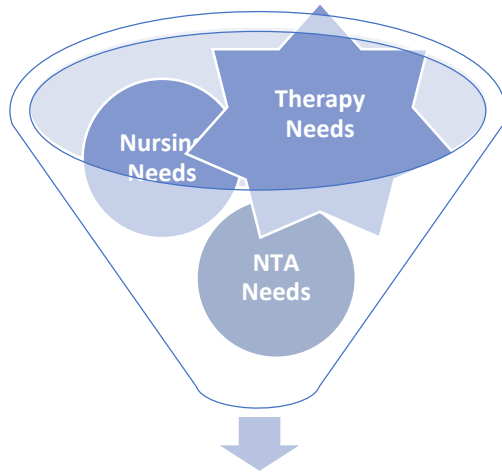


# **PDPM: The First 30 Days**

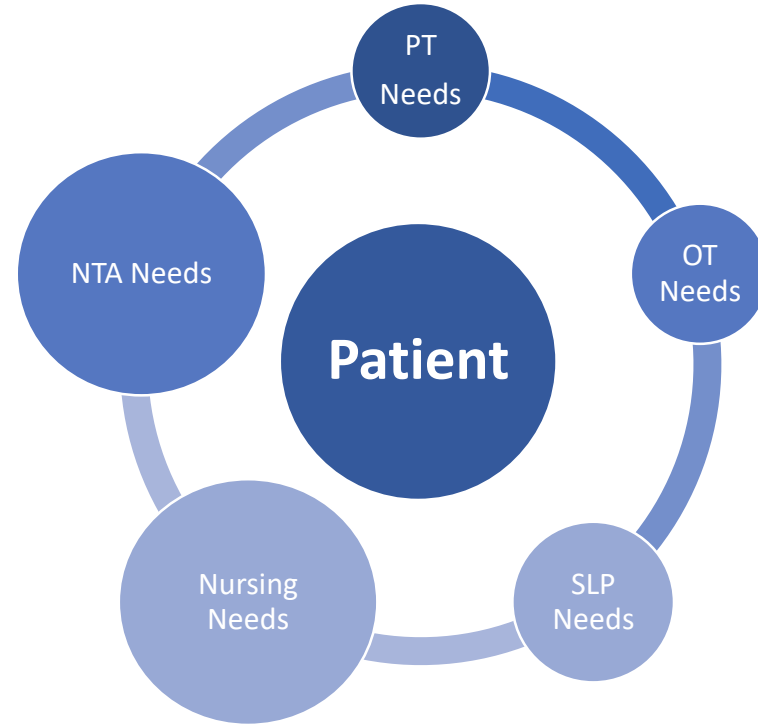
**Michalene Kinsler, Strategic Interests  
Jean Bauch, Rochester Regional Health**

**November 13, 2019**

# Patient Driven Payment Model: What is Changing?



**RUG IV/PPS Model**



**Updated PDPM Model**

**PDPM, adopted by CMS on October 1, 2019, is a shift toward “a more patient-driven approach to reimbursement for care in SNFs.”**

# Patient Driven Payment Model: What is Changing?

## Changes:

- Specific, data-driven patient characteristics will determine payment
- New rules and definitions for group and concurrent therapy: combined limit of 25%
- Methodology to determine function score and use of Section GG data (functional ability/goals)
- Non-therapy ancillary component weights 50 conditions and services identified by CMS

## Not Changing:

- Patient needs and medically necessary care as a baseline standard
- Criteria for skilled therapy coverage
- Clinical judgment to determine appropriate frequency, duration, and modality of services
- Documentation requirements regarding rationale for group therapy
- Reliance on functional status and presence of cognitive impairment for payment classification

# Pre-PDPM Common Concerns

## **1. Workflow changes, coding accuracy, potential audits and documentation**

Accurately capture nursing acuity

Document the best and most accurate ICD-10 coding

How to handle change in code, alerts to nursing staff

## **2. Potential decrease in therapy**

Utilize the value of group and concurrent therapy to drive outcomes

Consolidation of providers

ROI of therapy under new rules

## **3. Measuring success: uncertain about outcomes and reimbursement**

Efficiently deliver positive, well-documented performance outcomes

Period of transition, then correction

# Pre-PDPM Interviews: Key Learnings

Organizations that felt “ready for PDPM” had:

**1) Supportive corporate leadership**

“People always resist change, you need to roll up your sleeves and help them.”

**2) Proactive, curious culture**

“We are always trying to go beyond mandates and be innovative.”

**3) Demonstrated decision making ability**

“Once we adopt something, it becomes the culture.”

**4) Systems in place for handling change**

“Everyone wants to do a good job and have good documentation.”

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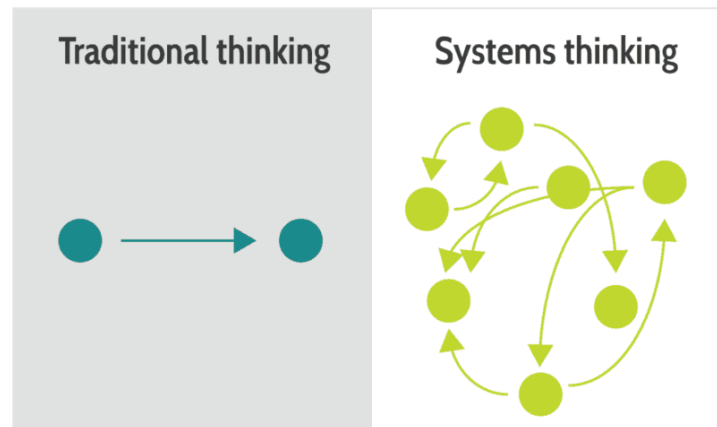
# PDPM Challenge: Change Management



