

# Episode Management Driving Clinical Impact of PDGM

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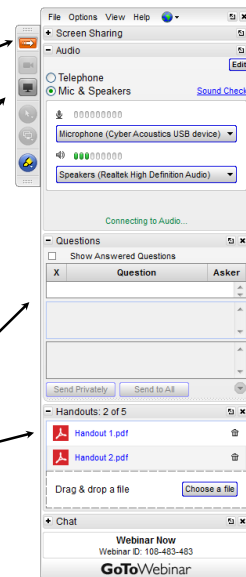
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## Summary of Clinical Impact from PDGM

Accuracy of clinical & comorbidity grouping

Accuracy of functional scoring

LUPA rates as a moving target

Visit utilization over two 30 day periods

## Episode Management Drivers

### Interdisciplinary Care



- Collaboration for OASIS accuracy
- Collaboration for diagnoses accuracy
- Care coordination for visit utilization
- Appropriate visit utilization

### Patient Centered Care



- Managing *episodes* not *visits*
- Primary clinician role
- Patient engagement in self care
- Tapered frequency of visits

### Clinical Management



- Facilitate accurate revenue drivers
- Clinician accountability
- Key performance metrics



- Interdisciplinary Care

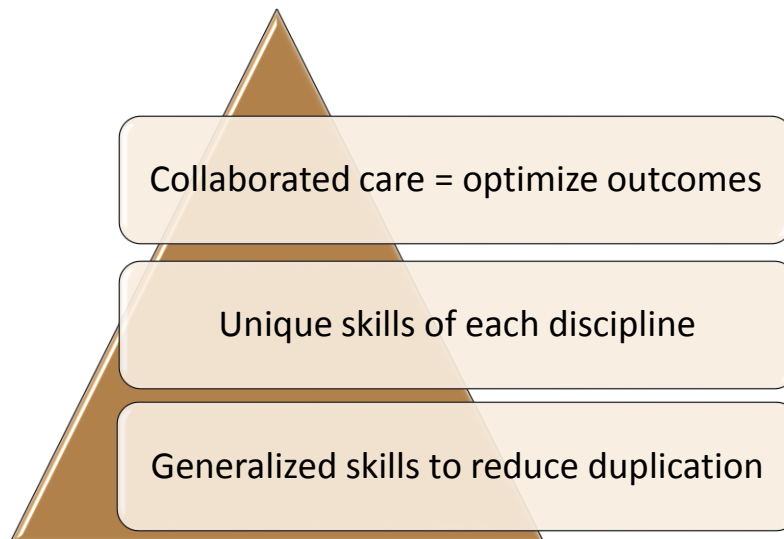


- Patient Centered Care

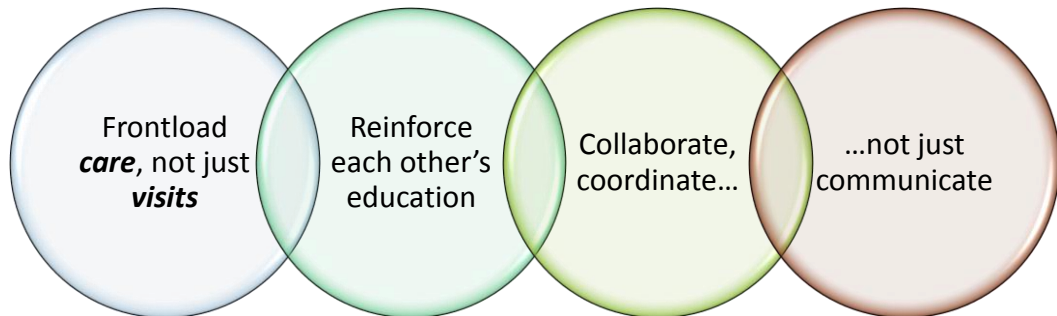


- Clinical Management

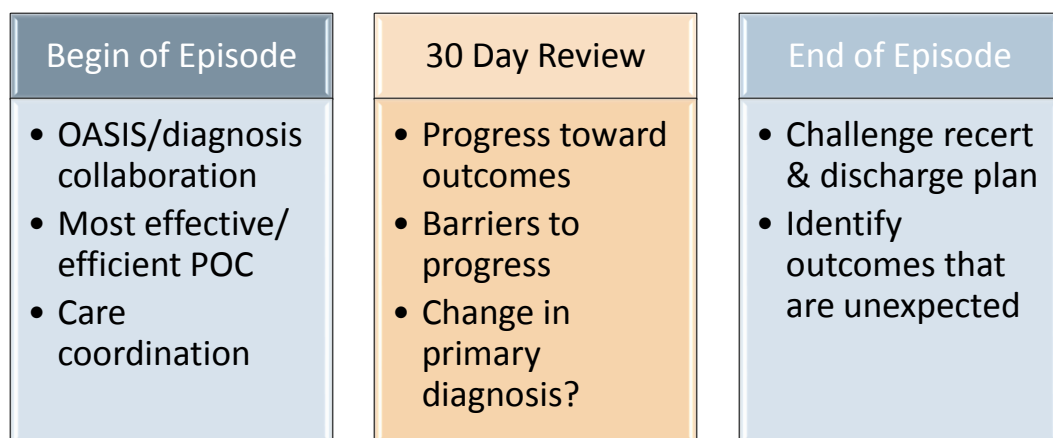
## Skill Mix on Interdisciplinary Team



## Care Coordination



## Interdisciplinary Case Conferencing



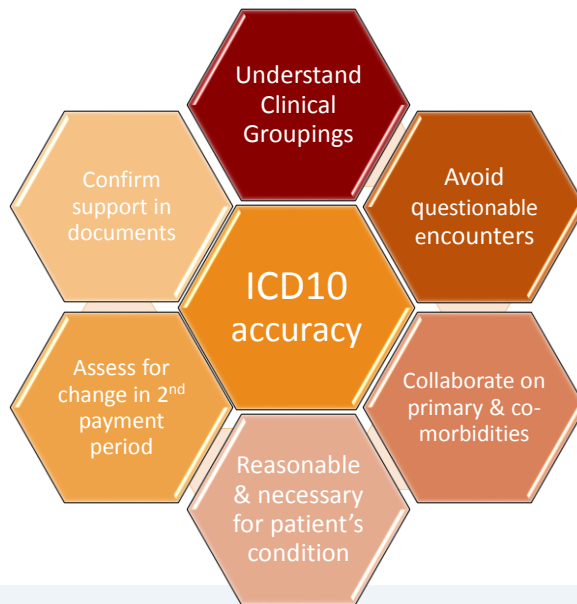
# Episode Einstein<sup>SM</sup> as a Conference Tool

**Case-Mix OASIS Ms**

	(01) SOC 11/23/2018	pts	(03) ROC 12/30/2018	pts	(04) Recert 01/17/2019	pts	HHC
Primary or Other DXs	see DX chart	21	see DX chart	-	see DX chart	8	
