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Home Health 2020: PDGM to COVID-19

Scott Rushanan, MS, OTR/L, MBA

- Presenter Disclosure: Financial: Scott Rushanan has received an honorarium for presenting this course. Non-financial: Scott Rushanan has no relevant non-financial relationships to disclose.
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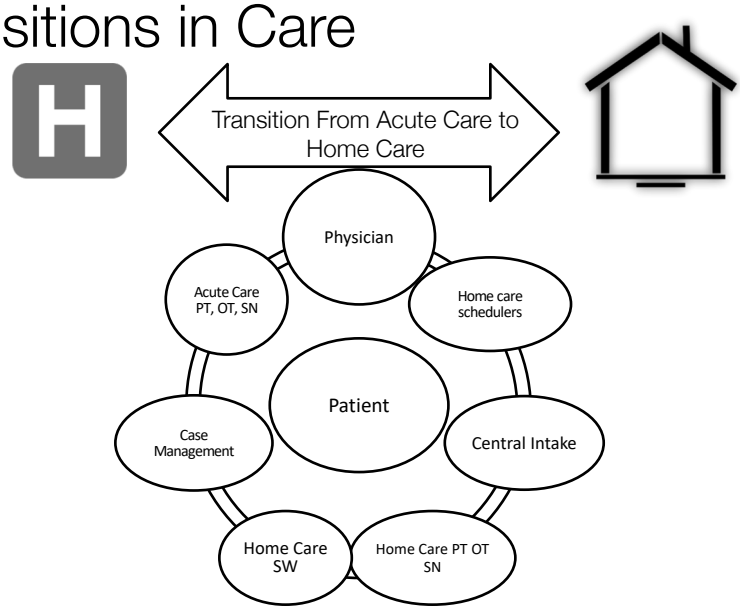
Learning Outcomes

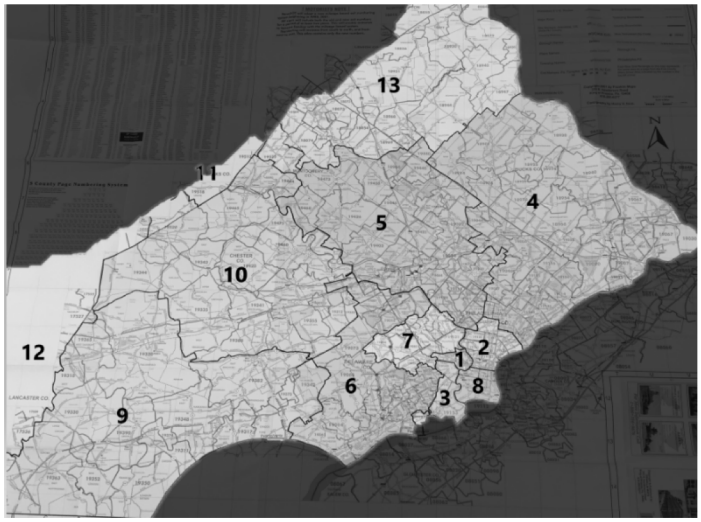
After this course, participants will be able to:

- Identify at least two ways of how the patient-driven groupings model (PDGM) affects home health reimbursement for therapy services.
- Identify at least two strategies on how home health agencies can benefit from PDGM changes to ensure both quality of care (i.e, improved patient function), increased therapy utilization, and financial success.
- Identify at least three strategies on how to adapt to changes in health care, in order to deliver effective and safe home health services.

