The Great Eight FY 2022
Leadership and Motivation

ACHCA

March 22, 2022

90 minutes

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The Great Eight FY 2022 Leadership and Motivation

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"HHI C.A.R.E.S. About Care"

March 4, 2022

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HHI C.A.R.E.S. About Care

Compliance | Analysis | Audit | Regulatory | Rehabilitation
Reimbursement | Education | Efficiency | Survey

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About Kris

Kris Mastrangelo OTR/L, LNHA, MBA
President and CEO

Owns and operates
Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in **C.A.R.E.S.**
There are no nonfinancial disclosures to share.

"HHI C.A.R.E.S. About Care."

C Compliance ™
A Analysis Audit
R Regulatory Rehabilitation Reimbursement
E Education Efficiency
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The Great Eight FY 2022
Speaker and Planning Committee Disclosure

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose.
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- **Presenters:**
  - Kris Mastrangelo, OTR/L, LNHA, MBA

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The Great Eight FY 2022
Learning Objectives

1. List the **8 Key Areas** of focus for operational, clinical and quality success.
2. State the **3 Strategies** to achieve excellent **Customer Satisfaction.**
3. Describe **Person-Centered Care Culture.**

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The Great Eight

1. **Compliance:** OIG Report September 2021, 7 Elements
2. **Analysis:** Five-Star PBJ
3. **Audit:** Quality Measures Five-Star, Quality Measures QRP
4. **Regulatory:** Public Health Emergency Extended, Person-Centered Care, Capitalize on Community
5. **Rehabilitation:** Minutes
6. **Reimbursement:** PDPM, Provider Relief
7. **Efficiency:** Census, Staffing Crisis
8. **Survey:** Vaccinations, Infection Control, Abuse/Neglect, QAPI

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Compliance Elements OIG

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Compliance

OIG Updates Work Plan HHS

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Compliance

HHS OIG Updates Work Plan
Adds Assessment of CDC Oversight & Support for NHSN Reporting

1

- The U.S. Department of Health & Human Services' (HHS') Office of the Inspector General (OIG) has added a **new study** to its work plan
- The OIG will evaluate the Centers for Disease Control & Prevention's (CDC's) **processes for nursing home reporting of COVID-19 data** to the National Healthcare Safety Network (NHSN).
- Specifically, the OIG will "assess CDC oversight and support of nursing home reporting and **identify challenges reporting to the NHSN** that nursing homes have faced."

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Compliance

HHS OIG Updates Work Plan
Adds Assessment of CDC Oversight & Support for NHSN Reporting

1

- OIG work will inform the Department's ongoing efforts to support **infection surveillance**, including the **collection of routine infection data** related to public health emergencies such as COVID-19.
- The study, which is entitled ***Nursing Home Reporting of COVID-19 Data to the National Healthcare Safety Network*** *(OEI-06-22-00030),* is expected to be issued in **FY2022.**

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Compliance

Elements

1

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Compliance Elements

P-R-E-P-A-R-E

Policies and Procedures

Reporting and Investigating

Education and Training

Prevention and Response

Auditing and Monitoring

Responsibility/Oversight of Compliance Officer/Committee

Enforcement, Discipline and Incentives

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Compliance

- The government only needs to show:
  1. The provider had **"actual knowledge of the information"** or
  2. The person acted in **"deliberate ignorance"** of the truth or the falsity of the information, or
  3. The person or provider acted in **"reckless disregard"** of the truth or falsity of the information

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Compliance Programs

- Providers have only **120 days to correct MDS errors and submit a billing adjustment for Medicare Part A claims**
- Late identification of billing errors yields mandatory self disclosure within **60 days of overpayment identification**
- It is a **felony not to return the payment**
- The civil penalty for the aforementioned is **$5,500 to $11,500 per false claim along with three times the amount of damages which the government sustained**

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Compliance Programs

The only defense for an incorrect claim is a **great offense** in the form of an effective

Compliance Program

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Analysis
Five-Star
PBJ

2

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Analysis
Five-Star Rating Composite Calculator

2

STEP #1 Health Inspection Score		Health Inspection Stars				
		1	2	3	4	5
		STEP #2 ADD to Staffing Star (if -1) then minus				
Staffing Stars	1	-1	-1	-1	-1	-1
	2	0	0	0	0	0
	3	0	0	0	0	0
	4	1	1	1	0	0
	5	1	1	1	1	0
		STEP #3 ADD Quality Measure Star (if -1) then minus				
Quality Measure Stars	1	-1	-1	-1	-1	-1
	2	0	0	0	0	0
	3	0	0	0	0	0
	4	0	0	0	0	0
	5	1	1	1	1	1
Step #4 Total 1, 2 and 3		Facility Five Star is 3 + 1 + 0 = 4				
Minimum		1	1	1	1	1
Maximum		2	4	5	5	5

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Analysis
Five-Star
Nursing Home Compare

2

- The **Five-Star Quality Rating** of one to five stars is based on the facility's performance of **3 Domains:**

1. **Health Inspections**
2. **Staffing**
3. **Quality Measures**

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Analysis
Five-Star
History

2

- In December 2008, CMS enhanced the **Nursing Home Compare** public reporting site to include a set of quality ratings for each nursing home that participates in **Medicare or Medicaid**
- This website displays **facility star rating for the public**
- **The goal** is to provide residents, families and the public with an easy way to **understand nursing home quality** and make informed decisions regarding high and low performing facilities

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Analysis
Five-Star
The IMPACT Act

2

- Improving Medicare Post Acute Care Transformation Act of 2014 (IMPACT Act)
- Expand and strengthen Medicare's widely-used Five-Star Quality Rating System
- Improve quality home health care received by Medicare beneficiaries through a proposed rule that strengthens patient rights, improves communication and focuses on patient well-being

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Analysis
Five-Star 2021

2

- What Changed January 2021
  - CMS resumed calculating the health inspection rating domain and began to use results from surveys that occurred after March 3, 2020
  - Beginning with the January 2021 refresh, facilities that did not report staffing for the November 14, 2020, deadline or that reported four or more days in the quarter with no registered nurse will have their staffing ratings suppressed
  - CMS used data for July 2019 – June 2020 for all the measures that were updated

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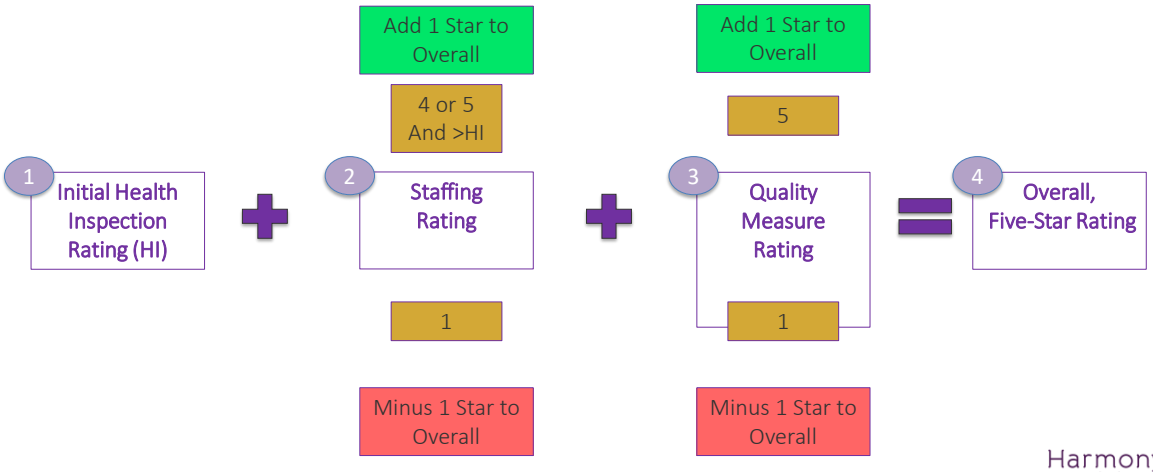
Analysis
Five-Star 2021

2



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Analysis
Five-Star 2021

2

- **Bonus star** is limited by Health Inspection Rating
- If **Health Inspection = 1** , Overall Rating can only increase by 1 Star
- **Special Focus Facility (SFF) –** No Five-Star is reported

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Analysis
Five-Star
Formula for Calculating "Overall 5-Star Rating"

2

STEP #1 Health Inspection Score		STEP #1 Health Inspection Stars				
		1	2	3	4	5
		STEP #2 ADD to Staffing Star (if -1) then minus				
STEP #2 Staffing Stars	1	-1	-1	-1	-1	-1
	2	0	0	0	0	0
	3	0	0	0	0	0
	4	1	1	1	0	0
	5	1	1	1	1	0
		STEP #3 ADD Quality Measure Star (if -1) then minus				
STEP #3 Quality Measure Stars	1	-1	-1	-1	-1	-1
	2	0	0	0	0	0
	3	0	0	0	0	0
	4	0	0	0	0	0
	5	1	1	1	1	1
Step #4 Total 1, 2 and 3		Facility Five Star is __ + __ + __ = ___				
Minimum		1	1	1	1	1
Maximum		2	4	5	5	5

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Analysis
Five-Star
The Rankings

2

- 5-Star rating = "much above average"
- 4-Star rating = "above average"
- 3-Star rating = "average"
- 2-Star rating = "below average"
- 1-Star rating = "much below average"

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Analysis
Five-Star
Formula for Calculating "Overall 5-Star Rating"

2

Step By Step Guidance from CMS

- **Step 1:** Start with the **health inspections rating**
- **Step 2:** Add 1 star if the **staffing rating** is 4 or 5 stars and greater than the health inspections rating. Subtract 1 star if the staffing rating is 1 star.
- **Step 3:** Add 1 star if the **quality measures** rating is 5 stars; subtract 1 star if the quality measures rating is 1 star
- **Step 4:** If the **health inspections** rating is **1 star**, then the overall rating **cannot be upgraded by more than 1 star** based on the staffing and quality measure ratings
- **Step 5:** If a nursing home is **a special focus** facility, the **maximum** overall rating is **3 stars**

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Analysis
Five-Star
October 2019 Revisions

2

Impacts

- Health Inspection
- Quality Measure

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Analysis
Five-Star
October 2019 Revisions

2

Health Inspection Domain

Abuse Icon added

- **Harm Level abuse citation in the most recent survey cycle:**

  (Scope and Severity G or higher) most recent survey or on a complaint survey within last 12 months
- **Repeat Abuse Citations**: **(Scope and Severity D or higher)** most recent standard survey or complaint survey within last 12 months and on the Previous (2nd most recent) standard survey or on a complaint survey in the prior 12 months (i.e., from 13-24 months ago)

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Analysis
Five-Star
October 2019 Revisions

2

A provider with **Abuse Icon**

- **Health Inspection rating capped at 2 stars**
- **Best Overall Quality rating is 4 stars**

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Analysis
Five-Star
October 2019 Revisions

2

Quality Measure Domain

Removal of 2 Quality Measures

- Percentage of short-stay residents who report moderate to severe pain
- Percentage of long-stay residents who report moderate to severe pain

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Analysis
Health Inspection
Domain

2

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Analysis
Health Inspection Domain

2

- Under the most recent recalibration, **within a state:**
  - **Top 10%** of all nursing facilities will receive **5 Stars**
  - **23.33%** of all nursing facilities will receive **4 Stars**
  - **23.33%** of all nursing facilities will receive **3 Stars**
  - **23.33%** of all nursing facilities will receive **2 Stars**
  - **Bottom 20%** of all nursing facilities will receive **1 Star**

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Analysis
Health Inspection Domain

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- Nursing homes that participate in Medicare or Medicaid programs have an **onsite standard** survey approximately **annually**
- **Surveys are unannounced** and are conducted by a team of health care professionals

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Analysis
Health Inspection Domain
Scoring Rules

2

- **Scoring Rules** based on:
  - The **3 most recent recertification** surveys for each facility. Based on two most recent surveys prior to that date
  - **Complaint deficiencies** during based on the two years prior
  - Any **repeat revisits** needed to verify that the corrections were made and the facility is now in compliance

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Analysis
Health Inspection Domain
Scoring Rules

2

- **Health Inspection** results
  - Points are assigned to individual health deficiencies according to their **scope** and **severity**
  - **More serious**, widespread deficiencies receive **more points**
  - **G-level deficiencies** are assigned if the status of the deficiency is "**past non-compliance,**" or the severity is "**immediate jeopardy**"

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Analysis
Health Inspection Domain
Five-Star Formula for Calculating "Overall 5-Star Rating"

2

Substantial Compliance

Substandard Quality of Care

Health Inspection
Scope, Severity and Levels

Severity	Scope: Isolated	Scope: Pattern	Scope: Widespread
Immediate Jeopardy to resident health or safety	J **PoC Required** **50 points** (75 points)	K **PoC Required** **100 points** (125 points)	L **PoC Required** **150 points** (175 points)
Actual harm that is not immediate jeopardy	G PoC Required **20 points**	H **PoC Required** **35 points** (40 points)	I **PoC Required** **45 points** (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required **4 points**	E PoC Required **8 points**	F **PoC Required** **16 points** (20 points)
No actual harm with potential for minimal harm	A **No PoC Required** No Remedies Commitment to Correct Not on CMS- 2567 **0 points**	B PoC Required **0 points**	C PoC Required **0 points**

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Analysis
Health Inspection Domain
Scoring Rules

2

- **Life Survey** deficiencies are not included in the calculations
- **Federal Comparative Surveys** are not reported on Nursing Home Compare or included in the Five-Star calculations
- **Results of the State Survey determinations** made during a Federal Oversight Survey **are** included
- **Complaint inspections are** included based on the calendar year in which the complaint survey occurred

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Analysis
Health Inspection Domain

2

- **Points** from **complaint deficiencies** from a given period are added to the health inspection score before calculating revisit points, if applicable
- **If only two standard surveys** are available, the surveys will be weighted at **60% and 40%**

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Analysis
Health Inspection Domain

2

- To avoid potential double-counting:
  - If a **deficiency** appears on both **standard and complaint surveys** and the complaint survey is conducted **within 15 days of the standard survey**, it will only be counted once
  - If scope and severity differ, the **highest scope-severity** combination is used

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Analysis
Health Inspection Domain Scoring Rules

2

- **Repeat Revisits** – Number of repeat revisits required to confirm that correction of deficiencies have restored compliance
- **No points** are assigned for the **first revisit**
- **Points are** assigned for the **second, third** and **fourth revisits** and are proportional to the Health Inspection Score for the survey cycle

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Analysis
Health Inspection Domain Scoring Rules

2

Revisit Number	Non-Compliance Points
First	0
Second	50% of health inspection score*
Third	70% of health inspection score*
Fourth	85% of health inspection score*

*Note: Includes points from deficiencies cited on standard health inspection and complaint inspections during a given survey cycle

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Analysis
Health Inspection Domain
Scoring Rules After November 28, 2017

2

- In calculating the total weighted score, **more recent surveys** are **weighted more heavily** than earlier surveys:
  - The **most recent** survey (Cycle 1) is **weighted 60%**
  - The **previous survey** (Cycle 2) is **weighted 40%**
- The individual weighted scores for each cycle are then summed to calculate the total weighted score for each facility

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Analysis
Health Inspection Domain
Rating Methodology

2

- **Variation remains among states** in the inspection process and outcomes for factors including:
  - **Survey Management**: Skill sets of inspectors, supervision of inspectors and the process
  - **State Licensure**: Differences between State enforcement and Federal enforcement in complaint investigations
  - **Medicaid Policy**: Nursing Home eligibility rules, payment in the State administered program may be associated with differences in survey outcomes

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Analysis
Health Inspection Domain Rating Methodology

2

- Because of these variations, the Five-Star ratings in Health Inspections are based on the **relative performance of facilities within a state:**
  - The **top 10%** (lowest health inspection weighted scores) in each state receive a health inspection rating of **5 stars**
  - The **middle 70%** receive a rating of **2, 3 or 4 stars**
  - The **bottom 20%** receive a **1-star** rating

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Analysis
Health Inspection Domain Rating Methodology

2

- The rating for a facility stays the same until there is a change in the weighted health inspection score regardless of the statewide distribution. Items that will change health inspection score include:
  - A **new health inspection**
  - A **complaint investigation** that result in deficiencies
  - A second, third or fourth revisit
  - **Changes in scope/severity of deficiency** related to **IIDR** Resolution of an Informal Dispute Resolution or Independent Informal Dispute Resolution
  - **"Aging"** of complaint deficiencies

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Analysis
Health Inspection Domain
2021

2

- What Changed January 2021
  - CMS resumed calculating the health inspection rating domain and began to use results from surveys that occurred after March 3, 2020
  - Beginning with the January 2021 refresh, facilities that did not report staffing for the November 14, 2020, deadline or that reported four or more days in the quarter with no registered nurse will have their staffing ratings suppressed
  - CMS used data for July 2019 – June 2020 for all the measures that were updated

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Analysis
Health Inspection Domain
2021

2

- Q1 2020
  - QSO-20-28-NH Temporarily maintain and hold constant the health inspection domain of the rating system results of health inspections conducted on or after March 4, 2020, will be posted publicly, but will not be used to calculate a nursing home's health inspection star ratings.
- Q2 2020
  - QSO 20-31 States authorized to expand beyond Immediate Jeopardy, Focused Infection Control, and Initial Certification Surveys

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Analysis
Health Inspection Domain
2020

2

- Q3 2020
  - QSO-20-35-ALL Revised guidance of QSO 20-31- All to **resume annual recerts** "as soon as [SA] have the resources (e.g., staff and/or Personal Protective Equipment) to do so."

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Analysis
Health Inspection Domain
2020

2

What happened Q1 2020

- Dear Jane, The health inspection rating is being held constant using only survey data that occurred on or before March 3, 2020. **Any changes to surveys prior to March 4, 2020, or new survey information that occurred before March 4, 2020,** that enter the national database will be incorporated in the Five-Star Health Inspection rating.
- Additional information about the Health Inspection rating calculation was provided on the May 2020 provider preview report in the Health Inspection section. Provided below is an excerpt from the May 2020 provider preview report:

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Analysis
Health Inspection Domain
2020

2

- The Five-Star Health Inspection Rating listed on the first page is based on **3 cycles of survey data** and **3 years of complaint inspections**.
- The health inspection rating **includes data** only from surveys that were conducted **on or before March 3, 2020**.
- Surveys conducted on **March 4, 2020, or after** are not being used to calculate the health inspection rating at this time.

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Analysis
Health Inspection Domain
2020

2

- Any new surveys or changes to survey results that were conducted on or before March 3, 2020, that enter the national database will be included in the health inspection rating calculation, potentially causing a change in the health inspection rating for an individual facility.
- **Citations from complaint surveys will not be moving between rating cycles (or dropping out of the calculation)** while new health inspections are not being included in the health inspection rating calculation

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Analysis
Health Inspection Domain
2020

2

What happened Q3 2020

- Dear Jane, Thank you for your note. There is currently **not a specific date** for when the **health inspection rating domain** will be recalculated. CMS will continue to monitor inspections, including the restarting of certain inspections (i.e., surveys) per CMS memorandum QSO-20-31-ALL (https://www.cms.gov/files/document/qso-20-31-all.pdf).
- CMS will **restart the inspection ratings** as soon as possible and will communicate any changes to stakeholders in advance of updating the Nursing Home Compare website.

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Analysis
Health Inspection Domain
2020

2

What happened Q3 2020

- Dear Steven, The infection control surveys are posted publicly on Nursing Home Compare. There is a link to these surveys in the spotlight section. **These surveys will not be used in the calculation of the Five-Star Rating for facilities.**

Sincerely,

CMS Better Care

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Analysis
Health Inspection Domain
2021

2

What happened Q1 2021

- Ref: QSO 21-06-NH
- CMS **resumed calculating health inspection ratings on January 27, 2021**.
- Findings from the **focused infection control inspections used** to calculate each nursing home's inspection rating. These findings will be included the same way findings from complaint inspections are used in the Five-Star Quality Rating System.

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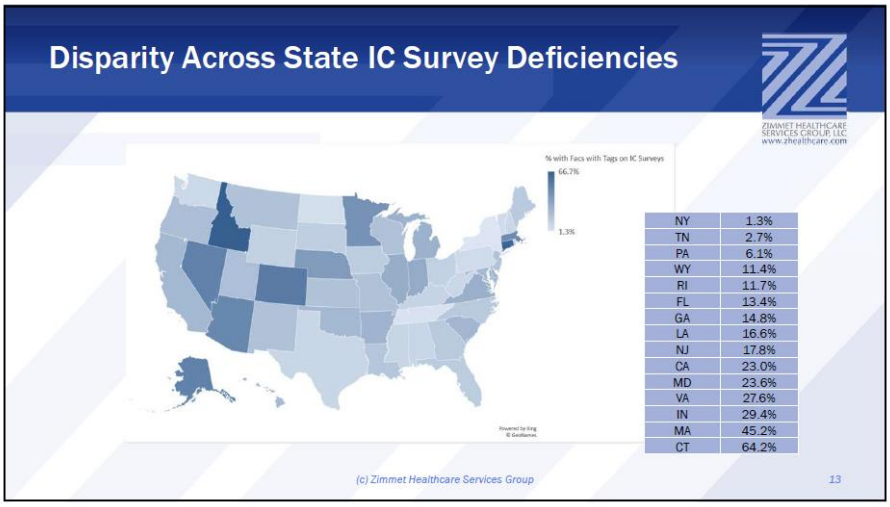
Analysis
Health Inspection Domain
Disparity Across State IC Survey Deficiencies

2



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Analysis
Health Inspection Domain
Five-Star Deficiencies

2

Two types of health citations –

- F731 (Waiver of requirement to provide licensed nurses of a 24-hour basis) and
- F884 (COVID-19 reporting to the Centers for Disease Control) – are not considered in the health inspection score calculation

- Deficiencies from Life Safety Surveys are not included in the Five-Star Rating calculations
- Deficiencies from Federal Comparative Surveys are not reported on Care Compare or included in rating calculations, though the results of State Survey Agency determinations made during a Federal Oversight Survey are included

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Analysis
Health Inspection Domain
Five-Star 2021

2

- Surveys that occurred after March 3, 2020, now count
  - Focused infection control surveys are included
  - They are treated like complaint survey citations – 36 months (3 - 12-month periods)

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Analysis
Health Inspection Domain
Five-Star 2021

2

- **Special Focus Facility (SFF) program**, and **icon for noncompliance** related to abuse are updated.
  - Updates to the **health inspection** data and time frames impact both
  - There are positive and negative outcomes for facilities
  - Once facilities no longer **meet criteria for the abuse icon**, their health inspection rating will no longer be capped at two stars

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Analysis
Health Inspection Domain
Infection Control Deficiency
Both Standard and Complaint Survey

2

- **Deficiencies** that appear on complaint inspections that are conducted within 15 days of a recertification inspection are counted only once.
- The **highest scope-severity combination** is used if they differ
- If **two or more infection control inspections** cite the same deficiency within a **15-day period**, all are included

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Analysis
Staffing Domain
2

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Analysis
Staffing Domain
2

What Happened Q1 2020 Ref: QSO-20-28-NH

- **Waived timeframe** requirements for **submitting staffing data** Payroll-Based Journal by prior deadline
- Waiver related to the timing of PBJ data submissions will not impact the Q1 updates to staffing domain

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Analysis
Staffing Domain

2

- What Happened Q2 2020 Ref: QSO-20-34-NH
  - 40% of facilities did not submit Q1 PBJ as part of waiver
  - Unable to update staffing domain
  - Q4 2019 data used
  - Q4 penalties for missing > 4 days of RNs had one-star downgrade removed, and domain suppressed
  - Emergency blanket waiver for PBJ ended. PBJ for Q2 required This Photo by August 14, 2020

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Analysis
Staffing Domain
PBJ Data Submission

2

Fiscal Quarter	Reporting Period	Due Date
1	October 1 – December 31	February 14
2	January 1 – March 31	May 15
3	April 1 – June 30	August 14
4	July 1 – September 30	November 14

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Analysis
Staffing Domain

2

- CMS stresses the relationship between nursing home **staffing levels, staffing stability** and **resident outcomes**
- The CMS **Staffing Study** found a clear association between nurse staffing ratios and nursing home quality of care
- **Lower staff to resident ratios** put patients at substantial risk for quality problems and lower quality of care

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Analysis
Staffing Domain

2

- The rating for staffing is based on **two Case Mix adjusted measures**:

1. **Total Nursing Hours** Per Resident Day **(RN + LPN + Nurse Aide Hours)**
2. **RN Hours** Per Resident Day

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Analysis
Staffing Domain

2

- RN Hours include registered nurses (Job Code 7) , RN Director of Nursing (Job Code 5) and registered nurses with administrative duties (Job Code 6)
- LPN Hours include licensed practical/licensed vocational nurses with administrative duties (Job Code 8) , and practical/licensed vocational nurses (Job Code 9)
- Nurse Aide Hours include certified nurse aides (Job Code 10) , aides in training (Job Code 11) and medication aides/technicians (Job Code 12)

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Analysis
Staffing Domain
COVID-19 and Respiratory Therapy

2

- Respiratory Therapy (Job Code 24) (Job Code 25)

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Analysis
Staffing Domain

2

- The staffing data include both **facility employees** (full/part time) and **agency staff**
- The staffing data does **not include "private duty"** staff who are funded by the resident's family
- Also **not included** are **hospice staff** and **feeding assistants**

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Analysis
Staffing Domain

2

- Data for the staffing domain comes from the **Payroll Based Journal (PBJ)** completed and transmitted to CMS (QIES) database quarterly
- Data is due **45 days after the end of each reporting period** and only data submitted by the deadline is used by CMS for staffing calculations
- **Resident Census** data is based on **MDS assessments** using assessments for **the year prior** to the quarter reporting period and the discharge assessments and assuming that if an interval of 150 days with no assessments, the resident no longer lives in the facility
- **Complete and transmit discharge assessments** timely

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Analysis
Staffing Domain

2

1. Direct Care Staff
2. Submission Requirements
   - Category
   - Census
   - Turnover
3. Employee from Agency
4. Data Format
5. Submission Schedule

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Analysis
Staffing Domain
Hours Record

2

Time entered is calculated in fractions, not as hours or minutes
Submission Requirements

- 01 to 06 minutes = 0.1
- 07 to 12 minutes = 0.2
- 13 to 18 minutes = 0.3
- 19 to 24 minutes = 0.4
- 25 to 30 minutes = 0.5
- 31 to 36 minutes = 0.6
- 37 to 42 minutes = 0.7
- 43 to 48 minutes = 0.8
- 49 to 54 minutes = 0.9
- 55 to 60 minutes = 1.0

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Analysis
Staffing Domain
Workday, Date

2

- Calendar Day
- Midnight is cutoff
  - 11-7 shift, day 1 has 1 hour and day 2 has 7 hours

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Analysis
Staffing Domain
Hours

2

Do not pay hours

- Paid for leave
- Paid for non-work-related absence

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Analysis
Staffing Domain
Labor Classification

2

Primary Role

- Can modify if shift primary roles in a day (4 hours as shift manager second 4 hours as a floor nurse)

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Analysis
Staffing Domain
Labor Category

2

- Not needed for electronic uploads

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Analysis
Staffing Domain
Pay Type Code

2

Pay Type Code	Pay Type Description	Comments
1	Exempt	Not entitled to overtime pay
2	Non-Exempt	Entitled to overtime pay
3	Contract	All Contract and Agency Staff must each have a unique Employee ID when entered into the system

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Analysis
Staffing Domain

2

- Ratings based on **expected** staffing levels calculated based on resident **acuity using RUGs**
- Staffing is **Case Mix adjusted** based on **RUG-IV (66-grouper version)** categories:
  - **RUG-IV** groups are calculated on **last business day of each quarter** for each active resident during the quarter in which the staffing data was collected
  - Uses most recent info — can be composite from **most recent comprehensive, full, quarterly, and PPS assessments** for a particular resident

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Analysis
Staffing Domain

2

- **Adjusted Staffing** = (Reported/Expected) (National Average)

  Expected = Case Mix adjusted acuity based expected staffing

  National Average = Mean across all facilities

Adjusted Hours = (Reported Hours/Case Mix Hours) (National Average Hours)

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Analysis
Staffing Domain

2

- The nurse staffing hours reported through PBJ and the daily MDS census are both aggregated (summed) across the quarterly reporting period
- The quarterly reported **nurse staffing hours per resident per day (HRD)** are then calculated by dividing the aggregate reported hours by the aggregate resident census
- Only days that have at least some (>0) nurse staffing (for any job category 5-12) and at least one resident are included in the calculations

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Analysis
Staffing Domain
April 2019 (Table 4)

2

Staffing and Rating April 2019						
RN Rating and Hours		Total Nurse staffing rating and hours (RN, LPN and Nurse Aide)				
		1	2	3	4	5
		<3.108	3.108 – 3.579	3.580 – 4.037	4.038 – 4.407	≥4.408
1	<0.317	★	★	★★	★★	★★★
2	0.317 – 0.507	★★	★★	★★	★★★	★★★
3	0.508 – 0.730	★★	★★★	★★★	★★★	★★★★
4	0.731 – 1.048	★★★	★★★	★★★★	★★★★	★★★★
5	≥1.049	★★★	★★★★	★★★★	★★★★★	★★★★★
Adjusted staffing values are rounded to three decimal places before the cut points are applied.						