M1030 Ther at Home	4: none of the above	-	4: none of the above	-	4: none of the above	-	
M1200 Vision	1: partially impaired	NA	1: partially impaired	-	1: partially impaired	NA	
M1242 Freq of Pain	3: daily, not constant	-	2: less than daily	-	1: does not interfere	-	
M1311 Cur Unheal PUs 3-4	stg 3 - stg 4	-	stg 3 - stg 4	-	stg 3 - stg 4	-	
M1324 Stg of Prob PU	NA: no observe PU	-	NA: no observe PU	-	NA: no observe PU	-	
M1334 Stat Prob Obs SU		-		-		-	
M1342 Stat Prob Obs SW	3: not healing	8	3: not healing	-	3: not healing	4	
M1400 Dyspnea	2: w/ mod exertion	1	2: w/ mod exertion	-	1: +20 feet/stairs	-	
M1620 Bowel Incont Freq	0: rarely/never	-	0: rarely/never	-	0: rarely/never	-	
M1630 Ostomy	0: no ostomy	-	0: no ostomy	-	0: no ostomy	-	
M1810 Dressing Upper	3: dependent	-	1: able if placed	-	2: needs assist	-	
M1820 Dressing Lower	3: dependent	-	3: dependent	-	3: dependent	1	
M1830 Bathing	4: able at bed/chair	-	3: needs assist	-	3: needs assist	5	
M1840 Toilet Transfer	1: able w/ assist	-	1: able w/ assist	-	1: able w/ assist	-	
M1850 Transferring	3: unable to bear wt	-	2: can bear weight	-	2: can bear weight	2	
M1860 Ambulation	4: chairfast can wheel	7	2: w/ two hand device	-	2: w/ two hand device	4	
M2030 Mgt of Injct Meds	3: unable to manage	NA	3: unable to manage	-	3: unable to manage	NA	
M2200 Therapy Need	017	17	010	-	000	-	
		30 (C3)		-			
		7 (F2)		-			
		17 (S2)		-			
<b>Clinical Total:</b>						12 (C3)	
<b>Functional Total:</b>						12 (F3)	
<b>Service Ut Total:</b>						0 (S1)	



