Oregon – PDGM Clinical Episode Management – November 21, 2019

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PDGM
Case Management
Clinical Episode Management

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Unity is strength... when there is teamwork and collaboration, wonderful things can be achieved.

Mattie Stepanek

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Clinical Episode Management by Any Term

- Collaboration of Interdisciplinary Team
- Coordination of Care
- Case Management
- Team Management

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Clinical Episode Management
Case Management

- Positive Effects
  - Improve Patient Outcomes
  - Improve Agency Outcomes
  - Improve Patient and Family Satisfaction
  - Improve Employee Satisfaction
  - Improves Compliance to Regulations
  - Manages Costs - Value over Volume!

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What is Clinical Episode Management?

- The Entire Interdisciplinary Team caring for the Patient working together to achieve goals and improve patient's outcomes during the Home Health admission.
- Each discipline – Skilled Professionals, Assistants, Aides
  - Including Contractors
- Clinical Manager
- The Patient, Caregiver(s) and Representative (if any)
- The Patient's Physician(s)

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The Team Works Together

KEEP IT SIMPLE

- Plans the care
- Talks to each other
- Writes it down
- Focuses on improving patient outcomes

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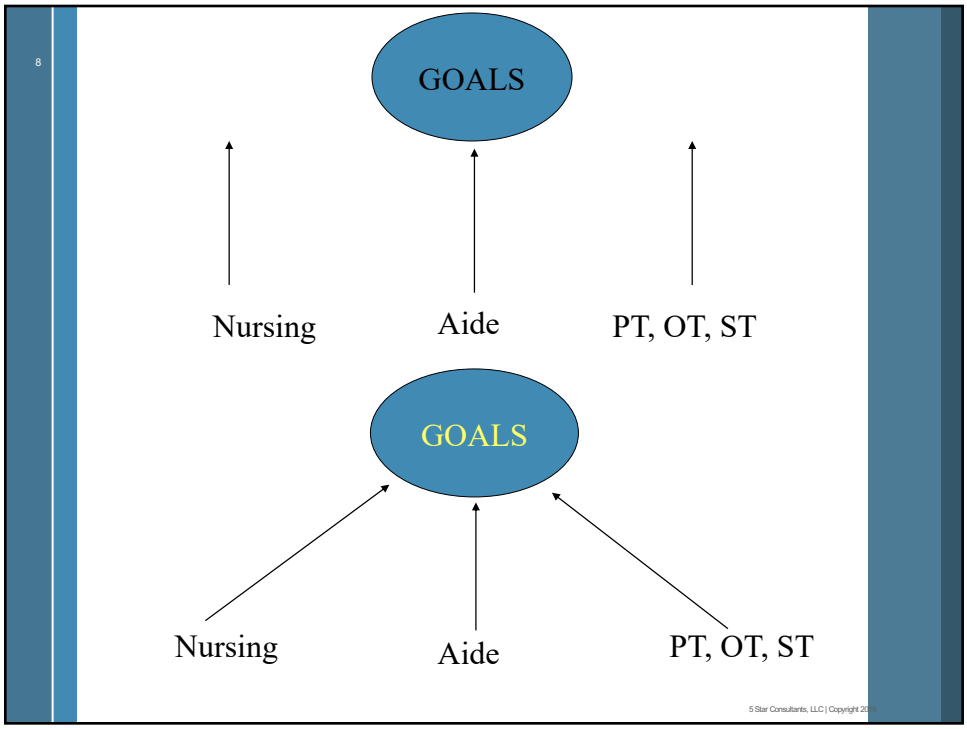

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Interdisciplinary Patient Care

- The interdisciplinary team works together towards collaborative goals and coordinating the patient care in a proactive manner
- The primary goal of the team is to enhance patient outcomes by planning a course of interventions and developing a plan to achieve the goals.
- The Case Manager for the patient (an RN on multidisciplinary cases) takes this a step further by coordinating the patient care with the other disciplines caring for the patient to ensure a collaborative team approach.
  - However, this does NOT take the responsibility for Coordination of Care off of every team member
  - Everyone is involved that sees the patient!

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CoP 484.60

- **CoP 484.60 - Care Planning, Coordination of Services, Quality Care Standard – (d) Coordination of Care**
  - "Coordination of care," requires the HHA integrate services to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness, the coordination of care provided by all disciplines, and communication with the physician".

