Core Competencies for Success Under PDPM

Summary

The patient driven payment model (PDPM) replaces RUG-IV on October 1, 2019.

To help members prepare for PDPM, AHCA has collected feedback from members on anticipated changes and best practices to be successful under the new payment system. Member feedback, combined with AHCA’s analysis of PDPM policy and impact, informed these 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 6G Process in place to complete Interim Payment Assessment*.

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.

PDPM Readiness Considerations and Checklist

CMS Outlines Benefits of New Payment Model

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<tr>
<th>Current RUG-IV Payment Model</th>
<th>Patient Driven Payment Model (PDPM) Criteria</th>
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<tr>
<td>1. Payment is primarily determined by number of therapy minutes</td>
<td>▶ Removes therapy minutes as basis for payment</td>
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<td>2. Does not fully consider wide range of clinical characteristics that influence the relative resource use of SNF residents</td>
<td>▶ Intended to enhance payment accuracy for therapy, nursing, NTA services by making payment dependent on a wide range of clinical characteristics</td>
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<td>▶ Rather than primarily a function of therapy minutes/ADL present in &gt;90% of RUG days</td>
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<td>▶ Intended to improve targeting of resources to beneficiaries with diverse care needs</td>
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<td>▶ Designed to provide more equitable resources to facilities treating vulnerable populations</td>
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Therapy minutes drive payment ➔ Patient characteristics drive payment
Core Competency #1: Understand New Payment Drivers’ Impact

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
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Understand New Payment Drivers’ Impact: Readiness Checklist
- What are the goals of PDPM?
- What are the key differences in RUG-IV and PDPM?
- What types of patient characteristics drive payment under PDPM?
- How does the assessment schedule change under PDPM?
- How would your organization’s current patient mix perform under PDPM?
- How will per-diem payment adjustments under PDPM affect your processes?
- How will LOS change under PDPM?
- What are your organization’s gaps (e.g., ICD-10 and MDS coding, training) that would affect payment under PDPM?
- How will your organization’s quality measures, compliance, and improvement processes be affected?
- How will the interrupted stay (i.e., return to SNF <3 days) policy affect your organization?
- How does organizational culture support (or not) patient characteristic driven payment model?
- How do we facilitate change across the organization necessary to support success under PDPM?
- Which components are relevant to each role: nursing, therapy, social work, food and nutrition, activities, etc.?
Core Competency #2: Accurate Collection of Clinical Information

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 competency
✓ Process in place to complete Interim Payment Assessment

Accurate Collection of Clinical Information: Readiness Checklist

☐ How accurate is diagnosis and MDS coding today? If unknown, do you need to hire an external consultant to evaluate accuracy of coding?

☐ Are MDS coordinators getting detailed enough information from attending physicians and SNF clinicians to accurately code today? Are they guessing if there is not enough information?

☐ How hard will it be to use multiple ICD-10 codes in Section I on the MDS? How likely is it that ICD-10 codes will be accurate (do not generate RTP errors)?

☐ Do your Medical Director and attending physicians understand that information needs to be more complete prior to completion of the admission assessment (days 5-8)?

☐ Who will assess patient’s full history/active diagnoses at admission and throughout stay?

☐ Have you discussed with admitting hospitals how you can obtain sufficient surgery information necessary to code the new items in J2000 of the MDS?

☐ Do you send a nurse/liaison to hospital to do a clinical assessment with patient? Can your liaison look at record while in hospital to expand understanding of patient’s health? Does liaison need training to look at hospital record and compare diagnostic info sent to nursing home? Do you need to develop a pre-admission screening tool that aligns with PDPM case-mix data drivers?

☐ Do you have names and phone numbers for staff in hospital’s coding department? Are there opportunities for your coding staff to network with hospital coding staff?

☐ How will discrepancies between therapy and nursing documentation be reduced?

☐ Does your team need to improve accuracy of MDS Section GG (days 1-3), depression, and restorative nursing items (min 6 days) and for selecting appropriate ARDs? Does your staff need training on these?

☐ What is your training plan around new MDS changes and MDS items that will drive payment rates?

