

Changes in Medicare Payments to Skilled Nursing Facilities: Know Your Value!

Part 2

Speakers: Sarah Warren, Renee Kinder

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Sarah Warren: Hello. Thank you for joining me today for this webinar entitled, Changes in Medicare Payments to Skilled Nursing Facilities: Know Your Value webinar. This is a second in a series of two webinars focused on the transition to a Medicare payment system for skilled nurse facilities.

The new payment system, the Patient Driven Payment Model or PDPM, focuses on patient clinical characteristics and the value of services provided to Medicare beneficiaries as opposed to the previous payment systems known as the RUG IV, which really focus on the volume of services delivered to patients.

In the first webinar about knowing your facts, we went over the structure of the PDPM payment system and introduced the concept of SLPs engaging in the value proposition under PDPM. This webinar, which will be led primarily by our member expert, Renee Kinder, of Encore Rehabilitation, will focus on what you can practically do under PDPM to engage in that value proposition and show your value under PDPM.

So, without further ado, I would like to turn it over to Renee. Take it away Renee. Thank you.

Renee Kinder: Thank you Sarah. And thank you to everybody for joining us today. As Sarah mentioned, we are participating in a two-part series with the first course really being the foundation for the history, the background, the why on the reason that Medicare is looking to change the reimbursement system into one that's more based on value and individual patient characteristics.

As you will see on the next slide, the time is coming for us to have a significant change in the industry. So, essentially for those of you that are relatively new to the skilled nursing environment or even in the past 10 years, all that you've really known is the RUG system, RUG III moved to RUG IV.

And essentially, we've been in a similar reimbursement model since 1998. So, the changes in October are significant. However, it's also important to know that we're on the road to change. And the changes that you are going to see impacting skilled nursing facilities in October are also impacting essentially the entire post-acute care spectrum.

We've seen significant changes – and as we go to the next couple of slides through the road to change into this healthcare paradigm shift on the next slide historically across the entire post-acute care spectrum.

We've had reimbursed that models that are in essence more provider centric. And in short, there have been (incentives) for volume. Currently under the RUGs IV model, we're reimbursed based on some clinical element tied to the section G functional status but largely focused on the volume of care that's provided.

Additionally, if you look at the post-acute care spectrum – and I'm going to do that multiple times today, I'm referring to any setting that an individual would access following an acute care stay in the hospital; so, skilled nursing facility, inpatient rehab facility, long-term care hospital or home health agent stay.

If you look at the models currently on how we're reimbursed, there really – there's not a lot of requirement for collaboration across teams within that individual setting or even across settings. And we also historically have had a fee-for-service model. So, we perform a service, we get a reimbursement.

It's a very exciting time in the industry to see where we are reforming to. So, essentially, what we see happening is this drastic change to models that are more person inpatient centric; hopefully, moving towards more models that are incentivizing us for the clinical for the clinical outcomes that we'll achieve.

And we'll talk a little bit about some of the very recent updates that we saw from this year's proposed rule for skilled nursing facilities on what some of those outcomes maybe. That's been a big question for all of us.

Additionally, there's a greater focus on coordinated care. And what we're doing to coordinate care within our individual settings and across settings. And you see this overall move towards more alternative payment models.

And when we say APMs, they're very broad terms. So, any reimbursement model that really shift the focus from volume to value or quality or focus on an outcome is known as an alternative payment model.

So, as we shift to the next slide, you will see how we got here. This is not an overnight change. But, it's something that it's really the key elements that we are going to talk about today in regards to value based purchasing and quality reporting in your short and long stay quality measures and your five star rating, and PDPM really all began with the IMPACT Act of 2014.

So, let's go back a few years and talk about what the initial discussions at the CMS level included so that we have an understanding of where we're going. Those of you that have been following IMPACT Act know that it really began with a higher level conversation on – if we want to look at the spectrum of care, we need to start with the outcome measure.

And across the post-acute care spectrum, we have a variety of – you can go back one more and I'll work through this one – we have a variety of reimbursement data collection forces if you will. So, those of you that are practicing within skilled nursing facilities, you have the minimal data set or the MDS as your data source. Some health agencies have the Oasis. Inpatient rehab facilities have the IRF-PAI.

And so, before we look to have similar and consistent models across the spectrum, CMS is looking at how we standardize the outcomes measures. And that's also the reason why we see so many similar elements being embedded in those measures across the spectrum. So, that was the initial

conversation. We need an apples-to-apple versus an apples-to-orange-to-lemon comparison.

Next, we had recommendations from MedPAC. And for those of you that are not familiar with MedPAC, MedPAC is a group that advises Congress on Medicare reimbursement. Another important element of all of the regulation that we're going to discuss is that it's not secret. It's not done in isolation.

So, when MedPAC has meetings, their agenda is posted publicly before. Their handouts and materials are accessible. You could even attend the meetings as an observer if you were to wish to do so. So, none of these regulatory changes are done in isolation separate from individual providers being able to have an understanding of what they mean. So, that's a positive.

