FHCA 2019 Annual Conference & Trade Show

CE Session #2 – Camping Successfully Through PDPM and Beyond

Monday, August 5 – 8:00 to 9:30 a.m.

Celebration 3-4 – Clinical/Care Practices

Upon completion of this presentation, the learner will be able to:

- Identify the benefits of a successful rehab partnership with the Patient Driven Payment Model (PDPM)
- Articulate how clinical pathways can be utilized as a road map to enhance clinical outcomes
- State additional opportunities for rehab collaboration with other areas such as the Rules of Participations, skilled nursing center Quality Reporting Program (QRP) and skilled nursing center Value Based Purchasing (VBP)

Seminar Description:

Major changes are occurring because of the Patient Driven Payment Model (PDPM). These changes have caused different emotions such as confusion, anxiety and indifference. When camping in different environments, campers typically collaborate and utilize a map to navigate unfamiliar territory. This session will provide the road map for successful collaboration with rehabilitation. Partnership opportunities will also be presented with other areas such as the Requirements of Participation and the skilled nursing center Value Based Purchasing (VBP).

Presenter Bio(s):

Angela Edney is a national Clinical Director for Aegis Therapy with 25 plus years of management experience in senior care providing field support for clinical practice specialists, area vice presidents and OT, PT and SLP staff. Angela has co-authored many resources on dementia, incontinence management, seating and positioning, etc.

Victoria Franco, RPT has been a Physical Therapist practitioner for over 25 years. She is currently an Area Vice President for Aegis Therapies. Victoria has a background in multiple settings such as outpatient, inpatient hospital, home health and skilled nursing centers. Her experience encompasses clinical and managerial tasks.

Jessica Pranke, M.S. CCC-SLP is currently a Clinical Practice Specialist for Aegis Therapies in Florida. She has been a Speech-Language Pathologist for 15 years. Working with Aegies Therapies since 2004, Jessica has served in both operational and clinical roles. She provides training in the areas of neurocognitive impairments and complex disease management.

Reda Shihadeh is an Occupational Therapist who works for Aegis Therapies. Reda has been an Occupational Therapist since 1992. He has been practicing in the areas of Geriatrics and Management for over 20 years. Reda has served in many roles with Aegis Therapies, currently serving as an Area Vice President.

Camping Successfully Through PDPM and Beyond

Camping Successfully Through PDPM and Beyond

Welcome and Introductions

Angela Edney, National Clinical Director

Victoria Franco, Area Vice President

Reda Shihadeh, Area Vice President

Jessica Pranke, Clinical Practice Specialist

Camping Successfully Through PDPM and Beyond

- Identify the benefits of a successful rehab partnership with the Patient Driven Payment Model (PDPM)
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PDPM is Here!!!

Not the end of the world, in fact …

It's a significant step in the right direction!

"Pele Takes What Pele Wants…"

What Can Be Done With This New Landscape?

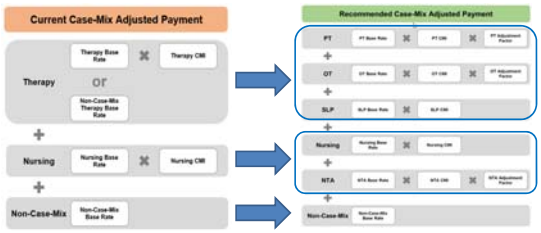
We Have a New Foundation…

What's Our Point?

- We've done this before and we happen to be very good at it
- PDPM is an outgrowth or "flow" from a much larger source of change
- That "source" is the desire to achieve meaningful outcomes more efficiently, resulting in a better experience for the consumer
- We ALL want these goals to be achieved
- Our planned response to all of these "flows" (and "future flows") can have a similar focus

What Has Changed?

RUG-IV vs PDPM



Minutes of Therapy drive reimbursement
Two care components (Therapy, Nursing)
Extensive reporting / documentation

Payments tied to Patient Condition
Five care components (PT, OT, SLP, Nursing, NTA)
Reduced administrative burden

Budget Neutral?

	% of Stays	Percent Change in Reimbursement
Utilization of Days		
1-15 days	35.4%	13.7%
16-30 days	33.8%	0.0%
31+ days	30.9%	-2.5%
Therapy Level		
Rehab Ultra	58.4%	-8.4%
Rehab Very High	22.4%	11.4%
Rehab High	6.8%	27.4%
Rehab Medium	3.3%	41.1%
Rehab Low	0.1%	67.5%
Non-Rehab	9.1%	50.5%

Budget Neutral?

