Potential strategies for PDPM preparation and planning

An overview of a possible approach

What To Be Doing Now

1. Educate yourself about the new system
2. Develop accurate diagnostic and MDS coding capabilities
3. Evaluate and strengthen your ability to manage complex patients
4. Align resources

1 Educate yourself about the new system

1. Download the AHCA PDPM Core Competencies and other tools
2. Attend AHCA webinars
3. Be able to answer these questions:
   - What drives payment under the new system?
   - What are my organization's operational and clinical gaps?
   - What capabilities do I need to build or add?

2 Develop accurate diagnostic and MDS coding capabilities

1. Evaluate accuracy of current documentation for clinical diagnoses and ICD-10 codes
2. Develop plan for accurate and rapid collection of full clinical picture
3. Ensure organizational ability to accurately capture ICD-10 codes
4. Improve ability to accurately complete MDS, particularly section GG

3 Evaluate and strengthen your ability to manage complex patients

1. Enhance care planning capabilities and ability to substantiate
2. Evaluate who needs to be on the care team and how the team will communicate
3. Consider repurposing MDS coordinators to be care coordinators
4. Assess your ability to deliver NTA services and clinical care that addresses complex needs

4 Align resources

1. Adjust therapy contracts
2. Review technology needs
3. Consider hiring and training for new clinical capabilities

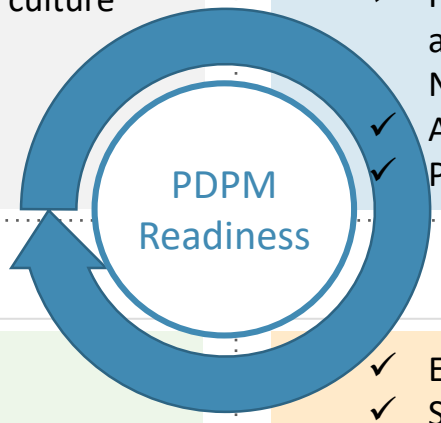
Core Competencies for Success Under PDPM

1 Understand New Payment Drivers' Impact

- ✓ Executive staff understands PDPM payment drivers and expected facility adjustment if no changes to patient mix
- ✓ Executive staff understands organizational gaps that will affect implementation and subsequent payment under PDPM
- ✓ Executive staff discussion on changes in organizational culture to support PDPM
- ✓ Operational staff understands overall model goals and individual components relevant to role on team
- ✓ Build ICD-10 coding capacity to ensure payment

2 Accurate Collection of Clinical Information

- ✓ Staff understands importance of clinical documentation
- ✓ Ability to capture admission information quickly: clear picture of hospitalization/surgeries, comorbidities, chronic illnesses, and social determinants of health
- ✓ Highly proficient and accurate approach to determining ARD and coding initial diagnoses, comorbidities, and nursing and NTA services received throughout stay
- ✓ Ability to capture functional status correctly – Section GG
- ✓ Process in place to complete Interim Payment Assessment*



4 Optimize Resources to Support PDPM

- ✓ Evaluation of MDS coordinators' abilities and growth potential
- ✓ Evaluation of need for / investment in additional clinical staff (e.g., NPs)
- ✓ Evaluation and optimization of therapy contracts
- ✓ Evaluation of need for / investment in training to improve coding accuracy
- ✓ Evaluation of current business office capabilities
- ✓ Evaluation of internal / vendor software readiness

3 Strengthen Care Delivery Process

- ✓ Evaluation of care planning team and processes
- ✓ Standup meetings and daily communication between nursing and therapist staffs
- ✓ Understanding of how therapy practices may change to ensure best outcomes for patient
- ✓ Exceptional restorative nursing program
- ✓ Ability to support complex patients
- ✓ Evaluation and development of specialized clinical programs (e.g., cardiac, respiratory) and transitions program

*CMS has not yet finalized the Interim Payment Assessment Policy

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Possible PDPM Prep Guide

- **ADL Case mix/ Section GG -**
- **Committee: Primary Lead and interdisciplinary team members (MDS lead, clinical, ops, rehab, compliance)**
- Sub - MDS Technical training
- Sub - POC/CNA Training (ID LEAD) - daily documentation/Capturing of services.
- Sub – Nursing skilled documentation to support dx or condition captures new to process – See also below
- Sub - Interviews – need to done timely, accurately. BIMS, PHQ9. –

Possible PDPM Prep Guide

- **ICD 10 Coding/ Primary Clinical Reason**
- **Committee – Primary Lead and IDT members**
  - Sub – Non-Therapy Ancillary Services (NTAS) coding with focus on most common, highest scoring - Clinical Leader as Primary
  - Sub – Documentation needs to support NTAS coding by nursing, as well as clinical evaluation to support acuity and documentation needs
  - Tools – Need to create a CODING MAP – Have AANAC map as baseline/starting point
  - Training – who should get certified? How much truly needed if we have the right maps and tools

Quick side note on ICD-10 coding from Steven Littlehale of Point Right, McKnights, 2-25-19

- *Clearly, the new system is focused more on nursing and clinical aspects of care, including non-therapy ancillaries. As a result, certain competencies that aren't therapy-related must be better developed and polished. Among Littlehale's noted observations:*
- *• While ICD-10 coding becomes a critical tool, the "hospital ICD-10 code is almost irrelevant. The SNF one is important."*
- *• No extra hiring is required. A facility simply needs someone with ICD-10 expertise — from the SNF's viewpoint, of course. "'Good enough' is just fine with PDPM." There is no need for super-precise sub-categorization within ICD-10, he added.*