MedPAC is also called to have reform across this post-acute care spectrum. And what we saw initially at first in iteration goes for PDPM in skilled nursing facilities was an Advanced Notice of Proposed Rule Making or an ANPRM.

And I remember when this was first published and being in communication with Sarah and she immediately knew that this meant something special. Because, typically, we – in rule making season – get a proposed rule and we get a final rule.

And so, when we saw that CMS was allowing this additional ruling via an advanced notice of proposed rulemaking, it gave us, I feel like a level of comfort in knowing that they were really going to continue to engage the industry in individual providers in building this new reimbursement model. So, CMS consulted with a group to build the model. They allowed us an advanced notice of proposed rulemaking followed by a proposed, in a final rule, for PDPM.

The next in the final piece that you see here is Unified PAC, terms that you may hear start popping up in conferences or other sessions that you attend is the term UPAC. And so, if we go all the way back to the first piece on the IMPACT Act of 2014, we initially saw CMS looking to have this apples-to-

apples comparison of outcomes. And now, we see even more of a grand scale of a focus in potentially moving us to a unified post-acute care system.

Those of you that are here today are likely practicing in the skilled nursing or another spectrum setting across the PAC. So, if you are working in SNF, it's also important for you to know that there's a similar model that's going to be impacting your home health agencies in January of 2020.

And what's interesting – so, a lot of the changes that we see in the industry usually began with the SNF and then filter into other settings. So, we have PDPMs impacting your skilled nursing facilities in October of 2019, which will be followed by PDGM which will be impacting our home health agencies in January of 2020.

And there's a lot of very similar themes that we see across those two rulings in regards to the greater level of focus on individual patient clinical characteristic as a determiner for reimbursement.

So, what is CMS's ultimate aim here? And I'm a visual learner. So, you'll see on the next slide that we got this nice infographic of CMS's quality strategy. And at the end of the day, what CMS is looking to do is tri-fold in nature. So, they say they have a triple aim – triple aim for quality.

And they're looking to improve care. So, improving the overall quality of care by making healthcare more patient centric. Or, you may be even working in a setting where there's been a very purposeful focus and aim to move the patient totally out of your vernacular and using more person centered care, also having reliable, accessible, and safe care.

They're also looking to make care affordable. So, where are their opportunities to not just improve care but also reduce the costs for the individuals, the families, employers, and the federal government?

And then, if we can have better care and more affordable care, what can we do to improve the overall health of people and the communities? And this is broad and beyond just a primary clinical presentation.

So, they're looking to focus on behavioral and social and environmental determinants so that at the end of the day we're yielding not just an immediate clinical outcome for the individuals that we're serving but also having a broader focus on their overall health and their wellbeing.

The first iteration of what we're going to see for those of you that are practicing in skilled nursing facilities is PDPM. However, I will need you to also remain focused on the fact that there are other quality and survey expectations that will not change. And that's what we're going to discuss on the next slide.

So, those of you that are in a portion of the nation that have had the opportunity to participate in survey since 2017, you're hopefully seeing some very positive changes that fold into that person centeredness from a CMS perspective.

So, CMS has requirement of participations that are being rolled out in three phases. And in addition to the changes that we're going to see this fall under PDPM, we are also going to see phase 3 requirements of the requirement of participation.

A lot of that is focused on infection and other areas. However, I want everybody to have an understanding of the positive impact of what we've seen in survey and how that folds in to the elements that we see under PDPM.

So, those of you that listened in to the first call, hopefully, have a foundational understanding now of where and how your reimbursement is going to be determined for your Medicare Part A beneficiary within skilled nursing facilities. And the data source is the minimal data set.

Furthermore, when you look at these new clinical care pathways that CMS developed for the survey process, they began with review of the minimal data set. So, CMS has developed just over 19 different clinical element pathways that are used during survey. And they're specific to various areas of clinical care in addition to various areas of individual patient or person presentation.

So, for example, there are care pathways for activities of daily living. There's care pathways for communication and sensory needs. There's specific care pathway tied to dementia. There's specific care pathway tied to the (dining) environment and honoring individual person choice. And they all began with the minimal data set. And they're set up to be proactive in nature to identify areas of improved opportunity within our system, OK?

So, another part of this (raw) process is they're looking at how effectively we QA ourselves; so, moving from quality assurance to quality assurance and performance improvement. And I really do believe the way that these pathways are set up makes that effective.

So, let me give you an example of how they look. They start with MDS portions. So, for example, the communication and sensory clinical pathway has elements where the state survey would be looking in sections B and C of the minimal data set. So, section B is hearing, speech, and vision; and section C is cognition.

And for those of you that listened to the first PDPM training should have some light bulbs going off right now, OK? Where else is section C tied in? Section C is tied in as cognitive impairment which impacts your case mix for reimbursement under PDPM.

So, likewise, when surveyors come in to review care paths, they're going to be starting with section C seeing what we've documented as a team; so, important to know that the MDS is interdisciplinary in nature. It's (not just the science that) MDS coordinator.

The second piece of this care pathway involves individual resident interviews followed by caregiver interview. So, they're looking at the clinical documentation step 1. Step 2, they're interviewing the individual patient that you're serving. Step 3, they're coming to talk to you.