	% of Providers	Percent Change in Reimbursement
Ownership		
For Profit	72.0%	-0.7%
Non-Profit	22.6%	1.9%
Government	5.4%	4.2%
Number of Certified SNF Beds		
0-49	10.0%	3.5%
50-99	38.2%	0.6%
100-149	34.7%	-0.2%
150-199	11.1%	-0.3%
200+	5.9%	-1.8%
Location		
Urban	72.7%	-0.7%
Rural	27.3%	3.8%

PDPM Impact file

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

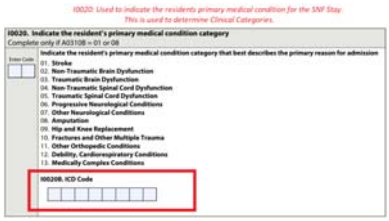
PDPM Patient Classification

- Patient classifications are used for each of the components (PT, OT, SLP, NTA and Nursing)
- Breakdown of criteria for classification

Component	Criteria
PT	Clinical Category, Functional Score
OT	Clinical Category, Functional Score
SLP	Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder
NTA	NTA Comorbidity Score
Nursing	Same as RUG-IV

PDPM Clinical Category

- Clinical categories are assigned based on the **primary reason for the SNF stay.**
- Item I0020B is used to then map to one of the ten PDPM clinical categories.
- Section J of MDS is used to adjust clinical classifications.



PDPM Drivers:
Achieving Outcomes and Financial Viability Requires…

Accuracy in Coding

- ICD-10 – Primary reason for the SNF Stay
- Functional Score: MDS Section GG – 10 items for Physical and Occupational Therapy; 7 of those 10 items for Nursing (unlike Section G – ADL Index; with Section GG, the higher the functional score, the greater the level of independence

Clinical picture of the patient: Coding all of the MDS items related to mood, cognition, comorbidities (active diagnoses, all systems), special treatments/procedures/programs/services, nutrition, swallowing, medication, skin conditions, prior surgeries

Cultural Changes Related to PDPM

Patient Centered Care Planning, All-staff Communication

MDS Coordinators

- Increased face-to-face patient assessment
- Validation of supportive documentation
- Oversight in completion of MDS; with an elevated focus on "high impact" items under PDPM

Therapy – Nursing Collaboration

- Eliminating metric-based therapy; focus on clinical picture of the patient
- Section "O" – reporting therapy minutes and days for compliance with concurrent/group utilization (evaluation minutes still not included)
- Section GG collaboration – coding the patient's "usual baseline performance" prior to the benefit from therapy intervention

PT, OT and ST Clinical Categories

PDPM Clinical Categories	PT & OT Clinical Categories	% of all
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery	1%
Acute Neurologic (ST)	Non-Orthopedic Surgery & Acute Neurologic	5%
Non-Orthopedic Surgery		
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic	25%
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)		
Medical Management	Medical Management	26%
Cancer		
Pulmonary		
Cardiovascular & Coagulations		
Acute Infections		
RTP		42%

Our Early Impression of Prime Opportunities for Better Coding

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NTA	NTA Comorbidity Score
Nursing	Same as RUG-IV

SLP Comorbidities

SLP has 12 comorbidities under PDPM

- SLP comorbidity flag combines conditions and services.
- The presence of only **one** of the following is required for patient to qualify (mainly sections I and O):

Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
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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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

NTA and Comorbidity Coding

- Comorbidity score is a weighted count of comorbidities
  - Comorbidities associated with high increases in NTA costs grouped into various point tiers
  - Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers
- Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD10-CM codes reported in Item I8000

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

Non-Therapy Ancillary Component

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Diabetes Mellitus (DM) Code	MDS Item I2900	2

Non-Therapy Ancillary Component

Condition/Extensive Service	Source	Points
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1

Non-Therapy Ancillary Component

Condition/Extensive Service	Source	Points
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Malnutrition Code	MDS Item I5600	1

Non-Therapy Ancillary Component

Condition/Extensive Service	Source	Points
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

One Point Matters!!!

If NTA Group is "NC" (8 points):

Base Rate (Urban)	X	CMI	X	Variable Payment (1st 3 days of stay)	=	Per Diem
$80.45		1.84		3.0		**$444.09**

If NTA Group is "NB" (9 points):

Base Rate (Urban)	X	CMI	X	Variable Payment (1st 3 days of stay)	=	Per Diem
$80.45		2.53		3.0		**$610.62**

+ $166.53 for days 1-3, + $55.51 for days 4-20, + $1,443.26 for 20-day stay.

