

PDGM: KEYS TO CLINICAL BEST PRACTICES

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TODAY'S OBJECTIVES

Discuss the Clinical Groupings component of the PDGM case mix model

Review key concepts to effective case management, and

Discuss effective approaches to visit utilization including managing LUPAs



IT'S A CHANGING WORLD!



In a world of change...
there is no standing still!



PATIENT DRIVEN GROUPINGS MODEL (PDGM) GOALS

- Better align payment with costs
- Increase access to vulnerable patients associated with lower margins
- Address payment incentives in current system, i.e. eliminate impact of therapy volume on payment
- Place patients into clinically meaningful payment categories
- Effective January 1, 2020

Used with Permission: Ailt Associates, Medicare Home Health Prospective Payment System: Case Mix Methodology Refinements, Overview of Home Health Grouping Model, November 18, 2016

HH, CHL, Medicare and Medicaid Programs: CY 2019 Home Health Prospective Payment System Rate Update and Proposed CY 2020 Case Mix Adjustment Methodology Refinements; Home Health Value Based Purchasing Model; and Home Health Quality Reporting Requirements, Final Rule.



30-DAY UNIT OF PAYMENT

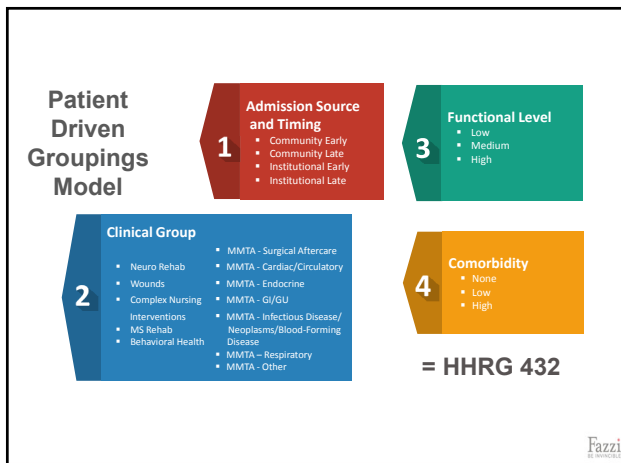
- 30-day period = days 1-30 of a current 60-day episode where "day 1" is the current 60-day episode's *From Date*. Second period is days 31 and above.
- CMS will calculate a proposed, national, standardized 30-day payment amount. Would propose the actual 30-day payment amount in the CY 2020 HH PPS proposed rule.
- Going forward will calculate payment amount by updating the preceding year by the HH payment update percentage.



PDGM AND QUALITY EPISODE

- Two 30-day payment periods within a 60-day certification period
- 60-day timing for certification periods remains unchanged
- Assessment within 5 days of SOC and, no less than last 5 days of every 60 days if unchanged
- Plan of Care corresponds with 60-day certification
- OASIS time points remain unchanged





ADMISSION SOURCE

- Uses a 14 day “look-back” period
- Community**: no acute or post-acute care in the 14 days prior to the HH admission (30 day periods; second 30 days of a 60 day episode is assigned community)
- Institutional**: acute or post-acute (SNF, inpatient rehab facility, long term care hospital, psychiatric inpatient) care in the 14 days prior to the HH admission

Medicare claims processing system would check for presence of an acute/post-acute Medicare claim occurring within 14 days of the HH admission on an ongoing basis.

Manual Occurrence Codes will be allowed

TIMING

Only the first 30-day period in a sequence of periods be defined as **early** and all other subsequent 30-day periods would be considered **late**.

First episodes are those where the beneficiary has not had home health in the 60-days prior to the start of the first episode.

To identify the first 30-day period in a sequence, Medicare claims processing system would verify that the claims “From date” and “Admission date” match.

AVERAGE RESOURCE USE BY ADMISSION SOURCE

Admission Source	Average Resource Use	Number of Periods	25 th Percentile	Median	75 th Percentile
Institutional	\$2,171.00	2,215,971 (25.7%)	\$1,246.05	\$1,920.06	\$2,791.91
Community	\$1,363.11	6,408,805 (74.3%)	\$570.26	\$1,062.05	\$1,817.75
Total	\$1,570.68	8,624,776 (100%)	\$679.12	\$1,272.18	\$2,117.47

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMS-1689-P, CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements, Proposed Rule, Filed July 2, 2018.



AVERAGE REVENUE COMMUNITY AND INSTITUTION

Admission Source	Percent of 30-Day Periods	PDGM Payment/Period
Community Early	13.38%	\$2,135
Community Late	60.60%	\$1,400
Institutional Early	19.31%	\$2,419
Institutional Late	6.72%	\$2,221

Source: Fazzi Business Intelligence Division

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CLINICAL GROUPINGS

- Each 30-day period of care will be assigned to one of twelve groups based on the reported principal diagnosis.
- Diagnosis code must support the need for HH services.
- Secondary diagnosis codes would then be used to case-mix adjust the period further through additional elements of the model, such as the comorbidity adjustment.