And what's really nice about these care pathways and from what I've heard from therapists across the nation, it's a positive experience is that their formal interview questions tied to the rehab team, this co-occupational and speech therapy in addition to your therapy managers.

And then, after they interview the care team, they go back to the entirety of the medical record to see if everything is in a really nice place and organized in a quality fashion so that we're yielding the best and the most appropriate clinical outcome for the individual that we're serving. So, that's not changing.

The new survey process is not going away. It really did lay a foundation a couple of years before we see PDPM going into effect. And for those of you that really took the opportunity to learn those care paths, hopefully, you're a little bit ahead of the game in regards to MDS collaboration across your teams.

Other areas that are not changing under PDPM include your short and long stay quality measures. So, quality measures impact a variety of areas including your five-star rating system and what reported on nursing home compare.

So, the five-star rating system is meant to help guide medical beneficiaries in selecting an appropriate post-acute care setting. And the short and long stay quality measures are at large part of that.

Another element that is not going away that is part of CMS's quality strategy is the quality reporting program. And the quality reporting program is one that depending on your setting there may be a greater level of engagement for your physical and occupational therapist. Or, it may appear that there's a greater level of engagement for your PTs and OTs.

And the QRP program is really tied to, again, going back to the IMPACT Act of 2014, and having specific data elements as measures across the spectrum. And a couple of the areas that are more tied to function or tied to those self care and mobility item set for PT and OT.

Other areas that are impactful for QRP include individuals with pressure ulcers, individuals with falls with major injuries, individuals that have a care plan that addresses function. So, as you can see, there are other areas speech pathology can have a level of engagement to show your value.

So, as Sarah mentioned, our hope today was to give you some practical ideas. And when you look at quality measures in QRP, think about the impact for example of the basic fall measure, application of residents experiencing one or more falls with major injury.

Are you part of your fall (coffee) team within your community? Is that something that your therapy program manager attends or your physical therapist? Are they looking at areas associated with cognitive decline? Are they looking at areas associated with impulsivity?

Are they looking at areas simply associated with lack of ability to verbalize needs or lack of ability to voice that's resulting in a fall when someone tries to meet a need independently due to a lack of communication?

So, keep all of those in mind when you're considering your value on the team and how that's impacting the safety and the wellbeing of the individuals within your community. So, there's always this quality aspect to all of this regulation.

The next part is the financial element. So, your communities are required to report these areas. And if they don't, there's a risk for reduction in reimbursement. And it's typically on a two-year rolling. And it can be up to a 2 percent reduction in the annual payment for noncompliance for reporting this information. So, keep that in mind.

First and foremost, the therapist, we think about the quality piece, the care piece but also realize when you are seeking greater levels of engagement in your team that there's also a financial impact for your communities when this information is not reported in the appropriate time frame. The data source is the MDA. So, it's not a secondary data source from what you're going to be doing for PDPM.

And then, the final piece that I wanted to report was value base purchasing before we get into some of the meat of where you can have a greater level of engagement for PDPM. And when we look at the NQF or the National Quality Forum measure for value base purchasing, it's tied to hospital readmissions.

So, think about your value there. You have an individual that comes into your setting. And they're there for post-acute care stay. And you improve their cognitive status or you improve their swallow function or you improve their ability to communicate to a certain level. And that's fantastic.

But more important is what do we do to effectively transition them to either a lesser level of care or to help them maintain that level of function and reduce their risk for re-hospitalization for the same area. And that's the measure that's tied to value base purchasing.

And when people see value base purchasing, the term to be confusing. I don't think that it's very clear depiction of what the measure is aimed to measure. But, it's really tied to, at the root, hospital readmission.

So, you hear greater level of conversation in the industry now about – what are we doing to have that discharge planning conversation day one? What do we need to do to ensure that the individual that we're serving have an adequate understanding of their disease process?

Go back to CMS's triple aim. They want the individuals that we serve have a better understanding of their complexities and comorbidities. We should be doing the same in order to protect them; and then, other measures that are being tied into all of these elements.

And when we look at care coordination is transitions in care and how we're affectively communicating with other SLPs across the spectrum in addition to other care providers the individual patient at the center and their families.

So, it's an updates recently, in a very positive way that we wanted to include here came from Administrator (Verma) and these were published about a week ago. And interestingly, I had the opportunity to hear a speaker from CMS talk about these was that CMS is looking at their quality initiative as a continual evolving process.

And per (Verma), she said, CMS is approached to over side of nursing homes is constantly evolving. She added, just as we're unleashing innovative

strategies and technologies and other areas of CMS, we are continuously looking for ways to improve our approach to nursing home safety and quality. We must never be complacent. We should always push ahead to continuously improve our efforts.

When I saw this, full agreement, just very positive to see that CMS is not looking to be stagnant. And that they've also asked for significant amount of funding to continuously have this comprehensive review to ensure that they're remaining focused on that triple aim.

Sarah, do you want to take some of the information on slide nine based on some anecdotal questions that you all have been receiving?