Transition to PDPM

- There is NO transition period between RUG-IV and PDPM:
  - RUG-IV ends on 9/30/2019
  - PDPM effective on 10/1/2019
- Billing beginning on Oct 1, 2019 requires all providers to *complete an IPA with an ARD no later than Oct 7, 2019.*
  - Variable Per Diem - 10/1 is considered day one even if stay began prior
  - "Transitional IPAs" with an ARD after 10/7/19 will be considered late and penalties applied for late assessments

Latest Updates from Proposed Rule

SNF PPS Proposed Rule Published by CMS April 19, 2019

- Proposed Payment Update: 2.5% for FY 2020 (increase is aggregate payment of $887 million, compared to FY2019
- PDPM Changes
  - Proposes to change the definition of group therapy in a SNF to match the definition in the IRF setting – "a qualified rehabilitation therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities."
  - Proposes using a subregulatory process to provide "non-substantive" updates to ICD-10 codes used in PDPM through the PDPM website
  - Proposes to officially change regulation text to reflect changes in the MDS assessment schedule already finalized in the FY2019 Final Rule. The text will call for "an initial patient assessment" to be completed "no later than the eighth day of post-hospital SNF care"

Latest Updates from Proposed Rule

SNF PPS Proposed Rule Published by CMS April 19, 2019

- Quality Reporting Program (QRP)
  - Beginning with **FY2022**, proposed to adopt two process measures related to requirement for "transfer of health information" –
    - 1) to the PAC provider. The measure will assess whether or not a current reconciled medication list is provided to the subsequent provider when a patient is discharged or transferred from current PAC setting (% of stays with a discharge assessment indicating that a current reconciled medication list was provided)
    - 2) to the Patient. The measure will assess whether or not a current reconciled medication list is provided to the patient, family or caregiver when a patient was discharged from a PAC setting to a private home/apartment, a board and care home, assisted living, group home, transitional living or home under home health or hospice (% of stays with a discharge assessment indicating that a current reconciled medication list was provided to patient, family or caregiver at the time of discharge)

Latest Updates from Proposed Rule

SNF PPS Proposed Rule Published by CMS April 19, 2019

- Quality Reporting Program (QRP)
  - Proposes to update the specifications to Discharge to Community QRP measure to exclude baseline nursing facility (NF) residents from the measure
  - Proposes to collect standardized patient assessment data and other data required to calculate quality measures using the MDS on all patients, regardless of payer source

Latest Updates from Proposed Rule

SNF PPS Proposed Rule Published by CMS April 19, 2019

- Quality Reporting Program (QRP)
  - Measure remains the same – SNF 30-day All-cause Readmission Measure

Aegis Therapies PDPM Resource Center

Video Topics:
- Overview
- MDS
- Sec GG
- I0020B
- NTA
- IPA
- Group & Concurrent
- Physicians
- Communication & Collaboration
- Restorative

Delivery Methods:
- Videos
- White paper summary (20+ pages)
- 1 & 4-page summaries
- FAQs
- Podcasts

www.AegisTherapies.com
Resources - PDPM

Models for Success – Clinical Foundations

Level of Delivery
- Clinical Pathways (determining the 'right amount of therapy' for each patient)
- Evidence-based protocols
- Outcomes

Staff Readiness
- Clinical competencies
- Considerations for additional "extenders"

Modes of Therapy Delivery
- Individual Therapy
- Group Therapy
- Concurrent Therapy

Models for Success – Clinical Service Delivery

Modes of Therapy Delivery

- Individual Therapy
- Group Therapy
- Concurrent Therapy

Focus on hand offs

- Extender support

Models for Success – Facility Collaboration

Communication and Collaboration

- Formalized communications
- Frequency of communications
- Impact on IPA

Role Shifts

- Therapy Manager
- MDS Coordinator
- IDT members

Models for Success – Measures of Value

Outcomes

- Section GG
- Rehab Outcome Measures (ROM)

Quality Reporting Program (QRP)

- Therapy impact

Value Based Purchasing (VBP)

- New proposals
- Therapy role – rehospitalization reduction

Models for Success – QRP

The two measures CMS is proposing to adopt are:

- **(1) Transfer of Health Information to the Provider – Post-Acute Care (PAC).** This measure is will assess whether or not a current reconciled medication list is given to the subsequent provider when a patient is discharged or transferred from their current PAC setting; and
- **(2) Transfer of Health Information to the Patient – Post-Acute Care (PAC).** This measure will assess whether or not a current reconciled medication list was provided to the patient, family, or caregiver when the patient was discharged from a PAC setting to a private home/apartment, a board and care home, assisted living, group home, transitional living or home under care of an organized home health service organization, or a hospice.