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CoP - 484.60

› **CoP's - 484.60- Care Planning, Coordination of Services, Quality Care - Standard – (d) Coordination of Care**
  – (3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs & factors that could affect patient safety & treatment effectiveness & the coordination of care provided by all disciplines.

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G606
Interpretive Guidelines 484.60(d)(3)

› The HHA must integrate services provided by various disciplines by:
  – Managing the scheduling of patients, taking into consideration the type of services that are being provided on a given day.
    › Example: a patient may become fatigued after a HH aide visit assisting with a bath, making a PT session scheduled directly after the HH aide visit less effective.
  – Managing pain during therapy or physical care (i.e. dressing changes for wound care) in order to minimize patient discomfort while maximizing the effectiveness of the therapy session.
  – Working with the patient to recommend and make safety modifications in the home.
  – Assuring that staff who provide care are communicating any patient concerns and patient progress toward the goals identified in the plan of care with others involved in the patient's care.

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CoP 484.60

- 484.60 - Care Planning, Coordination of Services, Quality Care Standard – (d) Coordination of Care
  - (4) Coordinate care delivery to meet the patient's needs, involve patient, representative, & caregiver(s), as appropriate, in coordination of care activities.
  - (5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care & services identified in the plan of care.
  - The HHA must provide training, as necessary, to ensure a timely discharge.

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G610
Interpretive Guidelines 484.60(d)(5)

- The comprehensive assessment, patient-centered plan of care & goals identified inform the training and education objectives for each patient.
- The goals of the HHA episode are established at admission and revised as indicated by the patient's condition.
- With the discharge plan clearly identified, patient education and documentation of the patient response to the education begins upon admission and continues throughout the provision of HHA services. The HHA must monitor patient and caregiver responses to and comprehension of any training provided.

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Comprehensive Assessment

› Uses a Holistic Approach to see the full story of the patient
  - Clinical and functional
  - Psychosocial and cognitive status
  - Caregivers
  - Other services the patient may have
  - Environment

› Perform a comprehensive assessment of the patient that includes:
  - Observation
  - Interview
  - Input from Caregiver / representative, if applicable
  - Prior level of functioning
  - Patient history

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Comprehensive Assessment

› Must include
  - The patient's current health psychosocial, functional, and cognitive status
  - The patient's strengths, goals, and care preferences, including the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA

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SO DOES PDGM MAKE THERAPY IN HH OBSOLETE??

ABSOLUTELY NOT!

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PDGM - Therapy

- **Therapy is a Key Part of Interdisciplinary Team!**
- BUT…….No separate reimbursement under PDGM tied to visits!
  - With Therapy as part of the team, Collaboration is Necessary
  - M1800 and GG / J items
  - Plan Visits as a Team
  - Be Each Other's Eyes and Ears
- **This leads to VALUE OVER VOLUME!**

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How Elimination of the Therapy Threshold Affects Clinical Care

- Instead of numbers of therapy visits, the episode relies more heavily on clinical characteristics and other patient information
- Clinical Care Management should always have included therapy services based on physician's orders and patient's clinical condition, not reimbursement and numbers of visits.
- HHA's who have provided care in a Team / Case Management – Outcome Oriented Model should not have to change their practice!

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CMS Rationale for Eliminating Therapy Thresholds

- CMS
  - "The presence of the therapy thresholds provided an incentive to overprovide services, and their removal deflates that financial incentive to help ensure that therapy services are based on actual patient needs.
  - The redesign of the home health payment system encourages value over volume and removes incentives to provide unnecessary care,"
  - CMS Administration Seema Verma said.

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Therapy Visits Under PDGM

- Need to be effective & efficient
  - Structured visit schedule to provide interventions and meet goals
- Case Management
  - Team Collaboration ongoing with ALL Disciplines
- Coordination of care with PTAs/COTAs
- Schedule visits based on :
  - Physician's orders
  - Based on Therapy Evaluation and collaboration with Nursing
  - In order to increase patient independence – FRONT LOAD
  - Opposite days of other disciplines visits – schedule as a team

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Maintenance Therapy Under PDGM

- There are many agencies that STILL do not "allow" their clinicians to treat patients under the Maintenance Therapy rule. This is truly doing a disservice to their clients.
- Why?
  - Lack of Staffing- (should be low % of total census)
  - Lack of full understanding of the Rule
  - Increased Cost (PT/OT/SLP only, no assistants)

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Maintenance Therapy Under PDGM

- Final Rule 2020
  - Therapy assistants are permitted to perform maintenance therapy services under a maintenance program established by a qualified therapist
  - As long as the services fall within scopes of practice defined by state licensure laws.

