It takes a village

The team approach to PDPM preparation

Feb 19 / Feb 26, 2019

Key education points

1. Engaging all nursing home professionals
2. Enhancing admission screening processes
3. Evaluating current documentation processes
4. Educating medical providers and expecting change
5. Options for deeper insight into patient data, frailty risk, and PDPM outcomes

Introduction & background

Jason Jones
Chief Technology Officer, SimpleLTC

Background for today's webinar

"Knowledge is Power" – *Francis Bacon*

- EHRs and data are not enough – providers need deeper insights
- Solution providers are finding new ways to help SNFs address upcoming payment model disruption (PDPM)
  - **SimpleLTC**: MDS data automation, CMS connectivity, data science and analytics
  - **Patient Pattern**: medical expertise, diagnosis insight and clinical decision support

Live poll

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Engaging all professionals

- All nursing home professionals must be educated and engaged
- Each member of your “village” will need to contribute

Turn your PDPM knowledge base into a call to action

Dr. Eugene Gonsiorek, Ph.D.
VP Long-Term Care, Kaleida Health, Buffalo, NY

Main messages on PDPM planning for TODAY

1. Educate all staff, including physicians
2. Consider pre-admission screening
3. Assess MDS competencies
4. Consider measuring risk
5. Start planning today

Dangers of PDPM

- Therapy no longer drives reimbursement
- 5-Day Admission MDS sets rate for stay
- ICD-10 coding drives reimbursement
- Clinical complexity must be captured
- PT/OT/NTA rate decreases over LOS
- **Questions to ask**
  - How do we measure clinical complexity?
  - How do we meet the 5-Day MDS deadline?
  - How accurate are PDPM's Assumptions?

Danger #1: Chasing Clinical Complexity for Reimbursement

- Developing new clinical programs will cost money in staff development and training
- Failure to cultivate the right programs could lead to decreased census, deficiencies, lawsuits
- Will CMS reimbursement outpace hidden costs?

Danger #2: Fewer MDS assessments means fewer MDS Coordinators

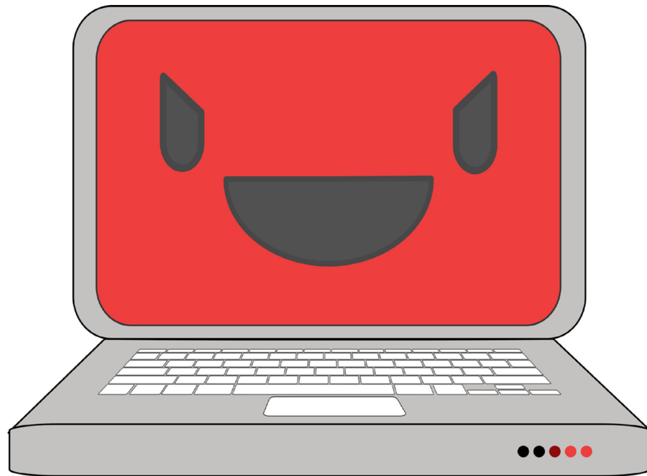
- Fewer MDS assessments does **NOT** mean fewer MDS coordinators
  - In RUGS-IV, there are approximately 20 MDS items that affect reimbursement
    - Therapy and ADLs
  - In PDPM, there will be 161 MDS item fields for MDS coordinators to track for reimbursement

Danger #3: If ICD-10 coding drives reimbursement, MDS Coordinators and Therapists can become ICD-10 coders

- How many ICD-10 codes are there?
  - 68,000
  - How much will a coding software cost?
  - How much will it cost to train staff?

How realistic is it for MDS Coordinators or Therapists to become coding specialists prior to Oct. 1, 2019?

Danger #4: Beware of PDPM and ICD-10 software



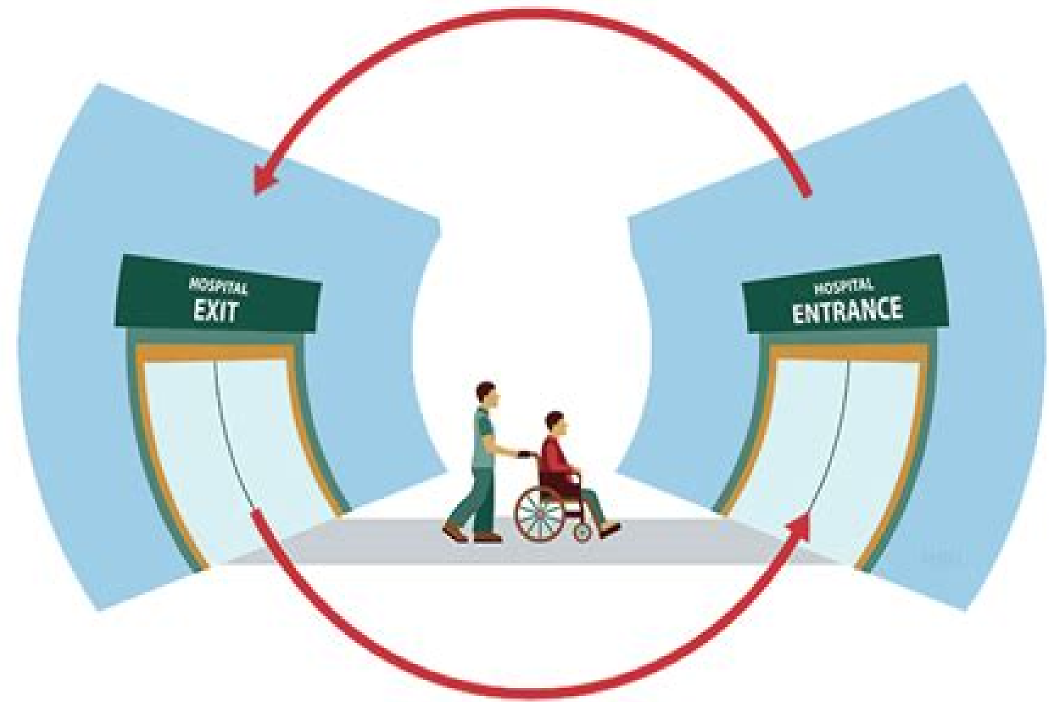
- Why was ICD-10 software created?
  - ICD-10 software was created to convert medical diagnoses into one of 68,000 specialized ICD-10 codes
- ICD-10 software was **NOT** constructed to assist you with increasing revenue with PDPM
- ICD-10 coding is important in determining the primary diagnosis, however there are many downstream components in determining a PDPM score
  - How would an ICD-10 coding software take these components into account?