Sarah Warren: Great. Thank you Renee. So, the other thing that we want to really address here is this is a fundamental change, right? We've – I think we've used that term ad nauseum at this point in terms of moving from the current payment system RUG IV to PDPM on October 1, 2019. Skill level definition is still the same. And your need to use clinical judgment to act on behalf of your patient's best interest that is the same under RUG IV as it will be under PDPM.

But moving from concept of value or reimbursement – I should say – driven by minutes to a concept of reimbursement based on clinical care (gistics) is a very fundamental change. And it really requires the SNF industry and therapist including speech language pathologist to fundamentally rethink the way that they deliver care. And that is the whole intent of this second portion of this webinar series is the practical tips around that.

So, to that point, we are hearing anecdotally from our members now that I'm not providing (raw) therapy in the form of minutes anymore, what is my role? Will I be employed in the skilled nursing facility industry anymore?

And – or, another way of referring to that is – we're hearing from a lot of folks that they're concerned that they may be fired in the months leading up to the PDPM or just after PDPM goes into effect.

And I think given the practical tips that Renee is going to be outlining throughout the remaining course of this presentation and she sort of summarized to this point that we really do not believe that layoff should be widespread in the skilled nursing facility space if SLPs and therapies and SNFs plan appropriately for the transition and fundamentally reconsider the rules speech language pathologists in this setting.

And so, I think the recent comments by Administrator (Verma) does reinforces this point. So, without further ado, I just want to turn it back to Renee to kind of go through the meat of this presentation. But, I just kind of felt this is something that we reinforce with all our communications and our members that we don't anticipate widespread layoff in the skilled nursing facility space as a result of the transition to PDPM.

Renee Kinder: Thank you Sarah. So, what is the role of the SLP in the new world? In addition to or to kind of extend on what Sarah was saying in regards to that myth or the concern that there's going to massive layoffs of speech language pathologist with the move to a new payment model, we have to – and I'm going to insert this here.

I know those of you that heard the first part of the series should have this information but let's reiterate that the reason for skill and the reason that individuals are able to access that post-acute care benefit is not changing.

So, if individuals are coming to your community and their skilled need is rehab, then they have to receive rehab; so, just kind of at the foundational root in order for the individual to even be able to turn on or access or benefit from using that Medicare Part A there has to be a skilled need. And often, therapy is a skilled need.

So, what can we do to further focus the true benefit of speech language pathology services and be at a greater level of engagement within your interprofessional team?

And interprofessionalism and interprofessional education is part of ASHA's strategic plan. It's also language that you're hearing used more in other care

settings across the PAC spectrum. And the way I look at it is – and when I started in skilled nursing facilities – we do a really good job as an IDT.

We have a patient at the center. And everybody has their own roles and responsibilities. However, moving into October and PDPM, when we look at the integration in MDS, we got to move to a level of interprofessionalism.

So, it's not just that I know my role. But, everybody else on the team understands the unique role, responsibility, and scope of practice of speech pathology. And that's consistent for speech in addition to PT/OT and nursing.

Because, remember, we all have a very distinct area within PDPM that's tied to our reimbursement. So, it's calls for a greater level of understanding and scope of practice and responsibility to ensure that we are capturing those clinical components that help to support your reimbursement.

So, to begin, how do we identify individuals that are appropriate for speech language pathology? And this can and really should even begin with that preadmission process when you know that someone is coming into the community where you're servicing patients as an SLP.

Because for the Part A benefit, we have to be treating for continued need associated with that inpatient stay. So, my first tip would be, if you're not engaged as part of that preadmission process or in constant or frequent communication with the facility social services director who is often the individual or the business office manager often the individual who is engaged in those conversations with hospital settings in order to determine appropriate skill sets and needs before an individual even comes into your setting.

Next, we move on to completion of the MDS. So, greater level of engagement is part of that pre-screener before anyone even enters your door, and then, (insisting in) completing the minimal data set. And I know we have this outlined in a few of the slides ahead. But, I'm going to give some pointers here before we get there.

So, if you look at the MDS and the MDS is part of the RIA or Resident Assessment Index. It has always been by definition a tool that is supposed to

engage each and every member of the care team. That's not a new conversation.

And what's really exciting and crucial to know about the MDS is that there are key elements that are associated with our scope of practice. So, section B is tied to hearing-speech-vision. Section C is tied to BIMS and cognitive measure. Section K is tied to swallowing and nutritional status.

So, outside of just PDPM alone but for the individuals who also are in your communities where it's their home or their long-term care resident, you have such a key role in MDS accuracy and engagement and supporting those coding efforts and also reducing the administrative burden on either your MDS coordinator or social services director that's been tasked with completing that information.

The next piece comes with assisting and compliance and quality reporting requirement. And when we look at how CMS is going to shift their focus when it comes to auditing and monitoring, we can be a very proactive element to ensure that our communities are in a good place from a compliance perspective.

So, we know under PDPM there's going to be this shift from auditing and monitoring based on volume element. That's essentially how the model is built right now under RUGs. And if you see an individual community in your region go under a targeted probe or TPE that CMS is now using, it's typically based on volume of care and intensity of care.