More on ICD-10 coding, 10 primary categories

Row Labels	Count of ICD10
Acute Infection	1368
Acute Neurologic	1916
Cancer	1021
Cardiovascular and Coagulations	1082
Major Joint Replacement or Spinal Surgery	797
Medical Management	16192
Non-Orthopedic Surgery	1855
Non-Surgical Orthopedic/Musculoskeletal	11312
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	4888
Pulmonary	493
Return to Provider	24114
(blank)	
(blank)	
Grand Total	65038

Possible PDPM Prep Guide

- **Therapy Efficiencies to recognize expected broader variances in services provided, per Clinical Needs and Functional Status**
- ICD-10 codes relative to the rehab categories are part of each of the below, and see above in the ICD 10 group
- **Committee – Primary Lead and Interdisciplinary team members**
- **Subcommittees as below**:
- PT/OT Case Mix;
- ST Case Mix (BIMS vs CFS)
- Nursing or RNA Case Mix –
- Alternative Service Therapy Delivery Models

Possible PDPM Prep Guide

- MDS Changes - scheduling of assessments; IPA (Interim Payment Assessment) MDS coding Suggested to not start training on IPA yet. CMS will have more details to come
- Financial and Billing issues, changes, etc., many not clear yet –
- Admission Process folds into several of the above, will need to wait till we have cross-disciplinary feedback
- Daily/Weekly/Monthly IDT Processes, similar, will need to wait till we determine what processes/systems, then incorporate-
  - Daily/Weekly meetings will shift to focus on nursing documentation to support and tie to the characteristics that defined the coverage and case mix of patient
- Audit Tools (Compliance) determine when we know more.
- PCC Changes

Pulling it together

- Steering Committee consisting of the leads for each committee, as well as a few other leaders from finance, compliance, and IT
- Monthly in-person meetings of steering committee, with calls as deemed necessary
- Each Committee has a work plan, with details on each element, including sub committee work, shared with Steering Committee
- Work Plans have been used to develop an overview consolidated timetable for field (see next)
- Accountability to timetables established

Sample of operations timetable

PDPM Communications:				
Diagnosis Coding Q&A 12.27.18				available at PDPM portal
Section GG and Skilled Documentation 1.4.19				available at PDPM portal
Therapy Utilization and Efficiencies 1.11.19				available at PDPM portal
By the end of Q1 2019, facility should have completed:				
I. Understanding New Payment Drivers				
Training for key IDT team (DON, MDS, ADON, DOR, BOM) on **PDPM Overview/ Payment drivers**.	ED			AHCA PDPM 101 video recommended
II. Accurate Collection of Clinical Information				
Assess current **facility admission process**. Are we able to capture a clear picture of resident hospitalization/surgeries, comorbidities, and chronic illnesses on admission. Do we have dedicated staff assigned to receive information from the referral? Do we have a dedicated/ trained admission nurse?	ADM/DON			
Do we have **relationships with hospital coding staff** (names and phone numbers) to obtain additional information as needed? If not, identify how to network now.	Admissions/ED			
Train LN staff on importance of **skilled nursing documentation** to support care delivery. Provide basic training on assessment and documentation.	DON	CML		

Tools and Deliverables

- Use of FAQ's and other weekly notices on work being done
- Weekly trainings on deliverables have begun, last week on "PDPM Therapy Ready: Understanding the How, When and Why with Group & Concurrent", this week "Section GG Outcomes, QRP, & Preparing for PDPM: Pilot Overviews", etc.
- All communications in central location on internal portal
- Continue to attend and monitor AHCA trainings, releases, etc.
- Utilization of the PDPM tools and materials available on AHCA site

Tools and Deliverables, example for GG piloting

- To identify best practices surrounding the collection of **multiple sources (interviews with Nursing, CNA, & Therapy) of supporting documentation** to complete Section GG – **Not just therapy-driven**
- To develop a more robust **IDT reconciliation/discussion of all documentation sources** during the (up to) 3-day assessment period to determine **"usual/baseline" performance**
- To ensure Section GG Assessment MDS coding is accurately reflective of **GG Outcomes**
- To create systems for competent **7-day per week documentation** and coding for completing Section GG
- PDPM Prep: I.D. best practice systems which ensure Section GG Assessment Data is supported in the documentation to ***protect your PDPM Case Mix reimbursement***

In PDPM, 25% of Group and Concurrent Therapy is allowed

- Why does that matter to you?
- Better patient outcomes and satisfaction
- Decreased cost to deliver therapy when using these modes

- How is the percentage tracked?
- In the discharge assessment Therapy MINUTES and group/concurrent PERCENTAGE will be reported
- Both can be triggers/red flags for further review

OPERATIONAL IMPACT OF CONCURRENT SKILLED

HMO LOC Daily Rate	**$ 350.00**	
Productivity	**75%**	
Mode of Delivery	**Individual**	**Concurrent**
Patient's Treated	2	2
Tx Minutes per patient	30	45
Total Billable Minutes	60	90
Rehab Cost per Day	$ 61.67	$ 46.25
Cost per Min (Billed)	**$ 1.03**	**$ 0.51**
Therapy Margin per Day	**$ 169.33**	**$ 184.75**
Margin per Min	$ 2.82	$ 2.05
% Margin	**73%**	**80%**

More therapy for the patients

Increased Margin and Margin %