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PDGM and Home Health: Are You Ready?

With less than eight months before the implementation of PDGM, how are home healthcare providers gearing up to be prepared? Patient groups will be determined by a combination of clinical group, functional level, admission timing and source, along with any comorbidity adjustments. Also, with a main focus on episodic outcomes, our partners need to know where their patients are going, where they are coming from, and how is their partnership with these entities performing compared to the benchmarks of quality and cost. Also, where are the opportunities for overall improvement? HealthPRO® Heritage is committed to supporting your efforts in establishing a successful continuum and developing a strong market strategy by supporting you with information you need to be assessing and asking about.

What Do We Currently Know About PDGM and Home Health?

The goal of PDGM is meant to better align reimbursement with patient needs and address payment incentives found within the current system. PDGM would change the unit of payment for home health agencies from a 60-day episode of care, to 30-day periods of care within a larger episode. Home health agencies were advised to immediately create a transition plan that identifies the clinical, operational, and financial requirements under PDGM and also establish the necessary process which is aligned with the new requirements. Upon referral and before admission, a patient will be grouped into one of the six categories:

- Musculoskeletal rehabilitation
- Neuro/stroke rehabilitation
- Wounds (post-op wound aftercare and skin/nonsurgical wound care)
- Behavioral healthcare
- Complex nursing interventions
- Medication management, teaching and assessment (MMTA-7 Groupings)

The patient's functional level (either low, medium, high) will be determined from the initial OASIS, then a comorbidity adjustment (either none, low, high) will be calculated based on the secondary diagnoses on the claim. Potential comorbidity adjustments can be made based on individual subgroups and 27 comorbidity subgroup interactions.

What Questions Should You Be Asking Your Home Health Partners?

- **What is your overall strategy specific to senior living given the change in reimbursement for institutional vs. community based admissions?** Under the PDGM, each 30-day period is classified into one of two admission source categories – **community** or **institutional**– depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute hospitalization in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay.
- **What are your CMS Star Ratings?** You need to know both the quality and patient satisfaction scores. Hospitals, doctors, and nursing homes may be reluctant to refer patients to agencies with fewer than three stars. Patients and families take these ratings into account now as well. According to a report by Patient Engagement, "If offered adequate patient education on the matter, 75 percent of patients said they would use the star ratings to determine their next health care choice." Based on these findings, it will be vitally important to choose provider networks that provide overall exceptional quality and evidence based outcomes.
- **What are your hospital readmission rates?** CMS believes that a large number of hospital readmissions are avoidable. Identify providers who use industry best practices and real-time data to keep patients from readmission. Find out what their 30-day penalty diagnose group, overall 30-day, and 60-day hospital readmission rates are and if it has increased or decreased over the past months or year(s). The hospital readmission rate will drastically impact referral partnerships across the continuum of care; acute care and inpatient rehab hospitals, skilled nursing facilities, senior living facilities, ALF/ILF's, and home health facilities.
- **What are your scores on quality, and how do they compare to the state and national averages?** Often overlooked, these outcome measures effect overall STAR ratings and the end result quality of care. Know how they perform in the following key areas of improvement: Ambulation, Bed Transfers, Bathing, Pain, Dyspnea, Surgical Wounds, and Management of Oral Medications.
- **How do they score with process measures?** This group of important factors explores how well your partner(s) scores with key patient care. It assesses such factors as: Timely Initiation of Care, Drug Education, Fall Risk Assessment, Depression, Diabetic Foot Care & Education, and Emergency Room Visits.
- **Can they accommodate same day referrals?** In a day where patients are discharging "quicker" and "sicker" it is so important to know that your home health partners have the ability to admit and access your patients in a timely manner. Studies show that admits of patients within 24- hours or less decrease hospital readmission rates and improve patient satisfaction.
- **What clinical programs and pathways do they have for specific diagnostic groups?** Find out if they have specific physician protocols or specialty programs in place for specific clinical pathways such as orthopedic, cardiovascular, neurological, surgical, respiratory, fall prevention, diabetes, etc. Ask them about their success stories or data/report cards that supports that their specialty programs bring value to the table.
- **Does the agency offer other disciplines for home health?** Do they have support staff or provide specialized nursing, medical social workers, certified home health aides. Missing one or two of these key figures can adversely affect overall patient care.
- **Does the agency have a healthcare professional on-duty 24 hours per day, 7 days a week to answer any questions?** Make sure that if a patient or caregiver has questions, concerns, or if emergencies take place that they have adequate ways to respond and prevent hospital readmissions if possible. It is good if they implement a "call us first" mentality so that communication is key to patient care and satisfaction.

- **What are they doing to improve their scores or measures?** In an ever changing and evolving insurance and payment system, providers have to be looking at ways to improve their overall quality and care. We are progressing to more "data driven" practices and "evidence based" programs and outcome reporting. New technology and research is at our fingertips to use. They should always be striving to become better.

Asking questions will encourage communication, forefront their current best practices, and highlight the need to make changes in order to prepare for the PDGM final ruling. To learn more, contact us at: homehealth@healthpro-heritage.com.