Models for Success – VBP

SNF Value Based Purchasing Program (VBP)

- CMS is proposing to change the name of the SNFPPR measure. In addition, the performance period for the FY 2022 program year will be FY 2020, and the baseline period will be FY 2018. CMS is also providing estimates of FY 2022 performance standard's numerical value. Lastly, CMS is not proposing any updates to the SNF VBP scoring or payment policies in this proposed rule.

VBP Overview

SNF Value-Based Purchasing (VBP) aims to reward quality and improve healthcare:

- Effective 10/1/18 DOS, SNFs will have an opportunity to receive incentive payments based on performance on the specified quality measures
- Payment determination in FY 2019 include:
  - 2% of SNFs' Medicare payments withheld to fund incentive payments
  - 60% of the total amount withheld from SNFs' Medicare payments for that FY will be paid as incentive payments to SNFs based on their performance in the program
  - Bottom 40% of SNFs must receive less in incentive payments than they would otherwise receive
  - SNF 30-Day All Cause Readmission Measure (SNFRM) - counted regardless of whether the beneficiary is readmitted to the hospital directly from the SNF or has been discharged from the SNF (Excludes planned readmissions)
  - Transition from CY to FY:

Table 1: Performance and Baseline Periods for FY 2019 & 2020 Program Years

Period	FY 2019 Program Year	FY 2020 Program Year
Performance Period	CY 2017 (Jan. 1, 2017-Dec. 31, 2017)	FY 2018 (Oct. 1, 2017-Sept. 30, 2018)
Baseline Period	CY 2015 (Jan. 1, 2015-Dec. 31, 2015)	FY 2016 (Oct. 1, 2015-Sept. 30, 2016)

VBP - Scoring

SNF VBP Performance Score:

- By statute CMS can distribute only 60% of the total dollars withheld
- Minimum performance for earn back is < ~20.4% - those at ~16.4% or less will score better
- SNFs assigned SNF VBP Performance Scores based on their SNFRM RSRRs in the applicable baseline and performance periods
- SNF VBP Performance Scores range from 0 to 100 points
- SNFs are assigned values for both their improvement from baseline year to the performance year and achievement in the performance period
- Performance score is the higher of a SNF's achievement score or improvement score
- For SNFs that only have performance period data, the achievement score will equal the performance score
- SNFRM data already available in nursing home compare

QRP Overview

Quality Reporting Program (QRP) for all SNFs to submit data.

Failure to do so results in 2% penalty. Includes:

- SNF QRP Assessment-Based Quality Measures (falls, pressure ulcers, % of pts with admit/discharge assessment/care plan)
- SNF QRP claims-based measures
- At least 80% of assessments must be 100% complete for all required elements
- Data used to determine compliance for FY2019 payments is from CY2017

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set	
Pressure Ulcer	Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)*
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
Change in Self-Care Score	Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
Claims Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB) – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
DTC	Discharge to Community – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

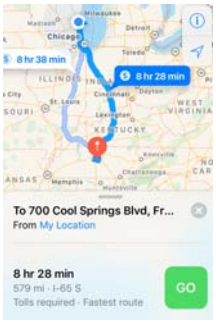
A Shift in Roles/ Focus for Therapy Managers and Therapists?

A Shift in Roles/ Focus for MDS Assessment Coordinators?

A Common Focus for ALL

Destination →

Estimated Arrival →



Pilot Study with 42 Facilities

1/7/19 - 2/28/19

- High Managed Care penetration
- Wellness program in place for at least half of those selected
- Strong on-site Therapy Dept. Manager

Goals:

- Analyze and further develop efficacy of care pathways with "guardrails" against outcomes.
- Analyze coding elements related to MDS risk scores (CMI) for completeness and impact on reimbursement/ outcomes.
- Test/ refine staffing mix models with use of extenders for non skilled tx, group/ concurrent approaches against outcomes.
- Enhance collaboration/ IDT processes and handoffs to ensure appropriate levels of communication related to IPA-related activities and changes in status that impact documentation and CMI.