Danger #5: If therapy no longer drives reimbursement, decrease therapy

- MDS will still document therapy minutes
- Therapy will always be needed for rehabilitation and discharge planning
- SNF Post-Acute Market has been based upon the need for therapy

Danger #6: If therapy and NTA reimbursement decreases over time, decrease length of stay

- PDPM incentivizes shorter lengths of stay
- However, shorter LOS may negatively impact:
    - Patient Satisfaction
    - Census
    - Claims-Based QMs
    - Value Based Purchasing



PDPM: New admission

Hospital history and physical

- Ms. Shirley G. is an 80-year-old female who was admitted at XYZ Hospital from 01/30/19 until 02/14/19 with a ***diagnosis of septic shock***
- Ms. G. has a past medical history of hypertension, morbid obesity, and s/p breast cancer (L mastectomy)
  - Pt. presented to the ED with a stroke but CT scan was negative
  - Pt. admitted to ICU for hypothermic shock with differential *diagnoses of stroke, moderate hypothermic shock related to possible infection, and acute encephalopathy*
- Is this patient clinically complex?
- Is your SNF capable of caring for this patient?
- Will your SNF receive more reimbursement under PDPM or RUGS-IV for this patient?

PDPM: New admission

<u>Admission note</u>

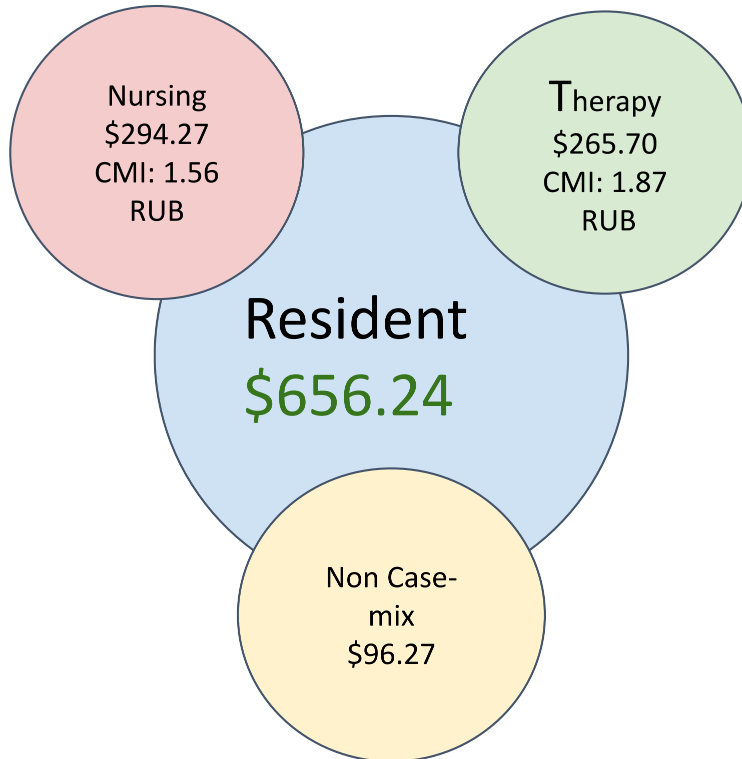
- Ms. G. arrived at SNF via stretcher at 1600 and admitted to room 155B for Septic shock. PMH consists of HTN, Obesity, A-Fib, Breast CA s/p mastectomy (left).
- Pt A&O X2-3, confused, and speaking to someone not there.
- Pt c/o pain at a 5, lungs clear bilaterally, abd soft non tender, regularly heart rate, + bowel sounds.
- **Function**: Exhibits left-sided weakness. Requires one assist with bed mobility. Two assist with transfers. Two assist with toilet use.
- **Mood**: Resident has no changes to mood or behavior. Confused..
- Resident is incontinent of bowel and bladder. No changes in skin integrity noted. Hearing is adequate. Resident wears glasses.
- **Diet**: puree and nectar thickened liquids. Lymphedema noted to left arm.