CMS is going to be shifting that focus. And they were very transparent in that thought in last year's proposed rule. And those of us that have had the opportunity to hear some of the architects of the model speak recently have continued to stress that there are clinical compliance areas that are going to be embedded in future monitoring.

And if you have been tied very specifically to speech pathology, I would advise you to share that with your administrator, with your MDS coordinator, with your (DON) so that you have the opportunity to set them up to be successful and then also to (copy) and measure the process internally.

The key elements that CMS is going to be auditing that are tied to the speech case mix include prevalence or increases and use of mechanically altered diet in addition to presence or increases in clinical complexity use again tied to speech pathology, and then, increases in the volume of cognitive based impairment.

So, think about your role if we work collectively to improve our coding initiative. Your community may see some shift, OK? But, it may be shift for the right reasons.

And when it comes to compliance in supporting that, you play a huge role in supported skill documentations, standardized testing, your short-term objective and your long-term goals to really show that there's been a skilled hands and eyes on the individual that we're serving which takes us to the next bullet.

How do you use your skill to help your patients achieve their goals? And we could do a full another 90-minute session on this. But, when it comes to goals, a few pointers that I've learned through the industry, first and foremost, is to make your goal smart, specific, measurable, attainable, realistic, and timely; so, building smart goals.

And when you build smart goals, it should also be tied to that are realistic and functional. So, from an SLP perspective, we don't see as much of a concern here as we sometimes see with the other therapy disciplines but don't make your goals task-based in nature, OK?

For example or basic example, you would not want your patient going forward dysphasia patient to be – Mrs. Smith will complete 10 reps of lingual, oral motor exercises. That doesn't show a goal. That's shows a task.

So, if you're talking about individual patient goals, it could be – Mrs. Jones wants to be able to return to her assisted living facility and consume regular diet. So, the goal would be, if there's truly lingual dysfunction, Mrs. Jones will demonstrate functional oral phase of swallow as demonstrated by ability

to consume 10 out of 10 trials of – and then, you tie in your texture and viscosity.

So, just using more skilled language, more functional language and not tying our goals to the task but tying it to the individual patient and person outcome really helps you to show at a more specific level why your role is so important and why you're needed.

If we can go on now Sarah to the next slide. And some of this I discussed in the prior reference. But, when you're considering what needs to be done preadmission and at admission from a therapy coding perspective for speech pathology section C, cognitive case swallow I, which are your active diagnoses, we also included here section GG for a couple of reasons.

There were some updates tied to quality reporting in October that added some prior level of function measures to GG. In addition, there are elements of GG that are tied to oral hygiene.

And depending on your level of engagement in that measure, it's not tied immediately to the speech pathology case mix. But, you may have some very important information to provide there.

Another key element is tied to individual patient preferences. So, we're talking a lot about the shift from volume to value. But, there's a greater focus if you look really broad spectrum at all of the regulatory changes around individual person and patient preferences.

Consider also on your admission documentation not documenting just what you see but using more I statements. So, having your patient use I statements – I would like to accomplish a, b, and c and including that in your admission documentation to support that you've really had that level of individual person engagement.

Risk factors and discharge plan go hand-in-hand. So, for example, if you have someone that has active COPD or CHF and they also have a chronic dysphasia or risk for sudden aspiration or even active diabetes mellitus, we

have to consider all of the risk factors when developing an effective discharge plan.

Think about individuals that have a chronic stroke condition. So, we've had some updates to the American Heart Association, American Stroke Association guidelines on how we look at stroke. And those came out I believe in 2016. I remember my training as an SLP I was taught that stroke was a transient event.

And after that, we would have spontaneous recovery. There may be some residual impairment. But, there's really been a call for looking at stroke as a long-term risk factor and that it's a chronic condition.

So, if you have someone – and those of you that are here today that work in SNF you know these patients. So, they may come to you with the one primary diagnosis but they've got the 20 medical complexities and one is history of stroke times three.

And it's that history of stroke times three that's impacting the functional abilities greater than the primary diagnosis. Maybe, they went in for COPD exacerbation or even a fall with a fracture. But, it's that residual stroke that is having a greater level of impairment.

Additionally, think about how the speech pathology reimbursement is built under PDPM. We're a very unique discipline in that risk factor complexities are tied into our case mix. That's not true for the other therapy disciplines or really nursing.

There is that NTA element that account for complexities that risk factors were tied to our clinical presentation because historical claims data had shown consistent alignment there. So, use that – use that to be part of the care team and to ensure that when we are discharging individuals, it's not just a discharge. It's a safe, effective transition in care.

But, as we go all the way back to what we talked about in the beginning with that UPAC that's what's going to be impactful. It's not just what you do in your individual care setting but that discharge plan and the transitioning care

and also discharged to a lesser level of care which is a forthcoming QRP measure.

Now, getting into some of the meat of the MDS in where you can have some engagement. So, we'll start with the key areas of the speech pathology component. So, remember, for speech pathology, the PDPM reimbursement is not based on level of impairment, base on number of impairments and how those impairments grow on top of each other.