## Managing diagnosis selection & coding accuracy



## Clinical & Functional Grouping Matrix

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 - Neoplasms, Infectious & 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+

## Unacceptable Primary Diagnoses

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

## Muscle Weakness (M62.81)

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



Avoid using diagnoses based on the need for a “therapy diagnosis”.

Expect the proper process:

- Inquire for patient goals
- Assess for functional performance
- Develop a plan of care appropriate to the patient’s condition

Variable	Category	OASIS Items	Points
M1800: Grooming	1	2, 3	4
M1810: Dress upper body	1	2, 3	6
M1820: Dress lower body	1 2	2 3	5 11
M1830: Bathing	1 2 3	2 3, 4 5, 6	3 13 21
M1840: Toilet Transferring	1	2, 3, 4	4
M1850: Transferring	1 2	1 2, 3, 4, 5	4 8
M1860: Ambulation/ Locomotion	1 2 3	2 3 4, 5, 6	10 12 24
M1033: Hospitalization Risk	4 or more items	From 1-7	11

## Managing OASIS Accuracy

Collaborate on data accuracy for all new episodes

Consensus discussion on discrepancies (observation or interview?)

Assessing functional tasks in isolation limits the picture of the patient's routine

Consider how time of day effects performance

Patients living alone are not necessarily performing ADLs safely just because they have no assistance

Be VERY aware of the response item in which assistive devices are introduced

Practice among therapists and nurses to be very familiar with how "25%" physical assistance really feels

Remember dressing items include getting things out of closets and drawers (and letting go of the walker?)

Some ADL items are best scored starting from the bottom up to capture the most accurate response item





- Interdisciplinary Care



- Patient Centered Care



- Clinical Management

## Patient Centered Care Management



- Focus on patient's priorities
- Get patient participation & engagement in POC



- Encourages 'in between visit progress' by patient
- Optimizes the 60 days in episode, not just visits made



- Focus on progress toward outcomes, not just visit compliance
- Taper frequency in response to patient progress to outcomes



- One primary clinician per discipline, managing progress
- Improved continuity of care & patient experience

## Care Coordination Between Disciplines

Instruction from other disciplines integrated into performance and routines by therapy

Spontaneous, consistent performance is the ultimate teach-back response

Use aides as an opportunity for patient to practice, refine performance (practice that does not require a skilled therapy practitioner to be present)

## Care Coordination Example: CHF

- Patient goal: stay out of hospital, regain access to bedroom and bathroom on upper level of house, be able to stay at home
- Care plan goals: Patient will
  - Take meds as ordered.
  - Incorporate energy conservation into ADL/IADL routines.
  - Be able to use stairs to access bedroom & bathroom.
  - Prepare meals consistent with dietary restrictions.
  - Spontaneously and consistently monitor weight.
  - Self monitor and respond appropriately

***Care plan goals focus on patient behavior and promote the patient's overarching goals.***

## Care Coordination Example: CHF

RN: Promote symptom monitoring, taking meds as ordered

PT: Increase mobility/activity tolerance (steps)