12 CLINICAL GROUPS

Clinical Group	Primary Reason for HH Encounter:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers, burns and other lesions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies

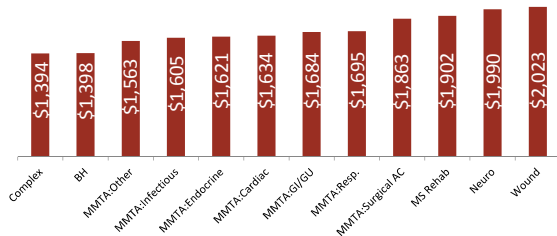
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12 CLINICAL GROUPS, CONTINUED

Clinical Group	Primary Reason for HH Encounter:
MMTA – Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA – Respiratory	Assessment, evaluation, teaching and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

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REVENUE BY CLINICAL GROUP



Source: Fazzi Business Intelligence Division

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Clinical Group	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Home Health Aide	Medical Social Services
MMTA Other	4.599	2.889	0.771	0.151	0.774	0.074
Neuro Rehab	3.129	4.350	1.721	0.817	1.016	0.105
Wounds	7.718	1.700	0.584	0.077	0.815	0.063
Complex Nursing	4.187	1.060	0.356	0.122	1.099	0.043
MS Rehab	3.140	5.181	1.258	0.084	0.706	0.063
Behavioral Health	3.317	2.914	0.976	0.403	0.649	0.108
MMTA - Surgical Aftercare	5.472	2.647	0.809	0.127	0.449	0.072
MMTA - Cardiac	4.734	2.719	0.807	0.112	0.809	0.077
MMTA - Endocrine	6.695	2.523	0.675	0.091	0.800	0.082
MMTA - GI/GU	4.535	2.734	0.857	0.139	0.820	0.087
MMTA - Infectious	4.763	2.309	0.687	0.116	0.779	0.086
MMTA - Respiratory	4.407	2.932	0.919	0.181	0.762	0.097

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LUPAs

- PDGM proposes that the approach to calculating thresholds change. LUPA thresholds will vary depending upon the payment group to which it is assigned.
- LUPA thresholds range from 2-6 visits.
- LUPA add-on factors will remain the same as current system.
- LUPA thresholds for each PDGM payment group would be reevaluated every year.

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AGENCY BEHAVIOR ASSUMPTIONS

1. Clinical Group Coding: Coding to maximize payments.
2. Comorbidity Coding: More 30 day periods will receive comorbidity adjustment.
3. LUPA Threshold: 1-2 extra visits will be made to receive the full 30 day payment.

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"...The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. ..."

HHCOPs, Care Planning, Coordination of Services and Quality of Care



KEY ELEMENTS OF CARE DELIVERY

1. OASIS Assessment

- OASIS D Expertise
- OASIS/Coding Competency Process
- Plan for More Changes

2. Coding Expertise

- Essential Competency
- Maintain experts and/or outsource

3. Effective Case Management and Care Management

- Implement/maintain case management processes
- IDT approach helps identify risks, goals and the plan
- Best practice care planning manages utilization and risk
- Bridges care delivery with QAPI



Practical Steps for PDGM Keep Big Picture Goals in Mind

Better Health

- Managing populations of health-partnering effectively across health systems, building key referral partnerships

Better Care

- OASIS competence, risk-stratified, evidence based care planning and care management yield better quality outcomes

Lower Cost

- Appropriate utilization of services and efficient operations

Well-being

- Happier clinicians mean happier patients. Lower staff turnover drives lower costs, better care, less LUPA financial stress



PDGM KEY ACTION: FOCUSED SMALL STEPS ACHIEVE BIG PICTURE GOALS

- **LEAN up and strengthen basic processes** to create high functioning teams
- Plan and execute a process to supervise, guide and measure individual or team's 'behavioral' adherence to the process.
 - **Key Performance Behaviors (KPBs) Drive Key Performance Indicators (KPIs)**
- Lower costs, capture revenue accurately through achieving desired KPBs:
 - Individual
 - Team
 - Department

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PDGM ACTION: LOWER YOUR COST PER VISIT PROCESS VARIATION IMPACTS LUPA EXPENSE

- Fazzi observes wide variation in adherence to processes in the best of organizations – seen in:
 - Intake, OASIS assessment, POC documentation, care planning, care execution, utilization management, coding, review, billing
- Getting costs down will help reduce financial burden of LUPA
- Hardwiring process excellence means going back to basics of analyzing some root-causes of variance.
- Rounding to identify the chain of workflow can bring us to root cause. It is worth it, now, to do this.

