Episode Management Driving Clinical Impact of PDGM
Karen Vance, BSOT
Senior Managing Clinical Operations Consultant
BKD, LLP Health Care Group
kvance@bkd.com

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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

Clinical & Functional Grouping Matrix

Unacceptable Primary Diagnoses

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

Unacceptable Primary Diagnoses

<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>M82.81</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>R51.1</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:
- Inquire for patient goals
- Assess for functional performance
- 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</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>M1830: Bathing</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3, 4</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>5, 6</td>
<td>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</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2, 3, 5</td>
<td>8</td>
</tr>
<tr>
<td>M1860: Ambulation/ Locomotion</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4, 5, 6</td>
<td>24</td>
</tr>
<tr>
<td>M1033: Hospitalization Risk</td>
<td>4 or more</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 affects 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

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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
- Use aides as an opportunity for patient to practice, refine performance (practice that does not require a skilled therapy practitioner to be present)
- Spontaneous, consistent performance is the ultimate teach-back response

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.

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

- **PDGM**
- **Front-loaded visits**
- **Tapered visits**
- **Full 30-day payment**

**LUPA or managed utilization?**

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

Comprehensive Assessment
- 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

QA
Episode Management Driving Clinical Impact of PDGM

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