OT: Incorporate energy conservation, incorporate dietary changes and weighing into existing habits and routines, advance ADLs as access to bathroom/bedroom are achieved

HHA: Fading assistance with ADL through transition from sponge bathing/BSC to accessing bathroom, reinforce revised routines

MSW: Ongoing resources for patient and caregiver

Physician: Reinforce patient & caregiver, ongoing care coordination

Caregiver: Assist/reinforce

***Interventions support patient overarching goal and care plan, and are coordinated***

## Patient Participation with Tapered Frequency

Clinician frequency

Patient engagement

Beginning of episode

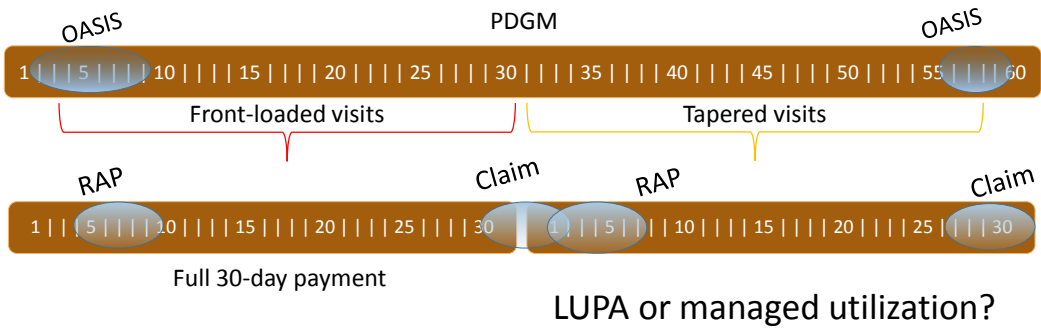
End of episode

Patient engagement

Clinician frequency



## Managing LUPAs with Tapered Frequency



## Managing LUPAs

Assess  
'unplanned'  
LUPAs

Rehospitalization risks reduced with known strategies?

Patient's clinical picture match visit utilization?  
Are the visit frequencies tapered?

LUPAs a result of missed visits, staffing issues, not homebound, patient refusal, and/or scheduling issues?

Did patient require more visits to meet goals/improve outcomes?

Were the right disciplines added during episode?

## Care Management with Primary Clinician

Performs bulk of own visits or in coordination with one other clinician for continuity of care

Autonomous self-scheduling for managing visits

Priority to perform own Comprehensive Assessment, OASIS data collection & develop POC

May be necessary to separate the Initial Assessment to allow case manager to perform own Comprehensive Assessment

## Separating Initial & Comprehensive Assessment

Initial  
Assessment  
(CoP §484.55, Standard a)

- Assessment focused on reducing hospitalizations
- Confirm eligibility criteria met, consents signed
- Admission packet reviewed
- Medication reconciliation, drug regimen review

Comprehensive  
Assessment  
(CoP §484.55, Standard b)

- Full comprehensive assessment, with OASIS
- Develop plan of care



- Interdisciplinary Care



- Patient Centered Care



- Clinical Management

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## Clinical Management Oversight

OASIS & diagnosis accuracy

Care management, care coordination

Caseload rather than visit productivity standards

Outcomes improvement

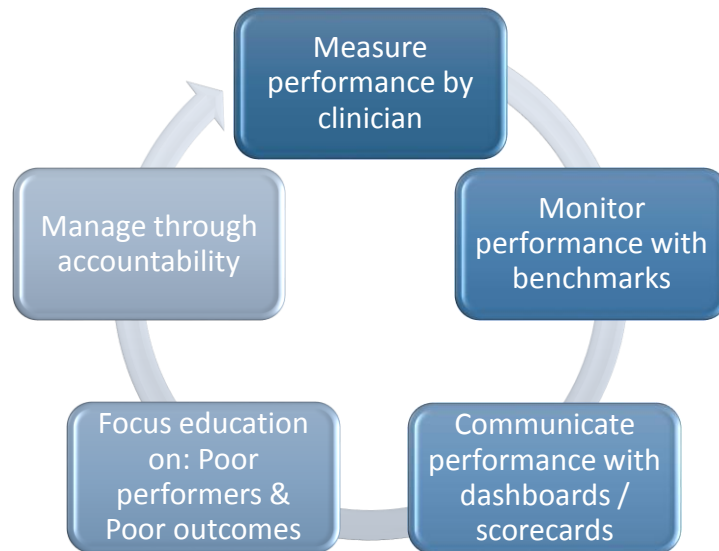
Episode management – clinical and financial outcomes