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Analysis
Staffing Domain
PBJ Changes

2

	Requirements	PBJ April 2018
Census	Report census on last day of each month **Required**	Daily census is calculated by CMS based on MDS submitted
Optional Staff	38: Blood Service Worker 39: Housekeeping 40: Other Service Worker	32: Dentist 33: Podiatrist 35: Vocational Service Worker 36: Clinical Lab Service Worker 37: Diagnostic X-Ray Service Worker
Dates Hired / Terminated	Report first and last date each staff is paid; employees and contractors **Required**	Turnover and tenure will be calculated by CMS **Optional**

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Analysis
Staffing Domain
PBJ Changes

2

	Before April 2018	After April 2018
Source Data	Staffing Hours 671	Staffing Hours PBJ
Case Mix Adjustment	RUG-III (53) 1995-1997 time study	RUG-IV (66) STRIVE time study
Reported to Adjusted	Staffing Five Star Ratings will continue to be risk adjusted to account for differenced in resident acuity. The formula is unchanged. Hours adjusted = (Hours reported/Hours expected)*Hours National Average Resident RUG-IV data based on most recent MDS and "drawn" on last business day of the last month of the quarter	

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Analysis
Staffing Domain
PBJ Deadlines

2

PBJ Reporting Quarter	PBJ Deadline 45 Days after end of period	Posting to Nursing Home Compare
10.1 to 12.31	2.14	4.26
1.1 to 3.31	5.14	7.25
4.1 to 6.30	8.14	10.24
7.1 to 9.30	11.14	1.23

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Analysis
Staffing Domain
PBJ Job Titles

2

Labor Cat.	Labor Description	Job Title	Job Description
1	*Administration Services*	1	Administrator
2	*Physician Services*	2	Medical Director
2	*Physician Services*	3	Other Physician
2	*Physician Services*	4	Physician Assistant
3	*Nursing Services*	5	Registered Nurse Director of Nursing
3	*Nursing Services*	6	RN with Administrative Duties
3	*Nursing Services*	7	Registered Nurse
3	*Nursing Services*	8	LPN with Administrative Duties (NEW)
3	*Nursing Services*	9	Licensed Practical/Vocational Nurse
3	*Nursing Services*	10	Certified Nurse Aide
3	*Nursing Services*	11	Nurse Aide in Training
3	*Nursing Services*	12	Medication Aide/ Technician
3	*Nursing Services*	13	Nurse Practitioner
3	*Nursing Services*	14	Clinical Nurse Specialist
4	*Pharmacy Services*	15	Pharmacist
5	*Dietary Services*	16	Dietitian
5	*Dietary Services*	17	Paid Feeding Assistant
6	*Therapeutic Services*	18	Occupational Therapy
6	*Therapeutic Services*	19	Occupational Therapy Assistant
6	*Therapeutic Services*	20	Occupational Therapy Aide
6	*Therapeutic Services*	21	Physical Therapist
6	*Therapeutic Services*	22	Physical Therapy Assistant
6	*Therapeutic Services*	23	Physical Therapy Aide
6	*Therapeutic Services*	24	Respiratory Therapist
6	*Therapeutic Services*	25	Respiratory Therapy Technician
6	*Therapeutic Services*	26	Speech/ Language Pathologist
6	*Therapeutic Services*	27	Therapeutic Recreation Specialist
6	*Therapeutic Services*	28	Qualified Activities Professional
6	*Therapeutic Services*	29	Other Activities Staff
6	*Therapeutic Services*	30	Qualified Social Worker
6	*Therapeutic Services*	31	Other Social Worker
7	*Dental Services*	32	Dentist OPTIONAL
8	*Podiatry Services*	33	Podiatrist OPTIONAL
9	*Mental Health Services*	34	Mental Health Service Worker
10	*Vocational Services*	35	Vocational Service Worker OPTIONAL
11	*Clinical Lab. Services*	36	Clinical Laboratory Service Worker OPTIONAL
12	*Diagnostic X-ray Services*	37	Diagnostic X-ray Service Worker OPTIONAL
13	*Admin/Stor of Blood Svcs*	38	Blood Service Worker OPTIONAL
14	*Housekeeping Services*	39	Housekeeping Service Worker OPTIONAL
15	*Other Services*	40	Other Service Worker OPTIONAL

Job Titles used to calculate Five Star Staffing currently

RN Hours

Total Nursing Hours

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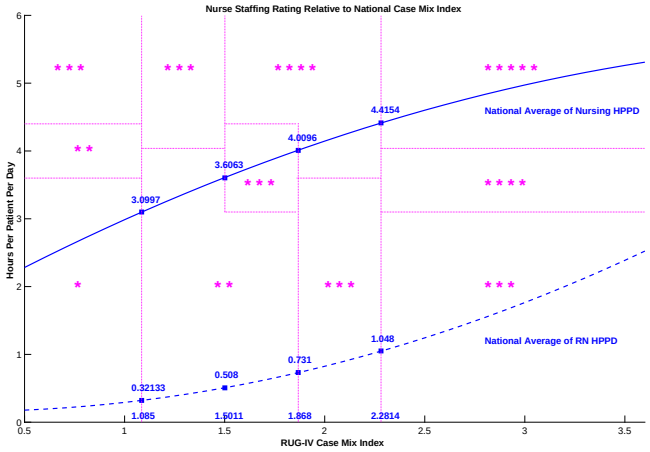
March 4, 2022

85

85

Analysis
Staffing Domain
PBJ, CMI and PPD Preliminary Data 4.28.20

2



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March 4, 2022

86

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Analysis
Staffing Domain
Five-Star Calculation

2

The same hours (risk-adjusted) are being used

- **RN Hours** per resident day (expect LPN with admin duties removed)
- **Total Nursing Hours** per resident day

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Analysis
Staffing Domain
Five-Star Calculation

2

1. Sum **Hours Paid** over the quarter
2. Sum **Daily Census** over the quarter
3. Calculate **Hours Per Resident Day** (divide hours paid/avg daily census)
4. Calculate **Expected HPRD** using RUGS-IV expected times from STRIVE study
5. **Risk Adjustment** measures by comparing expected Staffing

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Analysis
Staffing Domain
Distribution of Five-Star Ratings

2

March 2018

Five-Star Rating	# of Facilities	Distribution
None	976	6%
⋆	1,741	11%
⋆⋆	2,082	13%
⋆⋆⋆	4,311	27%
⋆⋆⋆⋆	4,735	30%
⋆⋆⋆⋆⋆	1,802	12%

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Analysis
Staffing Domain
Distribution of Five-Star Ratings

2

- Significant change in calculation
  - RN and LPN administrative hours split
  - Averages from latest PBJ data
  - STRIVE time study breaks out LPN and RN hours differently so expected hours ration is different
  - RUGS distribution has likely changed

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Analysis
Staffing Domain
1 Star in Staffing

2

- **Fail to submit** PBJ by submission deadline
  - Plus, all staffing ratios removed from Nursing Home Compare
- **Fail to respond** to an Audit request
- **Fail to submit requested documentation** in Audit
- **Significant gap in hours** reported vs. hours validated in Audit
- **Report 7 or more days in a quarter with 0 RN hours**

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Analysis
Staffing Domain
PBJ Audits

2

- Audits – Purpose is to **verify staffing hours** reported in PBJ
- Providers have **2 weeks** after being notified to provide response
- Requests an explanation of **payroll vs timekeeping** process, including the midnight cutoff process
- Includes **specific requests** for details on
  - Corporate employees
  - Non-nursing hours and secondary positions
  - Exempt time recorded
  - Training hours recorded

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Analysis
Staffing Domain
PBJ Audits

2

1. Contact name, phone number and e-mail address
2. Daily census summary report
3. Crosswalk between the employee ID numbers
4. Crosswalk between the job title code/labor category
5. Daily time systems reports
6. Payroll records and reports

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Analysis
Staffing Domain
PBJ Audits

2

7. Nursing Staffing Assignment
8. Description of payroll job code/department
9. Invoices to support all contracted personnel reported
10. Documentation to support portion of hours worked
11. Payroll records for corporate office employees included
12. Documentation for Medical Director hours submitted

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Analysis
Staffing Domain
PBJ Audits

2

- Required **meal breaks are being reviewed** and have been excluded by auditors for each employee – even if they did not take a meal break
- **MDS discharge assessments not submitted timely** which will cause inaccurate hours per resident day calculations
- Care provided to **non-certified nursing facility residents** must be excluded from reported time

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Analysis
Staffing Domain
PBJ Audits

2

- Audits will continue and **providers need to respond quickly** with the details requested once they are contacted
- **Corporate staff hours** can be included but must be documented and verifiable
- Staff working **over 80 hours in a week or over 300 hours in a month** a commonly audited for proof those hours were paid in payroll
- Expect to provide **contractor documentation** for reported hours

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Analysis
Staffing Domain
PBJ Census

2

- CMS is **calculating your census** based on MDS submitted
  - Census is **calculated daily** and averaged for the quarter
  - If there's no discharge assessment, CMS will count a resident in your facility **for 150 days after the last MDS assessment** then exclude them
- Inflated census will **lower your HPRD**, which may lower your staffing five-star rating
- Studies have shown a **correlation** between missing discharge assessments and lower reported staffing HPRD

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Analysis
Staffing Domain
HPRD Hours Per Resident Day

2

- To avoid inaccurate turnover calculations, **keep consistent ID's**
- **Aberrant HPRD** is calculated.
- Facilities with Aberrant HPRD are **not reported** and displayed as **"data not available"** on Nursing Home Compare (NHC)
  - **Excessively low** total nursing staffing **(Job Codes 5-12): < 1.5 HPRD**
  - **Excessively high** total nursing staffing **(Job Codes 5-12): > 12 HPRD**
  - **Excessively high** nurse aide staffing **(Job Codes 10-12): > 5.25 HPRD**

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Analysis
Staffing Domain
PBJ Data

2

PBJ data is **publicly available after** a 4-6 month period

https://data.cms.gov

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Analysis
Staffing Domain
PBJ, CMI and PPD MDS Accuracy

2

- Need accurate MDS. They are the foundation for everything!

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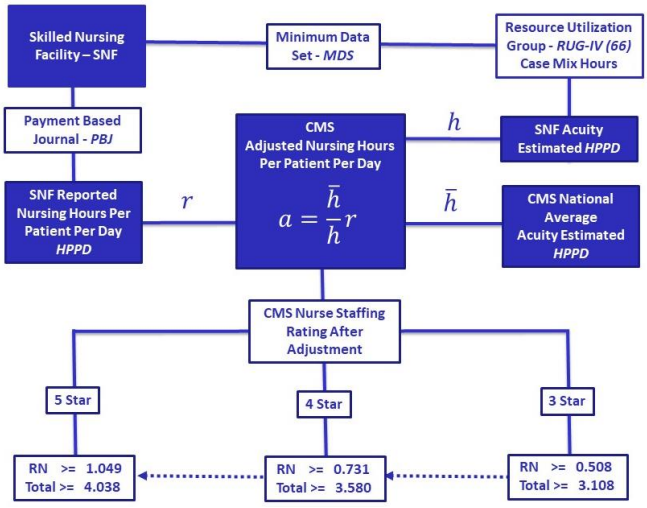
Analysis
Staffing Domain
Five-Star Nurse Staffing Rating Methology™

2



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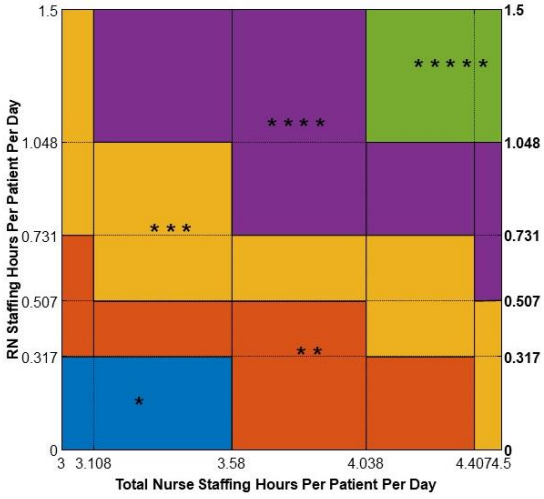
Analysis
Staffing Domain
Five-Star Nurse Staffing Rating Chart™

2



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Analysis
Staffing Domain
Summary of 2021

2

- Facilities that did not report staffing for the **November 14, 2020,** deadline or that reported four or more days in the quarter with no registered nurse will have their staffing ratings suppressed
- Their staffing ratings will show **"Not Available"** with the January, February, and March refreshes
- **April 2021 refresh**, nursing homes that do not report staffing data for October – December 2020 or that report four or more days in the quarter with no registered nurse will have their staffing ratings reduced to one star. (This is how it is typically done)

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Analysis
Staffing Domain
Electronic Submission

2

- **Payroll-Based Journal (PBJ)**
  - Exported file (XML) from automated systems (e.g., payroll, timekeeping), or
  - Manual entry directly through PBJ system, or
  - Combination of XML and manual entry (merging data)

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Analysis
Staffing Domain
Submission Deadlines

2

Direct care staffing and **census data** will be collected for **each fiscal quarter**

- **Staffing data** includes the **number of hours each staff member is paid** for working each day within a quarter.
- **Census data** includes the facility's census on the last day of each of the three months within a quarter.
- Submissions must be received by the end of the **45th calendar day (11:59 PM Eastern Standard Time) after the last day in each fiscal quarter** to be considered timely.

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Analysis
Staffing Domain
Submission Deadlines

2

Fiscal Quarter	Reporting Period	Due Date
1	October 1 – December 31	February 14
2	January 1 – March 31	May 15
3	April 1 – June 30	August 14
4	July 1 – September 30	November 14

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Audit

Quality Measures: Five-Star

Quality Measures: QRP

3

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Audit

Quality Measures: Five-Star

Fabulous 15

3

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108

Audit
Quality Measures – Five-Star Domain

3

- 15 Measures
  - 10 MDS Based
  - 9 Long-Stay
  - 6 Short-Stay

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Audit
Quality Measures – Five-Star

3

1. Need for Help with Activities (MDS based Long-Stay)
2. Ability to Move Independently Worsened (MDS based Long-Stay)
3. Pressure Ulcers (MDS based Long-Stay)
4. Catheter Inserted (MDS based Long-Stay)
5. Urinary Tract Infection (MDS based Long-Stay)
6. One or More falls with Major Injury (MDS based Long-Stay)
7. Antipsychotic Medication (MDS based Long-Stay)
8. Number of Hospitalizations (Claims based Long-Stay)

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Audit
Quality Measures – Five-Star

3

9. Emergency Department (ED) (Claims based Long-Stay)
10. Improvement in Function (MDS based Short-Stay)
11. Pressure Ulcers that are New or Worsened (MDS based Short-Stay)
12. Newly Received Antipsychotic Medication (MDS based Short-Stay)
13. Re-Hospitalized (Claims based Short-Stay)
14. Outpatient Emergency Department (ED) (Claims based Short-Stay)
15. Return to Home and Community (Claims based Short-Stay)

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Audit
Quality Measures – Five-Star

3

Measure	Comments
MDS Long-Stay Measures	
1. Percentage of residents whose need for help with daily activities has increased	This measure reports the percentage of long-stay residents whose need for help with Late-Loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment. This is a change measure that reflects worsening performance on at least two Late Loss ADLs by one functional level or on one Late Loss ADL by more than one functional level compared to the prior assessment. The Late Loss ADLs are bed mobility, transfer, eating, and toileting. Maintenance of ADLs is related to an environment in which the resident is up and out of bed and engaged in activities. The CMS Staffing Study found that higher staffing levels were associated with lower rates of increasing ADL dependence.

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Audit
Quality Measures – Five-Star

3

Measure	Comments
MDS Long-Stay Measures (continued)	
2. Percentage of residents whose ability to move independently worsened	This measure is a change measure that reports the percentage of long-stay residents who have demonstrated a decline in independence of locomotion when comparing the target assessment to a prior assessment. Residents who lose mobility may also lose the ability to perform other activities of daily living, like eating, dressing, or getting to the bathroom.
3. Percentage of high-risk residents with pressure ulcers	This measure captures the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers. Residents at high risk for pressure ulcers are those who are impaired in bed mobility or transfer, who are comatose, or who suffer from malnutrition.

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Audit
Quality Measures – Five-Star

3

Measure	Comments
MDS Long-Stay Measures (continued)	
4. Percentage of residents who have/had a catheter inserted and left in their bladder	This measure reports the percentage of residents who have had an indwelling catheter in the last seven days. Indwelling catheter use may result in complications, like urinary tract or blood infections, physical injury, skin problems, bladder stones, or blood in the urine.
5. Percentage of residents with a urinary tract infection	This measure reports the percentage of long-stay residents who have had a urinary tract infection within the past 30 days. Urinary tract infections can often be prevented through hygiene and drinking enough fluid. Urinary tract infections are relatively minor but can lead to more serious problems and cause complications like delirium, if not treated.

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Audit
Quality Measures – Five-Star

3

Measure	Comments
MDS Long-Stay Measures (continued)	
6. Percentage of residents experiencing one or more falls with major injury	This measure reports the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period of look-back period (one full calendar year).
7. Percentage of residents who got an antipsychotic medication	This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period. Reducing the rate of antipsychotic medication use has been the focus of several CMS initiatives.

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Audit
Quality Measures – Five-Star

3

Measure	Comments
Claims-Based Long-Stay Measures	
8. Number of hospitalizations per 1,000 resident days	This measures the number of unplanned admissions or outpatient observation stays that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of unplanned hospitalizations for every 1,000 days that the long-stay residents were admitted to the nursing home.
9. Number of outpatient emergency department (ED) visits per 1,000 resident days	This measures the number of outpatient ED visits that occurred among long-stay residents of a nursing home during a one-year period, expressed as the number of outpatient ED visits for every 1,000 days that the long-stay residents were admitted to the nursing home.

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Audit
Quality Measures – Five-Star

3

Measure	Comments
MDS Short-Stay Measures	
10. Percentage of residents who improved in their ability to move around on their own	This measure assesses the percentage of short-stay residents whose independence in three mobility functions (i.e., transfer, locomotion, and walking) increases over the course of the nursing home care episode.
11. Percentage of SNF residents with pressure ulcers/pressure injuries that are new or worsened	The measure captures the percentage of short-stay residents with pressure ulcers that are new or whose existing pressure ulcers worsened during their stay in the SNF and includes unstageable ulcers.
12. Percentage of residents with antipsychotic medication for the first time	This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.

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Audit
Quality Measures – Five-Star

3

Measure	Comments
Claims-Based Short-Stay Measures	
13. Percentage of short-stay residents who were rehospitalized after a nursing home admission	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted to a hospital for an inpatient or observation stay within 30 days of entry or reentry.
14. Percentage of short-stay residents who have had an outpatient emergency department (ED) visit	This measure reports the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident had an outpatient ED visit (i.e., an ED visit not resulting in an inpatient hospital admission) without 30 days of entry or reentry.
15. Rate of successful return to home and community from an SNF	This measure reports the rate at which residents returned to home and community with no unplanned hospitalizations and no deaths in the 31 days following discharge from the SNF.

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Audit
Quality Measures – Five-Star Long-Stay

3

Measures for **Long-Stay Residents** (defined as residents who are in the nursing home for greater than 100 days) that are derived from **MDS Assessments**

1. Perfect of residents whose **need for help with activities** of daily living has increased
2. Percent of residents whose **ability to move independently worsened**
3. Percent of high-risk residents with **pressure ulcers**
4. Percent of residents who have/had a **catheter inserted** and left in their bladder

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Audit
Quality Measures – Five-Star Long-Stay

3

5. Percent of residents with a **urinary tract infection**
6. Percent of residents experiencing **one or more falls with major injury**
7. Percent of residents who received an **antipsychotic medication**

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Audit
Quality Measures – Five-Star Long-Stay

3

Measures for **Long-Stay Residents** that are derived from **Claims Data**

8. **Number of hospitalizations** per 1,000 long-stay resident days
9. Number of outpatient **emergency department (ED)** visits per 1,000 long-stay resident days

*150 Points Possible Based upon National distribution (why is this important?)