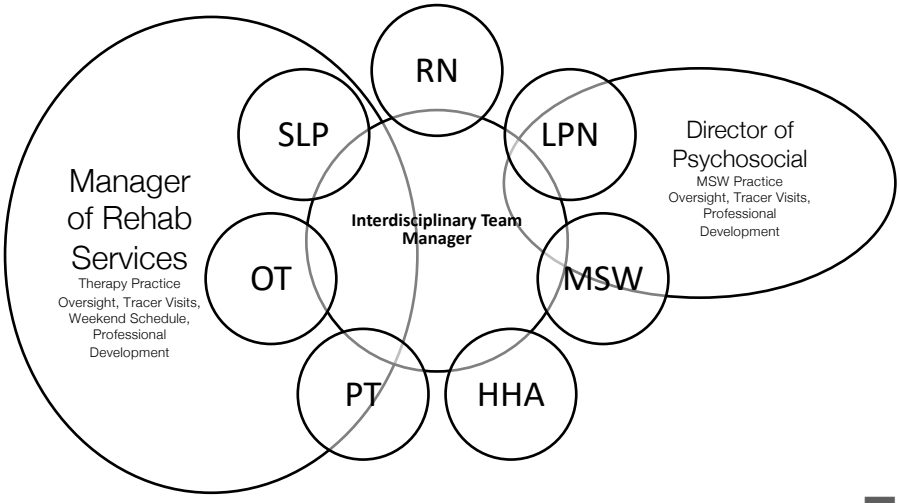
Transitions in Care



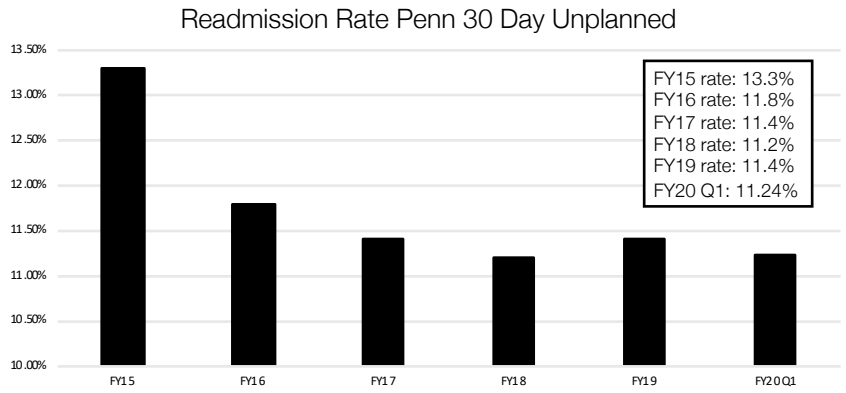
Penn Medicine Home Health Services Coverage



Interdisciplinary team structure



Penn Medicine at Home Readmissions



Patient-Driven Groupings Model (PDGM)

- Implemented January 1, 2020
- Number of therapy visits will not determine payment
- Higher emphasis on appropriate coding
- Attempt to promote value-based care that meets pt. needs
- Improve access to remote pt. monitoring - telehealth
- Unit of payments based on 30 days not 60
- Possible opportunity for therapy to shine

CONTINUED

Patient Driven Groupings Model (PDGM)

- Major change in reimbursement model for Home Health effective January 1, 2020

Current Model
153 case-mix
groups

⇨

PDGM
432 case-mix
groups

Current Model
60-day
billing period

⇨

PDGM
30-day
billing period

CONTINUED

Changes to the LUPA Episode in the PDGM

Current Model
4 visits or less
in 60-day period

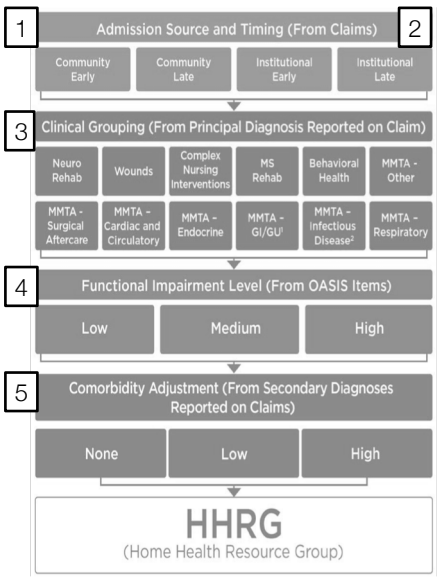
⇨

PDGM
1 to 5 visits
in 30-day period

Number of skilled visits resulting in a per diem payment

Patient Driven Groupings Model

For the first time
EVER
the word
"*patient*"
is
specifically included in a
reimbursement model



How the PDGM works

- 5 main case-mix variables
  1. Admission Source
  2. Timing
  3. Clinical Grouping
  4. Functional Impairment Level
  5. Comorbidity Adjustment
- 432 possible case-mix adjusted payment groups (HHRGs)

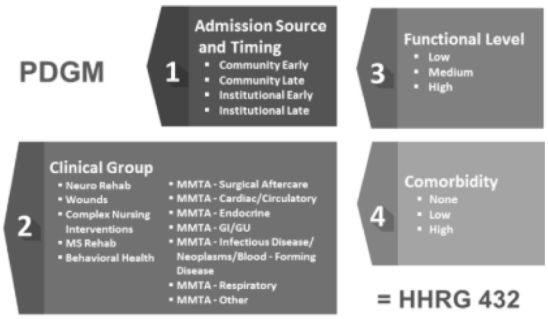
PDGM

- These characteristics are factored in when determining payment.
  - Acuity
  - Functional ability
  - Admission Source and Timing
  - Diagnosis group
  - Comorbidities
- Better aligns payments with:
  - Patient needs
  - Better ensures that clinically complex and ill patients have adequate access to home health care
- Clinical outcomes have always been and will always be critically important. This will not change.