Additionally, remember that I mentioned that across the national 44 percent of individuals are triggering none of these areas. And I had the opportunity recently to attend a national MDS conference for the group that certifies MDS coordinators. And they had a lot of conversation as part of one of their key notes about these section K elements.

And there's an expert in the field of MDS. And she looked out into the audience, (talk to these) MDS coordinators, and she said, now, you all know we're not getting this right. And it was just very telling that this is an area where there's a little bit of uncertainty perhaps and how to code this. But read the definitions and consider how you can better support your MDS coordinators. Also consider who's the data collection source for this presently.

So, I've had a lot of conversations with folks across the nation about who's giving this information and what's the margin of error. So, as a practical matter what I would do, if I were you now in a skilled nursing facility, is to do some immediate cross walking of your current caseload into PDPM. And do some investigation within the MDS and see if these data elements are being appropriately captured based on what you're also collecting within your bedside (dysphasia) eval.

And what I'm hearing, what I'm finding is in some cases this is even the responsibility of the registered dietician who may be on site one or two days a week or even a dietary manager. And if they don't have the opportunity to observe a full meal, this can be a complicated area for them to measure.

So, we can and should, if clinically appropriate for us to assess these areas, provide some support that include the loss of liquids or solids, holding of food in their mouth and the cheeks, coughing or choking, complaints of difficulty swallowing.

And the most effective way that I found to educate here is to give examples to your nursing teams, your CNAs, your dietary folks on what this means to an SLP and what the root cause is and why we need a level of engagement. And what I found is that the information is welcomed greatly. Once they have an understanding of what this means to us. So, stay with me for a second.

(Well), also liquid or solids from the mouth when eating or drinking, I've had some conversations with nursing teams or CNAs or dietary folks to ask them, kind of probe them, what do you think would cause this.

And more often than not, you'll get answers such as – well, I guess they don't like it. Or, it's too hot or too cold or too sweet. So, you have to remember that their thought process is not going to go to immediately weakness or reduced range of motion or coordination.

Similar to the holding of foods or mouths in the cheek or the coughing or choking or K0100D, complaints of difficulty or painful swallowing. So, the concept of a (diaphasia) or even the concept of CP dysfunction or doing further analytics to see if there's active GERD or to see if someone has had a history of needing dilation of the esophagus is an associated medical complexity that could result in K0100D.

And then, considerations for (K0150C2), I'm going to tie into all of the changes that many of us are seeing May 1st and that's the U.S. kickoff of (Ipsy) and making sure that there are systems in place for your dietary team and MDS in addition to your vendors to truly collect information if and when there's a mechanically altered diet. So, piece of information there to keep in mind.

From a cognitive perspective, what's happening in the majority of communities that we find is that this is collected either from MDS or from a social service director. And having the level of engagement from a speech

language pathologist that can expert and cognitive evaluation typically is going to yield a greater level of accuracy.

And it's also going to reduce the burden of someone that has a multitude of other responsibilities to collect this information taking off their plates. So, I found high level of acceptance and gratefulness when we offer to provide all level of support to collect this clinical information.

Additionally, as we talked about in the first course, we have really achieved some success here. So, I understand that the (BIMS) is greener in nature. So, in addition to your BIMS, in addition to section K, I should say, this is step one for you. So, you go in, you support the preadmission process, now, which the point where you're coding. The next piece is for your clinical documentation to support a true hands-on assessment.

And in the final piece which we have from an MDS perspective on the next slide deals with elements associated with complexities and comorbidities. So, as I mentioned before, speech a bit unique. And if you can tab ahead, we can see what those look like. Here we go. Thank you.

So, there are additional elements within the speech pathology case mix that are tied to clinical complexity. And when we talk about our value, I want you to consider if anyone else would take it upon themselves to add these codes to the medical record and also consider what systems (you come) into a place to ensure that these are in place now versus having significant shift in your facility's coding practices in October.

So, remember, CMS to auditing clinical. We can support clinical. And one of the key areas that we had that's unique to speech is this complexity component that impacts our reimbursement. So, in order to capture this, we have to have these areas coded appropriately in section I. And I now this may be getting into the weeds; but, it's important for you all to know anything that you see here that says I 8000, put a star beside that because that's a manual data entry for your MDS coordinator.

Meaning, for the other sections, here's the check box in the MDS. For anything that's I 8000, it requires them to manually enter the code set and the appropriate sequence. And it's not an all encompassing.

So, for example, and Sarah and I talked about in the first session how some of this is still (fluid). CMS is still updating the ICD 10 sets. But, if we were to go immediately with the code sets that we have today, the only dysphasia code that's included is a stroke code. So, we don't have the R series immediately embedded.

So, it would require someone to turn in a physician's order clarification request for these to be added to the diagnosis list. And you can play a huge part there in getting some systems in place so that we get the appropriate coding.

And additional tip that I give people is – and also just kind of a reality check when people talk about all the changes that we're seeing in the industry and it's just so much all at once – it's not just us.