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Maintenance Therapy Under PDGM

- Final Rule 2020
  - The qualified therapist would still be responsible for:
    - Initial assessment
    - Plan of care
    - Maintenance program development and modifications
    - Reassessment every 30 days
    - Supervising the services provided by the therapist assistant

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Maintenance Therapy Under PDGM

› Medicare has determined that it saves money when allowing therapy services to stay in, versus frequent Restorative Therapy treatment/Discharges cycles that may include decline, injury, rehospitalizations in between periods of intervention.

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Maintenance Therapy Under PDGM

› Key Points
- This is a tool in your toolbox!
- Still Requires Skilled Care!
- Therapy assistants may perform maintenance therapy
- No frequency or specific diagnoses requirements
- No special forms- same requirements as restorative services, including 30-day reassessments
- Not a one-time decision
  - › Can move from restorative to maintenance at any time in a cert period
  - › PT can be on a Maintenance Program and OT can remain on a Restorative Plan

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Maintenance Therapy Under PDGM

- A therapist who is thinking about whether to DC or continue a patient under Maintenance should be asking themselves…
  - If I discharge is there a likelihood that this patient will decline without skilled intervention?
  - Will my patient be at a higher risk for illness or injury if I discontinue services?
  - Has my treatment plan preserved certain functions or tasks for this patient?
  - Has my treatments prevented falls and rehospitalizations?

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Maintenance Therapy Under PDGM (continued)

- If you answer YES -
  - Even though the patient may have reached maximum potential, that patient has been successful under your treatment plan and guidance.
  - If you have determined that this patient will likely decline without you, then consider maintenance visits!
- Does treatment need to be special or different?
  - NO! No separate/new interventions
  - What has been working all along??
    - Stick with what you are doing!
    - Treatment plan does not need to be altered!
- GOALS: will be the TASKS that you are preserving

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Maintenance Therapy Under PDGM

› GOAL Examples:
  - Patient will maintain their ability to ambulate 200 ft to the dining room twice daily using a front wheeled walker independently without rest breaks
  - Patient will preserve the ability to participate in safe chair transfers with min A x 1 from ALF staff
  - Patient will maintain their ability to perform a.m. /p.m. upper body and lower body dressing tasks using adaptive equipment with supervision

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Therapy Role in Home Health

› Therapy remains a ***key*** component in determining a patient's functional impairment level and achieving patient outcomes
  - Ensure patient safety
  - Maximize functional improvement
  - Improve outcomes in ADL's and IADL's
  - Prevent emergent care & rehospitalizations

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Case Management

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Case Management At SOC, ROC, Recert & OASIS Timepoints

- Accurate & Consistent Comprehensive OASIS Assessments
- Interdisciplinary collaboration
  - Processes that involve ALL disciplines - Nsg, PT, OT, SLP, MSW, & Aide
  - Ensures effective utilization of resources
- Plan of Care Development
  - Individualized - patient specific
  - Directed interventions
  - Measurable goals
  - Team works together to improve specific patient outcomes

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Case Management

- Effective case management is dependent upon the interdisciplinary team working together towards collaborative goals and coordinating the patient care in a **PROACTIVE MANNER**
- The primary goal of the home care clinician and team is to enhance patient outcomes by planning a course of interventions and developing a plan to achieve a specific goal.
- The case manager takes this a step further by coordinating the patient care with the other clinicians caring for the patient to ensure a collaborative team approach.

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Case Management Teams

› Identify those qualified RNs to be Case Managers
  – Goal oriented, great organization and communication skills

› **Form Interdisciplinary Teams** consisting of RN Case Manager and Visit Nurses (RNs and LPNs), PT (PTA's), OT (COTA's), MSW, Aides

› Some disciplines have to cross over teams as volumes are low- Aide, ST, MSW

› Teams primarily selected by Geographic divisions, but must take skill into account – i.e., IV

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Accurate & Consistent OASIS/Comprehensive Assessment

- Accurate OASIS and comprehensive assessment of the patient will be more important than ever under PDGM.
- Ensure your clinicians understand the OASIS items and how to respond, as well as how to effectively complete the comprehensive assessment
- Every Clinician must do the OASIS comprehensive assessment in a standard fashion

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Accurate OASIS/Comprehensive Assessment