Impact of PDGM

- Care must continue to be
  - Highly coordinated
  - Interdisciplinary
  - Meaningfully planned
- Agencies are no longer incentivized for higher number of therapy visits.
  - Penn Medicine at Home has been below industry benchmark for therapy thresholds
- Change from payment of 60-day episodes to payment of 30-day “periods of care”
  - Cert periods will continue to be 60-days.
  - The first 30 days will be one period, the second 30 days will be another.

PDGM Architecture



SOC/ROC Source: Institutional or Community

- Two Sources – Institutional or Community
  - Institutional: Acute or post-acute care in the 14 days prior to the home health admission
    - Acute: Inpatient stay at acute care hospitals
    - Post-acute:
      - Skilled nursing facility (SNF)
      - Inpatient rehabilitation facility (IRF)
      - Long term acute care hospital (LTACH)
      - Inpatient psychiatric facility (IPF)
  - Community: No acute or post-acute care in the 14 days prior to the home health admission
    - Includes outpatient services and ER and observation
    - Or if SOC/ROC doesn't occur within 14 days of discharge from institutional setting.

Timing

- Early
  - First 30-day period of the home health admission
- Late
  - All other subsequent periods
- If a patient is discharged from home health and readmitted within 60-days it is considered a Late episode

Episode Timing and Admission Source

Penn Medicine at Home

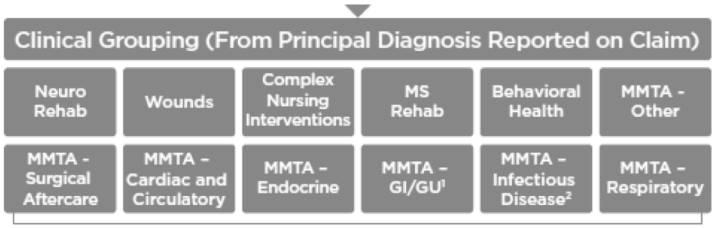
PDGM Periods	
Early - Institutional	2,942
Early - Community	1,213
Late - Institutional	851
Late - Community	4,300
Total	**9,306**
% of Episodes	
Early - Institutional	31.6%
Early - Community	13.0%
Late - Institutional	9.1%
Late - Community	46.2%
Average Case Mix Weight	
Early - Institutional	1.293
Early - Community	1.166
Late - Institutional	1.220
Late - Community	0.783
Total	**1.033**

Episode Timing and Source – Key Points

- Providing patients with intensive home health services, especially at the points in time when patients are most vulnerable for adverse events, improves clinical outcomes.
  - Start Home Health Services immediately after discharge or receipt of referral
  - Begin additional disciplines quickly
  - Reschedule missed visits
  - Ensure patients and caregivers are involved in the development of the plan of care to reduce refusal of additional disciplines
    - Rather than this: "Would you like me to have the therapist come out?"
    - State this: "I noticed that you were unsteady on your feet and were holding onto the couch to steady yourself, I am going to have the therapist come out to show you way to remain safe and steady and prevent you from having falls."

Clinical Grouping

- Each 30-day Period will be assigned to one of twelve Clinical Groups based on primary diagnosis:



Clinical Groupings

Penn Medicine at Home

Clinical Grouping	# PDGM Periods	%
Behavioral Health Care	25	0.3%
Complex Nursing Interventions	191	2.1%
MMTA- Surgical Aftercare	1,225	13.2%
MMTA- Cardiac/Circulator	1,549	16.6%
MMTA- Endocrine	258	2.8%
MMTA- GI/GU	325	3.5%
MMTA- Infectious Disease	874	9.4%
MMTA- Other	412	4.4%
MMTA- Respiratory	438	4.7%
Musculoskeletal Rehabilitation	1,767	19.0%
Neuro/Stroke Rehabilitation	843	9.1%
Wound	865	9.3%
Questionable Encounters	534	5.7%
Total	9,306	100.0%

Comorbidity Adjustment

- PDGM includes a comorbidity adjustment category based on the presence of multiple secondary diagnoses
  - No Comorbidity
    - No pertinent secondary diagnosis exists.
    - Secondary diagnosis does not meet the criteria for a comorbidity adjustment.
  - Low Comorbidity
    - There is a reported secondary diagnosis that falls within one of the home-health specific individual comorbidity subgroups.
  - High Comorbidity
    - There are two or more secondary diagnoses reported that fall within the same comorbidity subgroup interaction.