So, in addition to the changes that we're seeing, there've also been changes in requirements associated with our primary care physicians or the PCPs. And what they're required to do as part of the Medicare annual wellness visit.

So, if you're having challenges getting that prior level of function data, determining if someone has a longstanding cognitive impairment or if it's a new onset, in addition to getting true list of clinical complexities and comorbidities, put in a call to the primary care physician.

And the reason is that as part of their annual wellness visit, they're required to collect a greater volume of clinical data including cognitive measures. So, it could help you to obtain some information from their files that may not have fed in to the hospital discharge summary. And we have all dealt with this.

You get a discharge summary that's two pages long. It's got very limited information. You know that there's a greater story there. And sometimes, it just takes making that phone call to the primary care physician or the PCP to get a greater amount of information to ensure that we've got the full picture.

And then, as an SLP, you can help to support the efforts to, if and when appropriate, put in that physician's order request to have additional ICD 10 portions added to the diagnostics list.

Alright. Moving into more big picture. And we've touched on some of these. But, as we said in the first portion, we don't like to take it upon ourselves to cut or edit regulation and sometimes it's just good to give you some of the meat and the substance.

And when we look at why a lot of these changes have occurred, it goes back to the IMPACT Act of 2014. We're seeing similar changes that you all are going to see in SNF across the spectrum.

Additionally, when we look at some of the measures, we saw even further updates for IRF-PAI and home health Oasis in regards to outcomes data, which is then kind of that missing piece that we've all been looking for in the world of speech.

And while not finalized, we did see in the proposed rule last week that CMS is seeking input and considering the BIMS, which is the section C of the MDS also being used in the IRF-PAI and the Oasis.

So, thinking big picture, a lot of this is tied back to quality reporting, consistent measures, and looking across the spectrum so that CMS can have a greater level of standardization and follow folks across (to adhere) continuum.

If you want to learn more, we did include the link to the SNF QRP website on the next slide just if you want to take it upon yourself to do a little bit more research. And then, we are going to get into, on the next slide, some of the data elements.

And the reason I wanted to include this conversation is that you will have an idea of what some of these look back periods are when it comes to fiscal year and calendar year and when the reimbursement is impacted.

So, in fiscal year 2018, we did have some updated reporting requirements for skilled nursing facilities but they were looking at data from 2016. And the reason I wanted to include this was because CMS does allow some periods of time to correct and/or submit quality information.

And so, you may have a facility administrator or a nurse coming to you for some of the elements so that they can ensure that they're capturing 80 percent of the MDS information for the appropriate calendar year.

Now presently, the QRP requirements tied to skilled nursing facilities have largely been elements of section GG, some more specific to our physical and occupational therapist. However, I do think that it's important to remain focused here as we have seen some updates in proposed rule making.

And we also know similar to the work that CMS did with Acumen for PDPM that they've consulted with (Duran) Corporation to look at some of the cognitive measures. So, there's some activity there. And we also know that's part of (statute). So, we want to remain focused on our role as well in supporting the reporting requirements for the communities that we're servicing.

Going to the next slide, this one just give you an idea of what some of the assessment base measures are. So, when we look at measures within skilled nursing facilities, there are assessment base measures and there are claims base measures. And current assessment base measures – the first one should be jumping out at you – application of percentage of residents experiencing one or more falls.

So, do you have simple systems in place? Again, to be part of that fall committee, do you get screen request, not (eval), but a screen request so that you can determine the need for eval if you have someone that has frequent falls. Or, even better, episodes of a risk for fall within your sights.

In addition to, are you getting your hands consistently the (Casper) information that gives you some of this element, broad spectrum for your individual community? Additional assessment base measures include the percentage of patients or residents with pressure ulcers that are new or

worsened and the application or percent of long-term care hospital patients with an admission and discharge functional assessment, and a care plan that address dysfunction.

That sounds very convoluted and complex. But essentially, that's looking at the presence or absence of 80 percent of the assessment having the information tied to section GG functional status within the MDS. And then, the next couple of slides give you just an information on the timelines specific to these measures so that you have an idea of what to look back for.

So, those are the assessment based measures. In addition, it's important to know that CMS also has claims based measures. And these are based on the claims submission. And they include a variety of areas such as discharge to the community, 30-day post-acute care discharge readmission, and then also something that you'll hear people say Medicare spend per beneficiary or Medicare spend per bene.

And these measures will be affecting fiscal year 2020 payment determiners. So, discharge to community, post-acute care, CMS has been stressing the fact that they're looking specifically at not just the care that's provided but that transition and care; and additionally, what we do as a care team to transition someone to a lesser level of care.

And I want to give you maybe a couple of real world examples that I've seen where speech plays such a key role. And it's typically in safety, medical management, and even those dual tasking opportunities where we can be a voice with our physical and occupational therapists.

So, when it comes to gait and ambulation, for example, the patients that we serve look at gait is procedural, right, with ingrained and long-term memory similar to riding a bike, playing the piano. Gait is typically ingrained.

Where we can see difficulty is when we have a gait task such as ambulating through the hallway or maybe PT wants to advance someone to ambulating across an uneven surface, so outside in the corridor or even completing a couple of stairs. And they have a level of cognitive impairment.