- Do not simply ask the patient questions when doing the comprehensive assessment.
- Ask the patient to:
  - Walk you to the bathroom to show you how he does his toileting and hygiene
    - Walk to the kitchen for a drink of water and snack
    - Read you his medication bottles to you
    - Take his socks & shoes off for assessment and then put on again

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Accurate OASIS/Comprehensive Assessment

- By having the patient show you, the clinician will be able to answer the questions on the OASIS assessment in the most accurate fashion.
- The Team will be able to work together from the comprehensive OASIS assessments in order to improve routine visit quality.
- All disciplines on subsequent evaluations and visits need to perform the same type of assessment in order to be objective and assure accuracy of the patient outcomes.
  - This can ensure that each visit stands on its own
  - Will have Goal Oriented care and improve outcomes

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Accurate OASIS/Comprehensive Assessment

- Comprehensive assessment continues to be the responsibility of one clinician as required by the CoPs but, allows the assessing clinician to get feedback from other agency staff to complete any or all OASIS items.
- Collaboration between nursing and therapy will be vitally important to assure the most accurate OASIS responses to the functional items.
  - Multi- disciplinary cases will allow for therapy to assess the patient and determine the most accurate answers to M1800 items that take on more importance under PDGM
  - In addition, the GG items are difficult to assess in one SOC visit. Therapists can go in after the nurse to assess each in detail.

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Interdisciplinary Team Communication

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Interdisciplinary Communication

- Collaboration and communication essential to ensure the most accurate information is being utilized for development of an individualized plan of care, achieving patient goals and improving outcomes
- The Team caring for a patient ***must*** report to each other frequently and ***Notify the Physician Early and Frequently*** to:
  - Reduce emergent care and hospitalizations,
  - Be goal oriented, and
  - Improve clinical outcomes, such as pain and ambulation

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Interdisciplinary Communication

- **Initial communication:**
  - After RN does comprehensive assessment – contacts Team
  - After each Eval, the therapist contacts Team
  - Discusses POC and what outcomes to work on improving
- **Ongoing:**
  - Regular documentation in EMR in a user friendly coordination of care location –
    - NOT in VISIT NOTES – TEAM WILL NOT READ!
  - Case Conference/Team Updates – Weekly- EMR/FTF/PHONE/VM
  - Conference prior to end of 30 day period
    - Plan for next 30 day period

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Interdisciplinary Communication

- The patient's **progress** needs to be regularly assessed and discussed as a team.
  - Progress towards measurable goals is in the CoPs Frequently
  - Keeps team Goal Oriented and "On the Same Page"
- Formal case conference not frequent enough
  - Don't save up problems!
  - The goals and the plan of care may need revision
    - Managing the plan of care in "real time" will be vitally important for improving patient outcomes and resource utilization

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Interdisciplinary Communication

- Contracted Disciplines
  - Home Health Agency “owns” the patient and is responsible for coordination of care
  - Hold Contractors Accountable
    - Set up processes and meet with the company
  - They must interact with the team on all patients as if they were your employee
    - Processes may need to be revised:
      - Example: If contractor isn't on your EMR, how will they communicate to team after each visit?

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Coordination of Care

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Coordination of Care - Case Study

- Mrs. Jones is admitted to HH with a primary diagnosis of Diabetes with peripheral neuropathy.
- She has SN, PT, OT and Aide ordered
- One of her comorbidities is CHF. She has had no signs/symptoms of CHF since her admission.
- The PT / PTA are seeing Mrs. Jones for difficulty walking, muscle weakness and previous falls- partially caused by her peripheral neuropathy.

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Coordination of Care - Case Study (Continued)

- During the 3rd week of home health services, the PTA makes a visit to Mrs. Jones. This PTA has seen the patient on 2 previous visits.
- She notes that today, the patient is coughing, has more ankle edema and while walking with Mrs. Jones, she has is more fatigued than on other days.
- These are the first that the PTA has noted these signs and symptoms in Mrs. Jones. The patient says that they started the day before.
- The PTA knows that Mrs. Jones has CHF as a comorbidity, so he lets the other team members know this information via the communication notes in the EMR.