PDPM: New admission

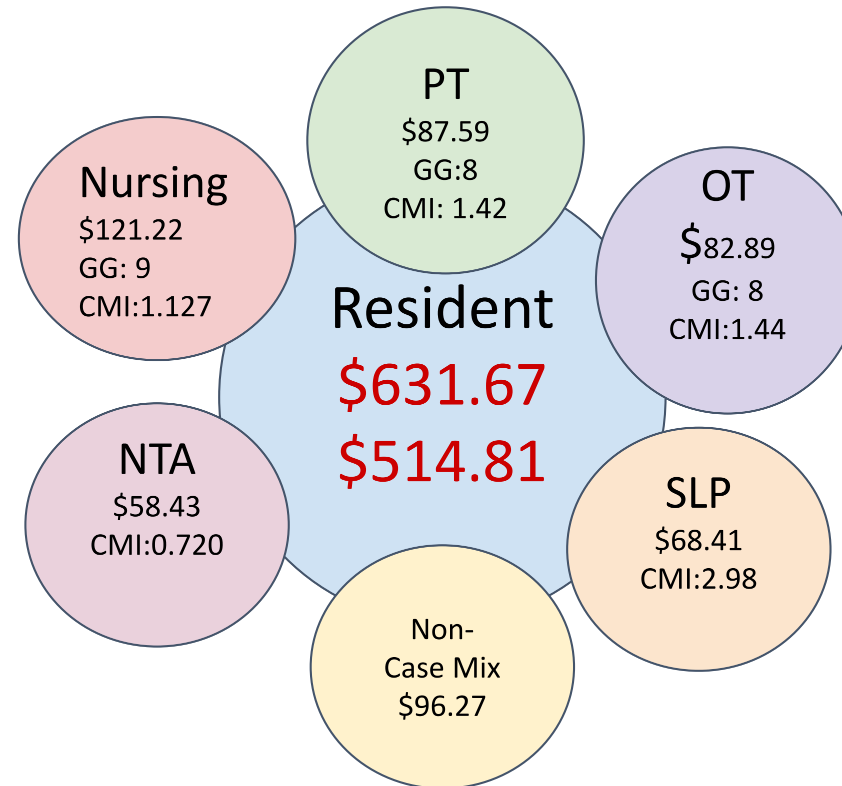
- Information asked for by a ***Free*** PDPM calculator online:
  - Location: Urban vs. Rural
  - Wage Index: Erie County, NY (1.0393)
  - Clinical Category: Medical Management
  - Section GG Score: 8 (Category :TJ)
  - SLP: Yes, swallowing disorder and mechanically altered diet (Category: SJ)
  - Non-therapy ancillary: 0 points based upon diagnoses
  - Nursing: Category PBC1
- Current Therapy
  - PT: 5x/wk for 300 min/wk
  - OT: 5x/wk for 300 min/wk
  - SP: 5x/week for 150 min/wk

Calculating PDPM

RUGS-IV



PDPM



RUGS-IV 20-Day Stay: **$13,124.80**

PDPM 20-Day Stay: **$10,646.78**

What happened?

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Calculating PDPM

- Did we miss anything?
  - Non-therapy Ancillaries
  - In our example, Ms. G. has a past medical history documented in the hospital of ***septic shock***, ***morbid obesity***, hypertension, s/p breast cancer with L mastectomy.
  - Ms. G. is 5'3" 228 lbs and is on the following medications:
    - Metopropolol Tartrate(hypertension)
    - Eliquis (atrial fibrillation)
    - Anastrozole (breast CA)
    - Aldronate Sodium (osteoporosis)
    - Kazano (***diabetes mellitus***)

- However, the following were not added into the PDPM Calculator, which led to a decrease in Non-Therapy Ancillary Revenue:
  - Morbid Obesity: I8000 (1pt)
  - Active diabetes mellitus : I2900 (2 pts)
  - Cardio-respiratory failure or shock : I8000 (1 pt)

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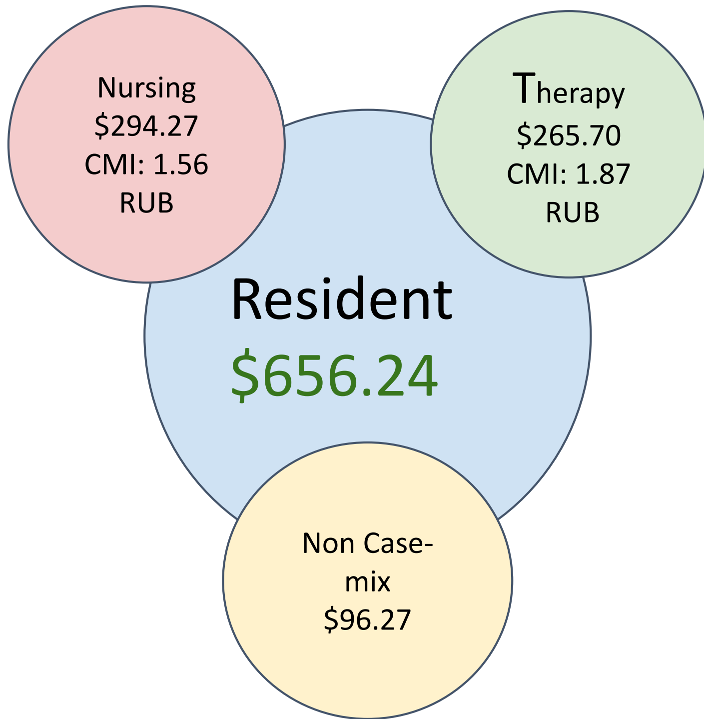
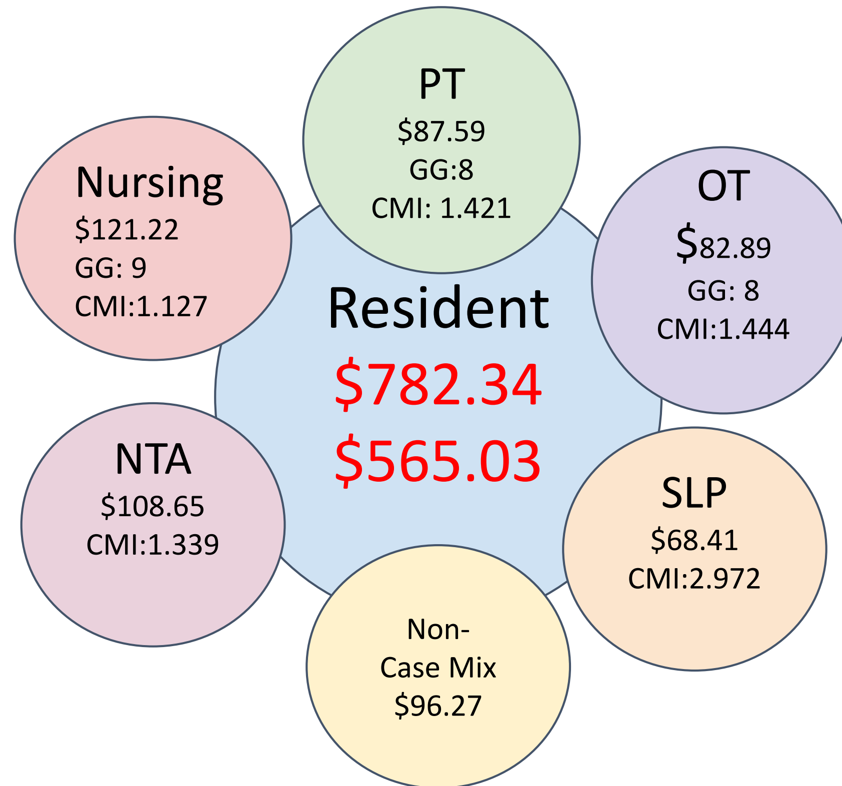
Adjust for Non-Therapy Ancillaries