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PDGM ACTION: PROACTIVELY LEAD PROCESS CHANGE *THE STATUS QUO HAS TO GO*

- **Lead to engaged-accountability**
- Hardwire' best-practice processes for success under PDGM
- For each area of change, leaders will need to:
 - clarify expectations of performance
 - provide skills training to understand and meet expectations
 - have consistent method to *supervise and measure* adherence to performance expectations (measure the KPB – know desired KPI)
 - hold people accountable with good human behavior
- **Re-visit basics/core processes**
- engage key stakeholders in the process to capture current process
- Identify possible root causes of challenges

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PDGM ACTION: LEARN FROM LEAN METHOD

- Get to root cause: picture a horse pulling a cart
- Horse = work process followed (e.g. OASIS assessment technique, field documentation habits, orders management or billing process, etc.)
- Cart = actual work produced (e.g. timely, quality OASIS, authorization before care delivery, timely order procurement, paid claims)
- Imagine a broken, or hobbled 'cart' (late and/or inaccurate OASIS documentation, aging orders, visits without auth, write-offs, inaccurate billing and aging receivables)
- If cart is broken – look at the horse!
- Go to where the work is done (gemba) – supervise, measure and manage the work process where it happens.

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**PDGM ACTION: MANAGE YOUR PROCESSES
REDUCE EXPENSE, ENHANCE REVENUE,
IMPROVE CASH FLOW AND CLINICAL OUTCOMES**

- Round with purpose, learn from what you see:
 - Is there variation of approach to the work process, method and discipline? If so, there is likely a negative financial impact (think of LUPA reimbursement vs. cost)
 - Process engineer to LEAN, working with key stakeholders in core functions. Map desired process.
 - Build the buy in to process, motivating consistent adoption of rules based behavior – with good rules set by a team)
 - Communicate process's impact to serving the organization's mission, patients and families

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PDGM ACTION: LUPA MANAGEMENT

- LUPAs-often caused by lack of OASIS assessment technique competence and timely, accurate data capture.
- Build OASIS Competence – More accurately capture acuity.
- OASIS and risk-profile drive plan of care using efficient, evidence based tools and analytics.
- Reduce LUPAs born of habit-bound or subpar behaviors (e.g. planned recert LUPAs, recert timing, etc.)
- Evaluate patterns of LUPAs and cause.
- Learn what you can and cannot control. Do the right thing by centering behavior on patient acuity capture, best practice care planning.
- For what is left with LUPAs, lower your cost.

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**PDGM ACTION: BUILD CASE MANAGEMENT SKILLS
BUILD PROCESS TO BUILD COMPETENCE**

- Core to PDGM is OASIS.
- Assessment, OASIS accuracy and Point-of-Care capture-measure where work is done (performance based competence).
- Measure competence in submitted documentation
 - Track and trend quantified performance
 - Outcomes, areas of OASIS knowledge and care planning deficit
 - Build effective QAPI in partnership with outsourced reviewers.
 - PIPs focus on areas of needed improvement.
- QAPI and Clinical Ops identify clinician trends, triaging field need, creating accountability while building engagement.

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**PDGM ACTION: CARE MANAGEMENT
BUILD BEST PRACTICE UTILIZATION MANAGEMENT**

- Best practice utilization management = Care Management, a QAPI and Clinical Operations collaboration.
 - Care Management creates cycle of care planning, micro-education meetings.
 - Interdisciplinary teams learn from each other and SMEs. High risk areas tied to learning, using case presentation in specific format.
 - Stacking of clinical skillsets through ongoing, care planning education - related to acuity/risk. CoP compliance supported .
 - Builds clinician engagement and skills AND improved outcomes of more efficient/effective care.
- GOAL- EPISODE PRODUCTIVITY: achieve optimal, realistic outcome within the most efficient use of goal-directed, multi-disciplinary visits). CoP intent met related to care planning to reduce risk of hospitalization.

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PDGM ACTION: CARE MANAGEMENT

- The 'churn' of patient admission/discharge will increase: shorter lengths of stay as care is focused. Not realistic for a manager to know every patient and keep track.
- Avoid enabling clinicians' dependence on a manager to 'know' the patient (desk-bound case management). Rather support, guide and teach competence in care planning.

PDGM High Ground – Build Case Management Competence:

- *Hardwire process to strengthen clinicians' ability to assess patient and plan care in line with best practice risk-management.*
- *Support with focused supervision (gemba!) and Care Management guiding best practice care planning.*

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PDGM ACTION: CONSTRUCTIVE COLLABORATION CARE MANAGEMENT

- QAPI/Ed Collaboration
- Manage to **best practice utilization**. Lose wasted visits to increase capacity management. Ask yourself, are there visits done absent a focus on a goal directed plan? Is there waste?
- Integrate best practice use of evidence based care protocols.
- Integrate today's tech optimally and innovative technology as it evolves
- **Lose the waste**, focus the care.

"Turn knowledge into practice."

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PDGM ACTION: MONITOR YOUR METRICS

- Key Performance Indicators are Driven By Key Performance Behaviors:
Identify key actions to impact movement of KPIs – moving you toward desired goals:
 - Individual behaviors
 - Organizational behaviors
 - Leadership behaviors
- Assure structure supports desired, key performance behaviors.
- Provide staff tools: OASIS D, IDT Process, Care Management, Case Management, Leadership.
- Monitor and measure. Hold staff accountable.

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PDGM AND VBP SUCCESS? CREATE COMMON GROUND WHICH VALUES COMPETENCE



"Management works in the system; Leadership works on the system"

Stephen R. Covey

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