Pilot Study

Resources/Tools developed/ enhanced:

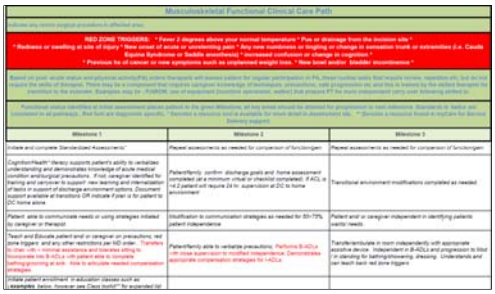
- Clinical Collaboration Tool
- Clinical Pathways
- Problem-Oriented Documentation (POD) Resources
- Clinical Group/Concurrent Resources
- Extender Tracking Form

Clinical Collaboration Tool

Clinical Collaboration Tool

Patient Name	
Date	
*Primary Dx (reason for SNF stay) – include ICD-10 code *[also include PT and OT Clinical Category utilizing the PDPM Clinical Category Mapping Tool]*	
Admission Assessment Date	
Discharge setting and transition date	
Physical Therapy SOC date	
**Physical Therapy – Section GG complete? (from therapy)	
Occupational Therapy SOC date	
**Occupational Therapy Section GG complete? (from therapy)	
Speech Language Pathology SOC date	
*Acute neurologic dx *[determine if reason for SNF stay is in the acute neurologic category according to the PDPM Clinical Category Mapping tool]*	

Clinical Pathways


Musculoskeletal Functional Clinical Care Path

Pilot Results

- Significant positive impact on Section GG completion and Problem-Oriented Documentation (POD) utilization.
- Did **not** see an overall negative operational impact.
- The therapy staff at these sites were able to stay focused on long stay clinical programming.
- Regarding Alternate Service Delivery Modes, four out of six sites averaged 3.74% - 8.88% group and concurrent combined.

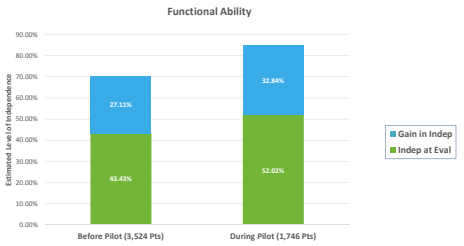
Pilot Lessons Learned

- Need for on-site leadership to be heavily involved in the process, to provide training, monitor results and provide oversight
- Need to create novel space for PDPM resources to house operational, leadership, and clinical tools
- Need to further develop Collaboration Tools between Therapy and the other IDT team members
- Additional Clinical Pathways were created with modifications based on feedback from Pilot sites
- The Pilot success resulted in expansion of the program to an additional 35+ sites. "BETA" objectives and reporting structure came as a direct result.
- Identified need for additional education and training for SLP on certain components

Pilot Lessons Learned

- Is the available technology able to meet PDPM needs?
- Method for training for additional sites refined, including timing and content
- Need for more emphasis on concurrent training
- Customer engagement is critical to the success or lack of success
- Competency and proficiency training needed for Extenders. Resources developed for self-assessment and competency check off.
- Site of service for extenders was identified to be most applicable in the rehab gym space close to or even in line of site of the therapist.
- Heightened awareness of primary diagnosis codes and review of CMS PDPM Clinical Category Mapping Tool in collaboration with IDT
- Enhanced awareness of the need for collaboration on early identification of cognitive status

Pilot Lessons Learned - Outcomes



What Can I Do Now: Clinical

- Begin identifying clinical leaders who can assist you in developing and monitoring clinical consistency.
- Develop processes and work through barriers to implement other service delivery options including Group and Concurrent.
- Gather and develop systems for regular use of standardized assessment tools and clinical pathways.
- Analyze the use of GG codes. Get to 100% compliance in entering GG codes for part A patients.

What Can I Do Now: IDT

- Knowledge Assessment
  - What PDPM trainings have the staff attended?
  - Do you have an active restorative nursing program?
  - How confident do you feel about your ICD coding knowledge?
  - What are your PDPM hot buttons (MDS, coding, IPA communication, outcomes, etc.)?
  - Use of Facility Readiness tool

What Can I Do Now: IDT

- Collaboration
  - Mtg between DOR and ED, DNS, MDS coordinator regularly?
  - Are you piloting or developing PDPM success strategies?
  - Is there an effective communication process for Section GG scoring?
  - Do you have a process in place to communicate clinical changes to MDS?

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Thank You!