RUGS-IV



PDPM



RUGS-IV 20-Day Stay: **$13,124.80**

PDPM 20 Day Stay: **$11,952.53**

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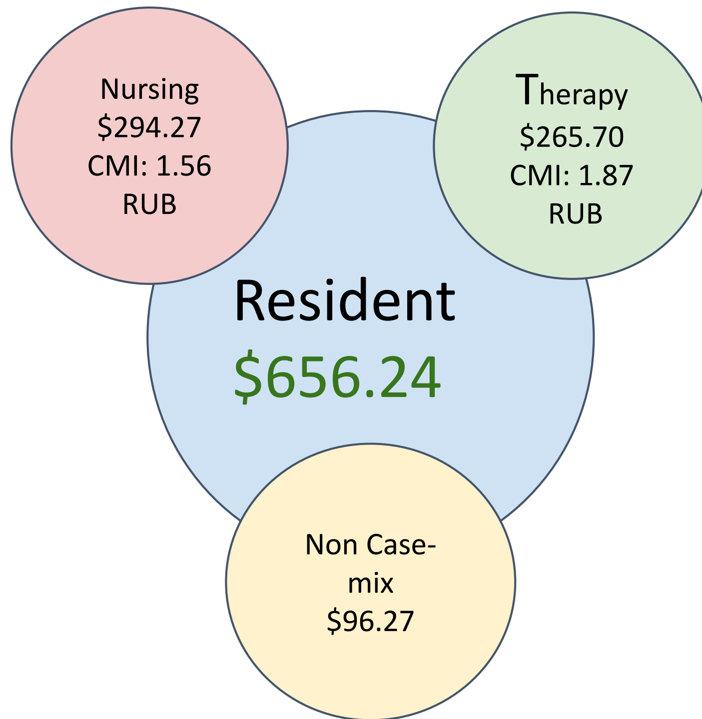
Calculating PDPM

- A major component of PDPM will be reconciling diagnoses between events in the hospital and the patient's admission into your SNF
- Ms. G. was diagnosed with septic shock with differential diagnoses of stroke vs. hypothermia vs. infection
- The hospital documentation and the admission screener never determined what caused the patient's diagnosis of septic shock.
  - However, upon admission the resident had L sided weakness, dysphagia, confusion, and was on an altered consistency diet
  - Did Ms. G. have an acute neurological event?

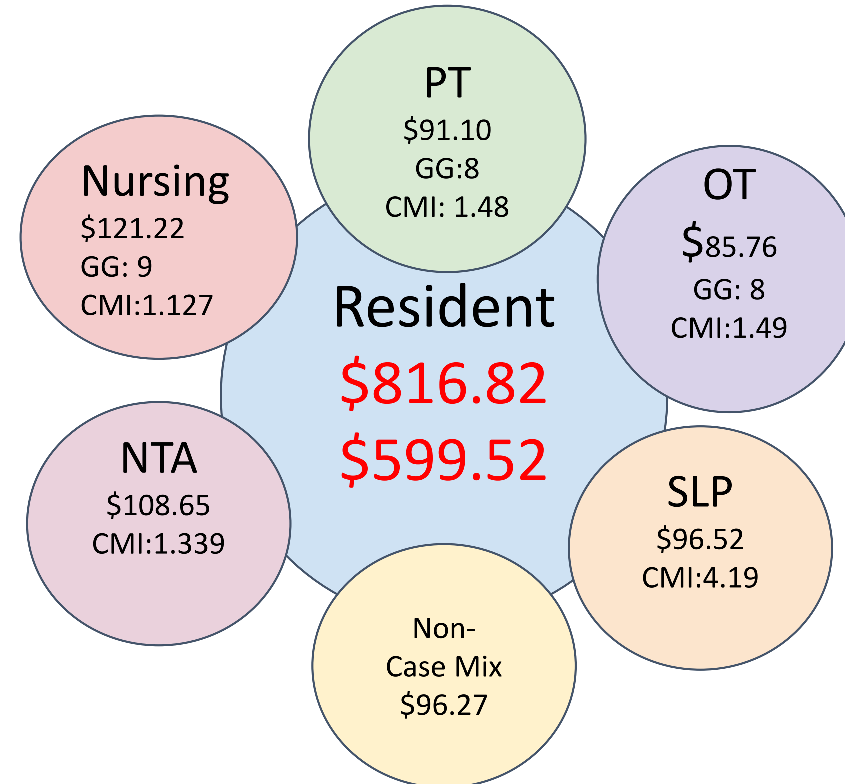
Adjust for Acute Neurologic for Primary Diagnosis