Comorbidity Adjustment

Penn Medicine at Home

PDGM Periods	
0 - No Comorbidity Adjustment	5,132
1 - Low Comorbidity Adjustment	3,277
2 - High Comorbidity Adjustment	897
% of Periods	
0 - No Comorbidity Adjustment	55.1%
1 - Low Comorbidity Adjustment	35.2%
2 - High Comorbidity Adjustment	9.6%
Average Case Mix Weight	
0 - No Comorbidity Adjustment	1.013
1 - Low Comorbidity Adjustment	1.033
2 - High Comorbidity Adjustment	1.142
Total	**1.033**

Comorbidity Adjustment Benchmark

Comorbidity Adjustment	Penn	National	State
No Comorbidity	55.15%	56.60%	54.70%
Low Comorbidity	35.21%	35.10%	35.90%
High Comorbidity	9.64%	8.20%	9.30%

- Learning Points:
  - Penn Medicine at Home patient have multiple comorbidities
  - These comorbidities should be addressed in the Plan of Care for the patient

Functional Level

Functional level will be determined by the point total of eight OASIS items:

1. M1800: Grooming
2. M1810: Current Ability to Dress Upper Body
3. M1820: Current Ability to Dress Lower Body
4. M1830: Bathing
5. M1840: Toilet Transferring
6. M1850: Transferring
7. M1860: Ambulation/Locomotion
8. M1033: Risk of Hospitalization

Functional Level Benchmarks

Functional Level	Penn	National	State
Low	55.59%	34.40%	31.70%
Medium	27.23%	33.30%	35.00%
High	17.18%	32.30%	33.30%

- Learning Points:
  - Accurate reporting of functional ability on the OASIS is critical
  - Interdisciplinary care is essential

Low Utilization Payment Adjustment (LUPA)

- Separate threshold for each 30-day period (**new**)
  - Currently, under PPS, there is only one LUPA scenario – 4 or less visits in one 60 day episode.
  - The change to a new LUPA threshold each 30-day period allows patients to receive the amount of service required for optimal outcomes.
- The thresholds will vary depending on patient acuity
  - There are over 400 different LUPA scenarios - ranging from 1-5 visits based on the clinical grouping diagnosis

LUPA – Key Points

- Use Best Practices for Case Management
  - Front-loading visits
    - Used by 64% of home health agencies that were the most successful at reducing hospitalizations.
    - Should be coordinated across all disciplines to ensure most patient-centered and efficient care delivery
  - Rescheduling missed visits
    - Reschedule missed visits rather than seeing at the next scheduled appointment
  - Decrease refusals of care
    - Build Patient Engagement: ensure that they are involved in the development of the POC and visit schedule

PDGM Summary

- PDGM presents the opportunity to better match the patient's acuity, physical status, ability to safely interact with environment and perform daily activities with payment. No longer is payment a one size fits all approach.
- Interdisciplinary and well-coordinated care ensures the most efficient care delivery and best patient outcomes.
- Strong Case Management is essential.
- Care Planning must be informed by an accurate Functional Assessment.

Response to PDGM

- Identifying functional deficits early.
- Early and intensive therapy services
- Increase inter-disciplinary collaboration
- Accurate OASIS assessments

Functional Level Benchmarks

Functional Level	Penn	National	State
Low	55.59%	34.40%	31.70%
Medium	27.23%	33.30%	35.00%
High	17.18%	32.30%	33.30%

- Learning Points:
  - Accurate reporting of functional ability on the OASIS is critical
  - Interdisciplinary care is essential

Function

- Do we assess any significant patient data point by patient self- report only?
  - How is your blood pressure today?
  - Has your wound gotten any larger over the past week?
  - Can you tell me your exact temperature today?
- How do we measure function?