March 4, 2022 121

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Audit
Quality Measures – Five-Star Short-Stay

3

Measures for **Short-Stay Residents** that are derived from **MDS Assessments**

10. Percent of residents who made **improvement in function**
11. Percent of SNF residents with **pressure ulcers that are new or worsened**
12. Percent of residents who **newly** received an **antipsychotic medication**

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Audit
Quality Measures – Five-Star Short-Stay

3

Measures for **Short-Stay Residents** that are derived from **Claims Data**

13. Percent of short-stay residents who were **re-hospitalized** after a nursing home admission
14. Percent of short-stay residents who have had an **outpatient emergency department (ED) visit**
15. Rate of successful **return to home and community** for a SNF

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3

Quality Measure Domain 2021

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Quality Measure Domain 3

What Happened Q1 2020 Ref: QSO-20-28-NH

- Waived timeframe requirements for submitting MDS
- Waivers related to the timing of MDS will not impact the updates to the quality measures domains

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Quality Measure Domain 3

- **What Happened Q2 2020 Ref: QSO-20-34-NH**
  - Quality Measures based on **data collection period** ending December 31, 2019, will be held constant
  - Quality Measures based on a data collection period **prior to December 31, 2019,** will continue to be updated until the underlying data reaches December 31, 2019

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Quality Measure Domain 3

Q1 2021 Ref: QSO 21-06-NH

- Quality Measures posted on the Nursing Home Compare website and used in the Five-Star Quality Rating System will be updated on **January 27, 2021.**
- These include **MDS and Claims based measures**, but not SNF QRP.
- CMS will use data based on the data collection period **ending June 30, 2020**

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Quality Measure Domain 3

Summary of 2021

- **Quarterly updates** of most of the quality measures (QMs) posted on Care Compare and used in the Five-Star Quality Rating System resumed with the January 2021 refresh.
  - CMS **used data for July 2019- June 2020** for all the measures that were updated.
  - The **two QMs** that are part of the Skilled Nursing Facility Quality Reporting Program
    - Percentage of SNF residents with **pressure ulcers/pressure injuries** that are new or worsened and
    - Rate of **successful return to home and community** from a SNF)

  will **not be updated in January 2021.**

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Quality Measure Domain
Recalibration

3

Recalibration was postponed

- Recalibration generally does not help
- Quality Domain never been recalibrated down

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Quality Measure Domain
Quality Measures Five-Star Long-Stay

3

1. **% Falls** with major injury
2. **Pressure Ulcers**
3. **UTI**
4. **Catheter Use**
5. **ADL Decline**

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Quality Measure Domain
Quality Measures Five-Star Long-Stay

3

6. **Antipsychotic Medication Use**
   a. Example; Compazine for Nausea needs to be coded on MDS as antipsychotic. Zofran does not need to be coded and is also used for nausea.
   b. Zyprexa used for bipolar/depression but needs to be coded on MDS as antipsychotic.
   c. Exclusion – Huntington's, Tourette's, schizophrenia
7. **Locomotion** on the unit
   a. 1 point difference
8. **Number of hospitalizations** per 1,000 resident days (claims based)
9. **Number of ER visits** per 1,000 resident days (claims based)

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Quality Measure Domain
Quality Measures Five-Star Short-Stay

3

10. Made **improvement in function** from admission to discharge
11. Newly received **antipsychotic medications**
12. **Pressure ulcers** new or worsened
13. **Successful return** to home/community (claims based)
14. **Rehospitalization after nursing home admission** (claim based)
15. Residents who had **ED visit**

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Quality Measure Domain
Five-Star
Purpose of the Quality Measures

3

- According to the CMS, Quality Measures (QMs) have **four purposes** for consumers
  1. To give you information about the quality of care at nursing homes in order to **help you choose** a nursing home for yourself or others
  2. To give you information about the care at nursing homes where you or your family members **already live**

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Quality Measure Domain
Five-Star
Purpose of the Quality Measures

3

3. To give you information to f**acilitate your discussions with the nursing home staff** regarding the quality of care, **and**
4. To give data to the nursing home **to help** them in their **quality improvement efforts**

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Quality Measure Domain
Five-Star
Purpose of the Quality Measures

3

- CMS has stated that the QMs are dynamic and will **continue to be refined** as part of a commitment to **ongoing quality**
- **Current Quality Measure User's Manual is v11.0 (revised 4/1/17)**
- Knowledge of the key MDS 3.0 items used to calculate each Quality Measure is key

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Quality Measure Domain
Quality Measures QRP

3

- **Quality Measures** at least 5 domains
- **Other Measures** at least 3 domains
- **NQF Endorsed** and "application of"
- Standardized- SNF, LTCHs, IRFs, HHA's identical assessment questions
- Define **"Standardized Resident Assessment"**

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Quality Measure Domain
Five-Star
Purpose of the Quality Measures

- According to the CMS, Quality Measures (QMs) have **four purposes** for consumers
  1. To give you information about the quality of care at nursing homes in order to **help you choose** a nursing home for yourself or others
  2. To give you information about the care at nursing homes where you or your family members **already live**

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Quality Measure Domain
Five-Star
Purpose of the Quality Measures

3. To give you information to f**acilitate your discussions with the nursing home staff** regarding the quality of care, **and**
4. To give data to the nursing home **to help** them in their **quality improvement efforts**

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Audit

Quality Measures: QRP

SNF Quality Reporting Program (QRP)

3

Harmony Healthcare INTERNATIONAL

139

Audit

Quality Measures: QRP

Lucky 13 (increasing to 15)

3

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Audit
Quality Measures (QRP) Lucky 13→15

3

No.	Fabulous 15		No.	"Lucky 13"	
1.	**% Falls** with Major Injury	Long-Stay	1.	**One or More Falls** with Major Injury (Long-Stay) (NQF #0674)	MDS Based Long-Stay Public 10.24.2018
2.	**Pressure Sores**	Long-Stay	2.	Admission and Discharge Functional Assessment & Care Plan that **Addresses Function** (NQF #2631)	MDS Based Public 10.24.2018
3.	**UTI**	Long-Stay	3.	**Drug Regimen Review**	MDS Based Public 10.28.2020
4.	**Catheter Use**	Long-Stay	4.	**Changes in Skin Integrity**	MDS Based Short-Stay Public 10.28.2020
5.	**ADL Decline**	Long-Stay	5.	**Change in Self-Care** (NQF #2633)	MDS Based Short-Stay Public 10.28.2020
6.	**Antipsychotic Medication Use**	Long-Stay	6.	**Change in Mobility** (NQF #2634)	MDS Based Short-Stay Public 10.28.2020
7.	**Locomotion on the Unit**	Long-Stay	7.	**Discharge Self-Care** (NQF #2635)	MDS Based Short-Stay Public 10.28.2020
8.	**Number of Hospitalizations**	Long-Stay Claims-Based	8.	**Discharge Mobility** (NQF #2636)	MDS Based Short-Stay Public 10.28.2020
9.	**Number of ER Visits**	Long-Stay Claims-Based	9.	Transfer of **Health Information to Provider PAC®**	MDS Based
10.	**Improvement in Function**	Short-Stay	10.	Transfer of **Health Information to Patient PAC®**	MDS Based
11.	Newly Received **Antipsychotic Medications**	Short-Stay	11.	COVID-19 vaccination coverage among health care personnel HCP	Claims-Based CDC NHSN
12.	**Pressure Ulcers** New or Worsened	Short-Stay	12.	**Medicare Spending Per Beneficiary**	Medicare Fee-For-Service Claims-Based Public 10.24.2018
13.	**Successful Return** to Home/Community	Short-Stay Claims-Based	13.	**Discharge to Community**	Medicare Fee-For-Service Claims-Based Public 10.24.2018
14.	**Rehospitalization** after Nursing Home Admission	Short-Stay Claims-Based	14.	**Potentially Preventable 30-Day Post Discharge**	Medicare Fee-For-Service Claims-Based Public 10.24.2019
15.	**ED Visit**	Short-Stay	15.	**SNF health care associated infections (HAI) requiring hospitalizations**	Medicare Fee-For-Service Claims-Based

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Audit
Quality Measures (QRP) Lucky 13→15
Measures & Technical Information

3

- CMS web provides information on the measures reported by SNFs in accordance with the SNF QRP. Details include:
  - **Descriptions of each measure,**
  - **Links** to measure specifications,
  - **Measure updates** and other measure-related information,
  - **Updated** as measure updates become available

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Audit
Quality Measures (QRP) Lucky 13→15
What are the SNF Quality Reporting Measures?

3

- Data for the SNF QRP measures are collected and submitted through **two methods:**
  - **Minimum Data Set (MDS) 3.0**
  - **Medicare Fee-For-Service Claims**
- 13 Measures:
  - 10 MDS Based
  - 3 Claims Based

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Assessment-Based IMPACT Act

3

1. Application of Percent of Residents Experiencing **One or More Falls** with Major Injury (Long-Stay) **(NQF #0674)**
2. Application of Percent of Long-Term Care Hospital Patients with an **Admission** and **Discharge Functional Assessment** and **Care Plan** That **Addresses Function (NQF #2631)**
3. **Drug Regimen Review** Conducted with Follow-Up for Identified Issues – PAC SNF ARP
4. Changes in **Skin Integrity** Post-Acute Care: **Pressure Ulcer/Injury**

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Assessment-Based IMPACT Act Measures

3

5. Application of IRF Functional Outcome Measure: **Change in Self-Care** Score for Medical Rehabilitation Patients **(NQF 2633)**
6. Application of IRF Functional Outcome Measure: **Change in Mobility** Score for Medical Rehabilitation Patients **(NQF 2634)**
7. Application of IRF Functional Outcome Measure: **Discharge Self-Care** Score for Medical Rehabilitation Patients **(NQF #2635)**
8. Application of IRF Functional Outcome Measure: **Discharge Mobility** Score for Medical Rehabilitation Patients **(NQF #2636)**

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Assessment-Based IMPACT Act Measures

3

New Measures to be implemented on **October 1st** of the year that is at least **1 full FY** after the end of the Public Health Emergency (PHE)

9. Transfer of **Health Information** to the **Provider** Post-Acute Care
10. Transfer of **Health Information** to the **Patient** Post-Acute Care

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Claims-Based IMPACT Act Measures

3

11. **Medicare Spending Per Beneficiary** – Post-Acute Care (PAC) SNF QRP
12. **Discharge to Community** – PAC SNF QRP
13. **Potentially Preventable 30-Day Post-Discharge** Readmission Measure – SNF QRP

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Audit
Quality Measures (QRP) Lucky 13→15
2021 Updates From CMS

3

– On **October 13, 2021**, CMS updated a table used in the Skilled Nursing Facility Quality Reporting Program (SNF QRP). The posting from CMS reads as follows:

*An update to the Skilled Nursing Facility Quality Reporting Program (SNF QRP) **Annual Payment Update (APU) Table** for Reporting **Assessment-Based Quality Measures (QMs)** and standardized patient assessment data elements to CMS is now available. This document has been updated to reflect the data elements required to meet the **APU minimum data completion** threshold for the **Fiscal Year (FY) 2024**.*

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Audit
Quality Measures (QRP) Lucky 13→15
2021 Updates From CMS

3

- The **first update** is related to the posting of the **Skilled Nursing Facility Quality Reporting Program (SNF QRP) Annual Update** for Reporting Assessment-Based Quality Measure and Standardized Patient Assessment Data Elements Affecting FY2024.
- The **second update** is related to SNF PPS Updates to the **Medicare Provider Reimbursement Manual**.
- Additional information on both updates is provided below.
  - SNF QRP Annual Update Table for Reporting Assessment-Based Quality Measure and Standardized Patient Assessment Data Elements Affecting FY 2024 posted

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Audit
Quality Measures (QRP) Lucky 13→15
2021 Updates From CMS

3

- The updated **SNF QRP Annual Table** is available at the bottom of the webpage under the "downloads":

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information

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Audit
Quality Measures (QRP) Lucky 13→15
Updates: October 13, 2021

3

- SNF QRP Annual Update Table for Reporting Assessment-Based Quality Measure and Standardized Patient Assessment Data Elements Affecting FY 2024 posted
  - An update to the Skilled Nursing Facility Quality Reporting Program (SNF QRP) Annual Payment Update (APU) Table for Reporting Assessment-Based quality measures (QMs) and standardized patient assessment data elements to CMS is now available. This document has been updated to reflect the data elements required to meet the APU minimum data completion threshold for the Fiscal Year (FY) 2024. The document can be found in the **Downloads** section below.

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Audit
Quality Measures (QRP) Lucky 13→15
Updates: August 19, 2021

3

- SNF QRP Risk Adjustment Appendix File and ICD-10 HCC Crosswalks are now available.
  - An update to the Skilled Nursing Facility Quality Reporting Program (SNF QRP) Risk Adjustment Appendix File is now available. This document has been updated to reflect the risk adjustment coefficients for quality measure calculation to be used in conjunction with the SNF QRP Measure Calculations and Reporting User's Manual (Version 3.0) and its corresponding addendum (Version 3.0.1). Additionally, the ICD-10 Hierarchical Condition Category (HCC) Crosswalks for SNF Mobility (NQF #2634 and #2636) and Self Care (NQF #2633 and #2635) functional outcome measures are available. These files can be accessed in the **Downloads** section of this webpage.

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Audit
Quality Measures (QRP) Lucky 13→15
Measures Removed From SNF

3

- Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)
  - This measure was finalized in the FY 2016 SNF PPS Final Rule which was published in the Federal Register on August 4, 2015 (80 FR 46433). Data collection for this measure began10/1/2016. Public reporting began 10/24/2018. As finalized in the FY 2018 SNF PPS Final Rule published in the Federal Register on 08/04/2017 (82 FR 36572), this measure was replaced in the QRP by a modified version of the measure entitled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury beginning with the FY2020 SNF QRP.

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Audit
Quality Measures (QRP) Lucky 13→15
SNF Quality Reporting Measures

3

- Data for the SNF QRP measures are collected and submitted through two methods:
  - Minimum Data Set (MDS) 3.0
  - Medicare Fee-For-Service Claims

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Assessment-Based IMPACT Act

3

1. Application of Percent of Residents Experiencing **One or More Falls** with Major Injury (Long-Stay) (NQF #0674)
2. Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and Care Plan That **Addresses Function** (NQF #2631)
3. **Drug Regimen Review** Conducted with Follow-Up for Identified Issues – PAC SNF ARP
4. Changes in **Skin Integrity** Post-Acute Care: Pressure Ulcer/Injury

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Assessment-Based IMPACT Act Measures

3

5. Application of IRF Functional Outcome Measure: **Change in Self-Care** Score for Medical Rehabilitation Patients (NQF 2633)
6. Application of IRF Functional Outcome Measure: **Change in Mobility** Score for Medical Rehabilitation Patients (NQF 2634)
7. Application of IRF Functional Outcome Measure: **Discharge Self-Care** Score for Medical Rehabilitation Patients (NQF #2635)
8. Application of IRF Functional Outcome Measure: **Discharge Mobility** Score for Medical Rehabilitation Patients (NQF #2636)

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Assessment-Based IMPACT Act Measures

3

New Measures to be implemented on October 1st of the year that is at least 1 full FY after the end of the Public Health Emergency

9. Transfer of **Health Information** to the **Provider** Post-Acute Care
10. Transfer of **Health Information** to the **Patient** Post-Acute Care

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Audit
Quality Measures (QRP) Lucky 13→15
SNF QRP MDS 3.0 Claims-Based IMPACT Act Measures

3

11. **COVID-19 vaccination coverage** among healthcare personnel HCP
12. **Medicare Spending Per Beneficiary** – Post-Acute Care (PAC) SNF QRP
13. **Discharge to Community** – PAC SNF QRP
14. **Potentially Preventable 30-Day Post-Discharge** Readmission Measure – SNF QRP
15. **SNF Healthcare Associated Infections (HAI)** requiring hospitalizations

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Audit
Quality Measures (QRP) Lucky 13→15

3

A. Change in Skin Integrity
B. Change in Self-Care
C. Change in Mobility Score
D. Discharge Self-Care Score
E. Discharge Mobility Score

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Audit
Quality Measures (QRP) Lucky 13→15

3

- The SNF FY 2018 Final Rule contains a section on the SNF Quality Reporting Program (QRP), which is how CMS is **operationalizing the IMPACT Act** legislation
- CMS finalized **four measures** for the SNF QRP and specified the changes necessary in the MDS
- CMS also finalized the **timeline for implementation** of the SNF QRP measures from the 2016 and 2017 rules

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Audit
Quality Measures (QRP) Lucky 13→15

3

- **Quality Measures** at least 5 domains
- **Other Measures** at least 3 domains
- **NQF Endorsed** and "application of"
- Standardized- SNF, LTCHs, IRFs, HHA's identical assessment questions
- Define **"Standardized Resident Assessment"**

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Audit
Quality Measures (QRP) Lucky 13→15

3

- **SNF Quality Reporting Program**
  - CMS proposed that beginning in **FY 2018**, SNFs that **do not satisfy** the **reporting requirements** for the FY 2018 SNF Quality Reporting Program (QRP), would have a **penalty of a 2.0 percent** reduction to the SNF market basket percentage change for that fiscal year, after any applicable adjustments
  - With the application of this penalty, those SNFs that do not meet the reporting requirements would receive a **market basket update of negative (-1.0 percent) for FFY 2018**

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Audit
Quality Measures (QRP) Lucky 13→15

3

- Under the SNF QRP, SNFs that **fail to submit** the required quality data to CMS will be subject to a **2-percentage point reduction** to the otherwise applicable annual market basket percentage update with respect to that fiscal year

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Audit
Quality Measures (QRP) Lucky 13→15

3

- SNF Quality Reporting Program Measure Calculation and Reporting User's Manual Version 1.0 is available at
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information

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Audit
Quality Measures (QRP) Lucky 13→15

3

- The development of cross setting post acute care Quality Measures was **mandated by the IMPACT Act**
- **QRP** applies to **only** to **Medicare Part A stays**
- **Target Period** includes all Part A stays with a Medicare admission assessment during the **most recent 12 months**
- **Medicare Part A Admission Record** Defined as a PPS 5-Day assessment (A0310B = [01])
- **Medicare Part A Discharge Record** A Part A PPS Discharge Assessment (**A0310H = [1]**) is required when a resident ends a Medicare Part A Stay

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Audit
Quality Measures (QRP) Lucky 13→15
Five Measures FY 2020

3

1. Changes in Skin Integrity Post-Acute Care **Pressure Ulcer/Injury**
2. Change in **Self-Care** Score for Medical Rehabilitation Patients (NQF #2633)
3. Change in **Mobility** Score for Medical Rehabilitation Patients (NQF #2634)
4. **Discharge Self-Care** Score for Medical Rehabilitation Patients (NQF #2635)
5. **Discharge Mobility** Score for Medical Rehabilitation Patients (NQF #2636)

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Audit
Quality Measures (QRP) Lucky 13→15
Data Collection & Final Submission Deadlines for the FY 2020 SNF QRP*

3

- Figure 1. Quarters for Which Data Are Optional or Except

Quarter	MDS Data Submission
October 1, 2019 – December 31, 2019 (Q4 2019)	Optional
January 1, 2020 – March 31, 2020 (Q1 2020)	Excepted
April 1, 2020 – June 30, 2020 (Q2 2020)	Excepted

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Audit
Quality Measures (QRP) Lucky 13→15
Summary of Data Refreshes

3

Quarter Refresh	Nursing Home Compare (SNF QRP) MDS Assessment-Based Measures
October 2020	Normal refresh (includes Q4 2019 data) (inaugural posting of 6 new quality measures)
January 2021	Freeze
April 2021	Freeze
July 2021	Freeze
October 2021	Freeze
January 2022	Public reporting resumes*
April 2022	Normal refresh

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Audit
Quality Measures (QRP) Lucky 13→15
Annual Payment Update (APU)

3

- Assessment Submission and Processing (ASAP) system **enhancement** in **September 2018**
  - Adding **Edit #3897** to Final Submitter Validation Reports
  - **Edit #3897** is a **Payment Reduction Warning Edit**. This warning will be received if the dash is submitted that impacts SNF QRP Quality Measures

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Audit
Quality Measures (QRP) Lucky 13→15
Quality Measure Management

3

- **Audit, audit, audit** for MDS accuracy!
- Risk adjustments often come from **prior or initial** assessments; therefore, it is critical to ensure accuracy early on
- By the time the QMs are posted it is **old news!**
- The first step to using these calculations in QAA is **verifying the data**!

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Regulatory

Public Health Emergency Extended

Person-Centered Care

4

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Regulatory

Public Health Emergency Extended

4

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Regulatory
Public Health Emergency Extended

4

- The US Department of Health and Human Services Secretary Xavier Becerra extended the ongoing COVID-19 public health emergency (PHE) for an additional 90 days.
- **The new expiration date for the COVID-19 PHE is now set for April 16, 2022.**
- Any decision to allow the PHE to lapse would come with 60 days prior notice. Telehealth flexibilities, enhanced FMAP, SNF-specific waivers (3-Day Stay, Spell of Illness) and other COVID-19 related Medicare, Medicaid, and regulatory waivers remain in place.

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Regulatory
Person-Centered Care
The New Gold Standard
"Ritz-level" Customer Service

4

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Regulatory
Person-Centered Care The New Gold Standard
Motto

4

"Ladies and Gentlemen
Serving Ladies and Gentlemen"

March 4, 2022 175

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Regulatory
Person-Centered Care The New Gold Standard
Ladies and Gentlemen

4

Horst Schulze,
Busboy 14 years old

"We could never go to this hotel; it is only for important people"

March 4, 2022 176

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Regulatory
Person-Centered Care The New Gold Standard

4

- As he watched the maitre d' over time, he realized that the staff were as important as the guests. Every guest was proud when he spoke to them. **Why**? Because the maitre d' was a **first-class professional! He was somebody exceptional because of the excellence he created for his guests.**

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Regulatory
Person-Centered Care The New Gold Standard

4

- **All of us who serve, can be Ladies and Gentlemen just like our Guests!**
- Treat our guests and each other with **respect and dignity**

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Regulatory
Person-Centered Care The New Gold Standard
Leadership Qualities

4

Ritz offers a rich tapestry of leadership successes

- **Respect** for staff
- **Quality** Improvement
- **Brand** Repositioning
- Corporate **Adaptability**
- Cultural **Consistency**
- Unparalleled **Service Excellence**

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Regulatory
Person-Centered Care The New Gold Standard
Define and Refine

4

- Define the pillars of enduring excellence that are **fundamental to original success** and longevity
- Refine strategic changes for **growth and evolution**

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Regulatory
Person-Centered Care The New Gold Standard

4

"If we could **turn back the time** to two months before the opening, what would we do to better?"

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Regulatory
Person-Centered Care The New Gold Standard
Stay Relevant

4

- Shanghai 24-hour club level
- Club level - family and business-separate spots
- Suit and tie, leave the resort

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Regulatory
Person-Centered Care The New Gold Standard
Cultural Considerations

4

- Omaha
- Indoor playground

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Regulatory
Person-Centered Care The New Gold Standard
Scenography

4

- San Francisco wine country
- Local relevance
- It's the experience

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Regulatory
Person-Centered Care The New Gold Standard
Curiosity

4

- Everyone you come in contact within business should be considered a valued customer, whether it's the janitors, the chairman of the board, salespeople, or defined clients

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Regulatory
Person-Centered Care The New Gold Standard
Messaging

4

- Meet the needs of the customer and message accordingly

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Regulatory
Person-Centered Care The New Gold Standard Messaging

4

- Motto
- Credo
- 3 Steps of Service

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187

Regulatory
Person-Centered Care The New Gold Standard

4

- Culture versus Cult, carrying around the Credo Card-1986
  1. The Ritz Carlton is a place where the genuine care and comfort of our guests is our highest mission
  2. We pledge to provide the finest personal service and facilities for our guests who will always enjoy a warm, relaxed, yet refined ambiance
  3. The Ritz-Carlton experience livens the senses, instills well-being, and fulfills even the unexpressed wishes and needs of our guests

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Regulatory
Person-Centered Care The New Gold Standard
3 Steps to Service

4

1. A warm, nice greeting. Use the guests' **name.**
2. **Anticipation and fulfillment** of each guests needs
3. Fond Farewell. Give a warm goodbye and use the guests' **name.**

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Regulatory
Person-Centered Care The New Gold Standard
Customer Centered

4

"The Art of Anticipation"

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Regulatory
Person-Centered Care The New Gold Standard
The Basics

4

- **Annual Training** Certification on each position
- Each employee will continually **identify defects**
- Each employee has responsibility to create a work environment **teamwork**
- Uncompromising levels of **cleanliness**
- Recording guest **preferences**
- Whoever receives a complaint, will **own it, record it**
- Be an **Ambassador** in and out
- Never point, always **escort**
- Take pride and care of your **personal appearance**
- **Smile** and **eye** contact

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Regulatory
Person-Centered Care The New Gold Standard
The Basics

4

- Guidelines, not Treadmill
- Follow the cues of the guest

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Regulatory
Person-Centered Care The New Gold Standard
Starbucks

4

Starbucks 5 principles of turning ordinary into extraordinary; **"coffee staged in an environment of affordable luxury"**

- Name on the cup
- Free wifi
- Ample seating and leather couches
- Free coffee if wrong order
- Looking to produce transformational customer **experiences**

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Regulatory
Person-Centered Care The New Gold Standard

4

- Looking to produce transformational customer **experiences**

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Regulatory
Person-Centered Care The New Gold Standard
The Daily Huddle

4

- The "Lineup"
  - 3 x per day,
  - motivational quotes,
  - guest feedback throughout the world,
  - includes the top

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Regulatory
Person-Centered Care The New Gold Standard

4

- Repetition of Values
- Common Language
- Visual Symbols
- Oral Traditions
- Positive Storytelling
- Modeling by Leaders

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Regulatory
Person-Centered Care The New Gold Standard
You Must Fail to Succeed

4

Just because they have a great reputation does not mean they do not make mistakes

- The pen, not tested fully
- Pool in the shade all day

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Rehabilitation
Therapy Minutes

5

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Rehabilitation
Therapy Minutes
Goals

5

- The PDPM system shifts payment away from the focus on volume-based (days and minutes of therapy services) towards **incentives** to **treat** the **whole patient**
- Incentivizes SNF to **take risks** with varying clinical complexities
- This shift also would come with "significantly" **reduced administrative burdens**
- **CMS expects no change in care delivery!**

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Reimbursement
PDPM
Provider Relief

6

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200

Reimbursement
PDPM
Provider Relief

6

HHS Distributing $560 Million in Provider Relief Fund Payments to Health Care Providers Affected by the COVID-19 Pandemic

- With this funding, nearly $19 billion will have been distributed from the Provider Relief Fund and the American Rescue Plan Rural provider funding since November 2021.
- The U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is making more then $560 million in Provider Relief Fund (PRF) Phase 4 General Distribution payments to more then 4,100 providers across the country in March 2022.

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Reimbursement
PDPM

6

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Reimbursement
PDPM
Overview

- Six Components
- CMGs
- Variable Per Diem Adjustments
- Payment Concept
- Adjustment Factor
- IPA

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Reimbursement
PDPM
Overview – Six Components

1. Physical Therapy
2. Occupational Therapy
3. Speech Therapy
4. Nursing
5. NTA
6. Non-Case Mix

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Reimbursement
PDPM
Overview – Variable Per Diem Adjustments

PT	OT	SLP	Nursing	NTA
Primary reason for SNF Care Functional Status	Primary reason for SNF care Functional Status	Primary reason for SNF care Cognitive status Presence of swallowing disorder or mechanically altered diet Other SLP related comorbidities	Clinical information from SNF stay Functional status Extensive Services received Depression RNRP	Comorbidities present Extensive services received
Point in the stay **(variable per diem adjustment)**	Point in the stay **(variable per diem adjustment)**	Not adjusted over the stay	Not adjusted over the stay	Point in the stay **(variable per diem adjustment)**

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Reimbursement
PDPM
6 Payment Components

- Urban

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63

- Rural

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case Mix
Per Diem Amount	$98.83	$74.56	$67.67	$62.11	$27.90	$94.34

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Reimbursement
PDPM
Interim Payment Assessment (IPA) Criteria

6

- Change in the resident's classification in **at least one of the first-tier classification criteria** for any of the components under proposed PDPM that differs from the 5-day scheduled assessment and the change results in a change in payment.
- Resident would **not be expected to return** to their original clinical status within 14 days
- Intent to **reflect substantial changes** to a resident's clinical condition (not every day, frequent changes).

