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# PDGM Executive Summary: Coordinated Service Delivery

Currently, and under PDGM, an agency needs to determine how often a patient needs to be seen to achieve their goals and improve their function. Many factors come into play with this important consideration such as – who is the right discipline to intervene with the functional deficits and underlying impairments present? How often does this discipline or others need to be present in the home to support the care plan and goals? Does the patient's medical status lend itself to more frequent sessions or is spreading the visits out over a longer period the better approach?

Your agency should examine its current practice for how it coordinates visits for care with the patient. What methods are used to effectively help the clinicians determine nursing and therapy frequency?

A good plan of action is to establish a process through which each clinician examines the patient, determines the current status and compares it to the prior level of function, and takes the homebound characteristics into consideration. Other things to look out for are patient motivation and stimulability for progress as well as the goals the patient wants to achieve. The clinician takes all these things into account and recommends the visit frequency for their discipline.

The next step is to then examine how each discipline interacts with other disciplines involved in a patient's care plan. When does this communication take place and how often thereafter? When each discipline knows each care team member's goals and areas of focus for a patient, every other discipline can help reinforce those areas in their own visits. This helps to increase the carryover and reinforce the expectation that the important aspects of condition management will endure over time.

Each discipline needs to discuss their estimated visit frequency with the care team and how that plays out over each 30-day payment period and the full 60-day certification period. Once the care team knows and understands the patient's needed areas of treatment, risk factors and determined priorities, the care team can establish an appropriate visit regimen and overall coordinated service delivery approach.

Additionally, within the visits planned, ensure there is an attempt to maximize the number of days the patient is seen by a clinician. This can be accomplished through deliberate and coordinated scheduling of discipline visits to achieve this goal. All of this can possibly help reduce the patient's risk for hospitalization.

Putting a process in place that can allow the care team time and space to have these care delivery discussions will put the agency ahead of the rest.

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