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A quality job: Clinical management and care coordination under PDGM

Simione Healthcare Consultants share their expert solution to succeeding under PDGM and achieving quality outcomes.

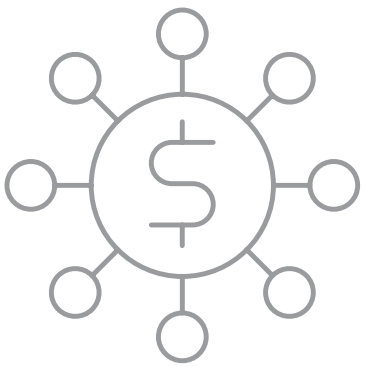
Simione™ HEALTHCARE CONSULTANTS

An overview of PDGM

If you're in the home health industry, PDGM is on your mind

PDGM affects all home health agencies – more specifically, all agencies that are Medicare certified. Going into effect on January 1, 2020, it's important to remember that PDGM is a payment change, not a regulatory change. And payment changes tend to affect everything we do. *Here's a quick refresher on the coming changes with PDGM implementation:*

- Payment change from 60-day PPS episodes to 30-day PDGM periods of care
- Eliminates therapy thresholds
- LUPAs can vary from 2 to 6 visits per period
- Increases secondary diagnoses documented to 24 on the claim
- RAPs will be paid at 20% for year 2020 and eliminated completely beginning 2021
- PTAs will be allowed to provide maintenance therapy
- All regulatory and compliance requirements remain unchanged
- Biggest change to Medicare since PPS implementation in 2000



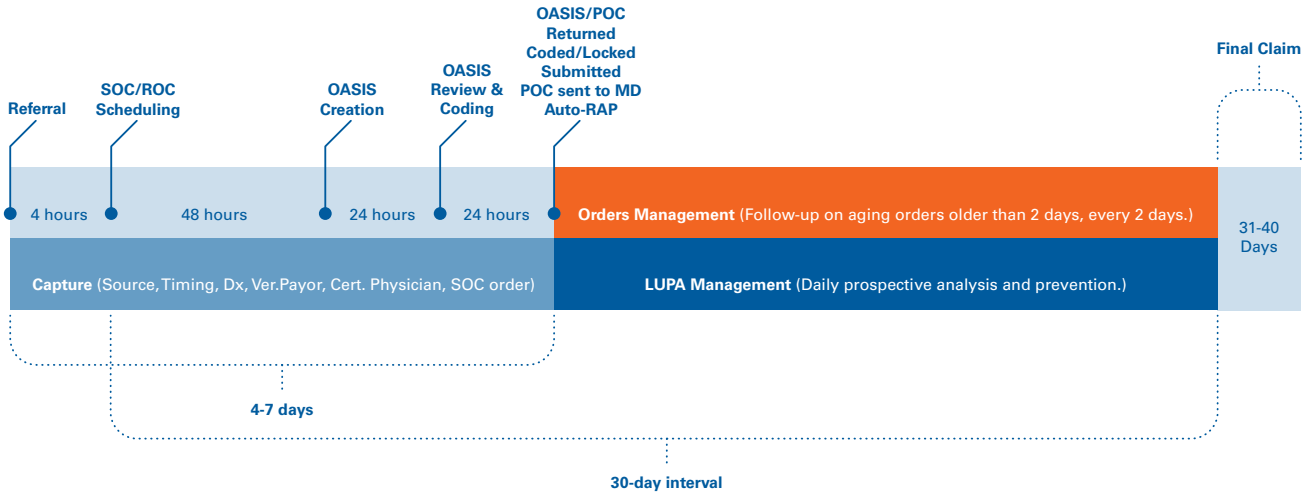
With PDGM, timing is everything

Simply put, everything that we're doing today will need to be done faster under PDGM. As you can see in the graphic below, you will no longer have 60 days to wait until day 45 to get face-to-face time and needed signatures. Nor will you be able to wait until 30 days to get your OASIS corrections and coding completed. After PDGM implementation, everything needs to happen within the new 30-day payment period – starting with referral capture.