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Reimbursement
PDPM
6 Payment Components

6

Component	Resident Characteristics
Physical Therapy	• Clinical Categories • Functional Score (Section GG)
Occupational Therapy	• Clinical Categories • Functional Score (Section GG)
Speech Therapy	• Clinical Categories • Swallowing Disorder • SLP Comorbidity or Cognitive Impairment • Mechanically Altered Diet
NTA	• Comorbidity Extensive Services Score from ICD-10 • NTAS Tiers • Age
Nursing	• Existing Nursing RUGS • Conditions, treatments, services • Functional Measure (Section GG)
Non-Labor	• Same Methodology as in RUGs

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Reimbursement
PDPM
Overview

6

- The PDPM uses **clinically relevant factors**, rather than **volume-based service** for determining Medicare payment
- **Patient characteristics** are used to assign patients into **Case Mix Groups (CMGs) across the payment components** used to derive payment
- **All patients** will have a PT, OT, SLP, Nursing and NTA Component, in addition to the Non-Case Mix base payment
- PDPM **adjusts per diem payments** to reflect varying costs throughout the stay in the NTA, PT and OT components

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Reimbursement
PDPM
Case Mix Index (CMI)

6

- The payment for each component is calculated by:
  - Multiplying the **Case-Mix Index (CMI)** that corresponds to the patient's **Case-Mix Group (CMG)** by the wage adjusted component base payment rate
  - Then by the **specific day** in the **variable per diem** adjustment schedule, when applicable
- The **payments** for each component are then **added together** along with the **non-Case Mix component** payment rate to yield the patient's total SNF PPS per diem rate under the PDPM

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Reimbursement
PDPM
Goals

6

- CMS believes that the Patient Driven Payment Model (PDPM) will **eliminate** an **incentive** to **furnish therapy** to SNF patients regardless of unique characteristics, goals and need by classifying patients into payment groups based on specific, data-driven patient characteristics
- Goals of PDPM are to **save money**, **improve care** and **reduce administrative burden**
- The prior PPS schedule was replaced with **one MDS** for the stay, with an **optional** Interim Payment Assessment **(IPA)** available

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Reimbursement
PDPM
Who is Impacted?

6

- **Fee for Service Medicare Part A** beneficiaries and providers
  - **Optional** for Managed Care Providers
  - What are your **Managed Care Provider's** expectation?
  - Eventually, CMS will no longer support RUG-III and RUG-IV (currently used for **Medicaid Case Mix**)
  - States **will decide** how to collect this information
  - See Map

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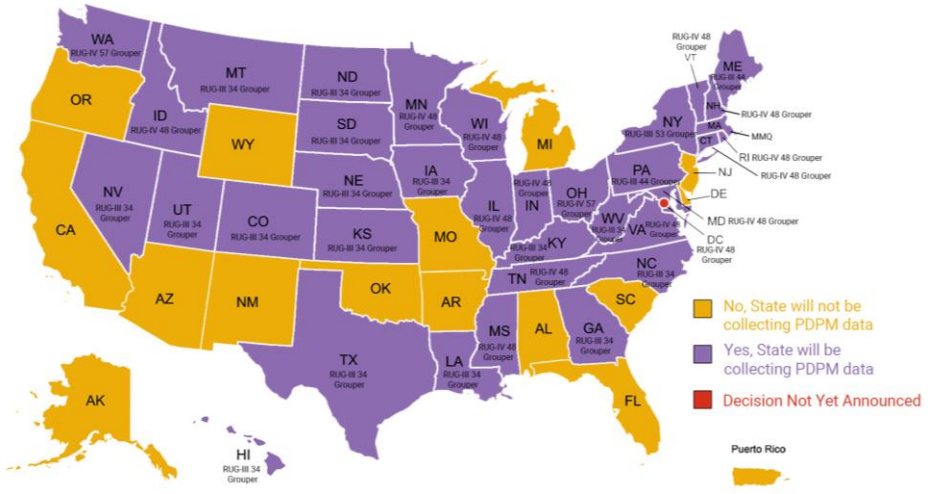
Reimbursement
PDPM
Who is Impacted?

6



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Reimbursement
PDPM
Medicaid Case Mix

6

- **Medicaid Case Mix:** CMS will no longer support RUG-III and RUG-IV Case Mix Methodologies via the Minimum Data Set (MDS) **effective October 1, 2020**
  - For States that rely on these assessments for calculating their Case Mix groups, an **Optional State Assessment** was created so that Medicaid payment was **not adversely impacted** when PDPM was implemented on **October 1, 2019**
  - The **Optional State Assessment** will be effective from **October 1, 2019 through September 30, 2020**

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Reimbursement
PDPM
Other Insurances

6

- Managed Medicare, Medicare Advantage or Replacement Plans **may elect** to use PDPM
- Inquire with insurance plans: **RUGs vs. PDPM**

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Reimbursement
PDPM
Hopforce PDPM Calculator

6

- https://pdpm-calc.com/

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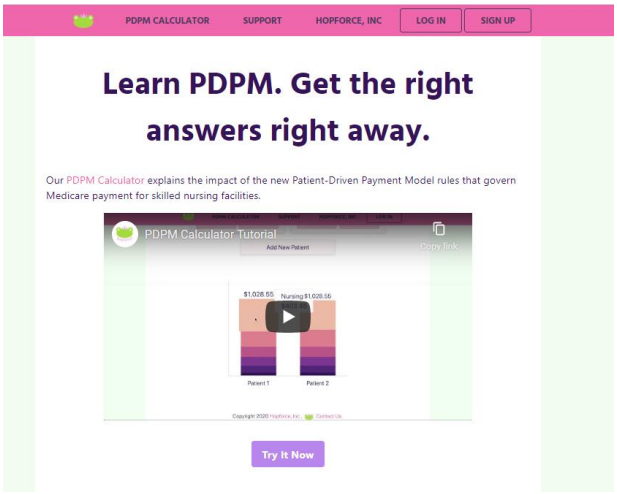
Reimbursement
PDPM
Hopforce PDPM Calculator

6



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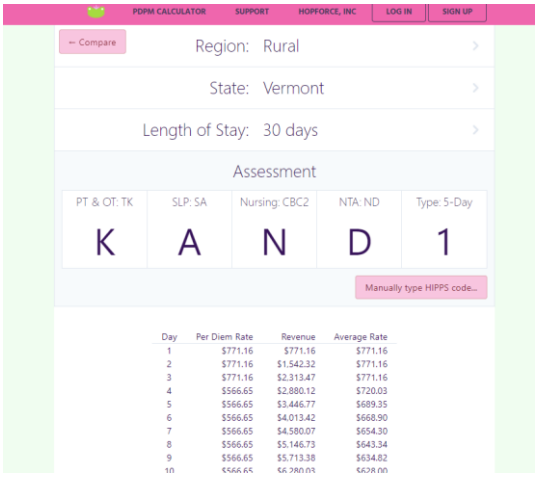
Reimbursement
PDPM
Hopforce PDPM Calculator

6



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Reimbursement
PDPM
Hopforce PDPM Calculator

6

Day	Per Diem Rate	Revenue	Average Rate
1	$771.16	$771.16	$771.16
2	$771.16	$1,542.32	$771.16
3	$771.16	$2,313.47	$771.16
4	$566.65	$2,880.12	$720.03
5	$566.65	$3,446.77	$689.35
6	$566.65	$4,013.42	$668.90
7	$566.65	$4,580.07	$654.30
8	$566.65	$5,146.73	$643.34
9	$566.65	$5,713.38	$634.82
10	$566.65	$6,280.03	$628.00
11	$566.65	$6,846.68	$622.43
12	$566.65	$7,413.33	$617.78
13	$566.65	$7,979.98	$613.84
14	$566.65	$8,546.63	$610.47
15	$566.65	$9,113.28	$607.55
16	$566.65	$9,679.93	$605.00
17	$566.65	$10,246.58	$602.74
18	$566.65	$10,813.23	$600.73
19	$566.65	$11,379.88	$598.94
20	$566.65	$11,946.53	$597.33
21	$562.70	$12,509.23	$595.68
22	$562.70	$13,071.94	$594.18
23	$562.70	$13,634.64	$592.81
24	$562.70	$14,197.35	$591.56
25	$562.70	$14,760.05	$590.40
26	$562.70	$15,322.75	$589.34
27	$562.70	$15,885.46	$588.35
28	$558.76	$16,444.22	$587.29
29	$558.76	$17,002.97	$586.31
30	$558.76	$17,561.73	$585.39

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Reimbursement
PDPM
Assessment Schedule

6

3 Assessments

- 5-Day MDS Assessment
- Discharge MDS Assessment
- Interim Payment Assessment **(Voluntary Assessment to change Payment)**

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Reimbursement
Patient Case Mix Groups (CMGs) Classification
6

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Reimbursement
Patient Case Mix Groups (CMGs) Classification
6

- Patient Case Mix Groups (CMGs) Classification
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Nursing
  - NTA
  - Non-Case Mix
  - Primary Medical Condition Category
  - Function Score
  - Comorbidities and Services
  - Cognition
  - Nursing Classification

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Reimbursement
Patient Case Mix Groups (CMGs) Classification

6

PT	OT	SLP	NTA	Nursing
Primary Medical Condition Category Functional Status	Primary Medical Condition Category Functional Status	Primary Medical Condition Category Cognitive Status Presence of Swallowing Disorder Mechanically Altered Diet Other SLP Related Comorbidities	Comorbidities and Conditions Extensive Services Received While A Patient	Clinical Information from SNF Stay Functional Status Extensive Services Received While A Patient Depression Restorative Nursing Rehabilitation Programs
Point in the stay (Variable Per Diem Adjustment)	Point in the stay (Variable Per Diem Adjustment)	Not adjusted over the stay	Point in the stay (Variable Per Diem Adjustment)	Not adjusted over the stay

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Reimbursement
Patient Case Mix Groups (CMGs) Classification

6

- All patients will yield a Case Mix Group for each of the following components. Classification is based on diagnosis, conditions and services. Classification for PT, OT or SLP is not based upon the receipt of such services.
  1. Physical Therapy
  2. Occupational Therapy
  3. Speech Therapy
  4. Nursing
  5. NTA
  6. Non-Case Mix

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Reimbursement
Patient Driven Payment Model
1. PT Grouper

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Reimbursement
PDPM Payment Components
1. PT Grouper

- MDS I8000
- 4 Clinical Categories
  - Major Joint Replacement or Spinal Injury
  - Other Orthopedic
  - Non-Orthopedic Surgery
  - Medical Management

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Reimbursement
PDPM Payment Components
1. PT 10 Characteristics into 4 Categories

6

Major Joint Replacements or Spinal Surgery	Other Orthopedic	Medical Management	Non-Ortho Surgery & Acute Neurologic
• Major Joint Replacement or Spinal Surgery	• Non-Surgical Orthopedic / Musculoskeletal • Orthopedic Surgery (except MJR or Spinal)	• Cancer • Pulmonary • Acute Infections • Cardiovascular & Coagulations • Medical Management	• Non-Orthopedic Surgery • Acute Neurologic

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Reimbursement
PDPM Payment Components
1. PT Grouper (1.08-1.88) 16 Groups

6

Primary Diagnosis	PT Case Mix Group	Function Score	CMI	HIPPS Code
Major Joint Replacement or Spinal Surgery (Clinical Category)				
Major Joint Replacement or Spinal Injury	TA	0-5	1.53	A
	TB	6-9	1.69	B
	TC	10-23	1.88	C
	TD	24	1.92	D
Other Orthopedic (Clinical Category)				
Orthopedic Surgery (except major joint replacement or spinal surgery)	TE	0-5	1.42	E
	TF	6-9	1.61	F
Non-surgical orthopedic / musculoskeletal	TG	10-23	1.67	G
	TH	24	1.16	H
Medical Management (Clinical Category)				
Acute infections				
Cardiovascular and Coagulations	TI	0-5	1.13	I
Pulmonary	TJ	6-9	1.42	J
Cancer	TK	10-23	1.52	K
Medical Management	TL	24	1.09	L
Non-Orthopedic Surgery and Acute Neurologic (Clinical Category)				
Non-Orthopedic Surgery	TM	0-5	1.27	M
Acute Neurologic	TN	6-9	1.48	N
	TO	10-23	1.55	O
	TP	24	1.08	P

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Reimbursement
PDPM Payment Components
1. PT GG Function

6

	GG Functions		Score
1.	Self-Care: Eating	GG0130A1	0-4
2.	Self-Care: Oral Hygiene	GG0130B1	0-4
3.	Self-Care: Toilet Hygiene	GG0130C1	0-4
4.	Mobility: Sit to Lying	GG170B1	0-4 (average of 2 bed mobility items)
5.	Mobility: Lying to Sitting or Side of Bed	GG170C1	
6.	Mobility: Sit to Stand	GG170D1	0-4 (average of 3 transfer items)
7.	Mobility: Chair/Bed-to-Chair Transfer	GG170E1	
8.	Mobility: Toilet Transfer	GG170F1	
9.	Mobility: Walk 50 feet with 2 turns	GG170J1	0-4 (average of 2 walking items)
10.	Mobility: Walk 150 feet	GG170K1	

- 6 Areas Maximum 24 Points (6x4)

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Reimbursement
PDPM Payment Components
1. PT GG Function Score

6

Admission Performance	Assist Level	Function Score
05, 06	S/I	4
04	CTG	3
03	MOD	2
02	MAX	1
01, 07, 09, 88	DEP	0

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Reimbursement
PDPM Payment Components
1. PT Clinical Category

6

Clinical Category	Function Score	PT Case Mix Group	CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88
Major Joint Replacement or Spinal Surgery	24	TD	1.92
Other Orthopedic	0-5	TE	1.42
Other Orthopedic	6-9	TF	1.61
Other Orthopedic	10-23	TG	1.67
Other Orthopedic	24	TH	1.16
Medical Management	0-5	TI	1.13
Medical Management	6-9	TJ	1.42
Medical Management	10-23	TK	1.52
Medical Management	24	TL	1.09
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08

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Reimbursement
Patient Driven Payment Model
2. OT Grouper

6

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Reimbursement
PDPM Payment Components
2. OT Grouper (1.08 – 1.92) 16 Groups

6

- MDS I8000
- 4 Clinical Categories
  - Major Joint Replacement or Spinal Injury
  - Other Orthopedic
  - Medical Management
  - Non-Orthopedic Surgery

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Reimbursement
PDPM Payment Components
2. OT 10 Characteristics into 4 Categories

6

Major Joint Replacements or Spinal Surgery	Other Orthopedic	Medical Management	Non-Ortho Surgery & Acute Neurologic
• Major Joint Replacement or Spinal Surgery	• Non-Surgical Orthopedic / Musculoskeletal • Orthopedic Surgery (except MJR or Spinal)	• Cancer • Pulmonary • Acute Infections • Cardiovascular & Coagulations • Medical Management	• Non-Orthopedic Surgery • Acute Neurologic

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Reimbursement
PDPM Payment Components
2. OT Grouper (1.08 – 1.92) 16 Groups

6

Primary Diagnosis	OT Case Mix Group	Function Score	CMI	HIPPS Code
Major Joint Replacement or Spinal Surgery (Clinical Category)				
Major Joint Replacement or Spinal Injury	TA TB TC TD	0-5 6-9 10-23 24	1.49 1.63 1.68 1.53	A B C D
Other Orthopedic (Clinical Category)				
Orthopedic Surgery (except major joint replacement or spinal surgery) Non-surgical orthopedic / musculoskeletal	TE TF TG TH	0-5 6-9 10-23 24	1.41 1.59 1.64 1.15	E F G H
Medical Management (Clinical Category)				
Acute infections Cardiovascular and Coagulations Pulmonary Cancer Medical Management	TI TJ TK TL	0-5 6-9 10-23 24	1.17 1.44 1.54 1.11	I J K L
Non-Orthopedic Surgery and Acute Neurologic (Clinical Category)				
Non-Orthopedic Surgery Acute Neurologic	TM TN TO TP	0-5 6-9 10-23 24	1.30 1.49 1.55 1.09	M N O P

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Reimbursement
PDPM Payment Components
2. OT GG Function

6

	GG Functions		Score
1.	Self-Care: Eating	GG0130A1	0-4
2.	Self-Care: Oral Hygiene	GG0130B1	0-4
3.	Self-Care: Toilet Hygiene	GG0130C1	0-4
4.	Mobility: Sit to Lying	GG170B1	0-4 (average of 2 bed mobility items)
5.	Mobility: Lying to Sitting or Side of Bed	GG170C1	
6.	Mobility: Sit to Stand	GG170D1	0-4 (average of 3 transfer items)
7.	Mobility: Chair/Bed-to-Chair Transfer	GG170E1	
8.	Mobility: Toilet Transfer	GG170F1	
9.	Mobility: Walk 50 feet with 2 turns	GG170J1	0-4 (average of 2 walking items)
10.	Mobility: Walk 150 feet	GG170K1	

- 6 Areas Maximum 24 Points (6x4)

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Reimbursement
PDPM Payment Components
2. OT GG Function Score

6

Admission Performance	Assist Level	Function Score
05, 06	S/I	4
04	CTG	3
03	MOD	2
02	MAX	1
01, 07, 09, 88*	DEP	0
* Walking items only: Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk		

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Reimbursement
PDPM Payment Components
2. OT Clinical Category

6

Clinical Category	Function Score	OT Case Mix Group	CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.53
Other Orthopedic	0-5	TE	1.41
Other Orthopedic	6-9	TF	1.59
Other Orthopedic	10-23	TG	1.64
Other Orthopedic	24	TH	1.15
Medical Management	0-5	TI	1.17
Medical Management	6-9	TJ	1.44
Medical Management	10-23	TK	1.54
Medical Management	24	TL	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.3
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.09

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Reimbursement

Patient Driven Payment Model

3. SLP Grouper

6

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Reimbursement

PDPM Payment Components

3. SLP Grouper (.68 – 4.19) 12 Groups

6

- MDS I8000
- Clinical Category
  - Condition (Acute Neurologic)
  - Comorbidities (SLP-related)
  - Cognitive Impairment
  - Swallowing Problem and/or Mechanically Altered Diet

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Reimbursement
PDPM Payment Components
3. SLP Grouper (.68 – 4.19) 12 Groups

6

SLP Case Mix Group	Condition Comorbidity Cognition	CMI	HIPPS Code	Mechanically Altered Diet or Swallowing Disorder
	None			
SA		0.68	A	Neither
SB		1.82	B	Either
SC		2.66	C	Both
	Any One			
SD		1.46	D	Neither
SE		2.33	E	Either
SF		2.97	F	Both
	Any Two			
SG		2.04	G	Neither
SH		2.85	H	Either
SI		3.51	I	Both
	Any Three			
SJ		2.98	J	Neither
SK		3.69	K	Either
SL		4.17	L	Both

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Reimbursement
PDPM Payment Components
3. SLP Related Comorbidities

6

SLP Related Comorbidities	
Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care While a Resident	Oral Cancers
Vent or Respirator Care While a Resident	Speech & Language Deficits

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Reimbursement
PDPM Payment Components
3. SLP Grouper: Conditions Acute Neurologic

6

Condition Acute Neurologic Examples	
ICD-10	Description
A0100	Typhoid fever, unspecified
A0221	Salmonella meningitis
A066	Amebic brain abscess
A390	Meningococcal meningitis
A3981	Meningococcal encephalitis
A3982	Meningococcal retrobulbar neuritis
A5044	Late congenital syphilitic optic nerve atrophy
A5214	Late syphilitic encephalitis
A800	Acute paralytic poliomyelitis, vaccine-associated
A801	Acute paralytic poliomyelitis, wild virus, imported
A802	Acute paralytic poliomyelitis, wild virus, indigenous
A8030	Acute paralytic poliomyelitis, unspecified
A8039	Other acute paralytic poliomyelitis
A804	Acute nonparalytic poliomyelitis
A809	Acute poliomyelitis, unspecified
A811	Subacute sclerosing pan encephalitis
A812	Progressive multifocal leukoencephalopathy

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Reimbursement
PDPM Payment Components
3. SLP Grouper: Conditions Acute Neurologic

6

Clinical Coding Mapping

- Resource

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Reimbursement
PDPM Payment Components
3. SLP Grouper: Comorbidities

6

Special Treatments, Procedures and Programs (O0100)
- Tracheostomy Care (E.)
- Ventilator or Respirator (F.)

Section I: Active Diagnosis
- Aphasia (I4300)
- Hemiplegia or Hemiparesis (I4900)
- CVA, TIA, or Stroke (I4500)
- TBI (I5500)

Other (I800 Additional Active Diagnosis)
- Laryngeal Cancer
- Apraxia
- Dysphagia
- ALS
- Oral Cancers
- Speech and Language Deficits

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Reimbursement
PDPM Payment Components
3. SLP Grouper: Cognition

6

Cognitive Impairment Mild to Severe		
BIMS Interview Summary Score 0-15	PDPM Cognitive Level	BIMS Score
	Cognitively Intact	13-15
	Mildly Impaired	8-12
	Moderately Impaired	0-7
	Severely Impaired	-
If BIMS Interview Summary Score is 99 or "-"	Use staff Assessment for PDPM Cognitive Level per Calculation Worksheet	

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Reimbursement
PDPM Payment Components
3. SLP Grouper Swallowing Disorder or Mechanically Altered Diet

6

Swallowing Disorder
or
Mechanically Altered Diet
Both
Either
Neither

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Reimbursement
PDPM Payment Components
3. SLP Grouper Swallowing Disorder or Mechanically Altered Diet

6

Swallowing Disorder (K0100)

Signs and Symptoms

A. Loss of liquids/solids from mouth when eating or drinking
B. Holding food in mouth/cheeks or residual food in mouth after meals
C. Coughing or choking during meals or when swallowing medications
D. Complaints of difficulty or pain with swallowing
Z. None of the above

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Reimbursement
PDPM Payment Components
3. SLP Grouper Swallowing Disorder or Mechanically Altered Diet

6

Nutritional Approaches (K0510)

- Needs to be performed during the last 7 days
- Mechanically Altered Diet- Require change in texture of food or liquids (i.e., Pureed food, thickened liquids)

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Reimbursement
PDPM Payment Components
3. SLP

6

- First, identify the Primary Medical Condition Category
  - Acute Neurologic Clinical Category
    - ICD-10 Section I0020B
  - Otherwise, defaults to Medical Management

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Reimbursement
PDPM Payment Components
3. SLP

6

- Second, does the patient have **one or more SLP- Related Comorbidities?**
- SLP-Related Comorbidities are diagnoses, conditions, deficits or Extensive Services, coded as
  - MDS Items ☒, or
  - **ICD-10 Codes** entered in **Section I8000**

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Reimbursement
PDPM Payment Components
3. SLP

6

- **SLP-Related Comorbidities**

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	Laryngeal Cancer (C32.0 – C32.9)
I8000	Apraxia (I69.990)
I8000	Dysphagia (I69.991)
I8000	ALS (G12.21)
I8000	Oral Cancers (C00.0 - C06.9)
I8000	Speech and Language Deficits (I69.920-I69.928)
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

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Reimbursement
PDPM Payment Components
3. SLP

- Next, Identify the Presence of **Cognitive Impairment** using the BIMS or CPS
  - **BIMS:** Brief Interview Mental Status
    - BIMS Summary Score on the MDS 3.0 based on the **patient interview**
      - C0200 **Repetition** of three words
      - C0300 **Temporal Orientation**
      - C0400 **Recall**

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Reimbursement
PDPM Payment Components
3. SLP

- BIMS Summary Score Item C0500 ranges from **00 to 15**
- The BIMS is not successful if the patient's
  - **Summary Score is 99**
    - The interview was not successful, or
  - **Summary Score is blank**
    - The interview not attempted and skipped, or
  - **Summary Score has a dash value**
    - This area was not assessed,
- Proceed the **Staff Assessment for Mental Status** for the PDPM cognitive level if the BIMS is not valid (99)

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Reimbursement
PDPM Payment Components
3. SLP

6

- Identify the Presence of Cognitive Impairment using the **Cognitive Performance Scale (CPS)**
- The patient classifies as **severely impaired** if one of following conditions exist
  - a. **Comatose** (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1, all equal 01, 09, or 88).
  - b. **Severely impaired cognitive skills for daily decision making** (C1000 = 3).

