Episode Management Driving Clinical Impact of PDGM

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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

Collaborated care = optimize outcomes

Unique skills of each discipline

Generalized skills to reduce duplication
Care Coordination

Frontload care, not just visits

Reinforce each other’s education

Collaborate, coordinate…

…not just communicate

Interdisciplinary Case Conferencing

**Begin of Episode**
- OASIS/diagnosis collaboration
- Most effective/efficient POC
- Care coordination

**30 Day Review**
- Progress toward outcomes
- Barriers to progress
- Change in primary diagnosis?

**End of Episode**
- Challenge recert & discharge plan
- Identify outcomes that are unexpected
Episode Einstein℠ as a Conference Tool

Managing diagnosis selection & coding accuracy

- Understand Clinical Groupings
- Confirm support in documents
- Assess for change in 2nd payment period
- ICD10 accuracy
- Avoid questionable encounters
- Collaborate on primary & co-morbidities
- Reasonable & necessary for patient’s condition
# Clinical & Functional Grouping Matrix

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

# Unacceptable Primary Diagnoses

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M54.5</td>
<td>Low back pain</td>
</tr>
<tr>
<td>M62.81</td>
<td>Muscle weakness (generalized)</td>
</tr>
<tr>
<td>R26.2</td>
<td>Difficulty in walking, not elsewhere classified</td>
</tr>
<tr>
<td>R26.81</td>
<td>Unsteadiness on feet</td>
</tr>
<tr>
<td>R26.89</td>
<td>Other abnormalities of gait and mobility</td>
</tr>
<tr>
<td>R26.9</td>
<td>Unspecified abnormalities of gait and mobility</td>
</tr>
<tr>
<td>R29.6</td>
<td>Repeated falls</td>
</tr>
<tr>
<td>R53.1</td>
<td>Weakness</td>
</tr>
<tr>
<td>Z48.89</td>
<td>Encounter for other specified surgical aftercare</td>
</tr>
</tbody>
</table>
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:
  o Inquire for patient goals
  o Assess for functional performance
  o Develop a plan of care appropriate to the patient’s condition
<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>OASIS Items</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1800: Grooming</td>
<td>1</td>
<td>2, 3</td>
<td>4</td>
</tr>
<tr>
<td>M1810: Dress upper body</td>
<td>1</td>
<td>2, 3</td>
<td>6</td>
</tr>
<tr>
<td>M1820: Dress lower body</td>
<td>1, 2</td>
<td>2, 3</td>
<td>5, 11</td>
</tr>
<tr>
<td>M1830: Bathing</td>
<td>1, 2, 3</td>
<td>2, 3, 4</td>
<td>3, 13, 21</td>
</tr>
<tr>
<td>M1840: Toilet Transferring</td>
<td>1</td>
<td>2, 3, 4</td>
<td>4</td>
</tr>
<tr>
<td>M1850: Transferring</td>
<td>1, 2</td>
<td>1, 2, 3, 4, 5</td>
<td>4, 8</td>
</tr>
<tr>
<td>M1860: Ambulation/ Locomotion</td>
<td>1, 2, 3</td>
<td>2, 3, 4, 5, 6</td>
<td>10, 12, 24</td>
</tr>
<tr>
<td>M1033: Hospitalization Risk</td>
<td>4 or more items</td>
<td>From 1-7</td>
<td>11</td>
</tr>
</tbody>
</table>

**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

**Patient**
- Focus on patient’s priorities
- Get patient participation & engagement in POC

**Participation**
- Encourages ‘in between visit progress’ by patient
- Optimizes the 60 days in episode, not just visits made

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

**Clinician**
- 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

Clinical Management Oversight

OASIS & diagnosis accuracy

Care management, care coordination

Caseload rather than visit productivity standards

Outcomes improvement

Episode management – clinical and financial outcomes
Measure, Monitor & Manage

Measure performance by clinician

Monitor performance with benchmarks

Communicate performance with dashboards / scorecards

Focus education on: Poor performers & Poor outcomes

Manage through accountability

Accountability Metrics

<table>
<thead>
<tr>
<th>Clinician Individual Avg</th>
<th>Clinical Supervisor Team Avg</th>
<th>Clinical Manager Agency Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual case mix weight</td>
<td>Team case mix weight</td>
<td>Patient payment by agency</td>
</tr>
<tr>
<td>Individual LUPA rate</td>
<td>Team LUPA rate</td>
<td>Unadjusted episode payments</td>
</tr>
<tr>
<td>Caseload averaged over quarter</td>
<td>Caseloads averaged over quarter</td>
<td>Patient volume for a quarter</td>
</tr>
<tr>
<td>New patients in a quarter</td>
<td>New admissions in a quarter</td>
<td></td>
</tr>
<tr>
<td>Average visits per patient</td>
<td>Average visits per all patients</td>
<td>Average cost per patient</td>
</tr>
<tr>
<td>Re-hospitalization rate</td>
<td>Average re-hospitalization rate</td>
<td>Re-hospitalization rate</td>
</tr>
<tr>
<td>Targeted QAPI outcomes</td>
<td>Targeted QAPI outcomes score</td>
<td>Targeted QAPI outcomes score</td>
</tr>
</tbody>
</table>
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
Episode Management Driving Clinical Impact of PDGM

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