Assessing Function

- What does the literature say on assessing function?
  - It is impossible to examine a person's functional abilities outside of the context in which they live their lives (Dunn, Brown, & McGuigan, 1994).
  - One cannot assess functional performance abstracted from the context of performing the activity (Giles, 2018).
- Home Health is the only patient care setting that has the opportunity to examine the patient within the context in which the patient lives their life.
- Home Health nurses and therapists have an opportunity and obligation to accurately assess function.

Dunn, W., Brown, C., & McGuigan, A. (1994). The ecology of human performance: A framework for considering the effect of context. The American Journal of Occupational Therapy : Official Publication of the American Occupational Therapy Association, 48(7), 595-607. doi:10.5014/ajot.48.7.595
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Overview of the OASIS Mentor Program

- Goal: To enhance functional assessment so that appropriate care plans can be established to return patients to the highest functional level possible.

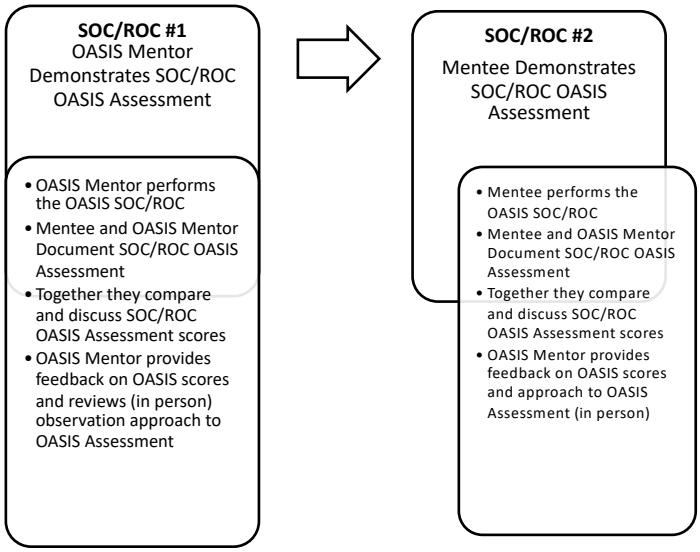
- **Program Objectives:**
  1. Support the educational needs of home health clinicians in achieving comprehension and accuracy in OASIS data collection.
  2. Supply the knowledge, skills, and tools necessary to boost clinical confidence while building a foundation of data collection precision.
  3. Use observation to assess functional status.
  4. Achieve OASIS accuracy that fully describes the picture of the patient in relationship to clinical acuity and functional mobility as it relates to 8 focus OASIS questions.

Functional OASIS Items
M1800: Grooming
M1810: Current ability to dress upper body safely
M1820: Current ability to dress lower body safely
M1830: Bathing
M1840: Toilet Transferring
M1850: Transferring
M1860: Ambulation/Locomotion
M1033: Risk for hospitalization

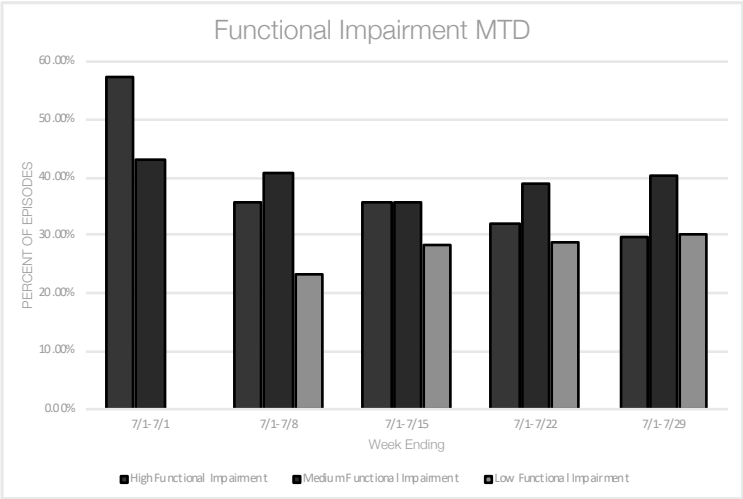
OASIS Mentor Program Design

1. OASIS mentors will provide real-time (in-home), individualized, shoulder-to-shoulder feedback and support to ensure OASIS assessment accuracy and excellence.
2. You and your mentee assess the same patient, at the same time, with the same background information e.g. referral, EMR
3. The OASIS Mentor and Mentee will be scheduled 2 SOC/ROC visits for the day. This will allow for sufficient time to:
   - Demonstrate the observation approach to actually observe what the patient can do before answering the functional questions.
   - Discuss how the observation approach can be incorporated into practice given varying clinical situations.
   - Compare and contrast OASIS scores between mentor and clinician.
   - Provide real-time action oriented feedback.
   - Demonstrate how to use the SHP OASIS scrubber tool.
   - Record individual performance on the 8 focus OASIS Questions.
   - Provide follow up as needed.