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Reimbursement
PDPM Payment Components
3. SLP

6

- If the patient is **not severely impaired per the CPS,** determine the patient's **Basic Impairment Count** and **Severe Impairment Count.**
  - For each of the conditions below that applies, add one to the **Basic Impairment Count.**
    a. In **Cognitive Skills for Daily Decision Making,** the patient has modified independence or is moderately impaired (C1000 = 1 or 2).
    b. In **Makes Self Understood,** the patient is usually understood, sometimes understood, or rarely/never understood (B0700 = 1, 2, or 3).
    c. Based on the Staff Assessment for Mental Status, patient has **memory problem** (C0700 = 1).
- Sum a., b., and c = the Basic Impairment Count

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Reimbursement
PDPM Payment Components
3. SLP

6

- According to CMS:
  - In order to receive a PDPM classification, **all required items** must be **completed**
  - Either a **BIMS** score **or CPS** score is required to classify the patient under the SLP component
  - **If neither** the BIMS nor the staff assessment (CPS) is **completed**, the patient will not be classified under PDPM, and a PDPM HIPPS code will not be produced for the assessment

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Reimbursement
PDPM Payment Components
3. SLP Cognitive Level

6

PDPM Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severely Impaired	-	5-6

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Reimbursement
PDPM Payment Components
3. SLP Three C's

6

1. **Clinical Category**: Acute Neurological
2. **Comorbidities**
3. **Cognitive Impairment**

- » **None** of the above
- » **Any one** of the above
- » **Any two** of the above
- » **All three** of the above

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Reimbursement
PDPM Payment Components
3. SLP Swallowing Disorder

6

- Next, Identify if the patient has the following:
  - **Swallowing Disorder**
    - Coded in MDS Section K (K0100A through K0100D)
  - **Mechanically Altered Diet, while a resident**
    - Coded in MDS Section K (K0510C2)
      - Does the patient qualify for:
        - Neither,
        - Either or
        - Both

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Reimbursement
PDPM Payment Components
3. SLP Mechanically Altered Diet

6

- K0510C, **mechanically altered diet** for the resident who requires a change in texture of food or liquids (e.g., pureed food, thickened liquids)
- The mechanically altered diet is specifically prepared to **alter the texture** or **consistency** of food to facilitate oral intake
- Examples include **soft solids**, **puréed foods**, ground meat, and thickened liquids
- **How are your diet orders written?**
- **How does the facility write diet orders?**

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Reimbursement
PDPM Payment Components
3. SLP Swallowing Disorder

6

- **Swallow Disorder (MDS K0100)**
  1. **Ask the resident** if he or she has had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D
  2. **Observe the resident** during meals or at other times when he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited
  3. **Interview staff members on all shifts** who work with the resident and ask if any of the four listed symptoms were evident during the 7-day look-back period

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Reimbursement
PDPM Payment Components
3. SLP Swallow Disorder

6

- K0100A
  - Loss of liquids/solids from mouth when eating or drinking. When the resident has food or liquid in his or her mouth, the food or **liquid dribbles down chin** or **falls out of the mouth**
- K0100B
  - Holding food in mouth/cheeks or **residual food in mouth** after meals. Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or **food left in mouth** because resident failed to empty mouth completely

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Reimbursement
PDPM Payment Components
3. SLP Swallow Disorder

6

- K0100C
  - **Coughing or choking during meals** or when swallowing **medications.** The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications "going down the wrong way."
- K0100D
  - Complaints of **difficulty or pain with swallowing.** Resident may refuse food because it is painful or difficult to swallow

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Reimbursement
PDPM Payment Components
3. SLP Swallow Disorder

6

- K0100Z
  - None of the above: If none of the K0100A through K0100D signs or symptoms were present during the look-back
  - Document findings. Consider adding to Skilled Nursing Note Template and educate staff on the importance of identifying every sign/symptom

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Reimbursement
PDPM Payment Components
3. SLP Swallow Disorder

6

- Do not code a swallowing problem **when interventions have been successful** in treating the problem and therefore the **signs/symptoms** of the problem (K0100A through K0100D) **did not occur during the 7-day look-back period**
- **Code** even if the symptom **occurred only once** in the **7-day look-back period**

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Reimbursement
PDPM Payment Components
3. SLP

6

- Neither,
  - a swallowing disorder nor a mechanically altered diet
- Either,
  - a swallowing disorder or a mechanically altered diet
- Both,
  - a swallowing disorder and a mechanically altered diet

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Reimbursement
PDPM Payment Components
3. SLP

6

Presence of: Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	CMI
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

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Reimbursement

Patient Driven Payment Model

4. Nursing Grouper

6

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Reimbursement

PDPM Payment Components

4. Nursing Grouper (.66-2.07) 25 Groups

6

- Nursing Classification
  - Extensive Services
  - Special Care High
  - Special Care Low
  - Clinically Complex
  - Behavioral Symptoms and cognitive Performance
  - Reduced Physical Function
- 18% add-on HIV/AIDS

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Reimbursement
PDPM Payment Components
4. Nursing GG Function

6

- Nursing Section GG Scoring does not include Oral Hygiene, Mobility Walk 50 feet with 2 turns, or Mobility: Walk 150 feet

GG Functions			Score
1.	Self-Care: Eating	GG0130A1	0-4
2.	Self-Care: Toilet Hygiene	GG0130C1	0-4
3.	Mobility: Sit to Lying	GG170B1	0-4 (average of 2 bed mobility items)
	Mobility: Lying to Sitting or Side of Bed	GG170C1	
4.	Mobility: Sit to Stand	GG170D1	0-4 (average of 3 transfer items)
	Mobility: Chair/Bed-to-Chair Transfer	GG170E1	
	Mobility: Toilet Transfer	GG170F1	

❖ 4 Areas Maximum 16 Points (4x4)

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Reimbursement
PDPM Payment Components
4. Nursing GG Function Score

6

Admission Performance	Assist Level	Function Score
05, 06	S/I	4
04	CTG	3
03	MOD	2
02	MAX	1
01, 07, 09, 88	DEP	0

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Reimbursement
PDPM Payment Components
4. Nursing GG Function Score

6

Section GG Item		ADL Score
GG0130A1	Self-Care: Eating	0-4
GG0130C1	Self-Care: Toileting Hygiene	0-4
GG0170B1 GG0170C1	Mobility: Sit to Lying Mobility: Lying to sitting on Side of Bed	0-4 (average of two items)
GG0170D1	Mobility: Sit to Stand	0-4 (average of three items)
GG0170E1	Mobility: Chair Bed-to-Chair Transfer	
GG0170F1	Mobility: Toilet Transfer	

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Reimbursement
PDPM Payment Components
4. Nursing Grouper (.66-2.07) 25 Groups

6

Nursing Case Mix Group	CMI	Function Score Section GG		Requirements
Extensive Services				
ES3 Extensive Services	4.04	0-14	A1-A6	Tracheostomy and Ventilator
ES2 Extensive Services	3.06	0-14	B1-B6	Tracheostomy or Ventilator
ES1 Extensive Services	2.91	0-14	A3	Infection Isolation
Special Care High				
HDE2 Special Care High	2.39	0-5	Depressed	Comatose and Dependent/Activity did not Occur
HBC2 Special Care High	2.23	6-14	Depressed	Septicemia
HDE1 Special Care High	1.99	0-5	Not Depressed	Diabetes with both daily injections and Insulin order changes on 2+ days
HBC1 Special Care High	1.85	6-14	Not Depressed	Quadriplegia with Functional Score <=11 COPD and SOB when Lying Flat Fever with pneumonia, vomiting, weight loss, and/or feeding tube with intake requirement Parenteral/IV feedings – while not or while a resident Respiratory therapy = 7 days Depression criteria is met if the Total Severity Score ≥ 10 but not 99

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Reimbursement
PDPM Payment Components
4. Nursing Grouper

6

Nursing Case Mix Group	CMI	Function Score Section GG		Requirements
Special Care Low				
LDE2 Special Care Low	2.07	0-5	Depressed	Cerebral Palsy
LBC2 Special Care Low	1.71	6-14	Depressed	Multiple Sclerosis
LDE1 Special Care Low	1.72	0-5	Not Depressed	Parkinson's Disease and Functional Score <=11
LBC1 Special Care Low	1.43	6-14	Not Depressed	Respiratory Failure and Oxygen Therapy While a Resident Feeding Tube >=51% of calories or 6-50% calories + fluid >=501cc during entire last 7 days (average across 7 days) 2+ Stage 2 pressure ulcers with 2+ skin treatments Stage 3 or 4 pressure ulcer, or unstageable with slough or eschar with 2+ skin treatments 2+ venous/arterial ulcers with 2+ skin treatments Stage 2 pressure ulcer (1) ad venous/arterial ulcer (1) with 2+ skin treatments Foot infection, diabetic foot ulcer, or other open lesion of foot with dressings Radiation therapy while a resident Dialysis while a resident Depression criteria is met if the Total Severity Score ≥ 10 but not 99

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Reimbursement
PDPM Payment Components
4. Nursing Grouper

6

Nursing Case Mix Group	CMI	Function Score Section GG	Requirements
Clinically Complex			
CDE2 Clinically Complex	1.86	0-5	Depressed
CBC2 Clinically Complex	1.54	6-14	Depressed
CA2 Clinically Complex	1.08	15-16	Depressed
CDE1 Clinically Complex	1.62	0-5	Not Depressed
CBC1 Clinically Complex	1.34	6-14	Not Depressed
CA1 Clinically Complex	0.94	15-16	Not Depressed
Behavioral Symptoms and Cognitive			
BAB2 Behavioral Symptoms	1.04	11-16	Nursing Rehab +2
BAB1 Behavioral Symptoms	0.99	11-16	Nursing Rehab 0-1
Reduced Physical Functioning			
PDE2 Reduced Physical Function	1.57	0-5	Nursing Rehab 2+
PBC2 Reduced Physical Function	1.21	6-14	Nursing Rehab 2+
PA2 Reduced Physical Function	1.13	6-14	Nursing Rehab 2+
PDE1 Reduced Physical Function	1.47	0-5	Nursing Rehab 0-1
PBC1 Reduced Physical Function	0.70	15-16	Nursing Rehab 0-1
PA1 Reduced Physical Function	0.66	15-16	Nursing Rehab 0-1

Harmony Healthcare INTERNATIONAL

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Reimbursement
PDPM Payment Components
4. Nursing Extensive Services

6

Extensive Services - While a Resident		
MDS	Services or Conditions	Case Mix Group
O0100E2	Tracheostomy care **and** ventilator/respirator	ES3
O0100F2	Tracheostomy care **or** ventilator/respirator	ES2
O0100M2	Isolation or quarantine for active infectious disease	ES1

- Qualifies for Extensive Services If at least one of the above treatments or services is coded and the total **PDPM Nursing Function Score** of **14 or less.**
- If **PDPM Nursing Function Score** is **15 or 16**, the CMG defaults to **Clinically Complex.**

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Reimbursement
PDPM Payment Components
4. Nursing Extensive Services

6

- **O0100F, Invasive Mechanical Ventilator**
  - Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support his or her own respiration in this item.
    During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy.
  - A resident who has been **weaned off** of a respirator or ventilator in the **last 14 days** or is currently being weaned off a respirator or ventilator, should also be coded here.
  - Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

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Reimbursement
PDPM Payment Components
4. Nursing Grouper

6

- O0100E, Tracheostomy Care
  - RAI Instruction: Code cleansing of the tracheostomy and/or cannula in this item
  - This item may be coded if the resident performs his/her own tracheostomy care

Harmony Healthcare INTERNATIONAL

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Reimbursement
PDPM Payment Components
4. Nursing Grouper

6

- O0100G, Non-Invasive Mechanical Ventilator (BiPAP/CPAP)
  - Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle
  - The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that "breathe" for the individual.
  - If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device

Harmony Healthcare INTERNATIONAL

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Reimbursement
PDPM Payment Components
4. Nursing Isolation

6

- O0100M, Isolation For Active Infectious Disease
  - Isolation or quarantine for active infectious disease is coded only when the resident requires transmission- based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic **and/or** have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.

Harmony Healthcare INTERNATIONAL

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Reimbursement
PDPM Payment Components
4. Nursing Isolation

6

Isolation: Code for **"single room isolation"** only when all of the following conditions are met:

1. The resident has **active infection** with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission
2. Precautions are over and **above standard** precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect
3. The resident is in a **room alone** because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must **remain in his/her room**. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.)

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Reimbursement
PDPM Payment Components
4. Nursing Isolation

6

Isolation:

- Do **not code** this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms).
- Do **not code** this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns
- Examples of when the isolation criterion would not apply include **urinary tract infections, encapsulated pneumonia, and wound infections**

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Reimbursement
PDPM Payment Components
4. Nursing Special Care High

6

Special Care High	
MDS	Services or Conditions
B0100, Section GG items	Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1, all equal 01, 09, or 88)
I2100	Septicemia
I2900, N0350A, B	Diabetes with both of the following: Insulin injections (N0350A) for all 7 days with Insulin order changes on 2 or more days (N0350B)
I5100, Nursing Function Score	Quadriplegia with Nursing Function Score <= 11 (Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.)
I6200, J1100C	Chronic Obstructive Pulmonary Disease and shortness of breath when lying flat
J1550A, others	Fever and one of the following; I2000 Pneumonia, J1550B Vomiting, K0300 Weight loss (1 or 2), K0510B1 or K0510B2 Feeding tube* *Tube feeding classification requirements: (1) K0710A3 is 51% or more of total calories OR (2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.
K0510A1 or K0510A2	Parenteral/IV feedings while a resident
O0400D2	Respiratory therapy for all 7 days

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Reimbursement
PDPM Payment Components
4. Nursing Respiratory Therapy

6

Respiratory Therapy

- Services that are provided by a qualified professional (respiratory therapists, respiratory nurse)
- Respiratory therapy services are for the **assessment, treatment, and monitoring of patients** with deficiencies or abnormalities of **pulmonary function**
- Respiratory therapy services include **coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc.,** which must be provided by a respiratory therapist or trained respiratory nurse
- A **respiratory nurse must be proficient** in the modalities listed above either through **formal nursing or specific training** and may deliver these modalities as allowed under **the state Nurse Practice Act and under applicable state laws**

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Reimbursement
PDPM Payment Components
4. Nursing Special Care High

6

Special Care High		
Nursing Function Score	Depression Indicator ≥ 10	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

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Reimbursement
PDPM Payment Components
4. Nursing Special Care Low

6

Special Care Low	
MDS	**Services or Conditions**
I4400, Nursing Function Score	Cerebral Palsy, with Nursing Function Score <=11
I5200, Nursing Function Score	Multiple Sclerosis, with Nursing Function Score <=11
I5300, Nursing Function Score	Parkinson's Disease, with Nursing Function Score <=11
I6300, O0100C2	Respiratory failure and oxygen therapy while a patient
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1, D1, F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A, B, C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a patient
O0100J2	Dialysis treatment while a patient

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Reimbursement
PDPM Payment Components
4. Nursing Grouper

6

Requirements
*Tube feeding classification requirements: 1. K0710A3 is 51% or more of total calories OR 2. K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.
**Selected skin treatments: • M1200A, B Pressure relieving chair and/or bed • M1200C Turning /repositioning • M1200D Nutrition or hydration intervention • M1200E Pressure ulcer care • M1200G Application of dressings (not to feet) • M1200H Application of ointments (not to feet)

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Reimbursement
PDPM Payment Components
4. Nursing Special Care Low

6

Special Care Low		
Nursing Function Score	Depression Indicator ≥ 10	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

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Reimbursement
PDPM Payment Components
4. Nursing PHQ9 / PHQ9-OV

6

PHQ 9 / PHQ 9-OV		
MDS		Mood Indicator Description
Patient	Staff	
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad about yourself- or that you are a failure or have let yourself down or your family down
D0200G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0200H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0200I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

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Reimbursement
PDPM Payment Components
4. Nursing Clinically Complex

6

Clinically Complex	
MDS	**Services or Conditions**
I2000	Pneumonia
I4900, Nursing Function Score	Hemiplegia/hemiparesis with Nursing Function Score <= 11
M1040D, E	Open lesions (other than ulcers, rashes, and cuts) with any selected skin treatment* or surgical wounds
M1040F	Burns
O0100A2	Chemotherapy while a patient
O0100C2	Oxygen Therapy while a patient
O0100H2	IV Medications while a patient
O0100I2	Transfusions while a patient
*Selected Skin Treatments: M1200F Surgical wound care, M1200G Application of nonsurgical dressing (other than to feet), M1200H Application of ointments/medications (other than to feet) Default for categories without Function Score requirements	

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Clinically Complex

6

Clinically Complex		
Nursing Function Score	**Depression Indicator ≥ 10**	**PDPM Nursing Classification**
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
15-16	Yes	CA2
6-14	No	CBC1
15-16	No	CA1

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Behavioral Symptoms

6

Behavioral Symptoms and Cognitive Performance	
MDS	**Cognitive Performance**
B0100	Coma (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
C1000	Severely impaired cognitive skills for daily decision making (C1000 = 3)
B0700, C0700, C1000	Two or more of the following impairment indicators are present: •B0700 > 0 Usually, sometimes, or rarely/never understood •C0700 = 1 Short-term memory problem •C1000 > 0 Impaired cognitive skills for daily decision making and One or more of the following severe impairment indicators are present: • B0700 >= 2 Sometimes or rarely/never makes self understood • C1000 >= 2 Moderately or severely impaired cognitive skills for daily decision making
Qualifies for one of the above- depends on the Nursing Function Score • Nursing Function Score: 11 or greater will qualify for Behavioral Symptoms/Cognitive Impairment Nursing Function Score that is less than 11, proceed to Physical Function	

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Behavioral Symptoms

6

Behavioral Symptoms and Cognitive Performance	
MDS	**Behavioral Symptoms**
E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral symptoms directed toward others (2 or 3)
E0200B	Verbal behavioral symptoms directed toward others (2 or 3)
E0200C	Other behavioral symptoms not directed toward others (2 or 3)
E0800	Rejection of care (2 or 3)
E0900	Wandering (2 or 3)
Qualifies for one of the above- depends on the Nursing Function Score • Nursing Function Score: 11 or greater will qualify for Behavioral Symptoms/Cognitive Impairment Nursing Function Score that is less than 11, proceed to Physical Function	

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Behavioral Symptoms

6

Behavioral Symptoms and Cognitive Performance	
MDS	Restorative Nursing Rehabilitation Programs
Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:	
H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training
**Count as one service even if both provided	

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Reduced Physical Function

6

Reduced Physical Function
Residents that do not qualify for: • Extensive Services • Special Care High • Special Care Low • Clinically Complex, and • Behavioral Symptoms and Cognitive Performance will be classified in this category
Nursing Function Score
Restorative Nursing Rehabilitation Programs

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Behavioral Symptoms

6

Behavioral Symptoms and Cognitive Performance	
MDS	Restorative Nursing Rehabilitation Programs
Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:	
H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training
**Count as one service even if both provided	

Harmony Healthcare INTERNATIONAL

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Behavioral Symptoms

6

Behavioral Symptoms and Cognitive Performance		
Nursing Function Score	Restorative Nursing Rehabilitation Programs	PDPM Nursing Classification
11-16	2 or more RNRP	BAB2
11-16	0 or 1 RNRP	BAB1

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Reimbursement
PDPM Payment Components
4. Nursing Grouper Reduced Physical Function

6

Reduced Physical Function		
Nursing Function Score	Restorative Nursing Rehabilitation Programs	PDPM Nursing Classification
0-5	2 or more RNRP	PDE2
0-5	0 or 1 RNRP	PDE1
6-14	2 or more RNRP	PBC2
15-16	2 or more RNRP	PA2
6-14	0 or 1 RNRP	PBC1
15-16	0 or 1 RNRP	PA1
11-16	0 or 1 RNRP	BAB1

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Reimbursement
Patient Driven Payment Model
5. Non-Therapy Ancillary (NTA)

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Reimbursement
PDPM Payment Components
5. Non-Therapy Ancillary (NTA)

6

- 50 Conditions
- Comorbidities
- Weighted Count
- Point Range
- 1 – 8
- Sum Points
- MDS/Source
- UB-04/Source

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Reimbursement
PDPM Payment Components
5. NTA Classification (.72 – 3.25) 6 Groups

6

NTA Score Range	NTA Case-Mix Group	NTA Case-Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

❖6 Groups

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Reimbursement
PDPM Payment Components
5. NTA Grouper

6

SNF Claims

	Condition/Extensive Service	MDS Item	Points
1.	HIV/AIDS	SNF Claim ICD-10 B20	8

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Reimbursement
PDPM Payment Components
5. NTA Grouper

6

MDS Section K

	Condition/Extensive Service	MDS Item	Points
2.	Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
5.	Parenteral IV feeding: Level Low	K0510A2 K0710A2 K0710B2	3
42.	Nutritional Approaches While a Resident: Feeding Tube	K0510B2	1

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Reimbursement
PDPM Payment Components
5. NTA Grouper

MDS Section O

	Condition/Extensive Service	MDS Item	Points
3.	Special Treatments/Programs: Intravenous Medication Post-admit Code	O0100H2	5
4.	Special Treatments/Programs: Ventilator Post-admit Code	O0100F2	4
7.	Special Treatments/Programs: Transfusion Post-admit Code	O0100I2	2
22.	Special Treatments/Programs: Tracheostomy Post-admit Code	O0100E2	1
24.	Special Treatments/Programs: Isolation Post-admit Code	O0100M2	1
27.	Special Treatments/Programs: Radiation Post-admit Code	O0100B2	1
37.	Special Treatments/Programs: Suctioning Post-admit Code	O0100D2	1

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Reimbursement
PDPM Payment Components
5. NTA Grouper

	Condition/Extensive Service	MDS Item	Points
6.	Lung Transplant Status	I8000	3
8.	Major Organ Transplant Status, Except Lung	I8000	2
9.	Active Diagnoses: Multiple Sclerosis Code	I5200	2
10.	Opportunistic Infections	I8000	2
11.	Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
12.	Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
13.	Chronic Myeloid Leukemia	I8000	2
14.	Wound Infection Code	I2500	2
15.	Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
16.	Endocarditis	I8000	1
17.	Immune Disorders	I8000	1
18.	End-Stage Liver Disease	I8000	1
20.	Narcolepsy and Cataplexy	I8000	1
21.	Cystic Fibrosis	I8000	1
23.	Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1

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Reimbursement
PDPM Payment Components
5. NTA Grouper

MDS Section I

	Condition/Extensive Service	MDS Item	Points
25.	Specified Hereditary Metabolic/Immune Disorders	I8000	1
26.	Morbid Obesity	I8000	1
29.	Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
30.	Chronic Pancreatitis	I8000	1
31.	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
33.	Complications of Specified Implanted Device or Graft	I8000	1
34.	Bladder and Bowel Appliances: Intermittent catheterization	H0100D	1
35.	Inflammatory Bowel Disease	I8000	1
36.	Aseptic Necrosis of Bone	I8000	1
38.	Cardio-Respiratory Failure and Shock	I8000	1
39.	Myelodysplastic Syndromes and Myelofibrosis	I8000	1
40.	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
41.	Diabetic Retinopathy - Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1

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Reimbursement
PDPM Payment Components
5. NTA Grouper

MDS Section I (continued)

	Condition/Extensive Service	MDS Item	Points
43.	Severe Skin Burn or Condition	I8000	1
44.	Intractable Epilepsy	I8000	1
45.	Active Diagnoses: Malnutrition Code	I5600	1
46.	Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
47.	Cirrhosis of Liver	I8000	1
49.	Respiratory Arrest	I8000	1
50.	Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1
43.	Severe Skin Burn or Condition	I8000	1
44.	Intractable Epilepsy	I8000	1
45.	Active Diagnoses: Malnutrition Code	I5600	1
46.	Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
47.	Cirrhosis of Liver	I8000	1
49.	Respiratory Arrest	I8000	1
50.	Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1
43.	Severe Skin Burn or Condition	I8000	1

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Reimbursement
PDPM Payment Components
5. NTA Grouper

6

MDS Section M

	Condition/Extensive Service	MDS Item	Points
19.	Other Foot Skin Problems: Diabetic Foot Ulcer Code	M1040B	1
28.	Highest Stage of Unhealed Pressure Ulcer - Stage 4	M0300X1	1
32.	Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	M1040A M1040B M1040C	1

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Reimbursement
PDPM Payment Components
5. NTA Grouper

6

MDS Section H

	Condition/Extensive Service	MDS Item	Points
34.	Bladder and Bowel Appliances: Intermittent catheterization	H0100D	1
48.	Bladder and Bowel Appliances: Ostomy	H0100C	1

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Reimbursement
PDPM Payment Components
5. NTA Grouper

6

- There are **Fifty (50) Non-Therapy Ancillary (NTA) Items** with associated points
- The sum total of the points determine the **Non-Therapy Ancillary (NTA) Case Mix Group (CMG) Classification**
- Non-Therapy Ancillary (NTA) Component Rate has a **Variable Per Diem Adjustment (VPA),** effective day 4
- **MDS Coded Items, Claims Item, ICD-10 Codes** (I8000)
- Identify NTA and associated points to obtain the **NTA CMG**

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Reimbursement
PDPM Payment Components
5. NTA Grouper

6

- Use the **Mapping of Comorbidities** for the **PDPM NTA Component to ICD-10-CM Codes Tool.**
- There are **1535** Comorbidities in the Mapping Tool

Comorbidity Description	ICD-10-CM Code	ICD-10-CM Code Description
HIV/AIDS	B20	Human immunodeficiency virus [HIV] disease
RxCC395: Lung Transplant Status	T8630	Unspecified complication of heart-lung transplant
RxCC395: Lung Transplant Status	T8631	Heart-lung transplant rejection
RxCC395: Lung Transplant Status	T8632	Heart-lung transplant failure
RxCC395: Lung Transplant Status	T8633	Heart-lung transplant infection
RxCC395: Lung Transplant Status	T8639	Other complications of heart-lung transplant
RxCC395: Lung Transplant Status	T86810	Lung transplant rejection
RxCC395: Lung Transplant Status	T86811	Lung transplant failure
RxCC395: Lung Transplant Status	T86812	Lung transplant infection
RxCC395: Lung Transplant Status	T86818	Other complications of lung transplant
RxCC395: Lung Transplant Status	T86819	Unspecified complication of lung transplant
RxCC395: Lung Transplant Status	Z4824	Encounter for aftercare following lung transplant
RxCC395: Lung Transplant Status	Z48280	Encounter for aftercare following heart-lung transplant
RxCC395: Lung Transplant Status	Z942	Lung transplant status
RxCC395: Lung Transplant Status	Z943	Heart and lungs transplant status
RxCC260 RxCC396 RxCC397: Major Organ Transplant Status, Except Lung	D89810	Acute graft-versus-host disease
RxCC260 RxCC396 RxCC397: Major Organ Transplant Status, Except Lung	D89811	Chronic graft-versus-host disease
RxCC260 RxCC396 RxCC397: Major Organ Transplant Status, Except Lung	D89812	Acute on chronic graft-versus-host disease

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Reimbursement
PDPM Payment Components
5. NTA Grouper

- For example, **Opportunist Infections**
  - Identified per the ICD-10 Codes

RxCC5: Opportunistic Infections	A072	Cryptosporidiosis
RxCC5: Opportunistic Infections	A310	Pulmonary mycobacterial infection
RxCC5: Opportunistic Infections	A312	Disseminated mycobacterium avium-intracellulare complex (DMAC)
RxCC5: Opportunistic Infections	B250	Cytomegaloviral pneumonitis
RxCC5: Opportunistic Infections	B251	Cytomegaloviral hepatitis
RxCC5: Opportunistic Infections	B252	Cytomegaloviral pancreatitis
RxCC5: Opportunistic Infections	B258	Other cytomegaloviral diseases
RxCC5: Opportunistic Infections	B259	Cytomegaloviral disease, unspecified
RxCC5: Opportunistic Infections	B371	Pulmonary candidiasis
RxCC5: Opportunistic Infections	B377	Candidal sepsis
RxCC5: Opportunistic Infections	B3781	Candidal esophagitis
RxCC5: Opportunistic Infections	B440	Invasive pulmonary aspergillosis

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Reimbursement
PDPM Payment Components
5. NTA Grouper

- Identify the **NTA Component** based on the **NTA Comorbidity Score**

NTA Comorbidity Score	NTA Case Mix Group	CMI
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

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Reimbursement

Patient Driven Payment Model

6. Non-Case Mix

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Reimbursement

PDPM Payment Components

6. Non-Case Mix

- Flat Per Diem Rate
- Capital Cost
- Dietary
- Maintenance
- Do Not Vary According to Resident Characteristics

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Reimbursement

Patient Driven Payment Model
Case Studies

6

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Reimbursement

PDPM Case Study # 16
(South Carolina, Florence County)
Isolation

6

State	South Carolina		
County	Florence County		
Diagnostic Category	Acute Neurological		
Component	Function Score		Case Mix Group
Physical Therapy	15		TK
Occupational Therapy	15		TK
Nursing	10		CBC2 → ES1
Speech Therapy	Any 2	Neither	SA
NTA	Points	2	ND

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Reimbursement
PDPM Case Study # 16
(South Carolina, Florence County)
Isolation

6

$ Impact Isolation

ES1 vs. CBC2

$622.33 - $503.88 = $118.45 Per Day

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Reimbursement
PDPM Case Study # 16
(South Carolina, Florence County)
Isolation

6

Nursing CBC2

← Compare

Region:	Urban
State:	South Carolina
County:	Florence County
Length of Stay:	30 days

Assessment

PT & OT: TK	SLP: SA	Nursing: CBC2	NTA: ND	Type: 5-Day
K	A	N	D	1

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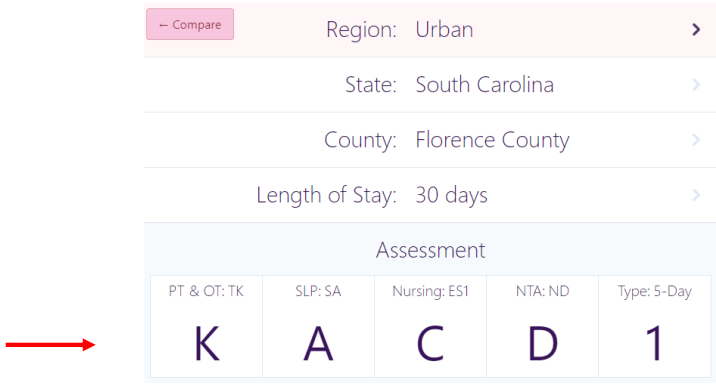
Reimbursement
PDPM Case Study # 16
(South Carolina, Florence County)
Isolation

6

Nursing ES1



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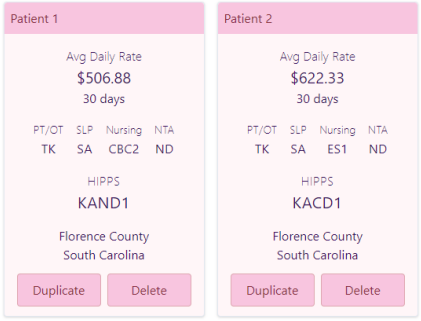
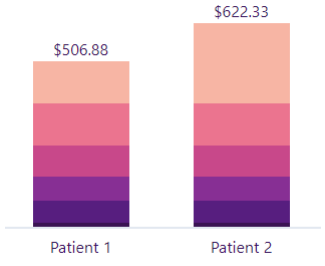
Reimbursement
PDPM Case Study # 16
(South Carolina, Florence County)
Isolation

6





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Reimbursement

PDPM

Core Elements

6

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Reimbursement

PDPM Core Elements

Skilling Isolation and Quarantine

6

- According to the CDC, **isolation is for people who are ill, while quarantine** applies to people who have been **in the presence of a disease** but have not necessarily become sick themselves. Per the CDC,

"Isolation separates sick people with a contagious disease from people who are not sick."