Our recommended best practices:

- Within 24 hours: OASIS documentation should get completed
  This will drive reimbursement and provide insight into what your HHRG will be under PDGM
- Within 4-7 days: OASIS should get returned, coded, locked and submitted
  This will give you the time and ability to manage LUPAs and get signatures back from physicians in a timely manner
- Within 31-40 days: Submit final claim
  Meeting this timeline will have huge cash flow implications

PDGM-critical patient interactions time intervals and milestones - referral to discharge

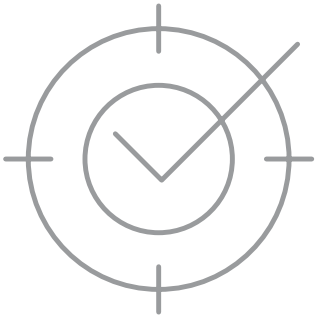


Key operational considerations for meeting these milestones:

- Regulatory and compliance requirements don't change, including face-to-face
- Cycle time must be reduced in each step of the process
  - Referral and intake
  - Admission and assessment
  - OASIS and Plan of Care completion
  - Documentation
  - Scheduling
- Accuracy must be improved
- Utilization must be carefully monitored
- Case management and coordination key to achieving quality outcomes

A timely approach to the PDGM cycle

The architecture of PDGM is broken down into four parts – admission, clinical grouping, functional impairment level, and comorbidity adjustment. Let's break down each step, focusing on timeliness and accuracy.



* CMS-ABT PDGM Model 2018

Admission Source and Timing (from Claims)

Community Early	Community Late	Institutional Early	Institutional Late

Clinical Grouping (from Principal Diagnosis Reported on Claim)

Neuro Rehab	Wounds	Complex Nursing Interventions	MS Rehab	Behavioral Health	MMTA - Other
MMTA - Surgical Aftercare	MMTA - Cardiac and Circulatory	MMTA - Endocrine	MMTA - GI/GU[1]	MMTA - Infectious Disease[2]	MMTA - Respiratory

Functional Impairment Level (From OASIS Items)

Low	Medium	High

Comorbidity Asdjustment (From Secondary Diagnoses Reported on Claims)

None	Low	High

HHRG
(Home Health Resource Group)

Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

1 Gastrointestinal tract/Genitourinary system
2 The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

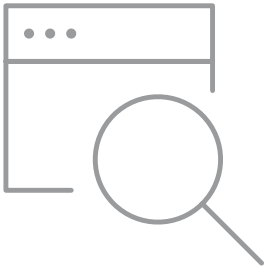
Referral and intake: Where it all starts

Welcome to referral and intake – the birthplace of accurate documentation. While it's critical that your team is able to grab as much accurate information as they can, also remember to design your referral and intake process from a customer's point of view. In other words, don't complicate it so much that people move to your competitors. It needs to be both customer-friendly and documentation-friendly.

Admission Source and Timing (from Claims)			
Community Early	**Community Late**	**Institutional Early**	**Institutional Late**

Keeping in mind that referral and intake are broken up into four areas – community early, community late, institutional early and institutional late – ***here are some more best practices when acquiring new patients:***

- Centralize the intake process to a team with customer service training
- RN leadership for decisions on complex care and regulatory compliance
- Determine admission source and timing
  - Facility liaisons and community engagement/sales should assist with this
  - If hospital referral, determine if ER or observation stay vs. inpatient
- Obtain F2F documentation and PCP to follow



5 PDGM impacts on referral and intake

1. Ensure referral accuracy – important in determining reimbursement
2. Gather patient secondary diagnosis information for comorbidities
3. Assist in eliminating questionable encounter diagnosis
4. Implement scripting for intake staff
5. Develop a checklist of required items, *including:*
   - ✓ Home health diagnosis
   - ✓ Physician face-to-face and supporting documentation
   - ✓ Any other general diagnosis information
   - ✓ Accurate referral source – if institutional, determine if qualifying inpatient stay
   - ✓ Requested services
   - ✓ Supporting documentation from physician, facility, etc.

5 PDGM impacts on admissions

1. Goal should be new patient acceptance within four hours of referral
2. Decision to accept new patients is a joint decision between intake and clinical team leadership
3. Potential NTUCs (not taken under care) decisions should escalate to clinical leadership
4. Start of care/admission visit scheduled and occurs within 48 hours of referral acceptance
5. OASIS, assessment, and plan of care completed within 48 hours

Functional impairment level: Where OASIS comes into play

The functional level is determined by an aggregate point total, based on eight OASIS items. Not only is this an opportunity for you to use in your performance plans and improvement, but it's also an opportunity to consider whether you should include occupation therapy in you plan of care.