OASIS Mentor Program Process



PDGM Results - Function



Ethics of PDGM

- Post-acute care recovery from an illness or procedure can cause occupational disruption, which is a temporary or transient reduction in the engagement of occupation (Nilsson & Townsend, 2010)
  - PDGM provides resources to address impairments in day to day activity, resulting from an illness or procedure.
  - PDGM has some ethical value

CONTINUED

Ethics from a Utilitarian Perspective

- Utilitarianism (Mill, 1957)
  - Founded by Jeremy Bentham
  - Focused on actions that maximize utility
  - Utility is defined as happiness, pleasure, and wellbeing
  - Meant to minimize pain an misfortune (human and animal)

CONTINUED

PDGM from a Utilitarian Perspective

- Maximizing Beneficence – As Therapists we want to improve health and function for all patients.
- Minimizing Maleficence – Minimize harm to our patients
- Fairness

CONTINUED

PDGM from a utilitarian perspective

- Does PDGM maximize health and well being for all patients (maximizing beneficence)?
- Does PDGM minimize maleficence?
- Was PDGM designed and implemented fairly?

CONTINUED

Ethics – Occupational Justice Perspective

- Occupational Apartheid is a type of occupational injustice where some individual are afforded opportunities to participate in occupation but others are restricted from these opportunities based upon race, disability, gender, age, nationality, and social status (Durocher et al., 2014).
  - Restricts home health services
    - Socio-economic status (ability to pay)
    - Age (must be 65 years of age for Medicare)
    - Disability (can have functional impairment without an acute medical condition)
  - Defines function in terms of ADL/IADL status and does not consider leisure, socialization, or employment
  - PDGM does not address societal structural factors that may lead to disability (economics, underemployment, over employment, political, and geographical factors).
  - Medical Model Based

CVA Home Recovery Program

Clinical Operations Metric	
Number of Patients Referred to HSRP	13
Number of Patients Enrolled in HSRP	11 (2 Declined PT/OT)
% HH Admission 24 hours (RN or PT)	85% (100% if 2 outliers removed)
Average Time D/C – HH PT Admission/Eval	1.27 days
Average Time D/C – HH OT Evaluation	1.8
Average Time D/C – HH RN Admission/Evaluation	1.6 days
% of at least 4 consecutive PT visits	75%
% of at least 4 consecutive OT visits	88%
# of patients requiring Telehealth/VCM	2
# of patients requiring MSW	3

CVA Home Recovery Program

Clinical Metric		
Readmissions	0	
ED Visits	2	
	Initial Evaluation	Discharge
AMPAC ADL	54.52 (Needs assistance with ADL)	70.06 (Independent with ADL, some assistance with IADL)
AMPAC Mobility	60.22 (Independent Indoors)	
TUG (Avg.)	15.8 seconds (>12 sec. = falls risk)	10.4 seconds (lower risk of falls)
Barthel (Avg.)	84 (moderate dependence)	90 (slight dependence)
Ambulation	Supervision	Independence
Allen's Cognitive Level		5.2 (needs assistance with IADL, medication management, and money management)

COVID-19 Response

- Staff Monitoring
  - Body Temperatures
  - Testing
- Patient Monitoring
  - Schedulers/Clinical Staff
  - Wellness Calls
- PPE
- Staff and Patient Education

COVID-19 Protocol

Penn Medicine At Home

PPE Matrix for COVID-19

Patient Status	Gloves	Goggles or Face Shield	Surgical Mask	Gown	N95	PAPR	Bouffant Cap*	Shoe Covers*
Universal PPE/ Negative Screen	X	EITHER	X					
Negative Screen with High Risk Medications / Treatments **	X	EITHER	X When using goggles, place surgical mask over N95 mask and discard after visit When using a face shield, a surgical mask is NOT needed		X			
Testing for COVID-19 OR Caring for known Positive COVID-19	Using N95: X	X (Face Shield preferred)	X When using goggles, place surgical mask over N95 mask and discard after visit	X	X		X For testing only	X Optional
	Using PAPR: X			X		X	X	X Optional

