CLINICAL MANAGEMENT OF PDGM PART II

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Objectives

- Identify clinical risk areas under PDGM and strategies for managing the risks
- Assess your agency's readiness for PDGM
- Describe the skills necessary for a clinical manager to be an effective 'PDGM Gatekeeper'
- Explain how interdisciplinary care management can mitigate the risks
- Outline steps to more appropriately use therapy services

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PDGM Risk Areas for Clinical Practice

- Inaccurate clinical/comorbidity grouping & functional scoring
- Increased LUPA rates
- Appropriate visit utilization over two 30 day payment periods
- Appropriate use of therapy services

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Strategies for Managing Risks

- Clinical manager as 'PDGM Gatekeeper' (Part 1)
  - Leadership & critical thinking skills
  - Management of expenses
    - Visit utilization
    - Wound management/supplies
  - Clinician performance metrics for accountability

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Strategies for Managing Risks

- Interdisciplinary collaboration & coordination (Part 1)
  - Data accuracy
  - Appropriate skill mix & visit utilization
- Right care management model to manage risks (Part 2)
  - Primary clinician/case management model
  - Managing the *patient* rather than just making *visits*
- Appropriate therapy utilization (Part 2)

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CARE MANAGEMENT MODEL

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Patient Centered Care Management

- Focuses on patient's priorities & engagement
- Patient engagement allows 'in between visit progress', optimizing the whole episode of care
- Focuses plan of care on patient outcomes, tapering the visit frequency in response to patient progress
- Requires a primary clinician & case management
- Improves continuity of care & patient experience

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Case Management Model

- Collaborative process to assess, plan, implement, coordinate, monitor and evaluate options and services to meet the patient's health needs
- Entire interdisciplinary team works toward collaborative goals led by the patient/caregiver and healthcare team
- Clinical Management of a team census and individual caseloads by the primary clinician/case manager

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Primary Clinician/Case Manager Model

- Performs bulk of own visits or in coordination with one other clinician for continuity of care
- Requires autonomous self-scheduling for managing visits
- Priority to perform own Comprehensive Assessment, OASIS data collection & develop POC
- Separate, as necessary, the Initial Assessment to allow case manager to perform own Comprehensive Assessment (e.g., weekend admissions)

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Initial vs Comprehensive Assessment

- Initial Assessment (within 48 hours of referral)
  - Assessment focused on reducing hospitalization risk
    - Assessment is the skill that qualifies this as the SOC
  - Confirm eligibility criteria met, consents signed
  - Admission packet reviewed, rights & responsibilities
  - Medication reconciliation, drug regimen review
- Comprehensive Assessment (within 5 days of SOC)
  - Perform full comprehensive assessment, with OASIS
  - Develop POC

(CoP §484.55, Standards a & b)

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Primary Clinician/Case Manager Role

- Coordinate care with patient/caregiver & others internally or externally involved in POC
- Frequently assess progress, promptly responding to changes in the patient's condition
- Identify patient/caregiver needs and refer for other services
- Establish realistic patient-centered goals with patient/caregiver
- Identify self-management and training needs
- Assess all factors pertinent to the patient's safety
- Plan for and terminate care when goals are met

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Goal: Patient Self Management

- Educate clinicians to engage & motivate patients (examples)
  - Active listening
  - Reflection
  - Teachback
  - Give patient ownership
  - Open ended questions (tell me why you were in the hospital)
  - Summarize (can I tell you some other things about diabetes?)
- Problem Solving vs Patient Education (examples)
  - Ask what they've done before that helped them feel better
  - Discuss how to remove barriers to do what they need to do

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Managing Visits

- Self-scheduling allows
  - Moving visits to make room for a new Comp Assessment
  - Identifying visits that can be seen by someone else
- Primary clinician making visits to monitor patient progress
- An LPN/therapist assistant or other RN/therapist
  - When patient is stable
  - Daily wound care
  - 'Task oriented' visits (e.g., lab draws, HEP, etc.)

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Managing Visits

- Discharge planning ongoing throughout the episode
- Tapering frequency to allow self-management
- Document patient discuss about progress toward goals and what that means moving toward discharge
- Ex: Your medications are now controlling your pain. That goal has been met. We still need to work toward you being independent with managing your diabetes. When that is completed we will no longer need to see you.

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Care Management Impact on PDGM

- Patient centered care management is essential to appropriate visit utilization and development of a holistic POC
- Risks of poor care management include:
  - Inappropriate reimbursement (over or under-utilization)
  - Increased LUPA rates
  - Poor clinical outcomes (Home Health Compare)
  - Negative satisfaction scores (HHCAHPS)

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APPROPRIATE THERAPY UTILIZATION

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PDGM Therapy Utilization Myths

- "Medicare is no longer paying for therapy"
- "Therapists should no longer treat. Focus on teaching and no more than 3 visits"
- "This is the death knell for therapy in home health"
- What do you anticipate the impact will be at your agency?