Even though the functional levels are the only portion of the OASIS assessment used under PDGM, OASIS accuracy is important for driving goals of care and outcomes. We recommend certification or training for those individuals completing the assessment. And since this isn't a document that is just completed by the nurse, we also recommend interdisciplinary collaboration. It should be a comprehensive plan of care, which is part of our Conditions of Participation. *Here are more best practices for functional impairment level:*

- Consider current functional status assessments
  - Outcome performance improvement opportunities
- Identify patterns of internal referral and use of rehabilitation services to improve outcome function
  - Occupational therapy
- Functional status changes from first to second 30-day periods are a SCIC (significant change in condition) and require an OFA (other follow-up assessment)

3 Important tips for OASIS review and POC development

1. OASIS accuracy is paramount
2. OASIS certification and/or training for clinicians completing assessments is KEY
3. Interdisciplinary collaboration is critical in development of a comprehensive plan of care and OASIS-D

4 Best practice considerations for OASIS

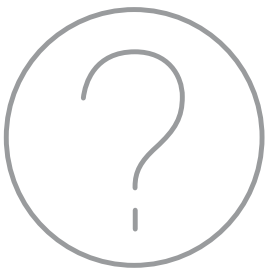
1. Functional items are to be completed through observation by the clinician, not through interview
2. POC and visit plan must be reviewed with the clinical team manager prior to submission
3. When possible, assessments are completed by the case manager responsible for ongoing care coordination
4. Use technology – secure texting, EMR, conference calls – to speed communication where appropriate

Coding under PDGM: Identifying the *why*

Coding is almost more of an art than it is a science. It identifies the reason that we're out there doing care in the first place, and it helps to identify one of the most important pieces of data in PDGM – the questionable encounters (QEs). Do you know what your most common QEs are? Start a list now, so that you have a solid understanding of your QE diagnoses.

Clinical Grouping (from Principal Diagnosis Reported on Claim)					
Neuro Rehab	Wounds	Complex Nursing Interventions	MS Rehab	Behavioral Health	MMTA - Other
MMTA - Surgical Aftercare	MMTA - Cardiac and Circulatory	MMTA - Endocrine	MMTA - GI/GU[1]	MMTA - Infectious Disease[2]	MMTA - Respiratory

Key considerations and questions for coding under PDGM



- Coding continues to be a key factor in determining reimbursement
- Specificity is necessary to avoid QEs
- Know your agency's current QE diagnosis
- Who is doing your coding?
  - If in-house, are they certified or what is the plan to educate?
  - If out-sourced, what is expected turnaround time and do they meet it?
- What is the turnaround time from receipt of OASIS to OASIS locked and coded?
  - Have a goal of 24 hours, but no more than 72 hours/3 days
- How long does it take the field clinicians to respond and make corrections?

Primary diagnosis and comorbidities

Symptom and unspecified codes will cause QE, which is why accuracy and detailed diagnoses are crucial. Consistently in the top-five primary diagnoses (and a CMS concern) is Muscle weakness (M62.81). When seeing this, consider muscle wasting and atrophy as a more detailed, accurate diagnosis. *Here are more things to consider for QE codes and comorbidities:*

- What are your top five QE codes?
  - Start a list of your common QEs
  - Plan and practice now to eliminate QEs
- 24 additional diagnoses are allowed on the claim
  - How will your agency get diagnoses beyond what is allowed on POC to the claim?
- Only one comorbidity adjustment is allowed per claim
- If the primary diagnosis changes in the first 30-day period, it should be indicated on the second 30-day period claim

LUPA changes under PDGM

The most challenging component of PDGM is the LUPA change. Under PDGM, a separate LUPA threshold will be required for each 30-day period. This is calculated at the tenth percentile or two visits – whichever is greater. *Here are some more LUPA changes to prepare for in 2020:*

- The threshold will vary depending on the PDGM payment group
  - Threshold ranges from 6 visits to 2 visits
  - LUPA episodes are 1 less than the threshold
- Scheduling will plan an important role in avoiding LUPAs
- CMS estimates LUPAs at 7% of claims
  - Determine your current LUPA percentage and consider how 30-day period LUPA's thresholds will be communicated to the field and scheduling

A staff-first approach

It takes a team

Just like any organization, quality care takes a team. We have the answer to what that team should be and how it can work together to achieve success under PDGM. *Here are some best practices for assembling clinical teams:*

- Organize care into clinical teams geographically servicing 125 to 175 patients
- The clinical team should be led by a clinician – generally an RN
- All disciplines report to the clinical team manager/supervisor
- Each team should include a dedicated scheduler, who also assists with clerical duties and phone triage

6 ways to facilitate interdisciplinary team coordination

Communication is key, which is why team coordination across all disciplines is a must when incorporating PDGM into your workflows. In fact, IDT/care conferences should be held bi-weekly (at minimum). *Here are six ways to facilitate interdisciplinary team coordination:*

1. Appropriate utilization of therapies
2. Ensure appropriate skill mix
3. Capitalize on interdisciplinary skill sets and perspectives
4. Review plan of care at admission, 25- to 30-day check-in before second period, prior to recertification
5. Update diagnosis, functional information, and POC if necessary
6. Engage patient/caregiver as a member of the team

What about the field?