# PDPM Challenge: Change Management

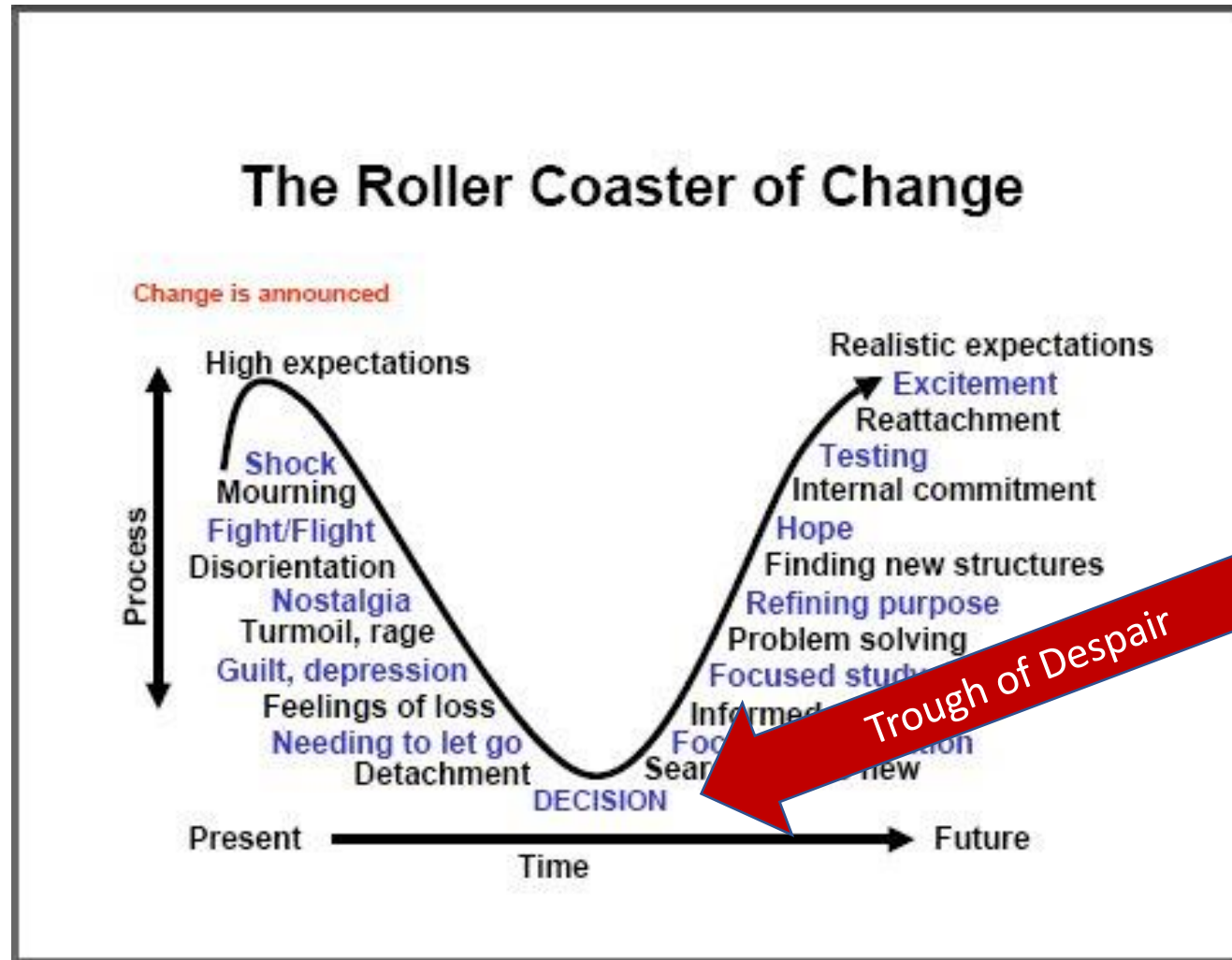
Ahead of PDPM, Strategic Interests worked to help their client:

1. Understand the way organizations approach change
2. Develop strategies to increase the customer's ability to manage change
3. Provide self-service tools to address barriers to/enablers of PDPM success  
e.g. customer readiness, stakeholder engagement and alignment, targeted communication, ways to better manage expectations





# PDPM Challenge: Change Management



Where and when  
is the bottom?

Does it depend on  
your role in the  
organization?

Trough of Despair

# Rochester Regional Health System

## PDPM Challenges

- Six long term care facilities spread over a large geographic area
- Nearly 1000 residents
- Many centralized services (HIM, Coding, Billing, IS&T, etc.) not on-site
- New clinical EMR system phased in from May to July 2019
- Different EMR for clinical documentation versus MDS/Billing
- Brand new VP of LTC

# Rochester Regional Health System

## PDPM Preparation

In early August, the new VP of LTC managed the PDPM readiness project.

All resources were involved:

- Hospital
- Providers
- Coding
- CDI (clinical documentation improvement)
- HIM
- Long Term Care Leadership
- MDS Coordinators, LTC Staff
- IS&T
- Consultants, vendors

# Rochester Regional Health System

## Early learnings from the first 30 days

1. Communication and collaboration are crucial
2. Think outside the box regarding effort and ROI
3. MDS take longer, though fewer MDS are required
4. Clinical Documentation Improvement is invaluable (per our pilot)
  - a. Investigative work on coding & documentation
  - b. Triple check more important than ever – everything in place before the bill goes out
  - c. Takes the burden off of MDS coordinators, etc.
5. Leverage the clinical EMR to capture required daily documentation
  - Can save time and substantiate need for skilled stays
6. Updates, service packs and patches are to be expected
7. Manual spot checks of audit scores pay off, especially at the beginning

*Ask us in another 30 days, when  
claims begin to be paid or denied!*