- **Isolation** is for patients with **symptoms** and or **positive tests**
- **Quarantine** is for patients **exposed** but exhibits **no symptoms**

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Reimbursement
PDPM Core Elements
Skilling Isolation

6

- Isolation (Z29.0) and COVID-19 (UO7.1)
- Coding isolation for a patient with an active infectious disease places them into an ES1 nursing category under both Medicare Part A and certain Medicaid Case Mix states

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Reimbursement
PDPM Core Elements
Skilling Isolation

6

To properly code isolation on the MDS, the patient requires:

- Isolation for a minimum of one day
- MD Orders for isolation
- Active Infectious disease ICD-10 coded:
  - On the UB-04 and
  - On the MDS (Section O. and I.)
- All treatments rendered in the patient's room with documentation to support said services are provided at bedside
  - Isolation cannot be coded if the patient is being "co-horted", meaning rooming with another patient

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Reimbursement
PDPM Core Elements
Daily Skilled Documentation

6

- **Skilled (Medicare Part A) Observation and Assessment** is Indicated when there is a reasonable probability or possibility for complications or the potential for further acute episodes
- This references conditions where there is a **"reasonable probability or possibility"** for:
  - Complications
  - Potential for further acute episodes
  - Need to identify and evaluate the need for modification of treatment
  - Evaluation of initiation of additional medical procedures

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Reimbursement
PDPM Core Elements
Daily Skilled Documentation

6

- Daily observations and assessments include but are not limited to, fever, dehydration, septicemia, pneumonia, nutritional risk, weight loss, blood sugar control, impaired cognition, mood, and behavior conditions
- **Example of Daily Skilled Documentation**
  - "This patient requires daily skilled nursing observation and assessment of signs and symptoms related to exacerbation of COVID-19, pneumonia, and related medical conditions."
- Skilled observation is required until the **treatment regimen is essentially stabilized, and the patient is no longer at risk for medical complications**

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Reimbursement
PDPM Core Elements
Quarantine and Skilled Care

6

- Although a quarantined patient may not have symptoms, the mere fact the patient was **potentially exposed to COVID-19** warrants daily skilled nursing to observe and assess for signs and symptoms of COVID-19
- **Observation and Assessment** references conditions where there is a "reasonable probability or possibility" for the nurse to:
  - Evaluate the patient's condition i.e., observe and assess for fever, body aches, loss of appetite,
  - Identify acute episodes, and
  - Identify the need for treatment (modifications)
  - Initiate treatment changes

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Reimbursement
PDPM Core Elements
Quarantine and Skilled Care

6

- In addition, the nurse may provide **observation and assessment** of signs and symptoms related to:
  - Dehydration,
  - Septicemia,
  - Pneumonia,
  - Nutritional risk,
  - Weight loss,
  - Blood sugar control,
  - Impaired cognition and
  - Mood and behavior conditions

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Reimbursement
PDPM Core Elements
Quarantine and Skilled Care

- Nurses need to document the defined assessment **on a daily basis**
- This may include neurological, respiratory, cardiac, circulatory, pain/sensation, nutritional, gastrointestinal, genitourinary, musculoskeletal, and skin assessments
- In these situations, the Nurse may write:
  - **"This patient requires daily skilled nursing observation and assessment of signs and symptoms related to COVID-19."**
- Skilled observation is required until the **treatment regimen is essentially stabilized**

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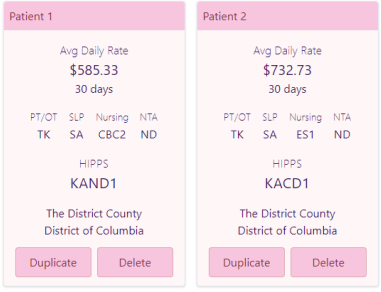
PDPM Core Elements
Reimbursement Medicare Part A Skilled Care

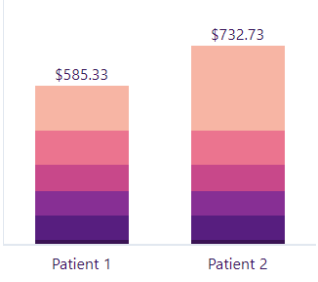
- The difference in the reimbursement for accurately coding **isolation** for a patient with **active infectious disease** in the District of Columbia



$ Impact Isolation COVID-19 (DC) =

$732.73 - $585.33
$147.40 per day
X 100 days =
$14,740.00

*Courtesy of **Hopforce PDPM Calculator**: https://pdpm-calc.com/



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Reimbursement
PDPM Core Elements
Reimbursement Medicaid Case Mix – D.C.

6

- In D.C., the coding of isolation also impacts the **Medicaid Case Mix** Index
  An **ES1** Level for Isolation yields 2.22 CMI
- Conservatively, the **CMI Impact Isolation**

  COVID-19 = ES1 versus CB2 = 2.22 - .95 = 1.27
- When identifying patients who are isolated and quarantined, it is imperative to assess **if the condition warrants skilled care**
- Currently, each state uses its own **Medicaid reimbursement** system
- Multiple states are collecting data in preparation for **applying the PDPM model**

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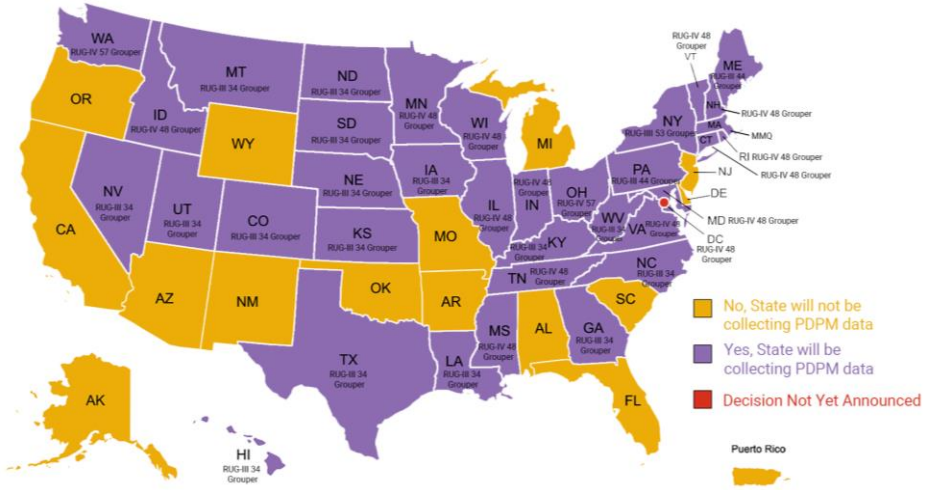
Reimbursement
PDPM Core Elements
Conversion MDS Collection OBRA Assessments

6



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Reimbursement
PDPM Core Elements
ICD-10 Active Infectious Disease

6

- The **ICD-10-CM Diagnosis Code** is **U07.1, Virus Identified**
  - **U07.1** is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes
  - **ICD-10-CM U07.1** is a new 2021 ICD-10-CM code that became effective on **October 1, 2020**
  - This is the American ICD-10-CM version of U07.1 - other international versions of ICD-10 U07.1 may differ

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Reimbursement
PDPM Core Elements
ICD-10 Active Infectious Disease

6

- **ICD-10-CM U07.1** is grouped within Diagnostic Related Group(s) (MS-DRG v38.0):
  - 177 Respiratory infections and inflammations with mcc
  - 178 Respiratory infections and inflammations with cc
  - 179 Respiratory infections and inflammations without cc/mcc
  - 791 Prematurity with major problems
  - 793 Full term neonate with major problems
  - 974 HIV with major related condition with mcc
  - 975 HIV with major related condition with cc
  - 976 HIV with major related condition without cc/mcc

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Reimbursement
PDPM Core Elements
ICD-10 Active Infectious Disease

6

- The **ICD-10-CM Diagnosis Code** is **U07.2, Virus NOT Identified**
  - **Clinically-epidemiologically diagnosed**
  - **Probable COVID-19**
  - **Suspected COVID-19**
- https://www.who.int/classifications/icd/icd10updates/en/
- **9.29.2020 ICD-10 Update COVID-19**
- A set of **additional categories** has been agreed to be able to **document or flag** conditions that occur in the context of COVID-19
- Both, 3 character and 4-character codes have been **defined to respond** to the different levels of coding depth that is in place in **different countries**

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Reimbursement
PDPM Core Elements
ICD-10 Active Infectious Disease

6

- **Personal history of COVID-19**
  - **U08.9 Personal history of COVID-19, unspecified**
  - This optional code is used to record an earlier episode of COVID-19, confirmed or probable that influences the person's health status, and the person no longer suffers from COVID-19. This code should not be used for primary mortality tabulation
- **Post COVID-19 condition**
  - **U09.9 Post COVID-19 condition, unspecified**
  - This optional code serves to allow the establishment of a link with COVID-19 This code is not to be used in cases that still are presenting COVID-19

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Reimbursement
PDPM Core Elements
ICD-10 Active Infectious Disease

6

Multisystem inflammatory syndrome associated with COVID-19

- **U10.9 Multisystem inflammatory syndrome associated with COVID-19, unspecified** (Temporarily associated with COVID-19)
- Cytokine storm
- Kawasaki-like syndrome
- Pediatric Inflammatory Multisystem Syndrome (PIMS)
- Multisystem Inflammatory Syndrome in Children (MIS-C)
- **Excludes**
  - Mucocutaneous lymph node syndrome {Kawasaki} (M30.3)

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Reimbursement
PDPM Core Elements
HHI Recommendations

6

- **Educate staff** on Skilled Coverage **Criteria**
- **Educate staff** on **ICD-10 Coding**
- **Educate staff** on **Isolation versus Quarantine**
- Perform ongoing and retroactive **Medical Record Reviews**
- All patients should be **reviewed immediately**
- It may not be possible to **retroactively correcting any errors**

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Reimbursement
PDPM Core Elements
Infection Control

6

- Per the NSVH, the **demographics of the age** and **mortality** show that **78.23 % of deaths** thus far are **65 years old or older!**
  - 65-74 years old **22.02%**
  - 75-84 years old **27.92%**
  - 85 and older years old **28.29%**

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Efficiency
Census
Staffing Crisis

7

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Efficiency
Census
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Efficiency
Census
7

- COVID in Community
- Population Density
- Urban versus Rural
- Larger Facilities
- Medicaid Census
- Above Average Minority Population

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Efficiency
Census

7

- 80.2% January 2020
- 72.4% July 2021
- March 2021 to Recover

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Efficiency
Census

7

- Waivers
- Provider Relief Funds Applications due by October 26th

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Efficiency
Census
Nursing Home Closures

7

- Delta Variant
- 100 closures per decade now 100 per month
- Currently (June 2021) 15,300

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Efficiency
Census
Population Growth

7

- 80-84 years of age, average age 82 years of age
- 2010-2017 no increase in age bracket
- In 2017, started to increase
- 2020, significant growth of 1.5 million of the 6 million
- 2025 oldest baby boomers turn 80, increase from 8 million to 10.5 million, 30% increase in 5-year period
- Aging in place difficult to accomplish

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Efficiency
Census
Population Growth

7

- 80-84 Year Olds

Year	Population
2012	5,783,000
2015	5,792,000
2020	6,470,000
2025	8,061,000
2030	10,513,000
2040	13,501,000
2050	12,963,000

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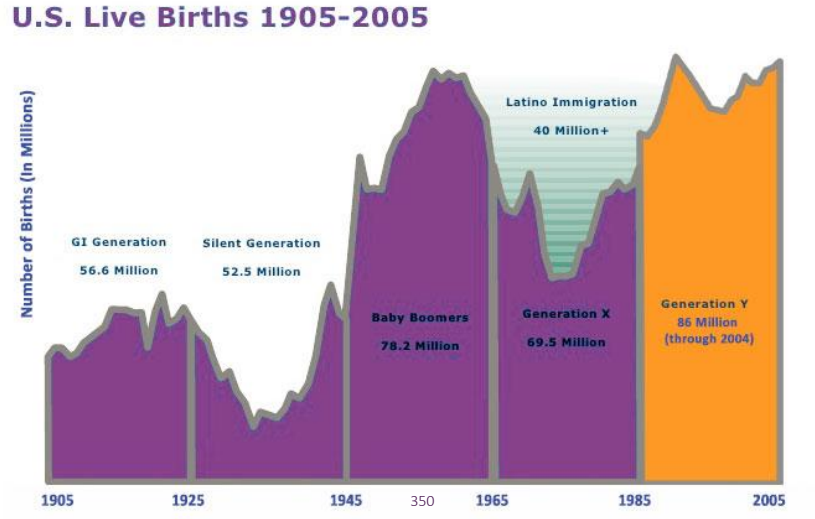
Efficiency
Census
Demographics from 2018

7



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Efficiency

Census

Key Indicators

Data through June 2016

March 4, 2022

	Current Month	Mo./Mo. [2] Chg (bps)
Occupancy	82.2%	-11
Quality Mix	34.1%	-38
Skilled Mix	24.5%	-50
Patient Day Mix		
Medicaid	65.9%	38
Medicare	13.5%	-39
Managed Care	5.8%	-28
Private	9.5%	12
Revenue Per Patient Day		
Medicaid	$198	0.1%
Medicare	$499	-0.2%
Managed Care	$438	-0.2%
Private	$252	0.2%

[2] Same Store Data

Source: The National Investment Center for Senior Housing & Care (NIC)

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Efficiency

Staffing Crisis

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Efficiency
Staffing Crisis

- National Issues requiring national solutions
- Immigration
- LPN and RN
- WSJ nursing homes and residential care employ 3 million people July 2021 which is down 380,000 workers since February 2020

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Efficiency
Staffing Crisis

- Possible minimum staffing requirement

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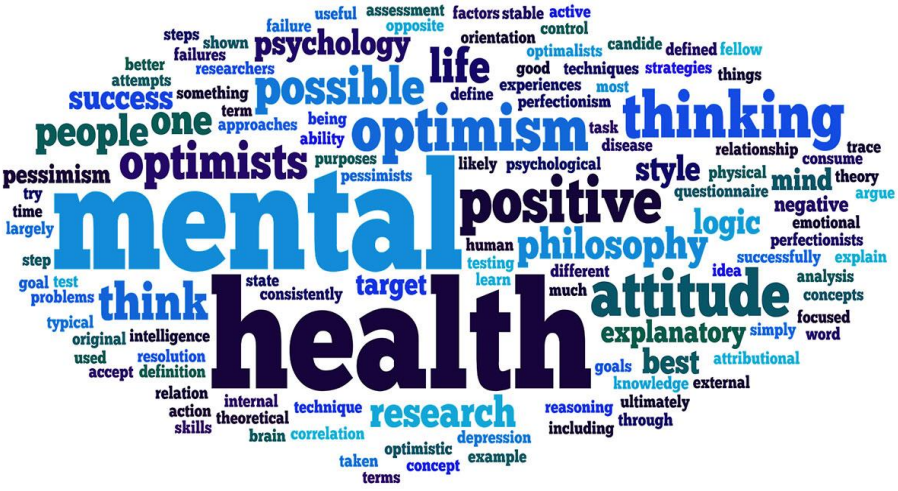
Efficiency
Staffing Crisis
Mental Health

7



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Efficiency
Staffing Crisis
SAMHSA

7

- Substance
- Abuse
- Mental
- Health
- Services
- Administration

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Efficiency
Staffing Crisis
The Future

7

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Efficiency
Staffing Crisis

7

When we talk about the future....the Future of care, we need to take a look at today and the **confluences of technology**

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Efficiency
Staffing Crisis

7

- The **speed** of technology
- The **volumes** of information
- Transparency and **messaging**
- The evolution of the **brain**
- Impact on **Human Labor**
- Law of Unintended **Consequences**

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Efficiency
Staffing Crisis

7

- **Evolution of the Brain**
  - Mapping of the Human Brain will determine how we live
  - More connections in the human brain than stars in the universe
  - Mankind to Mind Kind
  - Singularity

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Efficiency
Staffing Crisis

7

- Space
  1. Inner Space
  2. Outer Space
  3. Time Space-time is not linear. This will change what we do.
  4. Design Space
  5. Green to Blue Space
  6. Storage Space
  7. Brain Storage
  8. Micro Space – Sensor in teeth to detect disease

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Survey

Vaccinations
Infection Control
Abuse/Neglect
QAPI
Facility Assessment

8

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Survey
Vaccinations

8

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Survey
Vaccinations
Vaccination Project Newsletter

8

- Vaccine Project Newsletter
  - 218.9 million people ages 12 and older have received at least one dose of COVID-19 vaccine (77.2% of the vaccine-eligible)
  - 189.4 million people 12 and older are fully vaccinated (66.8% of the eligible)
  - 95.8% of seniors 65+ have received at least one dose of vaccine and 84.4% are fully vaccinated

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Survey
Vaccinations
Vaccination Project Newsletter

- In the past three weeks (October 21, 2021), 5 million people have joined the ranks of the vaccinated
- Overall, 10.9 million people have received a booster, 6.2% of all adults and 14.9% of seniors

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Survey
Vaccinations
More United Than We Think

- John Dick, CEO of the Pittsburgh-based market research form CivicScience, maintains that the country is not divided on the question of COVID-19 vaccination

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Survey
Vaccinations
More United Than We Think

8

"I'll venture this ranks as one of the LEAST divided things we've ever studied," Dick wrote in his weekly newsletter. "I can't even tell you how rare it is when 67% of Republicans agree with 91% of Democrats." Folks are more likely to split ranks on the weighty matters of beer (51%) versus wine (49%) or Friends versus Seinfeld (a dead heat at 50% each).

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Survey
Vaccinations
More United Than We Think

8

- When asked what media source they trust the most for COVID-19 information, 22% of U.S. adults named the news, 19% government sources, 17% research journals and a mere 5% social media. Tellingly, 24% said they don't trust anyone.

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Survey
Vaccinations
More United Than We Think

- Dr. Francis Collins, who will soon retire after leading the National Institutes of Health for the past 12 years, says the U.S. underestimated the extent of vaccine hesitancy. He told MSNBC, "I wish we had seen that coming and come up with some kind of a myth-buster approach to block all of the misinformation and disinformation that has gotten out there and is all tangled up in politics and which is costing lives." Dr. Collins characterized the 1,500 lives lost each day as the equivalent of five jumbo jets going down.

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Survey
Vaccinations

- Staff Vaccinations
  - High California 82.8%
  - Low Wyoming 53.5%
- Resident Vaccinations
  - High South Dakota 94.3%
  - Low Nevada 71.2%

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Survey
Infection Control

8

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Survey
Infection Control
COVID-19 Reporting Requirements for LTC Facilities

8

- CMS is also finalizing revisions to the infection control requirements that Long-Term Care Facilities (which include both Medicare skilled nursing facilities and Medicaid nursing facilities) must meet to participate in the Medicare and Medicaid programs.
- By doing so, LTC facilities will be required to continue the COVID-19 reporting requirements published in the May 2020 (85 FR 27550) and May 2021 (86 FR 26306) Interim Final Rules until December 31, 2024.
- Until December 31, 2024, LTC facilities will be required to continue to report on a weekly basis to:

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Survey
Infection Control
COVID-19 Reporting Requirements for LTC Facilities

8

1. Centers for Disease Control and Prevention
2. National Healthcare Safety Network (NHSN),

- The following items:
  - Suspected and confirmed COVID-19 infections,
  - Total deaths and COVID-19 deaths,
  - Personal protective equipment (PPE) and hygiene supplies,
  - Ventilator capacity and supplies,
  - Resident beds and census,

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Survey
Infection Control
COVID-19 Reporting Requirements for LTC Facilities

8

  - Access to COVID-19 testing,
  - Staffing shortages,
  - Therapeutics administered to residents for the treatment of COVID-19 requirements.

- According to CMS, extending the mandatory COVID-19 reporting requirements will allow for effective surveillance of COVID-19 to continue well beyond the end of the PHE and ensure that CMS has timely and actionably data to help drive additional response or action should facilities experience new COVID-19 infections or outbreaks.

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

- The statement is attributable to Mark Parkinson, present and CEO of AHCA/NCAL.
  - "Once again, we appreciate the Biden Administration's efforts to ensure that as many workers as possible in all health care settings are vaccinated. Nursing home providers have dedicated themselves to increasing staff vaccination rates, and as a result, three-quarters of employees are full vaccinated today. We are committed to forging ahead and encouraging all staff members to get these safe and effective COVID-19 vaccines."

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

- "While we support the overall intent of this CMS policy, we are concerned that the execution will exacerbate an already dire workforce crisis in long-term care. **A hard deadline with no resources for providers or glide path for unvaccinated workers is likely to push too many out the door and ultimately threaten residents' access to long-term care**."

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

- "Even a small percentage of staff members leaving their jobs due to this mandate would have a disastrous impact on vulnerable seniors who need around-the-clock care. Across the country, access to long-term care is becoming strained as providers have no choice but to limit admissions or even close their doors due to workforce shortages. We hope to continue working with the Administration to make the federal vaccine mandate successful while supporting our residents and caregivers."

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

- On November 4, 2021, the Centers for Medicare & Medicaid Services (CMS) released an **interim final rule** requiring direct care workers in Medicare and Medicaid certified heath care settings to be **vaccinated against COVID-19**.
  1) **December 5th, 2021, First Dose**
     Staff at these health care facilities must receive the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine by December 5, 2021. All eligible staff must be fully vaccinated by January 4, 2022.

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

2) **Vaccination Policy**
Facilities covered by this regulation must **establish a policy** ensuring all eligible staff have received the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine prior to providing any care, treatment, or other services by December 5, 2021.

3) **January 4th, 2021, Fully Vaccinated**
All eligible staff **must have received the necessary shots to be fully vaccinated** – either two doses of Pfizer or Moderna or one dose of Johnson & Johnson – **by January 4, 2022**.

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Infection Control
COVID-19 Vaccination Mandate

8

4) **Exemptions**
Includes both religious and medical exemptions. This regulation provides for exemptions based on **recognized medical conditions** or **religious beliefs, observances, or practices**. Facilities must develop a similar process or plan for permitting exemptions in alignment with federal law.

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

5) **Enforcement**
CMS will ensure compliance with these requirements through **established survey and enforcement processes**. If a provider or supplier does not meet the requirements, it will be cited by a surveyor as being non-compliant and have an opportunity to return to compliance before additional actions occur.

6) **Applies**
Applies to 16 Medicare and Medicaid provider types, not Physician offices. Including:

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Infection Control
COVID-19 Vaccination Mandate

8

- Ambulatory Surgical Centers,
- **Hospices**,
- Programs of All-Inclusive Care for Elderly Hospitals,
- Long-Term Care facilities,
- Psychiatric Residential Treatment Facilities,
- **Intermediate Care Facilities for Individuals with Intellectual Disabilities,**
- **Home Health Agencies,**

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

- Comprehensive Outpatient Rehabilitation Facilities,
- Critical Access Hospitals,
- Clinics,
  - Rehabilitation agencies, and
  - Public health agencies as providers of outpatient Physical Therapy, and
  - Speech-Language Pathology services,
- Community Mental Health Centers,

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Survey
Infection Control
COVID-19 Vaccination Mandate

8

- Home Infusion Therapy suppliers,
- Rural Health Clinics/Federally Qualified Health Centers, and
- End-Stage Renal Disease Facilities.

7) The OSHA ETS rule for companies with 100 or more employees:
   - Deadline is January 4th for vaccination or workers must produce a negative COVID test at least once a week.
   - Employers do not need to pay for testing.
   - Workers must have time off to get vaccinated.