RUGS-IV



RUGS-IV 20-Day Stay: **$13,124.80**

PDPM



PDPM 20-Day Stay: **$12,642.30**

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Reimbursement Current & Future

from MDS Data

RUGs-IV

Over 90% of resident days reported via Rehab RUGs

RUGs based upon nursing, therapy, and non-case mix index

Rehab RUG rates determined by 20 MDS item fields

Therapy minutes/days-12 items

ADL-8 items

PDPM

Payments based upon nursing, PT, OT, SLP, non-therapy ancillary, and non-case mix index

161 MDS item fields

PT-14 MDS items

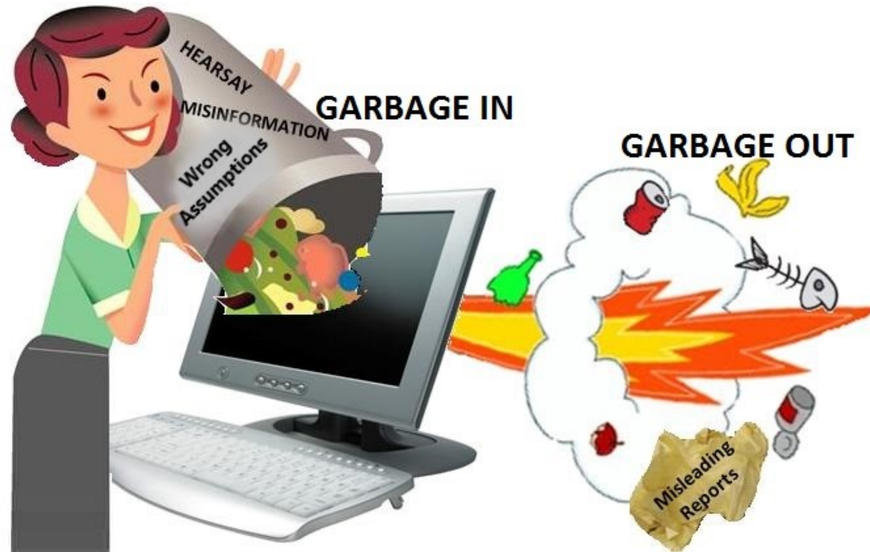
OT-14 MDS items

SLP-33 MDS items

Nursing: 129 MDS items

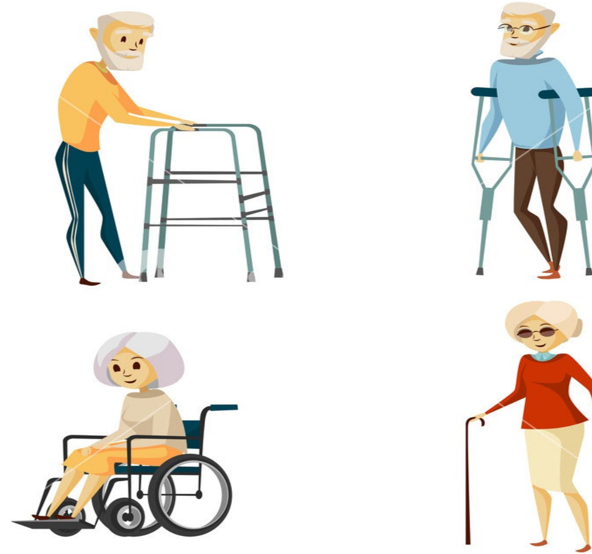
Non-therapy Ancillary: 33 MDS items

Integrity of MDS data



1. What are the completion rates for each MDS question?
2. What is your current process for completing mood and cognitive assessment?
3. What is your process for primary and secondary diagnoses being uploaded into your EMR?
4. Are these diagnoses the same as the hospital?
5. How do these diagnoses compare to the physician diagnoses in your SNF?

October 1, 2019: PDPM begins



MDS integrity is essential

- There will not be a sudden influx of new complex patients on Oct. 1, 2019 because SNF reimbursement changed
- PDPM preparation and assumptions should begin with your current population
- Need to evaluate the risk and rewards of taking more complex residents

Documentation changes

Margaret Sayers, MS, NP
Geriatric Nurse Practitioner, Patient Pattern, Inc., Buffalo, NY

