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PDGM Executive Summary – Extending the Stay of Wellness and Condition Management

There is a period of time when a patient is not receiving acute health care services — whether it's hospitalization, emergency department need, or home care services. This is the concept of stay of wellness. During this time the patient manages their medical conditions by following the advice and recommendations of their physician and care team.

Stay of wellness facts and best practices:

- Patients with chronic conditions make up a large percentage of the home care population. A recent study shows that the size of this population – particularly patients with multiple comorbidities – is projected to grow to 157 million Americans by 2020.
- Data from a 2012 CMS report shows that Medicare beneficiaries with multiple chronic conditions were significantly more likely to have multiple hospital admissions and readmissions, ED visits, and home health visits than a comparable population with zero or one chronic condition.
- Many patients have follow up appointments. Best practice is to ensure the patient has a plan to attend the appointment and for the care team to follow up with any recommendations that result from that meeting.
- Inadequate or lackluster communication among homecare team members can lead to incomplete education or follow-through with important interventions that could improve the patient's overall health and risk for rehospitalization. Examine your agency's communication and collaboration methods to close any gaps that may exist.
- Myocardial infarction, heart failure, and pneumonia all have high rehospitalization rates. It is important that clinicians have an exceptional understanding of their scope of practice and how it supports intervention for the patient's primary clinical diagnosis.
- Team members should interact early and often regarding the care delivery of the patient to fully understand the implications of each discipline's care plan and goals, which employs a transdisciplinary approach to care.
- Therapists should understand the patient's chronic disease process and determine the best possible treatment intervention for that particular disease.
- Therapists should begin to educate the patient on how their disease process can affect them and how it relates to mobility, endurance, cognitive functioning, and ADL performance. The transition of care from the skilled provider to the patient is crucial to bridging the gap from an acute episode to a stay of wellness.

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