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Your PDGM Resource

PDGM Executive Summary: Durability of Response and Alternative Delivery Options

Durability of Response is the ability for the patient to maintain gains made while participating in skilled intervention/rehabilitation when that skilled intervention is no longer being provided. In other words, this ascertains whether or not the patient can maintain the gains made while under the care of the home care team when the team is no longer in the home.

To do this, the team must begin to transition some of the care over to a care extender — whether that is a family member or other non-skilled entity. When care can be given to someone who is not "of a skilled background" that means the care intervention is not so complex that it can only be provided by a skilled clinician. That's good news for the patient because it shows they are moving towards independence in that area.

Best practices for Durability of Response:

Patient education: Therapists should educate the patient and caregiver on how the specific disease process can affect them and how it relates to mobility, endurance, cognitive functioning, and ADL performance.

Therapist responsibilities: The therapist should begin education with the first visit and start to shift the routine tasks, practice or condition management over to the patient and family as soon as possible in the treatment process. This 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. The sooner the patient and/or family begin to understand the process to manage the patient's condition, the sooner the therapist can begin to determine their ability to maintain progress made in absence of skilled care.

Analyze patient needs through various levels of monitoring:

Routine exercises or repetitious tasks: These can be performed independently by the patient if able or by a care extender such as a home health aide, family friend or family member. The therapist would determine what activities would be appropriate and then schedule a follow up to reassess the durability of the result and adjust the program as needed. This same approach can be applied to condition management. Allowing the patient to practice what they have learned helps give the patient and the therapist confidence that the progress made during the skilled intervention will be maintained. That the response is durable.

A phone call to the patient: This could be to remind him or her of the need to perform any exercises or reinforcing activities that do not need the monitoring of another person. Additionally, the therapist (or designee) can inquire as to whether the patient has any questions about their exercises, recent activity or trips outside the home and general overall performance since a therapist was last in the home. If someone other than a clinician is making this call, they can forward any concerns to the therapist. This then allows the therapist to test that durability of response and make any alterations to the care plan the next time they visit the home.

New payment methodology:

Under PDGM, reimbursement is determined by patient characteristics and the value of the service over volume. Evidence supports various forms of follow up to empower the patient to manage their condition. What does the delivery of value based care that will support the durability of response, extending the patient's stay of wellness look like for your agency?

Questions about this information? Contact AskAtHome@AegisTherapies.com or visit our Resource Center for more information at AegisTherapies.com/Resources.