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Survey
Infection Control
COVID-19 Vaccination Mandate

- Unvaccinated workers must wear masks.
- Religious and medical exemptions allowed.

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Survey
Infection Control

- What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws | U.S. Equal Employment Opportunity Commission (eeoc.gov)
  - **Notice:** September 9, 2021
  - The EEOC recognizes that "long COVID" may be a disability under the Americans with Disabilities Act (ADA) and Section 501 of Rehabilitation Act in certain circumstances.

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Survey
Infection Control

- The EEOC agrees with the analysis of "long COVID" by the Departments of Health and Human Services and Justice in their "Guidance on 'Long COVID' as a Disability Under the ADA, Section 504, and Section 1557." EEOC technical assistance about COVID-19 and ADA "disability" in the employment context will be released in the coming weeks.

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Survey
Infection Control
B. Confidentiality of Medical Information

- With limited exceptions, the ADA requires **employers to keep confidential any medical information** they learn about any applicant or employee. Medical information includes not only a diagnosis of treatments, but also the fact that an individual **has requested or is receiving a reasonable accommodation**.
  - **B.1. May an employer store in existing medical files information it obtains related to COVID-19, including the results of taking an employee's temperature or the employee's self-identification as having this disease, or must the employer create a new medical file system solely for this information?** (4/9/20)

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Survey
Infection Control
B. Confidentiality of Medical Information

- The ADA requires that all medical information about a particular employee be stored separately from the employee's personnel file, thus limited access to this confidential information. An employer may store all medical information related to COVID-19 in existing medical files. This includes an employee's statement that he has the disease or suspects he has the disease, or the employer's notes or other documentation from questioning an employee about symptoms.

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Survey
Infection Control
B. Confidentiality of Medical Information

- **B.2. If an employer requires all employees to have a daily temperature check before entering the workplace, may the employer maintain a log of the results?** (4/9/20)
- Yes. The employer needs to maintain the confidentiality of this information.
- **B.3. May an employer disclose the name of an employee to a public health agency when it learns that the employee has COVID-19?** (4/9/20)
- Yes.

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Survey
Infection Control
B. Confidentiality of Medical Information

8

- **B.4. May a temporary staffing agency or a contractor that places an employee in an employer's workplace notify the employer if it learns the employee has COVID-19?** (4/9/21)
- Yes. The staffing agency or contractor may notify the employer and disclose the name of the employee, because the employer may need to determine if this employee had contact with anyone in the workplace.

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Survey
Infection Control
B. Confidentiality of Medical Information

8

- **B.5. Suppose a manager learns that an employee has COVID-19, or has symptoms associated with the disease. The manager knows she must report it but is worried about violating ADA confidentiality. What should she do?** (9/8/20; adapted from 3/27/20 Webinar Question 5)
- The ADA requires that an employer keep all medical information about employees confidential, even if that information is not about a disability. Clearly, the information that an employee has symptoms of, or a diagnosis of, COVID-19, is medical information.

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Survey
Infection Control
B. Confidentiality of Medical Information

8

But the fact that this is medical information does not prevent the manager from reporting to appropriate employer officials so that they can take actions consistent with guidance from the CDC and other public health authorities.

- The question is what information to report: Is it the fact that an employee -unnamed- has symptoms of COVID-19 or a diagnosis, of is it the identity of that employee? Who in the organization needs to know the identity of that employee? Who in the organization needs to know the identity of the employee will depend on each workplace and why a specific official needs this information.

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Survey
Infection Control
B. Confidentiality of Medical Information

8

Employers should make every effort to limit the number of people who get to know the name of the employee.

- The ADA does not interfere with a designated representative of the employer interviewing the employee to get a list of people with whom the employee possible had contact through the workplace, so that the employer can then take action to notify those who may have come in contact with the employee, without revealing the employee's identity.

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Survey
Infection Control
B. Confidentiality of Medical Information

8

- For example, using a generic descriptor, such as telling employees that "someone at this location" or "someone on the fourth floor" has COVID-19, provides notice and does not violate the ADA's prohibition of disclosure of confidential medical information. For small employers, coworkers might be able to figure out who the employee is, but employers in that situation are still prohibited from confirming or revealing the employers in that situation are still prohibited from confirming or revealing the employee's identity.

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Infection Control
B. Confidentiality of Medical Information

8

- Also, all employer officials who are designated as needing to know the identity of an employee should be specifically instructed that they must maintain the confidentiality of this information. Employers may want to plan in advance what supervisors and managers should do if this situation arises and determine who will be responsible for receiving information and taking next steps.

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Survey
Infection Control
B. Confidentiality of Medical Information

- B.6. An employee who must report the workplace knows that a coworker who reports to the same workplace has symptoms associated with COVID-19. Does ADA confidentiality prevent the first employee from disclosing the coworker's symptoms to a supervisor? (9/8/20; adapted from 3/27/20 Webinar Question 6)
- No. ADA confidentiality does not prevent this employee from communicating to his supervisor about a coworker's symptoms. In other words, it is not an ADA confidentiality violation for this employee to inform his supervisor about a coworker's symptoms.

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Survey
Infection Control
B. Confidentiality of Medical Information

After learning about this situation, the supervisor should contact appropriate management officials to report this information and discuss next steps.

- **B.7. An employer knows that an employee is teleworking because the person has COVID-19 or symptoms associated with the disease, and that he is in self-quarantine. May the employer tell staff that this particular employee is teleworking without saying why?** (9/8/20; adapted from 3/27/20 Webinar Question 7)

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Infection Control
B. Confidentiality of Medical Information

8

- Yes. If staff need to know how to contact the employee, and that the employee is working even if not present in the workplace, then disclosure that the employee is teleworking without saying why is permissible. Also, if the employee was on leave rather than teleworking because he has COVID-19 or symptoms associated with the disease, or any other medical condition, then an employer cannot disclose the reason for the leave, just the fact that the individual is on leave.

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Survey
Infection Control
B. Confidentiality of Medical Information

8

- **B.8. Many employees, including managers and supervisors, are now teleworking as a result of COVID-19. How are they supposed to keep medical information of employees confidential while working remotely?** (9/8/20; adapted from 3/27/20 Webinar Question 9)
- The ADA requirement that **medical information be kept confidential includes a requirement that it be stored separately from regular personnel files.** If a manager or supervisor receives medical information involving COVID-19, or any other medical information, while teleworking, and is able to follow an employer's existing confidentiality protocols while working remotely, the supervisor has to do so.

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Survey

Infection Control

B. Confidentiality of Medical Information

8

But to the extent that is not feasible, the supervisor still must safeguard this information to the greatest extent possible until the supervisor can properly store it. This means that paper notepads, laptops, or other devices should not be left where others can access the protected information.

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Survey

Facility Assessment

8

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Survey
Facility Assessment

8

- **Facility Assessment**: Update annually or whenever changed
- Banned **Pre-dispute** arbitration
- **QAPI – Plan** needs to be handed to Surveyors!!!

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Survey
Facility Assessment

8

- New Construction / OR Reconstruction
  - Each room must have its own **bathroom**!
- Conduct regular inspections of beds and Mattresses

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Survey
Facility Assessment

8

- Facility Assessment Requirement (483.70(e))
  - Due in Phase 2, November 28, 2017
  - Completed at the facility level, not at corporate
  - What resources a center needs to care for its residents competently both during day-to-day operations and in emergency
  - Intent:
    - Determining staffing requirements
    - Establishing a QAPI program
    - Conducting emergency preparedness planning
    - Determine niche for competency

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Survey
Facility Assessment

8

- Facility Assessment links to patient-centered care
  - A "Competency-Based Approach" rather than a prescriptive approach to staffing and resource allocation
  - Regulatory intent is to accommodate multiple care delivery models to meet needs of diverse populations served by nursing centers and ensure that residents receive care that allows them to maintain or attain their highest practicable physical, mental and psychological well-being.

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Survey
Facility Assessment

8

- A systems approach to ensuring resident health and safety from the bottom up
  - Starting with an assessment of residents and their needs and matching those needs to a center's staff and other critical resources.
- Provides and opportunity to seek input from residents and their representatives or family members in determining residents needs and wishes

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Survey
Facility Assessment

8

- Components of Facility Assessment
  - A facility assessment is a working tool
  - Implemented in Phase 2, November 28, 2017
  - 3 Components with 12 topic areas
    - Resident Population: Component 1
    - Center Resources: Component 2
    - Risk Assessment: Component 3

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Survey
Facility Assessment

8

- Number of Residents and centers resident capacity
- Care required by the resident population, considering
  - Types of diseases and conditions
  - Physical and cognitive disabilities
  - Overall acuity
  - Other pertinent facts present within the population

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Survey
Facility Assessment
Component 1: Resident Population

8

- **Component 1: Resident Population**
  - **Staff competencies** necessary to provide the level and types of care needed for resident population
  - **Physical environment**, equipment, services, and other physical plant considerations necessary to care for the resident population
  - **Any ethnic, cultural, or religious factors** that may potentially affect the care provided, including activities and food and nutrition services

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Survey
Facility Assessment
Component 2: Center Resources

8

- Component 2: Center Resources
  - All buildings and/or other physical structures and vehicles
  - Equipment (medical and nonmedical)
  - Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies

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Survey
Facility Assessment
Component 2: Center Resources

8

- Component 2: Center Resources
  - All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care
  - Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the center during normal operations and emergencies
  - Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations

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Survey
Facility Assessment
Component 3: Risk Assessment

- **Component 3: Risk Assessment**
  - The facility assessment must include a **center-based and community-based** risk assessment, using an all-hazards approach

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Survey
Facility Assessment
Timeline

- **Timeline**
  - At least annually
  - Whenever there is, or the facility plans for any changed that would require a substantial modification to any part of the assessment

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Survey
Facility Assessment
Competency-Based Staffing Assessments

- **Competency-Based Staffing Assessments**
  - Providers must use the facility assessment to determine **sufficient staffing** and appropriate **competencies and skill sets**. This applies to all staff in the facility, and is specifically mentioned in these requirements:
    - Nursing Services (483.35)
    - Behavioral Health Services (483.40)
    - Food and Nutrition Services (483.60)

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Survey
Facility Assessment
Competency-Based Staffing Assessments

- **Competency-Based Staffing Assessments**
  - Your facility assessment must define how you determine sufficient staffing, staff competencies, and demonstrate that clinical skill sets are tied to the assessment of the resident population

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Survey
Facility Assessment & QAPI

- **Facility Assessment and QAPI (483.75)**
  - The rule requires providers to design a QAPI program that is ongoing, comprehensive, and addresses the full range of care and services provided by the facility
  - The QAPI program must document how the facility assessment is being used to inform data collection, feedback, performance measurement, and monitoring

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Survey
Facility Assessment & Infection Control

- **Facility Assessment and Infection Control (483.80)**
  - Providers must establish an **infection prevention** and **control program (IPCP)** that includes a system for **preventing, identifying, reporting, investigating**, and **controlling infections** and communicable diseases…**based upon the facility assessment** conducted according to 483.75(e) and following accepted national standards.
  - Providers must show how the facility your assessment of the resident population and staffing has informed the IPCP

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Survey
Facility Assessment & Infection Control

- Facility Assessment and Infection Control (483.80)
  - For example:
    - How do resident characteristics including acuity and diagnoses inform your assessment of infection risks?
    - How have you incorporated infection control skills and training into your assessment of staff competencies?

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Survey
Facility Assessment & Training Requirements

- Facility Assessment and Training Requirements (483.95)

"Nursing centers must develop, implement, and maintain an **effective training program** for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles"

  - Nursing centers must determine the amount and types of training necessary **based on the facility assessment** as specified at **483.75(e)**

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Survey
Facility Assessment & Training Requirements

- **Facility Assessment and Training Requirements (483.95)**
  - Training topics must include but are not limited to:
    - In-service training for nurse aides based on areas of need determined by facility assessment
    - Behavioral health training based on areas of need determined by facility assessment

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Leadership

Lessons From General Colin Powell
A Leadership Primer

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Leadership
General Colin Powell
18 Lessons

1.) "Being responsible sometimes means pissing people off.“

2.) "The day soldiers stop bringing you their problems is the day you have stopped leading them. They have either lost confidence that you can help them or concluded that you do not care. Either case is a failure of leadership.“

3.) "Don't be buffaloed by experts and elites. Experts often possess more data than judgment. Elites can become so inbred that they produce hemophiliacs who bleed to death as soon as they are nicked by the real world."

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Leadership
General Colin Powell
18 Lessons

4.) "Don't be afraid to challenge the pros, even in their own backyard.“

5.) ""Never neglect details. When everyone's mind is dulled or distracted the leader must be doubly vigilant."

6.) "Don't be buffaloed by experts and elites. Experts often possess more data than judgment. Elites can become so inbred that they produce hemophiliacs who bleed to death as soon as they are nicked by the real world.“

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Leadership
General Colin Powell
18 Lessons

7.) "Keep looking below surface appearances.

Don't shrink from doing so (just) because you might not like what you find."

8.) "Organization doesn't really accomplish anything. Plans don't accomplish anything, either. Theories of management don't much matter. Endeavors succeed or fail because of the people involved. Only by attracting the best people will you accomplish great deeds."

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Leadership
General Colin Powell
18 Lessons

9.) "Organization charts and fancy titles count for next to nothing."

10.) "Never let your ego get so close to your position that when your position goes, your ego goes with it."

11.) "Fit no stereotypes. Don't chase the latest management fads. The situation dictates which approach best accomplishes the team's mission."

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Leadership
General Colin Powell
18 Lessons

12.) "Perpetual optimism is a force multiplier.“

13.) "Powell's Rules for Picking People:”

Look for intelligence and judgment, and most critically, a capacity to anticipate, to see around corners. Also, look for loyalty, integrity, a high energy drive, a balanced ego, and the drive to get things done.

14.) "Great leaders are almost always great simplifiers, who can cut through argument, debate and doubt, to offer a solution everybody can understand."

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Leadership
General Colin Powell
18 Lessons

15.) Part I:
"Use the formula P = 40 to 70, in which P stands for the probability of success and the numbers indicate the percentage of information acquired.”

Part II:
"Once the information is in the 40 to 70 range, go with your gut."

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Leadership
General Colin Powell
18 Lessons

16.) "The commander in the field is always right and the rear echelon is wrong, unless proved otherwise."

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Leadership
General Colin Powell
18 Lessons

17.)"Have fun in your command. Don't always run at a breakneck pace. Take leave when you've earned it:

Spend time with your families. Corollary: surround yourself with people who take their work seriously, but not themselves, those who work hard and play hard."

18.) "Command is lonely."

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Leadership
General Colin Powell
Lesson 1

"Being responsible sometimes means pissing people off."

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Leadership
General Colin Powell
Lesson 1

- Good leadership involves responsibility to the welfare of the group, which means that some people will get angry at your actions and decisions. It's inevitable, if you're honorable. Trying to get everyone to like you is a sign of mediocrity; you'll avoid tough decisions, you'll avoid confronting the people who need to be confronted, and you'll avoid offering differential rewards based on differential performance because some people might get upset. Ironically, be procrastinating on the difficult choices, by trying not to get anyone mad, and by treating everyone equally "nicely" regardless of their contributions, you'll simply ensure that the only people you'll wind up angering are the most creative and productive people in the organization.

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Leadership
General Colin Powell
Lesson 2

"The day soldiers stop bringing you their problems is the day you have stopped leading them. They have either lost confidence that you can help them or concluded that you do not care. Either case is a failure of leadership."

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Leadership
General Colin Powell
Lesson 2

- If this were a litmus test, the majority of CEOs would fail. One, they build so may barriers to upward communication that the very idea of someone lower in the hierarchy looking up to the leader for help is ludicrous. Two, the corporate culture they foster often defines asking for help as weakness or failure, so people cover up their gaps, and the organization suffers accordingly. Real leaders make themselves accessible and available. They show concern for the efforts and challenges faced by underlings, even as they demand high standards. Accordingly, they are more likely to create an environment where problem analysis replaces blame.

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Leadership
General Colin Powell
Lesson 3

"Don't be buffaloed by experts and elites. Experts often possess more data than judgment. Elites can become so inbred that they produce hemophiliacs who bleed to death as soon as they are nicked by the real world."

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Leadership
General Colin Powell
Lesson 3

- Small companies and start-ups don't have the time for analytically detached experts. They don't have the money to subsidize lofty elites, either. The president answers the phone and drives the truck when necessary; everyone on the payroll visibly produces and contributes to bottom-line results or they're history. But as companies get bigger, they often forget who "brought them to the dance:" Things like all-hands involvement, egalitarianism, informality, market intimacy, daring, risk, speed, agility. Policies that emanate from ivory towers often have an adverse impact on the people out in the field who are fighting the wars or bringing in the revenues. Real leaders are vigilant, and combative, in the face of these trends.

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Leadership
General Colin Powell
Lesson 4

"Don't be afraid to challenge the pros,
even in their own backyard."

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Leadership
General Colin Powell
Lesson 4

- Learn from the pros, observe them, seek them out as mentors and partners. But remember that even the pros may have leveled out in terms of their learning and skills. Sometimes even the pros can become complacent and lazy. Leadership does not emerge from blind obedience to anyone. Xerox's Barry Rand was right on target when he warned his people that if you have a yes-man working for you, one of you is redundant. Good leadership encourages everyone's evolution.

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438

Leadership
General Colin Powell
Lesson 5

"Never neglect details. When everyone's mind is dulled or distracted the leader must be doubly vigilant."

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Leadership
General Colin Powell
Lesson 5

- Strategy equals execution. All the great ideas and visions in the world are worthless if they can't be implemented rapidly and efficiently. Good leaders delegate and empower others liberally, but they pay attention to details, every day. (Think about supreme athletic coaches like Jimmy Johnson, Pat Riley and Tony La Russa.) Bad ones, even those who fancy themselves as progressive "visionaries," think they're somehow "above" operational details. Paradoxically, good leaders understand something else: An obsessive routine in carrying out the details begets conformity and complacency, which in turn continually encourage people to challenge the process. They implicitly understand the sentiment of CEO leaders like Quad Graphic's Harry Quadracchi, Oticon's Lars Kolind and the late Bill McGowan of MCI, who all independently asserted that the Job of a leader is not to be the chief organizer, but the chief dis-organizer.

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Leadership
General Colin Powell
Lesson 6

"You don't know what you can get away with until you try."

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Leadership
General Colin Powell
Lesson 6

- You know the expression, "it's easier to get forgiveness than permission." Well, it's true. Good leaders don't wait for official blessing to try things out. They're prudent, not reckless. But they also realize a fact of life in most organizations: If you ask enough people for permission, you'll inevitably come up against someone who believes his job is to say "no." So, the moral is, don't ask. Less effective middle managers endorsed the sentiment, "If I haven't explicitly been told 'yes,' I can't do it," whereas the good ones believed, "If I haven't explicitly been told 'no,' I can." There's a world of difference between these two points of view.

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Leadership
General Colin Powell
Lesson 7

"Keep looking below surface appearances. Don't shrink from doing so (just) because you might not like what you find."

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Leadership
General Colin Powell
Lesson 7

- "If it ain't broke, don't fix it" is the slogan of the complacent, the arrogant or the scared. It's an excuse for inaction, a call to non-arms. It's a mind-set that assumes (or hopes) that today's realities will continue tomorrow in a tidy, linear and predictable fashion. Pure fantasy. In this sort of culture, you won't find people who pro-actively take steps to solve problems as they emerge. Here's a little tip: Don't invest in these companies.

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Leadership
General Colin Powell
Lesson 8

"Organization doesn't really accomplish anything. Plans don't accomplish anything either. Theories of management don't much matter. Endeavors succeed or fail because of the people involved. Only by attracting the best people will you accomplish great deeds."

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Leadership
General Colin Powell
Lesson 8

- In a brain-based economy, your best assets are people. We've heard this expression so often that it's become trite. But how many leaders really "walk to talk" with this stuff? Too often, people are assumed to be empty chess pieces to be moved around by grand viziers, which may explain why so many top managers immerse their calendar time in deal making, restructuring and the latest management fad. How many immerse themselves in the goal of creating an environment where the best, the brightest, the most creative are attracted, retained and, most importantly, unleashed?

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Leadership
General Colin Powell
Lesson 9

"Organization charts and fancy titles count for next to nothing."

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Leadership
General Colin Powell
Lesson 9

- Organization charts are frozen, anachronistic photos in a workplace that out to be as dynamic as the external environment around you. If people really followed organizational charts, companies would collapse. In well-run organizations, titles are also pretty meaningless. At best, they advertise some authority, an official status conferring the ability to give orders and induce obedience. But titles mean little in terms of real power, which is the capacity to influence and inspire.

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Leadership
General Colin Powell
Lesson 9

Have you ever noticed that people will personally commit to certain individuals who on paper (or on the organization chart) possess little authority, but instead possess pizzazz, drive, expertise, and genuine caring for teammates and products?

On the flip side, non-leaders in management may be formally anointed with all the perks and frills associated with high positions, but they have little influence on others, apart from their ability to extract minimal compliance to minimal standards.

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Leadership
General Colin Powell
Lesson 10

"Never let your ego get so close to your position that when your position goes, your ego goes with it."

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Leadership
General Colin Powell
Lesson 10

- Too often, change is stifled by people who cling to familiar turfs and job descriptions. One reason that even large organizations wither is that managers won't challenge old, comfortable ways of doing things. But real leaders understand that, nowadays, every one of our jobs is becoming obsolete. The proper response is to obsolete our activities before someone else does. Effective leaders create a climate where people's worth is determined by their willingness to learn new skills and grab new responsibilities, thus perpetually reinventing their jobs. The most important question in performance evaluation becomes not, "How well did you perform your job since the last time we met?" but, "How much did you change it?"

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Leadership
General Colin Powell
Lesson 11

"Fit no stereotypes. Don't chase the latest management fads. The situation dictates which approach best accomplishes the team's mission."

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Leadership
General Colin Powell
Lesson 11

- Flitting from fad to fad creates team confusion, reduces the leader's credibility, and drains organizational coffers. Blindly following a particular fad generates rigidity in thought and action. Sometimes speed to market is more important that total quality. Sometimes an unapologetic directive is more appropriate than participatory discussion. Some situations require the leader to hover closely; others require long, loose leashes. Leaders honor their core values, but they are flexible in how the execute them. They understand that management techniques are not magic mantras but simply tools to be reached for at the right times.

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Leadership
General Colin Powell
Lesson 12

"Perpetual optimism is a force multiplier."

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Leadership
General Colin Powell
Lesson 12

- The ripple effect of a leader's enthusiasm and optimism is awesome. So is the impact of cynicism and pessimism. Leaders who whine and blame engender those same behaviors among their colleagues. I am not talking about stoically accepting organizational stupidity and performance incompetence with a "what, me worry?" smile. I am talking about a gung-ho attitude that says, "we can change things here, we can achieve awesome goals, we can be the best." Spare me the grim litany of the "realist," give me the unrealistic aspirations of the optimist any day."

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Leadership
General Colin Powell
Lesson 13

"Powell's Rules for Picking People:"
Look for intelligence and judgment, and most critically, a capacity to anticipate, to see around corners. Also look for loyalty, integrity, a high energy drive, a balanced ego, and the drive to get things done.

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Leadership
General Colin Powell
Lesson 13

- How often do our recruitment and hiring processes tap into these attributes? More often than not, we ignore them in favor of length of resume, degrees and prior titles. A string of job descriptions a recruit held yesterday seems to be more important than who one is today, what they can contribute tomorrow, or how well their values mesh with those of the organization. You can train a bright, willing novice in the fundamentals of your business fairly readily, but it's a lot harder to train someone to have integrity, judgment, energy, balance, and the drive to get things done. Good leaders stack the deck in their favor right in the recruitment phase

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Leadership
General Colin Powell
Lesson 14

"Great leaders are almost always great simplifiers, who can cut through argument, debate and doubt, to offer a solution everybody can understand."

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Leadership
General Colin Powell
Lesson 14

- Effective leaders understand the KISS principle, Keep It Simple, Stupid. They articulate vivid, over-arching goals and values, which they use to drive daily behaviors and choices among competing alternatives. Their visions and priorities are lean and compelling, not cluttered and buzzword-laden. Their decisions are crisp and clear, not tentative and ambiguous. They convey an unwavering firmness and consistency in their actions, aligned with the picture of the future they paint. The result: Clarity of purpose, credibility of leadership, and integrity in organization.

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Leadership
General Colin Powell
Lesson 15

Part I: "Use the formula P=40 to 70, in which P stands for the probability of success and the numbers indicate the percentage of information acquired."
Part II: "Once the information is in the 40 to 70 range, go with your gut."

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Leadership
General Colin Powell
Lesson 15

- Don't take action if you have only enough information to give you less than a 40 percent chance of being right, but don't wait until you have enough facts to be 100 percent sure, because by then it is almost always too late. Today, excessive delays in the name of information-gathering breeds "analysis paralysis." Procrastination in the name of reducing risk actually increases risk.

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Leadership
General Colin Powell
Lesson 16

"The commander in the field is always right and rear echelon is wrong, unless proved otherwise."

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Leadership
General Colin Powell
Lesson 16

- Too often, the reverse defines corporate culture. This is one of the main reasons why leaders like Ken Iverson of Nucor Steel, Percy Barnevik of Asea Brown Boveri, and Richard Branson of Virgin have kept their corporate staffs to a bare-bones minimum – how about fewer than 100 central corporate staffers for global $30 billion-plus ABB? Or around 25 and 3 for multi-billion Nucor and Virgin, respectfully? Shift the power and the financial accountability to the folks who are bringing in the beans, not the ones who are counting or analyzing them.

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Leadership
General Colin Powell
Lesson 17

"Have fun in your command. Don't always run at a breakneck pace. Take leave when you've earned it: Spend time with your families.
Corollary: Surround yourself with people who take their work seriously, but not themselves, those who work hard and play hard."

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Leadership
General Colin Powell
Lesson 17

- Herb Kelleher of Southwest Air and Anita Roddick of The Body Shop would agree: Seek people who have some balance in their lives, who are fun to hang out with, who like to laugh (at themselves, too) and who have some non-job priorities which they approach with the same passion that they do their work. Spare me the grim workaholic or the pompous pretentious "professional;" I'll help them find jobs with my competitor.