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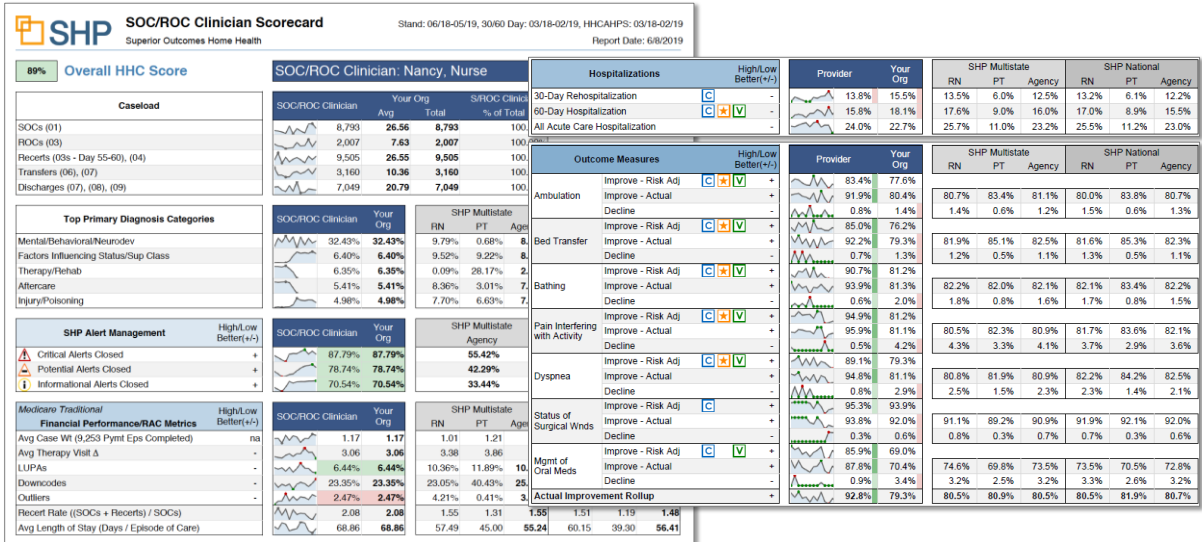
## Measure, Monitor & Manage



## Accountability Metrics

Clinician Individual Avg	Clinical Supervisor Team Avg	Clinical Manager Agency Avg
▪ Individual case mix weight	▪ Team case mix weight	▪ Patient payment by agency
▪ Individual LUPA rate	▪ Team LUPA rate	▪ Unadjusted episode payments
▪ Caseload averaged over quarter	▪ Caseloads averaged over quarter	▪ Patient volume for a quarter
▪ New patients in a quarter	▪ New admissions in a quarter	
▪ Average visits per patient	▪ Average visits per all patients	▪ Average cost per patient
▪ Re-hospitalization rate	▪ Average re-hospitalization rate	▪ Re-hospitalization rate
▪ Targeted QAPI outcomes	▪ Targeted QAPI outcomes score	▪ Targeted QAPI outcomes score

# Clinician Scorecard Provides these Metrics



## Byproduct of Episode Management

### Accurate payment

- Through data collaboration of OASIS and diagnoses

### Effective use of payment

- Coordinated skill mix
- Efficient use of visits

### Tapered frequency of all disciplines

- Reduced visits with patient engagement & coordinated care
- Reduce LUPA risk with visits drawn out over 60 day episode



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