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

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Episode Management Drivers

Interdisciplinary Care	Patient Centered Care	Clinical Management
☐ Collaboration for OASIS accuracy	☐ Managing *episodes* not *visits*	☐ Facilitate accurate revenue drivers
☐ Collaboration for diagnoses accuracy	☐ Primary clinician role	☐ Clinician accountability
☐ Care coordination for visit utilization	☐ Patient engagement in self care	☐ Key performance metrics
☐ Appropriate visit utilization	☐ Tapered frequency of visits	

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- Interdisciplinary Care
- Patient Centered Care
- Clinical Management

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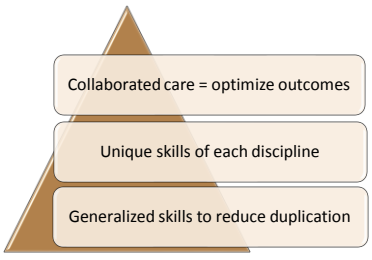
Skill Mix on Interdisciplinary Team



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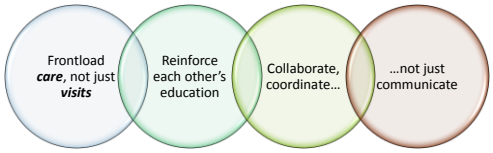
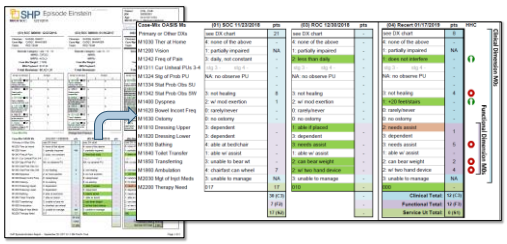
Care Coordination



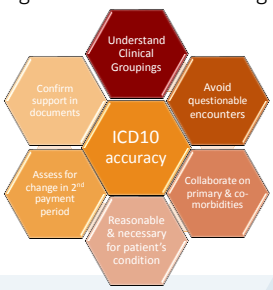
Interdisciplinary Case Conferencing

Begin of Episode	30 Day Review	End of Episode
• OASIS/diagnosis collaboration • Most effective/ efficient POC • Care coordination	• Progress toward outcomes • Barriers to progress • Change in primary diagnosis?	• Challenge recert & discharge plan • Identify outcomes that are unexpected

Episode Einstein℠ as a Conference Tool



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

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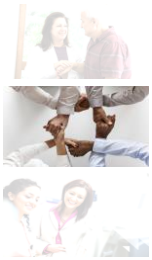

- Interdisciplinary Care
- **Patient Centered Care**
- Clinical Management

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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

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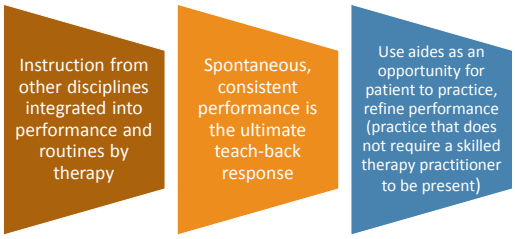
Care Coordination Between Disciplines



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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.

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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

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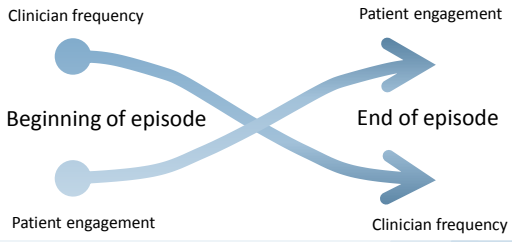
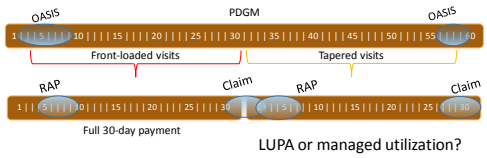
Patient Participation with Tapered Frequency



Managing LUPAs with Tapered Frequency



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
(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

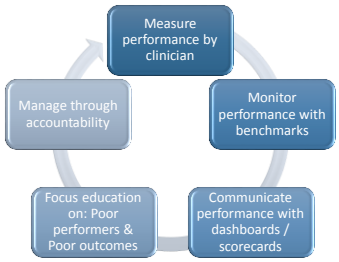
- Patient Centered Care

- 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



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

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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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