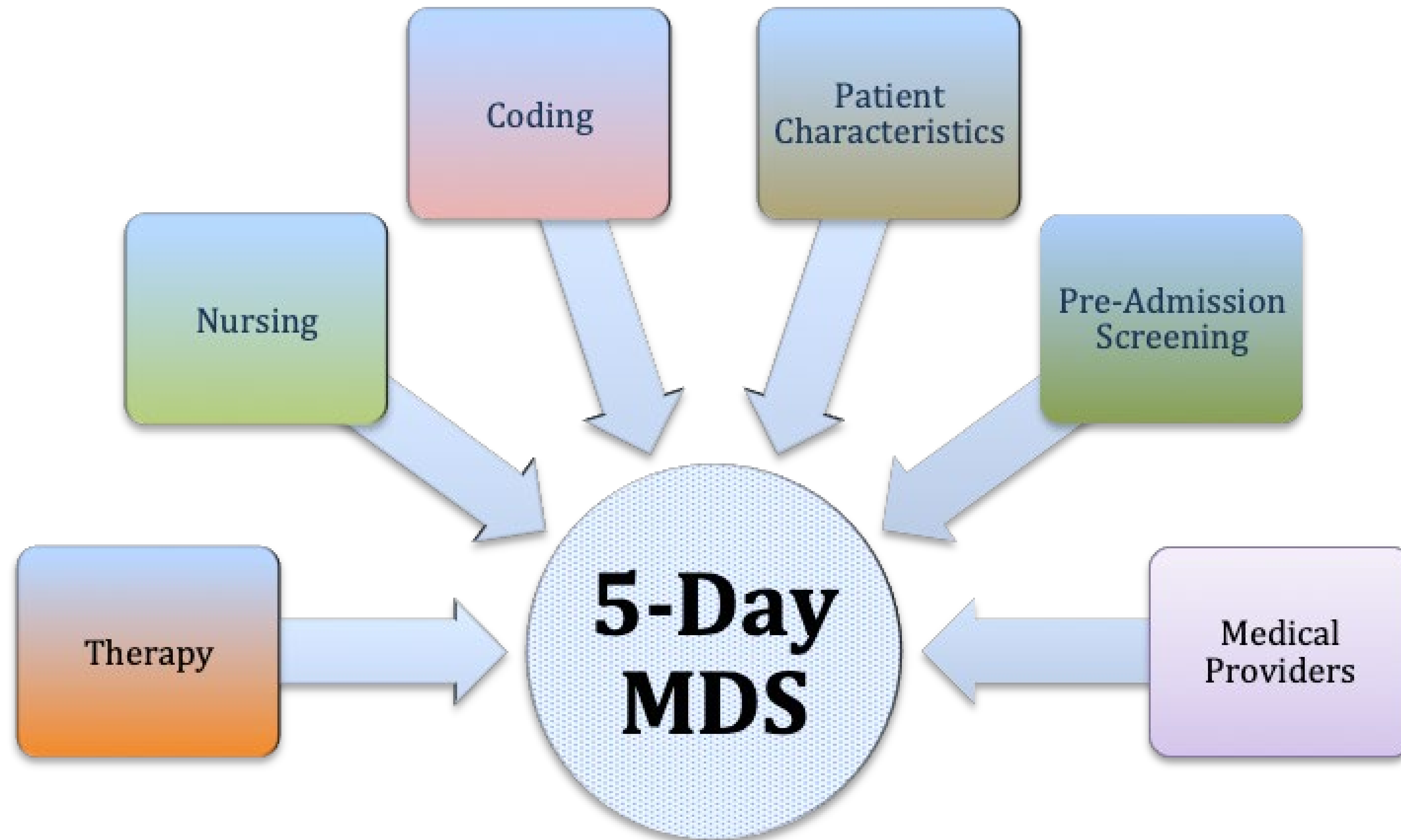
Let's talk about documentation for PDPM

- Accurate
- Comprehensive
- Precise
- On time

One opportunity

"Starting October 1, 2019, providers will have a single opportunity to set themselves up for financial success with a patient's initial assessment."

– Alex Spanko, Skilled Nursing News, Sept. 25, 2018



- All disciplines must contribute
- All disciplines must communicate
- All disciplines must be aware of the timeline

Pre-admission screening

Usual screening for admission

PDPM screening for admission

ICD-10 coding

Starting with the Primary Diagnosis

Nursing

Criteria for Patient Classifications	Documentation
Clinical Status/Extensive Services Functional Status: Section GG Cognitive Status – BIMS & CFS Depression – PHQ-9 or Staff Assessment PHQ-9OV Restorative Nursing	1. Professional assigned to cognitive, and mood assessments must complete them soon after admission 2. Function questions must be answered on the 1st or 2nd day 3. Precise and complete documentation

Therapies: PT, OT, SLP

Patient Characteristics For CMI	Documentation
PT: Primary reason for SNF care: (ICD-10) Type of inpatient surgery Functional Status: Section GG	1. It is important to ensure that the clinical rationale for the type of treatment is reflected in the documentation 2. Therapy capped at 25% (Concurrent + Group) 3. PT & OT components - always same Case Mix Group - will differ in Case Mix Adjustment Indices
OT: Primary reason for SNF care: (ICD-10) Type of inpatient surgery Functional Status: Section GG	
SLP: Primary reason for SNF care:(ICD-10) Presence of acute neurologic condition SLP comorbidities Cognitive Status ——— Swallowing Disorder &/or Mechanically Altered Diet	1. Acute neurologic ICD-10 must be present 2. Cognitive assessments are required 3. Accepted comorbidities must be coded 4. Clinical necessity of altered diet needed

MDS nurse

MDS changes

- **Streamlined assessments**
  - 5-day Admission PPS Assessment
  - PPS Discharge Assessment
- **New MDS Item Sets**
  - Interim Payment Assessment [IPA] (optional)
  - Optional Assessment (OSA) [State Medicaid]
- **New MDS Items**
  - Section A: Reason for Assessment
  - Section GG: Function
  - Section I: SNF Primary Diagnosis
  - Section J: Patient Surgical History
  - Section O: Discharge Therapy Items

Documentation

- Rapid and accurate collection of full clinical picture
- Organizational support for capturing ICD-10 Codes
- Accurate and timely completion of GG Function
- A care team that communicates and documents early and often

> **"MDS coordinators who are exceptional clinicians and can educate and drive a team of caregivers will be prized as never before."**
> Billers Association for LTC, 2018

Your documentation team

This is your village

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Summary

- 5-Day Admission MDS sets PDPM per-diem rate
- All disciplines contribute, starting with screeners
- ICD-10 codes required for diagnoses
- Assign professionals to complete assessments
- Educate and engage Medical Director

New expectations of medical providers

PDPM changes require increased involvement from all clinicians

Steven Buslovich, MD, MSHCPM
Medical Director and Geriatrician, Team Health, Buffalo, NY

Approach to therapy under PDPM

- Therapy minutes ≠ outcomes
- Facility still accountable for patient outcomes
- Acute hospital stay will continue to lack in adequate therapy provisions
- Patients typically come to SNF for complex needs and therapy
- Patients can benefit from group therapy when appropriately utilized
  - need to assess for cognitive impairment
  - specialized therapy, i.e. stroke, joint replacement
- Consider recreational therapy as valuable therapeutic activity
  - lack of social engagement and boredom often leads to isolation, depression, loss of hope → decline → poor outcomes

IPA
LOT WHEN I
RECEIVE LASIX

Determining when to perform an IPA

Medical providers

Primary diagnosis

Accurate primary diagnosis critical for PDPM payment category

- What is the best source?
  - Hospital Discharge Summary
  - Hospital H & P
  - Let SNF medical records staff assign
  - MDS coordinator assigns
  - Hire coders to help
  - Attending physician

Who can assign an ICD-10 diagnosis?