When it comes to coordinating field staff, we recommend somebody who truly is out in the field, is seeing the patient and is able to coordinate the entirety of care that's being delivered to that particular patient. This person is a case manager, usually an RN or PT in therapy-only cases, and they perform best when placed in a care team based on geography. *Here's what to expect of a case manager:*

- Responsible for establishment of POC, goals and coordination of care in conjunction with the patient/caregiver
- Whenever possible, case managers should conduct the admission visit, or at least complete the comprehensive assessment
- Productivity should be lower than visit clinicians to allow for OASIS events, coordination and communication

Utilizing field staff to the best of their abilities means using the right staff at the right time. Simply put, you want your staff to work at the top of their license. RNs, PTs, OTs – they should be conducting visits on the toughest patients, those with the most complex care needs. Oftentimes, their productivity is slightly lower to give them time to make those calls and coordinate care, especially if they're case managers (coordinating care).

Don't forget to utilize LPNs, PTAs and COTAs – they can perform the task-oriented visits and care for those that are more stable or toward the end of care. PTAs can not only be a part of maintenance therapy, but they can also be the eyes and ears for case managers, helping you to lower cost. The truth is that we're being paid slightly less for these cases, so it's important to be wise about how we're using care.

Getting physician orders signed

Everything under PDGM needs to happen faster, with the same quality and regulations, and that includes MD orders. We no longer have the luxury of waiting 45 days to get physician signatures. So what are some best practices that can ensure physician orders get signed on time?

- Establish a person in your agency who follows up on MD orders and plans of care
- Follow up on MD orders no signed after two days, and follow up every two days until received
- Use technology – physician portals, e-signature or EMRs
- Find out the best way to communicate with your MD partners
- Escalate to leadership as needed for delinquent orders
- Enlist your medical director to help carry the message
- Review MD orders your clinicians are creating now – can you consolidate orders to reduce volume?

How to prepare

The overarching principal of PDGM

Based on the Balanced Budget Act of 2018, we knew these changes were coming. CMS has designed these changes around the data that we have been sending them over the decades, and that data all points to the main focus of PDGM – patient need. It still needs to be easy and customer-friendly, but we need to gather more information than we used to, that's the reality of these coming changes. And it will all result in a better patient experience.

If you're well prepared for PDGM, finances for your agency should start normalizing within the first three to four months of 2020. The best way to prepare for PDGM is to assess your agency from stem to stern – from the beginning of your process to when the claim is paid. Every single process will be affected.

Milestone goals for PDGM preparation

Before you set any major goals for PDGM preparation, the first step you need to take is to create a taskforce. This taskforce should be the steering committee to drive all PDGM initiatives. Members should be from all departments that will be effected - which is everyone – including sales, intake, operations, clinical, finance, revenue cycle, technology, and executive. The next step is to create milestones and hold your taskforce available to achieve them in timeframes that have been developed. ***Here are some examples of milestones that will lead your agency to PDGM preparedness:***

- Conduct an organizational and operational analysis to gain an understanding of current structure, processes, workflows, and available reports
- Analyze claim information to determine financial impact of the new PDGM model
- Develop a proposed model for operations
- Develop an implementation plan for resources, timing and change management.
- Train and educate staff
- Develop an ongoing implementation management plan

3 ways to educate and communicate with your staff

1. Start now and repeat information often and in different formats – staff meetings, emails, flyers, text, voicemail, etc.
2. Clinical managers and supervisors will be the “air traffic controllers” and will need a thorough understanding of PDGM – they’ll be responsible for utilization, staffing, supplies, and quality of care
3. Case managers will need time and OASIS education, as their productivity is different from visit staff and they need to understand the necessary skills to coordinate care for patients
4. Don’t forget your referral partners!

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Simione Healthcare Consultants are experts in the home care and hospice industry. They have been in this particular space for over 50 years and offer consulting in all areas. Simione also has a talent management solution for you and are now able to support you in data analytics, as well as M&A activity.

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Content based on webinar with Simione Healthcare Consultants.