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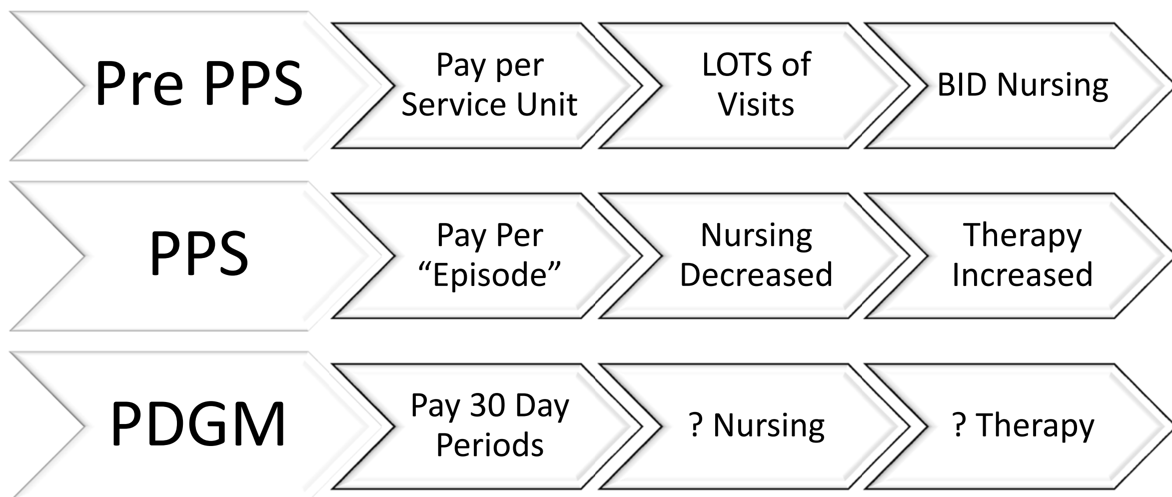
Quick History Lesson



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Therapy Track Record

Pre PPS	Initial PPS	Revised PPS
• Low Therapy Use Overall • < 10	• Therapy Use Increases • 10 - 13	• Therapy Use Increases • 14+ / 20+

Significant change in PDGM = Confirmation

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Defining "Best Practice"

- APTA Guide to Practice
- Guidelines for the Provision of Physical Therapy in the Home

- AOTA Occupational Therapy Practice Guidelines
- Home Health: A Guide for Occupational Therapy Practice

- ASHA Scope of Practice in Speech-Language Pathology
- ASHA Practice Policy

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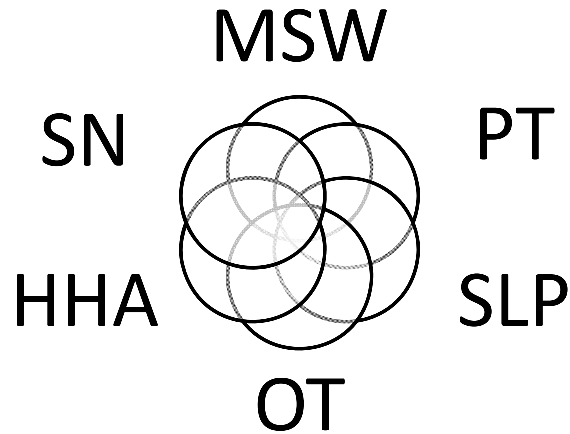
Do You Have A Functioning Team?



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Clinician Checklist

Clinician Name:

Discipline:

Key Area	Currently Proficient	Willing to Learn	Plan to Address
OASIS	Y/N	Y/N	
Comprehensive Assessment	Y/N	Y/N	
Medication Management	Y/N	Y/N	
Patient Centered Care Planning	Y/N	Y/N	
Care Coordination	Y/N	Y/N	
Collaboration	Y/N	Y/N	
Communication	Y/N	Y/N	
Documentation	Y/N	Y/N	

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Functional Item Comparison

Functional OASIS Items	PPS	PDGM
M1800: Grooming	No	Yes
M1810: Current ability to dress upper body safely	Yes	Yes
M1820: Current ability to dress lower body safely	Yes	Yes
M1830: Bathing	Yes	Yes
M1840: Toilet Transferring	Yes	Yes
M1850: Transferring	Yes	Yes
M1860: Ambulation/Locomotion	Yes	Yes
M1033: Risk of Hospitalization	No	Yes

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Thresholds Based on Clinical Grouping