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Coordination of Care- Case Study (continued)

- In order to prevent Mrs. Jones from having further symptoms without the physician being informed, the PTA contacts the RN Case Manager by telephone as well to report these signs/symptoms in the next hour.
- The nurse has a visit ordered for this week, therefore, she moves it and makes a visit on Mrs. Jones that day to assess the patient and identify all status changes.
- The nurse notes that what the PTA stated and documented is continuing for the patient. Therefore, she calls the physician and reports these changes in the patient. The physician orders an extra dose of the diuretic that the patient is prescribed.
- This coordination of care prevents Mrs. Jones from having a CHF exacerbation – with an ER visit or rehospitalization.

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Coordination of Care- Case Study (continued)

- **In the actual scenario found on reviewing a clinical record after hospitalization:**
  - The PTA did not know that the patient had CHF as a comorbidity
    - Didn't read the Plan of Care? Wasn't getting "reports" from team?
  - The PTA only documented the patient's fatigue, edema, coughing in visit note. Did not report to anyone.
  - The patient went into ER/hospital on Sunday, 3 days since the previous HH visit when the PTA saw the patient.
  - The patient had an exacerbation of CHF.
  - The team did not communicate with each other to recognize early signs of Exacerbation of CHF , so the physician wasn't notified.

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Communication and Documentation of Coordination of Care

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Documentation of Coordination of Care

WHO:
Everyone on the patient's team!

WHAT:
'Report' of patient status, change, symptoms and/or what you did.

WHEN:
Each time you have **ANYTHING** to tell the team about the patient.

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Documentation of Coordination of Care

WHERE:

In a section of the EMR that is shared with all of the team.

Easy for team to see as events unfold- "electronic email" section, Note section, etc.

If on not on EMR, secure agency email can be used.

WHY:

To show Ongoing communication between all of the team members taking care of a patient.

To tell the story of the patient!

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Coordination of Care – Case Study

- Aide sees that Mr. Smith has a red area on the left buttock that wasn't there on previous patient visits.
- She documents this in the EMR note section to the team. Also, in her visit note she states this and that she reported this to the RN.
- The Aide also calls the RN since she recognizes that this change in skin condition indicates that the nurse needs to know prior to his next re-synchronization of his laptop when he will see the note.

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Coordination of Care – Case Study (continued)

› The RN acknowledges the conversation and his actions in the Note section of the EMR.

› He states that he will visit Mr. Smith the next morning.

› He also asks the rest of the team members to ensure that the patient teaching on skin care, repositioning, and reporting any changes is done on each visit.

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Coordination of Care – Case Study

› In the actual clinical record review done during a Mock Survey:
- Aide visit note documented patient had "new red area on his bottom, left side". Checked box that she notified the RN.
- No notes from RN in the EMR that he was aware of this new change in skin condition from the Aide.
- Aide makes a visit in 2 days to pt. Documents, "red area on bottom is bigger today". Check box that she notified the RN.
- Again, No notes in Coordination of Care section that RN or Aide docs.
- RN does Aide supervisory visit 4 days later. No doc that communication with Aide occurred. No documentation of change in skin condition.
- No documentation in skin assess of visit note by the RN of the red area.
- The Aide documents same day after the RN visit that the red area is still present.

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PDGM
30–day Period Management

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PDGM – Case Management

- Management of the 30-Day Periods
  - Having the correct discipline visit at the correct time within the periods to achieve the best clinical outcomes
  - Monitoring progress toward goals
  - Updating POC as needed to facilitate goal achievement/clinical outcomes
- LUPA Management
  - Monitor visit utilization

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PDGM
Management Of The 30-day Period

- Provision of services should be made based on the patient's care needs
  - Interdisciplinary includes the physician(s) as well as the HHA Team
    - On Referral and/or Admission/ Initial Evaluations discuss plan with physician (or NP, PA, RN)
  - Consider Front-loading patients with three visits in the first seven days of care if appropriate to meet the patient needs.
    - Effective to reduce early emergent care visits
  - Some patients may benefit from visits that are provided over a longer period of time
    - Identify all visits per week / month of the full team
      - All inclusive- look at combined discipline visits

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PDGM
Management of the 30-day Period

- Utilize the comprehensive SOC/OASIS assessment and the Plan of care to determine the need for additional disciplines
  - Obtain orders quickly to support the patient's needs.
  - Send in the right discipline at the right time for the correct amount of time
    - Do not delay treatment days
      - Must follow physician orders and not Staff for "Convenience of the HHA" per IG's!

