT only seeing patients with Rehab Clinical Grouping. Patients with any primary diagnosis may have PD or an appropriate neuro diagnosis for treatment with LSVT BIG.

D. Remember that PD and movement disorders are fairly common co-morbidities that impact our patients' function and outcomes. **PDGM will incentivize**

agencies to identify and treat valid comorbidities such as PD and movement disorders, contributing to billing and payment.

E. Early 30-day billing periods will be emphasized in agency operations after January 2020. Best practice is always therapy assessments within the first 48 hours after SOC. Develop your plan of care together with the team at start of care timepoint to address the patient's identified functional needs for best outcome. **Use interdisciplinary team communication at SOC to establish need for protocol.** Transition to outpatient may occur prior to end of 30-day billing period.

F. Adhere to the protocol frequency of 4 times per week to provide evidence-based dosage. If you are not able to provide dosage according to protocol based on agency financial policies, you cannot provide LSVT BIG.

Disclaimer:
For up to date information on Medicare, please visit www.medicare.gov or consult your professional organization.