*Bouffant Cap and Shoe Covers not indicated for PHAR/PHACC or facility use

SPECIAL INSTRUCTIONS

Clinical Treatment COVID-19

- In person HH Admission with PAPR
- Combination of in person and tele health visits (PT, OT, RN, SLP)
- Focus on activity modification and energy conservation
- Return to in person visits 14-21 days post symptom onset

Clinical Treatment COVID-19

- 2x daily manager/director huddle with Infectious Disease CMO
- Track all patients who screen/test positive
- Plan initial visits and PPE
- Plan tele health install
- Resolve recovered patients

Covid-19 Clinical Summary Dashboard

	Total	Resolved	Monitoring	Active Positive	Positive	Negative	Pending	Not Sent (N/A)	Positive Resolved
HH 1	137	92	11	9	54	17	0	29	45
HH 2	165	112	11	6	59	33	0	25	53
HH 3	127	92	25	20	81	21	1	13	61
HH 4	96	76	9	7	39	19	0	17	32
HH 5	92	73	7	5	24	29	0	27	19
HH 6	84	59	5	3	23	18	1	16	20
HH 7	95	90	3	2	53	22	0	9	51
HH 8	77	69	9	5	51	8	1	9	46
HH 9	75	65	5	5	25	24	0	20	20
HH 10	92	68	9	5	28	15	1	24	23
Resource	48	29	1	0	5	14	0	7	5
Home Health Total	920	825	95	67	442	220	4	196	375
Infusion Without Dual	120	116	3	3	20	58	0	41	28
Palliative	99	87	12	7	31	30	3	33	24
PHAR	20	20	0	0	17	2	0	0	17
PHACC	14	14	0	0	11	0	0	3	11
Hospice	205	196	9	8	102	23	4	42	94
Princeton HH	70	69	7	7	49	17	1	3	42
Princeton Hospice	15	15	0	0	13	1	0	0	13
Lancaster	190	146	32	21	93	27	1	23	72
Total	**1612**	**1454**	**158**	**102**	**750**	**376**	**13**	**338**	**648**
	Total	Resolved	Monitoring	Active Positive	Positive	Negative	Pending	Not Sent (N/A)	Positive Resolved

Data as of 6/4/20 at 12:33pm

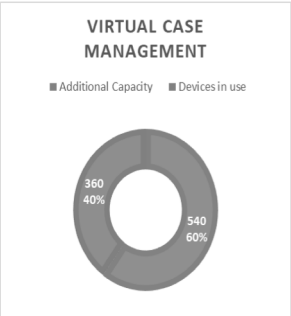
Tele Health Visits

- Cognitive Rehabilitation
  - Based in neuropsychology
  - Focused on retraining cognitive processes, such as short term memory, attention, and executive functioning (Schwartz & Sagiv, 2018)
  - Exercise, though bio-mechanically based, is similar.
    - Strengthen movements in hopes that it transfers to better performance with functional mobility.

Tele Health Visits

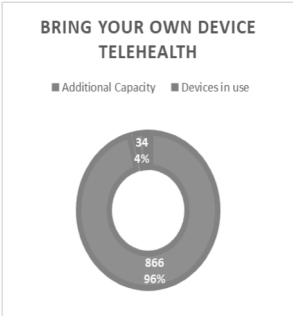
- Metacognitive Strategies
  - Patient driven goals
  - Therapists act as a coach, guiding patients in changing their own behavior.
  - All bodily systems interact with the environment, and adapt in response to new learning and environmental change (McEwen, Mandich, & Palatajko, 2018)
  - Plan, Do, Check, Act – CO-OP Strategy (McEwen, Mandich, & Palatajko, 2018)
  - Focus on improving functional performance
  - Assessments include AMPAC, COPM, BORG/RPE scales

Remote Patient Monitoring



Virtual Visits	
Virtual Case Managers	20,844
Skilled Nursing	8,713
Physical Therapy	5,145
Occupational Therapy	1,849
Speech Therapy	352
Total Virtual Visits	36,903

* Since March 1, 2020



Remote Patient Monitoring

- Video Conferencing
- Patient education/activity builders
  - Electronic sharing of information (email/text/share screen)
- Case Conferencing with MD, Rehab Director
- Low Readmissions
- COVID Recovery
- High Intensity of Visits

Questions?

Scott Rushanan, MS, OTR/L, MBA
Scott.Rushanan@pennmedicine.upenn.edu

CONTINUED

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