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PDGM
Management of the 30-day Period

- Utilize LPNs, PTAs, COTAs to effectively manage visit costs
- Be sure that you are not underutilizing services thinking that you must do so to survive financially
- Occupational Therapy is a valuable asset of the HHA for improvement in functional outcomes and is often underutilized
- Remote patient monitoring can be an important tool in managing the patient 30-day period reducing the need for additional visits
  - If no telehealth, make telephone calls between visits!

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PDGM
Management Of The 30-day Period

- Ensure that each team member communicates information to HHA and to all on team for appropriate scheduling of visits.
- Team Communication can prevent Missed Visits
  - Report regarding patient appointments
- Management of Missed Visits
  - Could the missed visit have been rescheduled?
  - Was a missed visit the result of staffing issues, patient refusal of care and/or scheduling issues?
  - Or poor coordination within the team?- ex: LPN knows patient has a MD appt Wed but doesn't communicate. OT goes to pt house Wed and when no one home, does a missed visit note.

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PDGM
Management of the 30-day Period

› Clinical Pathways
  - May consider having pathways for Disease specific
  - Identification of disciplines, visits – front loading
  - Goals / Outcomes
  - Short term Goals throughout care
  - Measure Progress towards Goals

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PDGM
Management of the 30-day Period

› Patient Education

› Team is coordinated in approach

› Teach patient/ caregiver(s) small amounts that progress each visit by various team members

› Utilize Teach Back Tools!
  - Then observe patient during visits to ensure teaching plan is working
  - Reevaluate with Team and Revise Education plan as necessary
  - Telephone Calls between visits in order to continue education and Teach Back

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PDGM
LUPA's

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PDGM - LUPAs

- Current LUPA threshold is 4 visits
- Under PDGM LUPA thresholds will be based on clinical grouping and episode timing.
- LUPA episodes will range from two-visit to six-visit thresholds
- Different visit threshold for each of the 432 home health resource groups (HHRGs)

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PDGM - LUPAs

- Potential to have a LUPA in each 30-day payment period within the 60-day episode of care.
  - Each 30-day payment period stands alone
  - Consecutive 30-day periods forward may be LUPAs
- Sometimes a LUPA is inevitable
  - i.e. Monthly foley catheter change, Monthly B12 injection, etc.

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PDGM - LUPAs

- Essential to begin thinking about visit management in the 30-day periods of care
- Example:
  - LUPA visits of two or less in the second 30-day period
    - Is low-visit count impacting clinical outcomes?
    - Would moving those visits into the first 30-day period impact patient outcomes?
- Consider if the first 30-day period of care with the additional visits might produce better outcomes and the second 30-day period may not be needed, therefore a LUPA could be avoided.

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Tips to Successful Coordination of Care

- Look at the big picture
  - You are caring for the Patient, not the wound
- Coordinate care & collaborate with multi-disciplines, do not act alone!
- Working with pt in home environment with family or caregivers interacting in a dynamic fashion is challenging …… It Takes A Village!
- Be Active, not passive
- Be GOAL Oriented!
  - This is the way to Improve patient outcomes!

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Tips to Successful Coordination of Care

- You and other clinicians are identifying issues and concerns relating to your patient's well-being
  - Be sure to address every one of these issues
- Your team must be responsible to follow through with problem-solving for your patient
  - The team can think outside the box in order to improve patient outcomes!
  - Effective coordination of care is imperative under PDGM!

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Coordination of Care Audit Tool

Criteria	Patient A	Patient B	Patient C	Compliance
Team Coordination (RN / Therapy / Aide / MSW etc.)				
• After first initial visit (each discipline)				
• When any changes in patient status				
• Minimum every two weeks				
Progress to Goals				
• Documented by RN				
• Documented by PT				
• Documented by OT				
Aide Reporting to RN and RN with follow-up				
• Aide reports every time a change in patient				
• Aide reports any time a need for a revised aide care plan				
• RN documents follow-up to aide				
Coordination of Care with Clinical Manager and/or designee				
• After evaluation/admission visit				
• Prior to discipline discharge				
• Prior to agency discharge				
Team Works on Outcomes to Improve with Patient				
• Within first week of admit, team documents communication that identifies outcomes to improve				
• Documentation of outcome progress documented at minimum every 30 days				
Physician Notified as Necessary				

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Conclusion

- Case management needs to be Central in Home Health for Viability under PDGM!
  - Compliance to CoPs
  - Avoid Denials
  - Improve Outcomes
  - Manage under PDGM
- Collaboration and Communication has never been more important than it will be to succeed under PDGM!

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Any Questions?

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Thank You!

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