Clinical Grouping Functional:	Low	Medium	High
MMTA – Surgical Aftercare	0-24	25-37	38+
MMTA – Cardiac & Circulatory	0-36	37-52	53+
MMTA – Endocrine	0-51	52-67	68+
MMTA – Gastrointestinal & Genitourinary system	0-27	28-44	45+
MMTA - Infectious Disease, Neoplasms, Blood-Forming Diseases	0-32	33-49	50+
MMTA – Respiratory	0-29	30-43	44+
MMTA – Other	0-32	33-48	49+
Behavioral Health	0-36	37-52	53+
Complex Nursing Interventions	0-38	39-58	59+
Musculoskeletal Rehabilitation	0-38	39-52	53+
Neuro Rehabilitation	0-44	45-60	61+
Wound	0-41	43-61	62+

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Unacceptable Primary Diagnosis

9 of the top 50 primary diagnoses used from 2015 – 2017 are not on the acceptable list

M54.5	Low back pain
M62.81	Muscle weakness (generalized)
R26.2	Difficulty in walking, not elsewhere classified
R26.81	Unsteadiness on feet
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R29.6	Repeated falls
R53.1	Weakness
Z48.89	Encounter for other specified surgical aftercare

Source: SHP

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Muscle Weakness (M62.81)

- CMS citing concern with this code since 2008
- One of the top 5 primary diagnoses in past several years
- CMS believes muscle wasting and atrophy codes ***could*** be more appropriate ***if muscle weakness is the primary focus of therapy***
- Determine underlying cause for the muscle weakness

OR

- Identify the true underlying reason for therapy

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- Avoid limiting therapists to just the ‘Rehab’ categories.
- Consider appropriate therapy plans of care for the MMTA categories that can improve patients’ outcomes.

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Demonstrate Value to Agency Outcomes

Measure	HHA	State	Nat’l
How often patients got better at walking or moving around.	72.3%	76.5%	75.6%
How often patients got better at getting in and out of bed.	76.9%	75.3%	74.8%
How often patients got better at bathing.	77.1%	80.7%	77.9%
How often patients had less pain when moving around	67.8%	79.9%	78.6%
How often patients breathing improved.	82.4%	75.8%	77.8%
How often HH began patients’ care in a timely manner.	96.5%	96.8%	94.3%
How often patients got better at taking their drugs by mouth.	59.0%	70.2%	66.7%
How often the HH team checked patients’ risk of falling.	100.0%	99.6%	99.6%
How often the HH team checked patients for depression.	99.4%	97.8%	97.6%
How often HH patients had to be admitted to the hospital.	17.8%	16.1%	15.8%
Would patients recommend the agency to friends and family.	79.0%	83.0%	78.0%

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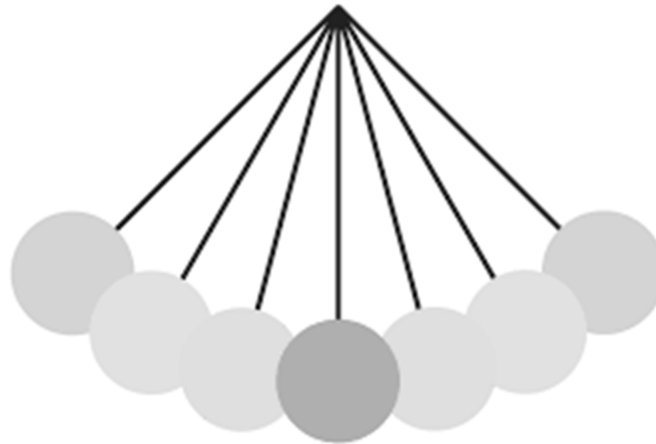
Stop the Pendulum Swing



Pre PPS low therapy utilization

Current PPS high therapy utilization

Appropriate Therapy Utilization

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Appropriate Therapy Impact on PDGM

- Understand the myths and the history contributing to current therapy utilization to stop the pendulum swing
- Know what to expect and where to access information for therapy 'best practice'
- Use collaboration for most accurate OASIS data
- Shift therapy practice from volume to value

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Summary

- PDGM is complex with changes heavily focused on clinical characteristics
- Keys to success include:
  - Strong clinical leaders
  - Proactive, coordinated and collaborative interdisciplinary care teams
  - Well-developed, holistic and individualized POC ensuring
    - Efficient discipline utilization
    - Focus on patient engagement and goals of care

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Upcoming Events

Home Care and Hospice Conference and Expo

October 13-15, 2019 | Seattle, WA

seattle2019.NAHC.org

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Upcoming Webinars

PDGM: Electronic Medical Record Readiness

Thursday, August 15, 2019 | 2:00-3:00 PM EDT

PDGM: Coding In Depth

Thursday, September 12, 2019 | 2:00-4:00 PM EDT

PDGM: Billing In Depth

Thursday, September 26, 2019 | 2:00-4:00 PM EDT

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