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Leadership
General Colin Powell
Lesson 18

"Command is lonely."

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Leadership
General Colin Powell
Lesson 18

- Harry Truman was right. Whether you're a CEO or the temporary head of a project team, the buck stops here. You can encourage participative management and bottom-up employee involvement, but ultimately the essence of leadership is the willingness to make the tough, unambiguous choices that will have an impact on the fate of the organization. I've seen too many non-leaders flinch from this responsibility. Even as you create an informal, open, collaborative culture, prepare to be lonely.

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Leadership
General Colin Powell

"Leadership is the art of accomplishing more than the science of management says is possible."

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MDS Bootcamp Level 1 Week 1
Learning Objectives

1. Articulate the impact of the MDS 3.0 assessment tool.
2. List the three components of the RAI.
3. Discuss why the RAI was implemented.
4. List three sources of information that can be used to complete the RAI.
5. Identify three areas that are impacted by accurate MDS coding.
6. State the overall goal of the RAI Process.

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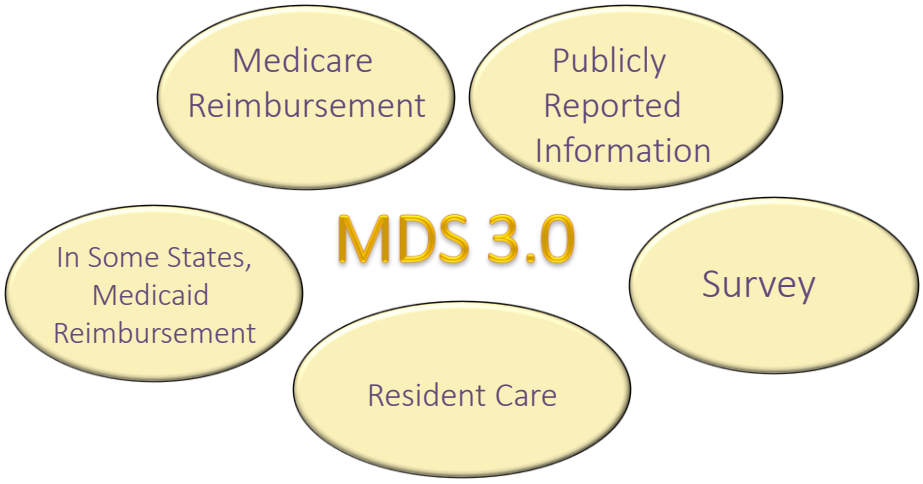
MDS Bootcamp Level 1 Week 1
Impact of the MDS 3.0



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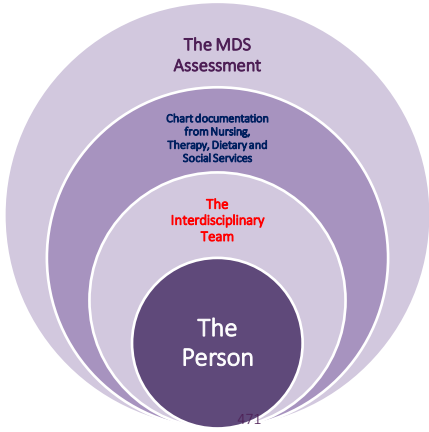
MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI)

The person is the center of it all



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MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI)

- The RAI consists of three basic components:
  - Minimum Data Set (MDS)
  - Care Area Assessment process (CAA)
  - RAI Utilization Guidelines

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MDS Bootcamp Level 1 Week 1
Scheduling Assessments

WHO must be assessed through the RAI Process?

- MDS Assessments MUST be completed and transmitted per the regulated schedule for all residents who are in Medicare and/or Medicaid Certified **Beds**.
- MDS Assessments for persons NOT in a Medicare and/or Medicaid Certified bed are **not required** and **cannot be transmitted** to CMS through the QIES System.

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MDS Bootcamp Level 1 Week 1
Scheduling Assessments

WHO must be assessed through the RAI Process?

- Facilities may have Assisted Living beds or “non-Certified” beds in addition to their Medicare and/or Medicaid Certified beds.
- As far as CMS is concerned for MDS Assessments, those beds do not exist.
- Residents who go back and forth between a Certified bed and a non-Certified bed will require MDS assessments while they are in a Certified bed, but when they return to their non-Certified bed, they will be discharged through the MDS as though they left the facility entirely.

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MDS Bootcamp Level 1 Week 1
Scheduling Assessments

WHO must be assessed through the RAI Process?

- The RAI Process works if you work the processes.
- It is an effective, efficient tool to guide the planning of care in the nursing home or AL setting because it uses a proven problem-solving method.
- Your company may **require** by policy that MDS Assessments are completed for all residents, regardless of whether they are in a Certified bed, but these assessments are not transmitted through QUIES.

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MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI)

- The Minimum Data Set (MDS):
  - Core set of screening, **clinical** and **functional** status elements
  - Foundation of the Comprehensive assessment for nursing home residents
  - Standardized to ease communication between nursing homes and outside agencies

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MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI)

- The Care Area Assessments (CAA):
  - Assists the assessor to systematically **interpret** the information recorded on the MDS
  - Determine if the triggered care area requires a Care Plan
  - Identify risks to the resident and complicating factors in their care
  - Format is not mandatory, but content is

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MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI)

- The Utilization Guidelines (Manual):
  - Provide instructions for when and how to use the RAI
  - Instructions for completing the MDS
  - Structured frameworks for synthesizing the MDS and other clinical information

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MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI)

- The Utilization Guidelines (Manual):
  - The RAI User's Manual is a **free resource**, provided by Centers for Medicare and Medicaid Services (CMS)
  - Option to buy from some companies
  - Updated when regulations change
  - Updates and Manual are posted:

    http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI) Manual Chapters

1. Resident Assessment Instrument (RAI)
2. Assessments for the Resident Assessment Instrument (RAI)
3. Overview to the Item-By-Item Guide to the MDS 3.0
4. Care Area Assessments (CAA) Process and Care Planning
5. Submission and Correction of the MDS Assessments
6. Medicare Skilled Nursing Facility Prospective Payment System (PPS)

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MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI) Manual Appendices

- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: PHQ-9 Scoring Rules and Instruction for BIMS (when administered in writing)
- Appendix F: MDS Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Item Sets

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MDS Bootcamp Level 1 Week 1
Purpose of the RAI

- RAI was mandated by the OBRA '87 Regulation
- The primary purpose of the MDS was to be a functional assessment tool
- This tool is used to identify potential resident care areas for Care Plan development
- Problems identified are then addressed in the individualized resident Care Plan

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MDS Bootcamp Level 1 Week 1
Purpose of the RAI

- Develop a Person-Centered Care Plan with each beneficiary and provide services in accordance with the Care Plan
- Provide services to **attain or maintain the highest practicable physical, mental and psychosocial well being** of each beneficiary in accordance with the Care Plan
- Plan for each beneficiary's discharge as desired to ensure safe transition to next care settings

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MDS Bootcamp Level 1 Week 1
Quiz

What are the 3 Components of the RAI?

- The MDS Assessment
- The Care Assessment Process (CAAs)
- RAI Utilization Guidelines

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MDS Bootcamp Level 1 Week 1
42CFR 483.20 Regulations Require

- The assessment accurately reflects the resident's status
- A Registered Nurse conducts or coordinates each assessment with the appropriate participation of health professionals
- The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts

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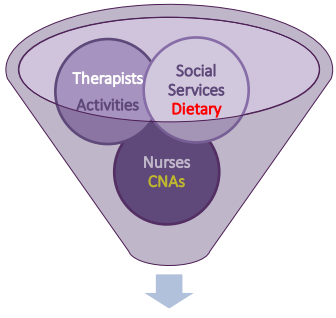
MDS Bootcamp Level 1 Week 1
42CFR 483.20 Regulations Require

Who is a "Healthcare Professional?"



Person Centered Care Plan

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MDS Bootcamp Level 1 Week 1
Where Can I Obtain This Information?

- Completion of the RAI is best accomplished by an Interdisciplinary Team (IDT) that includes nursing home staff with varied backgrounds, including nursing staff and the physician
- An RN must conduct or coordinate the assessment and sign that it is complete
- Accurate assessment requires that information be collected from multiple sources

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MDS Bootcamp Level 1 Week 1
Where Can I Obtain This Information?

- Sources of RAI coding information:
  - Resident observation and interview
  - Direct care staff (all shifts)
  - Medical record documentation
  - Physician
  - Family, guardian or significant other
- All coded items must be validated for accuracy by the IDT completing the assessment

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MDS Bootcamp Level 1 Week 1
Where Can I Obtain This Information?

The MDS as a "Source Document"

- The original RAI Manual 2.0 Published in 1995 identified the MDS as a "source document."
- Generally, this means that the document was self-supporting. If the person completing the MDS interviewed staff and directly coded the result in the MDS, it did not have to be documented in the chart as well.
- The MDS assessment changed in 2010 with MDS 3.0 with expanded data collection and giving the residents a voice in the form of interviews.
- The term "source document" is no longer in the RAI User's Manual
- Accurate charting is a standard of clinical practice.

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MDS Bootcamp Level 1 Week 1
Where Can I Obtain This Information?

- CMS has no specific documentation requirements for completing the RAI
- Good clinical practice for documentation is an expectation of CMS
- Completion of the MDS does not remove responsibility to document a more detailed assessment in the medical record

Source: MDS 3.0 RAI Manual v1.17.1_October 2019, page 1-8;
https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

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MDS Bootcamp Level 1 Week 1
Quiz

Can you name 3 areas impacted by accurate MDS Coding?

- Person-Centered Care
- Survey
- Reimbursement
- Publicly Reported Information

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MDS Bootcamp Level 1 Week 1
Linking the RAI to All Aspects of Long-Term Care

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MDS Bootcamp Level 1 Week 1
Linking the MDS 3.0 Assessment With the Care Plan

- The Care Plan shows how we plan to provide services to the patient for actual or potential problems, strengths and needs
- Care Area Assessments (CAAs) are the link between the MDS and the individualized resident Care Plan
- Issues discovered during the RAI Process must be addressed to determine Care Planning needs
- MDS accuracy leads to identifying areas that require a Care Plan, and to meeting all the patient's needs

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MDS Bootcamp Level 1 Week 1
Linking the MDS 3.0 Assessment with Accurate Reimbursement

- The MDS measures **acuity and resource utilization**
- A key step in denials management and prevention is to **support MDS coding through medical record documentation**
- Lack of medical record documentation for key items on the MDS may create the **appearance of fraud or abuse**

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MDS Bootcamp Level 1 Week 1
Quiz

TRUE or FALSE: Coding a clinical observation in the MDS is the same as documenting it in the medical record.

- FALSE- Clinical documentation in the chart is a CMS expectation. It is not fulfilled by coding the MDS.

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MDS Bootcamp Level 1 Week 1
Linking the MDS 3.0 Assessment with Publicly Reported Information

- The MDS 3.0 assessment generates the resident level and facility level Quality Measures
- Some Quality Measures are reported publicly through Nursing Home Compare at: https://www.medicare.gov/nursinghomecompare/search.html
- The Five-Star Quality Rating and SNF Quality Reporting Program is affected by certain Quality Measures (more later…)

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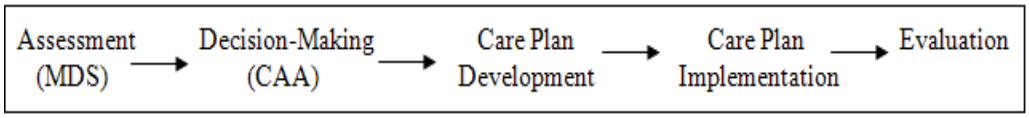
MDS Bootcamp Level 1 Week 1
Overall Goal of the RAI Process

- The delivery of care to meet the needs of a resident is based upon the completion of a Comprehensive Assessment (MDS) and the development of a resident-centered Care Plan based upon the MDS findings



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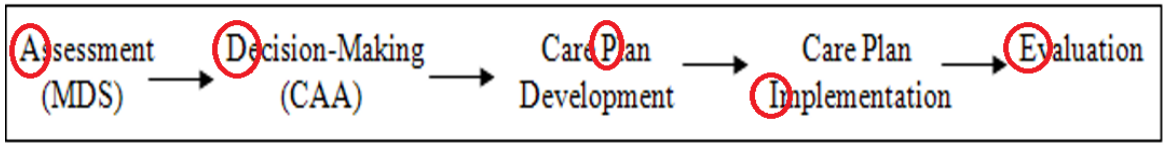
MDS Bootcamp Level 1 Week 1
Overall Goal of the RAI Process

Does all of this sound familiar?



Of course, it does.

ADPIE – Assess, Decide, Plan, Implement, and Evaluate is the nursing process!

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MDS Bootcamp Level 1 Week 1
Overall Goal of the RAI Process

- The RAI Structure is designed to:
  - Enhance resident care
  - Increase the resident's active participation in care
  - Promote the resident's quality of life
  - Create a system of "hands-on approach" that involves all disciplines
  - Address the patient's needs holistically
  - Allow for good communication and tracking of the resident's care

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MDS Bootcamp Level 1 Week 1
Overall Goal of the RAI Process

- The RAI provides each resident with:
  - A standardized, comprehensive, reproducible assessment
  - An assessment of the patient's ability to perform day to day life functions
  - Identification of significant impairments in the patient's functional capacity
  - Opportunity for inclusion of resident's voice through direct interview
  - Standardized communication

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MDS Bootcamp Level 1 Week 1
Overall Goal of the RAI Process

- The facility must develop a Care Plan that meets these guidelines:
  - Individualized
  - Comprehensive
  - Measureable goals
  - Timetable to meet the goals

Key Point: The Goal of the RAI Process is the Resident Centered Care Plan

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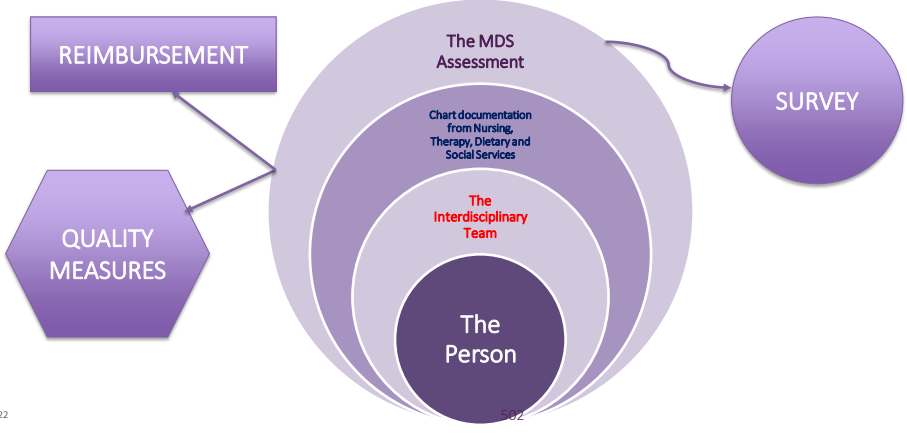
MDS Bootcamp Level 1 Week 1
Resident Assessment Instrument (RAI)

The person is the center of it all



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MDS Bootcamp Level 1 Week 1
Quiz

What is the GOAL of the RAI Process?

- Person-Centered Care:

The development of a Person-Centered Plan of Care that guides care and services to attain or maintain the person's highest practicable physical, mental and psychosocial well being

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MDS Bootcamp Level 1 Week 1
Questions?

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MDS Bootcamp Level 1 Week 1
BUT WAIT! There's More…

Coming Next Week

- Minimum Data Set (MDS) Scheduling, Basics and Coding Part 1 (A)
  - The Lookback Periods
  - Scheduling Assessments
  - Completing Section A

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MDS Bootcamp Level 1 Week 1
BUT WAIT! There's More…

Bootcamp Challenge:

- Define the term "Lookback Period" as it relates to the MDS Assessment

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About HHI

- HHI founded in 2001.
- Privately owned and operated.
- Female owned business.
- Ranked among Inc. Magazine's top 5,000 fastest growing private companies in America three years in a row.
- HHI active in all 50 states.
- HHI services over 1,000 Skilled Nursing Facilities.
- HHI trains thousands of clinicians every year.

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HHI Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care

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HHI
Services and Plans

Gold C.A.R.E.S.
2 Year Service Plan

Platinum C.A.R.E.S.
3 Year Service Plan

List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

Silver C.A.R.E.S.
1 Year Service Plan

A La C.A.R.E.S.
Customized Service Plan

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HHI Specialists

- HHI employs the best and brightest of the industry.
- All HHI Specialists are cross trained on the C.A.R.E.S. platform.
- HHI only employs positive, proactive and polite staff with a constant desire to learn, teach and improve patient care.
- HHI strives and thrives for Harmony within and outside of the work environment.

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https://www.harmony-healthcare.com/harmonyhelp

Knowledge
Support
Available

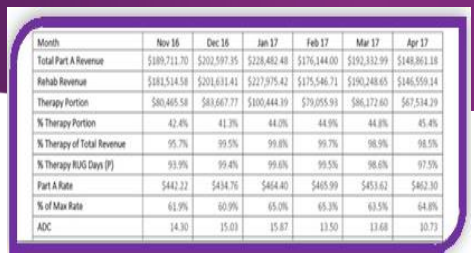
HarmonyHelp

HarmonyHelp provides resources for the entire interdisciplinary team. Access HHI's vault of information on Compliance, Regulatory, Reimbursement, Survey, Education, Manuals (RAI, Medicare, Billing, ICD-10), PowerPoints, On Demand Training, Toolkits, Forms, Library of Final Rules, Kris's Brain and much more.

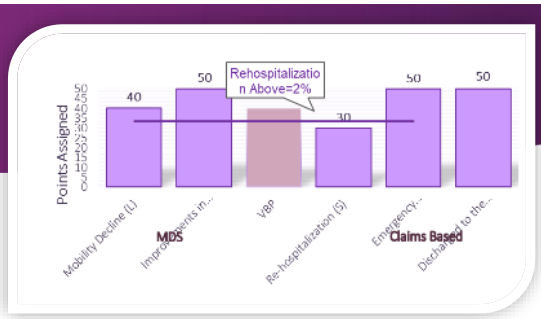
The **Knowledge Center** is loaded with **information** that will assist staff with daily responsibilities at the facility.

Manuals I Tools I On Demand Webinars I Rules and Regulations

Harmony Healthcare INTERNATIONAL



Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73



Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PEPPER Analysis

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Connect With HHI and Follow HHI Blog

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Harmony Healthcare International (HHI)

C.A.R.E.S.™

HHI C.A.R.E.S. About Care

Compliance | Analysis | Audit | Regulatory | Rehabilitation
Reimbursement | Education | Efficiency | Survey

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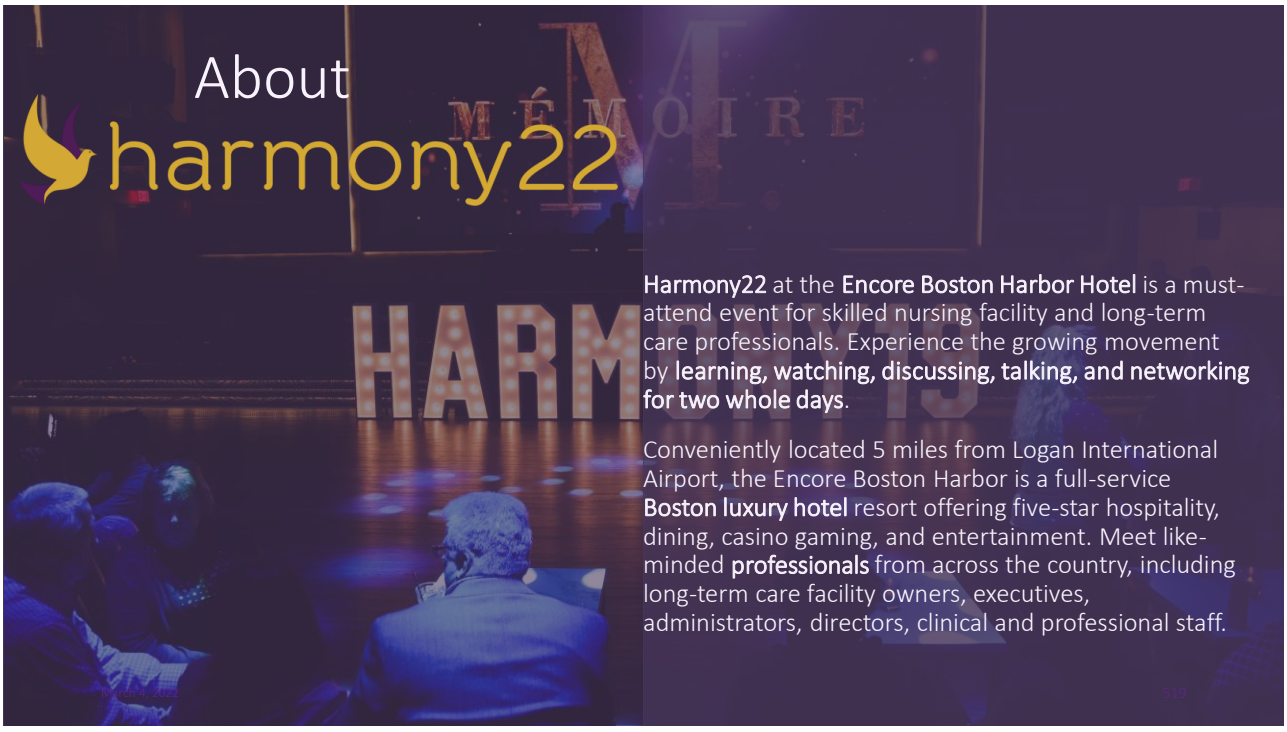

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About (HHI) Media Team

Harmony Healthcare International, Inc. (HHI) recognizes the importance of marketing and releasing high-quality content, especially within the domain of education. An in-house, professional **media team** now supports HHI's continued commitment to delivering knowledge. This group supports the marketing, education, and public relations department powerfully delivering their messages. Through creative **videos and images**, we make this team readily available to our high-level sponsors. Together, we can bring forth compelling content which undoubtedly produces **quantifiable, measurable results** to the benefit of one's company.

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harmony22 Agenda

Wednesday, October 19th, 2022
Arrival

Thursday, October 20th, 2022

7:30	Breakfast
8:30 - 4:00	Sessions
5:00 - 7:00	Networking Event
7:00 - 10:00	VIP Event (Invite Only)

Friday, October 21st, 2022

8:00	Breakfast
8:30 - 2:30	Sessions
2:30 - 3:30	HHI Dove Award and Closing Remarks

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Attendee Registration Fees

• Winter Rate	(January 1st, 2022 - March 31st, 2022)	$599 per person
• Spring Rate	(April 1st, 2022 –June 30th, 2022)	$650 per person
• Summer Rate	(July 1st, 2022 – September 30th, 2022)	$699 per person
• Last Minute Rate	(October 1st, 2022 – Event Date)	$799 per person

Contact:
symposium@harmony-healthcare.com
1.800.530.4413
KrisBHarmony@harmony-healthcare.com
617.595.6032

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Get Your Tickets Today!

https://bit.ly/harmony22tickets

symposium@harmony-healthcare.com
1.800.530.4413

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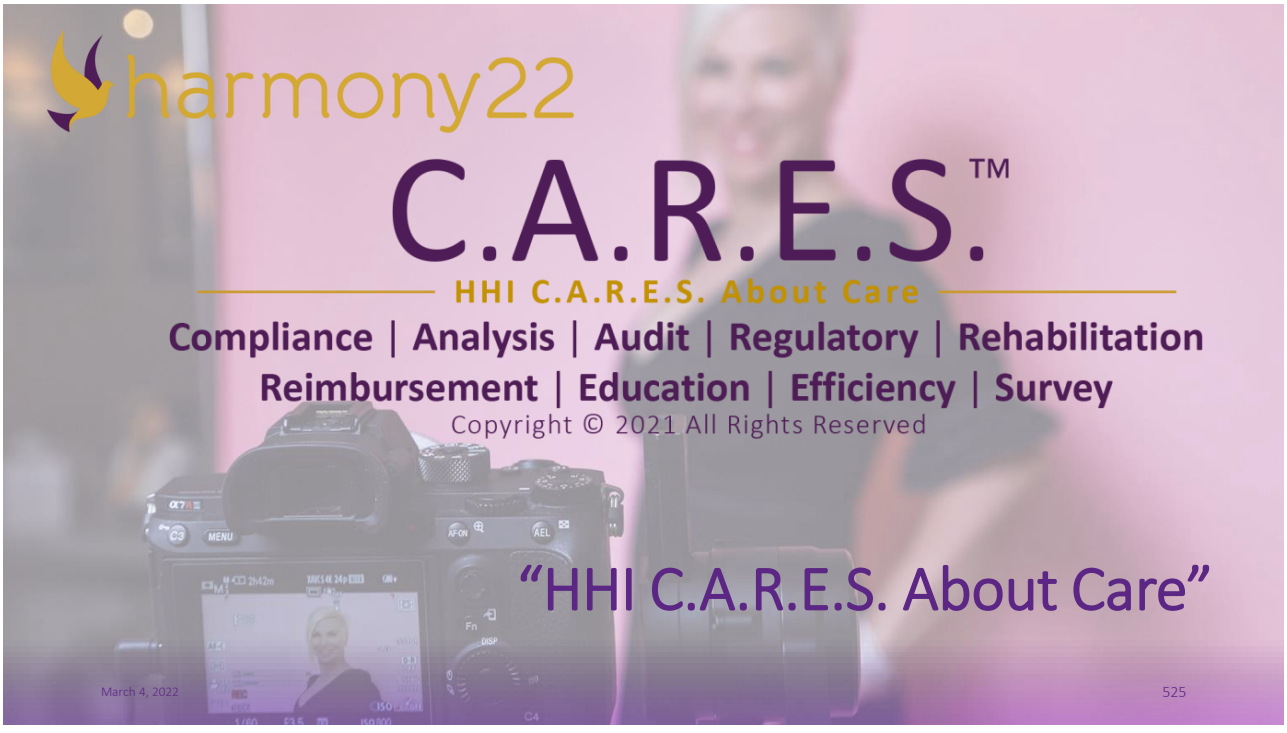

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