Statutorily: only a State licensed medical practitioner

Pitfalls to be aware of:

Don't expect staff to practice outside the scope of their license

- Let MDS Coordinators be MDS coordinators, not coders
- Let nurses be nurses
- Let medical records collect accurate records
- Coders cannot create ICD codes without supportive documentation

Key to assigning a primary diagnosis

Most accurate source will be the treating medical practitioner

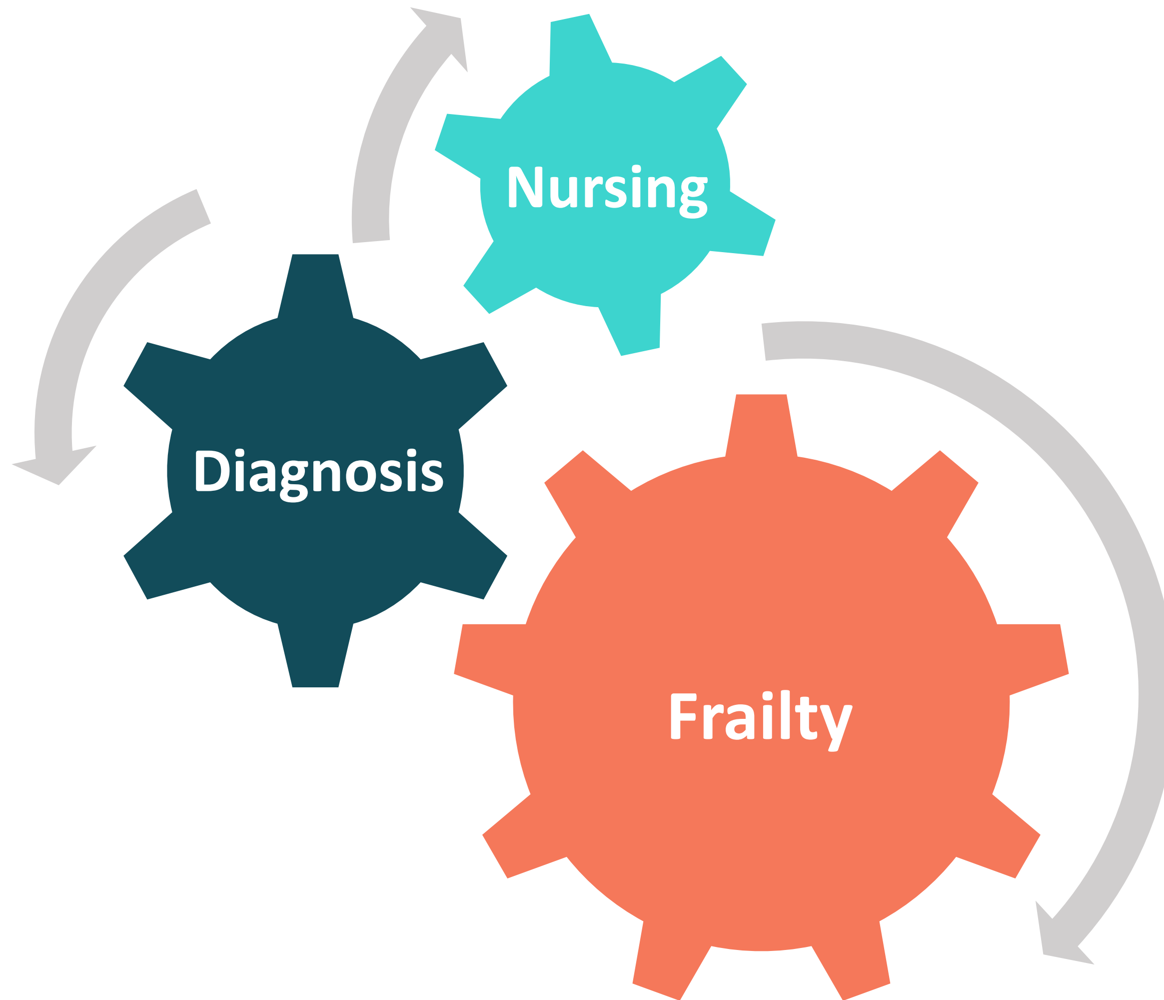
Challenge

- Trained on assigning ICD-10 codes, with variability
- Not trained in assigning primary diagnosis codes in the context of PDPM

RECAP: PDPM payment is based primarily on medical complexity & nursing needs

- ICD-10 Code ≠ clinical complexity
- ICD-10 Code ≠ nursing care needs

Drivers of PDPM

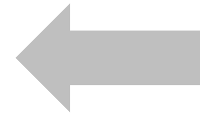


What is frailty?

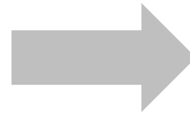
- The result of the natural aging process
- The accumulation of chronic illnesses + the loss of function and/or cognition
- Characterized by sudden declines and diminished recovery from illness or trauma

"A frail elderly person represents a complex system at the edge of failure" (Rockwood, 2009)

Which resident is clinically complex? Which has high nursing needs?