☐ Who will determine if/when an Interim Payment Assessment should be completed? How will this be communicated to pertinent team members? Do you have a backup plan when the primary person/people are absent?
<table>
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<tr>
<th>Accurate Collection of Clinical Information: Readiness Checklist</th>
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<tr>
<td>☐ Does your organization need additional coding resources or training (e.g., ICD-10 coders, experts, oversight)?</td>
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<td>☐ How will your organization update the triple check process to ensure accurate and documented MDS and claim coding?</td>
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<td>☐ Do staff understand why they are documenting in certain areas and how/what reviewers will look for when/if audited?</td>
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Core Competency #3: Strengthen Care Delivery Process

**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
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**Strengthen Care Delivery Process: Readiness Checklist**

- Who is involved in care planning? Who should be involved (e.g., therapists, MDS coordinators, nurses, nursing aides, patient, etc.)?
- How are therapists involved in care plan development and follow-through?
- Does your clinical team convene early to discuss admission details (primary diagnosis, comorbidities, etc.)?
- How will your team work with physicians/NPs to collect necessary diagnosis data if not originally provided?
- If you have large skilled census, do you have any/enough NPs to help diagnose and provide clinical information?
- What new or changes to existing communication processes can be made to highlight PDPM components and capture necessary changes in patients? Who else needs to be at the table for these communications?
- How effective is your restorative nursing program today? What changes are necessary for improvement?
- How will MDS coordinators’ roles change to support PDPM? How much time from previous assessment schedule will be required for admission, interim payment, and discharge assessments under PDPM? How much time will be freed up and how will that time be used?
- Do your MDS coordinators have patient assessment skillset? If not, can they be trained? Will MDS coordinators be more proactive in collecting clinical information to support diagnoses?
- Should MDS department be reduced or redefined as clinical care coordinators? Can money be reallocated to hire new clinical coordinators? Can MDS coordinators’ role be broadened to function as clinical coordinator with MDS responsibility?
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<td>- Have you assessed feasibility of doing group or concurrent therapy with your patient population? What percent of population has cognitive/physical abilities to permit effective concurrent/group therapy? How can nursing, activities, other schedules adapt to permit effective concurrent/group therapy scheduling?</td>
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<tr>
<td>- Should your organization explore opportunities to admit more complex patients now that payment is more appropriate? How will your policies and procedures need to change to admit more complex patients in compliance with the Requirements of Participation? What new staff competencies are needed to provide safe and effective care for more complex patients? How does this affect the organization’s facility assessment?</td>
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<td>- Based on resident population that PDPM directs payment to, what clinical capabilities do you need to develop or strengthen? What workforce implications exist to support/challenge this changing care provision?</td>
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Core Competency #4: Optimize Resources to Support PDPM Implementation

Optimize Resources to Support PDPM Implementation

- 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

Optimize Resources to Support PDPM Implementation: Readiness Checklist

- Do you have ability to assess which MDS coordinators could be redeployed as coding experts or care coordinators? Do you need an external consultant to assess your organization’s MDS and diagnosis coding accuracy?
- Does your organization need additional clinical staff to assess patients and deliver the best outcomes?
- Will clinical documentation support accurate MDS coding? Do nursing staff (including CNAs) need additional MDS training, especially for those items that impact PDPM payments and SNF QRP payment adjustments (e.g., section GG)?
- Does your organization need additional ICD-10 coding resources or training?
- (For smaller operators) Do you need to bring billing person on staff?
- Would your organization benefit from additional technology products (e.g., MDS scrubbing, ICD-10 mapping, alerts)?
- Do your therapy contracts need to change (if applicable)?
- Do your therapy contracts include/need quality outcomes provisions (e.g., SNF VBP, SNF QRP, SNF 5-Star)? Do your therapy contracts include provisions that pass-through any SNF QRP or SNF VBP adjustments applicable to the dates of service delivery? Do your therapy contracts include provisions that include bonus or claw-back provisions should the SNF earn a positive SNF VBP rate adjustment or be subject to SNF VBP or SNF QRP rate adjustments?
- Can therapy staff be deployed differently to help in other short- and long-stay quality programs – particularly those that impact SNF QRP, SNF VBP, and 5-Star (e.g., falls, wounds, functional maintenance, readmissions reduction, pain, restraints)?
PDPM Readiness Considerations and Checklist

Resources

1. AHCA’s Patient-Driven Payment Model (PDPM) Resource Center: https://www.ahcancal.org/facility_operations/medicare/Pages/PDPM-Resource-Center.aspx#

2. ahcancalED: https://educate.ahcancal.org/ (Keywords PDPM, FY 2019 SNF PPS Final Rule, MDS, ICD-10)

3. CMS Patient Driven Payment Model Page: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html