What can at risk happen? What we don't want to happen is that we have the ambulation task on addition to the cognitive task and that's known as a dual task. There's a lot of information and literature of PT in gerontology in general on dual tasking and how that can complicate things.

So, what is our role in helping the individual to achieve that next level of success with ambulation first in having to stay the long-term community because there's a concern that they cannot complete a gait task across an uneven surface?

So, just think about those little opportunities where with our level of engagement we can allow for a more safe and effective discharge but also more safe and effective discharge to prior level of function or even just to a least restrictive environment.

Another example that we see on occasion is in regards to medication management or instrumental activities of daily living. So, are you engaged in those conversations with individuals that perhaps come to your community and they knock it out of the park on the BIMS. They get a 15 when BIMS is a screening.

And they're working primarily with physical and occupational therapy. However, a barrier to discharge is medication management or some of those other instrumental activities that they were leaving if it were clinically appropriate and there's an evidence based need for that individual. Are you being engaged in those conversations so that you can help support their transitions in care in a more effective discharge back to the community?

OK. And then, a couple of other examples that we wanted to give, if you want to (go the) ahead, Sarah, to the approved QRP measures for fiscal year 2020. So, we recently completed a period of data collection for quality reporting. And this is also the area where we see that self care tied to oral hygiene and in addition to some mobility items set.

And essentially, what CMS collected data on it's going to impact the fiscal year 2020 annual payment update. So, the data collection window was 10-01 through 12-31 of 2018. And skilled nursing facilities that did not submit the

required measure data are at risk for receiving that 2 percent reduction in their annual payment update.

It's positive that we see this advancement from drug regimen and changes in skin integrity and to some more functional areas. So, this is more of an FYI for you. But, they're looking specifically at the change in self care, change in mobility. So, that's change from baseline of prior level of function. And then also, what the communities are doing to set those safe and effective discharge goals to return an individual to a lesser level of care.

I think I'm going to turn it back over to Sarah. And she's got some thoughts. And then, we'll go through some acronyms.

Sarah Warren: Thanks Renee. So, as we get to the conclusion of this presentation, and I will be showing our contact information in just a brief moment, first, I just want to stress that our contact information is there because we do want to hear from you. We want to be helpful to you guys as you make this transition with your skilled nursing facilities to PDPM.

And our engagement on this issue is not going to end with this webinar series. We did do a presentation ASHA conventional in 2018. We've submitted our proposal for 2019. As of the recording of this webinar, we don't know if that's been accepted. But, we definitely intend to continue to engage with you guys and make sure you have the resources necessary to be successful in this transition.

I also just wanted to stress the time for action is now. I know Renee has mentioned that I think at least two or three times in this presentation, probably more. We need to start having this conversation to drive the paradigm shift now, not in September, so that we can be effective in these discussions and provide the adequate time to accommodate changes in MDS completion or interdisciplinary team meetings or in that nature.

So, the time to engage is now. And I think that your role is even more critical not only to ensure that your patients are well cared for now and in the future and to ensure that your value is recognized under PDPM.

But, I think moving to a culture where you're engaged in diagnostic coding and identifying comorbidities and diagnoses that need to be recognized and addressed and your role in quality reporting, value based purchasing, all of these things that we've kind of outlined in this second webinar is important to help drive our advocacy in the future to effectuate change in PDPM over time.

As we noted in the first part of this webinar series and Renee has (identified) at the beginning of this webinar as well, the transition to PDPM is about two-and-a-half years in the making. And the claims data and the MDS data and other data sources that CMS had drove the way PDPM looks and for better or worse.

And we – our engagement in coding and quality will help give CMS a more robust status set that we can utilize to effectuate change in the future. So, it's – this is a continuing process. And ASHA with Renee's help and other of our member experts out in the SNF field are truly committed to continue the engagement with the Medicare program to effectuate change over time.

We have not accepted that PDPM is going live in October 1st. And it is what it is. And we're just going to live with it. There are some great changes that we were able to effectuate in the last two-and-a-half years. And there is a definite need for continued refinement and engagement with CMS to effectuate change over time.

So, I just want to reassure folks that we remain committed to that. And we remain committed to helping you and learning from you as PDPM goes in effect so we can continue to effectuate change.

So, with that, I just wanted to flash our contact information on this slide. And thank you for your participation today. I don't know if you have any other additional closing remarks Renee?

Renee Kinder: I don't think I have anything additional. I second to everything that Sarah said. While we're looking for I think a greater level of granularity in some of the outcomes and QRP measures specific to speech and cognition, now is the time to get our data in an effective and accurate place so that when we take and ask to CMS we have the data to support it.

Because, essentially, if you don't have the data and if you don't understand your internal systems and what your claim (status) is going to show, it makes it very difficult to have a true ask. It's going to be an exciting couple of years and looking forward to what the future holds.

Sarah Warren: Absolutely. So, with that, thank you very much. And I would just again reiterate, we welcome your questions, so please feel free to get in touch with us. Have a good afternoon.

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