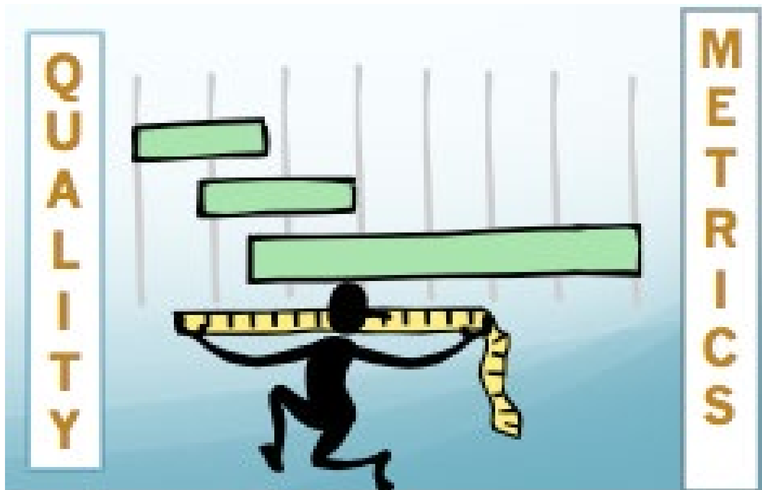


Patsy has diabetes & heart failure



Rosie has diabetes & heart failure

What happens if you are not prepared to determine patient risk and complexity of care needs?



- Lower revenue
- CMS audits
- Unfavorable outcomes
- May lead to empty beds

Engage your medical staff

Partnering with Medical Directors

- Are your Medical Directors aware of PDPM?
- How do your current MDS diagnoses match your practitioners' diagnoses/billing?
- Assigning a primary PDPM diagnosis impacts reimbursement for the building only
- Facility EHRs lack practitioner diagnoses visibility
- Engage and educate your medical directors and practitioners now to prepare for October 1st, 2019. How...?

Aligning with medical staff

- **Create a communication bridge to streamline workflow**
  - Chasing medical practitioners causes them to run faster in the opposite direction
- **Consider higher engagement from your medical director to help facilitate needs**
  - increased medical staff time requirement
  - additional documentation requirement
- **May require greater practitioner presence to ensure patient is seen and documentation completed within 5-day window**
  - contact practice group operators
  - initiate PDPM dialogue

Medical Director PDPM Resources

patientpattern.com/pdpm

AMDA Annual Conference

paltc.org/annual-conference

Summary

- Frailty predicts Length of Stay and Readmission
- Therapy and NTA reimbursement decreases over length of stay
- Educating & engaging medical directors and practitioners is key
- Those with early, accurate primary diagnosis will see increased reimbursement
- Those with more frail residents will see increased complexity of care and nursing needs
- Depression and Dementia require full assessment & impact reimbursement

SimpleLTC/Patient Pattern integration

- **GOAL: Use automation and scale to provide the most efficient, cost-effective way for SNFs to get ahead of PDPM payment impacts**
- SimpleLTC shares real-time MDS data and analytics (QMs, rehospitalizations, etc.) with Patient Pattern
- Patient Pattern provides further insight via PDPM scorecards, frailty indexing and other clinical measurements

Activating the SimpleLTC/ Patient Pattern integration

Current customers: One-click activation under Admin > Connections

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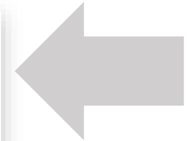
Patient Pattern
Patient Pattern is the expert in Frailty Risk for long term care facilities. Our software identifies the degree of frailty in each patient and gives clinicians the ability to engage the resident and their family in person-centered care and risk-based decision making. Frailty Risk Scoring provides clinicians with actionable information and insights for proactive management of clinical outcomes. Using our validated Frailty scores, facilities can quickly cut hospital readmissions, lower costs by hundreds of thousands annually, and increase quality stars.

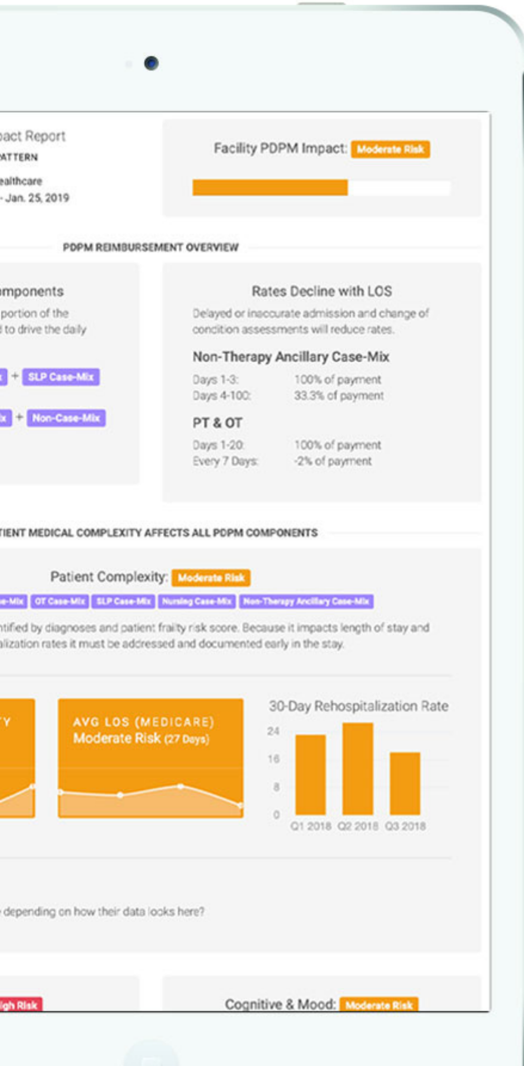
Enable



Non-customers: Call to set up a free trial account: 469-916-2800

PDPM Impact Report

from Patient Pattern and SimpleLTC



Detailed insights of your facilities to help you prepare over the next 6 months

- Anticipated financial impact
- Patient complexity
- Case-mix components
- Top diagnoses
- Non-therapy ancillary
- Cognition and mood
- Therapy utilization
- Completion rates
- MDS weaknesses

MORE INFO:

bit.ly/pdpm-impact

Live poll

Q&A

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Thank you for attending!

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Slides and recording available at: **simpleltc.com/pdpm**

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