MDS Alert

PDPM: Start These PDPM Preparations ASAP

Check your readiness for PDPM by covering these bases.

With the patient-driven payment model (PDPM) only months away, you're probably deep in your preparations. But if you're feeling rather more like an ostrich with its head under the sand or you're not sure where to begin to ensure the most effective preparations, you can focus on these five areas, says **Kris Mastrangelo,** president and CEO of **Harmony Healthcare International**, in Topsfield, Massachusetts.

Consider Current Systems

Before you dive further into preparations, it's important to know where you stand now. Evaluate your facility's current systems for delivering care, documenting care, and updating the clinical record - among other crucial aspects of day-to-day life in the facility. When doing your self-assessment, Mastrangelo recommends utilizing the acronym SWOT: strengths, weaknesses, opportunities, threats.

For example, with PDPM requiring particularly intensive documentation for full and proper payment, you should find out now whether your staff's current habits are sufficient for the level of accuracy that will be necessary.

Accuracy on the MDS has always been important, but under PDPM, supporting documentation must be collected and included by the five-day assessment reference date (ARD) in order for your facility to receive accurate payment, says **Jane Belt, Rn, MS, RAC-MT, RAC-MTA, QCP,** curriculum development specialist at the **American Association for Nurse Assessment Coordination** (AANAC) in Columbus, Ohio.

So, figuring out how to improve your documentation, if that's a current weakness (or, a threat, considering the increased significance of documentation to your bottom line), will be a key means of preparing for PDPM.

Really Focus on ICD-10

The Centers for Medicare and Medicaid Services (CMS) is especially interested in why a resident ends up in a nursing facility, and documenting the primary diagnosis will become a key driver of payment. The ICD-10-CM system has thousands of codes for extremely specific diagnoses, and the specificity both enables and demands accurate selection.

Knowing ICD-10 is a skill that constitutes many people's entire careers, so the thought of navigating such an immense system - in addition to all of your other responsibilities that utilize skills you've already acquired - may feel especially overwhelming.

However, knowing how to find the correct ICD-10 code for each resident's situation will be crucial. Now's the time to evaluate your current practices for ICD-10 documentation and coding - on individual, team, and facility-wide levels, Mastrangelo says.

While an entire industry has been built upon teaching, knowing, and using ICD-10 codes correctly across specialties, there is less aggregated information surrounding the health conditions common to people in nursing facilities, and their respective diagnosis codes. To get ahead of the game, get a copy of the 2019 RapidCoder Chart for Skilled Nursing Facility, which includes many of the most common and useful ICD-10 codes for nursing facilities. See the box on page 64 for more details.

Prepare for Section GG

While coding the MDS is already a collaborative exercise for many nurse assessment coordinators (NACs), the shift to

PDPM will probably impact how some assessment responsibilities shake out. However, Section GG (Functional Abilities and Goals) will continue to be a collaborative endeavor because of the RAI Manual guidance, which necessitates an assessment of "usual" performance.

The definition of usual performance is crucial for completing this part of the MDS correctly. The RAI Manual notes that varying environments or situations can vastly affect residents, so assessments for Section GG should encompass multiple interactions and circumstances for a comprehensive understanding of a resident's functional status.

"No one discipline should be assessing the resident's self-care and mobility activities," Belt says.

With emphasis kept to note CMS's adjustments, the RAI Manual notes on page GG-9:

Assess the resident's self-care performance based on direct observation, as well as the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.

"If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance," the RAI Manual continues on page GG-9.

The cumulation of the assessments that the NAC and colleagues complete for Section GG plays into each resident's function score, and accuracy will matter more than ever. Use the time remaining before PDPM's implementation to educate staff on Section GG accuracy for function scores, Mastrangelo says.

Review Cognitive Function and Mood Assessment Practices

With PDPM, each resident's cognitive function and brief interview for mental status (BIMS) results will factor into the case-mix group that determines payment for that resident. Mastrangelo recommends reviewing how your staff and facility assess cognitive function and mood indicators.

Context: "The PDPM cognitive level is utilized in the [speech-language pathology] SLP payment component of PDPM. One of four PDPM cognitive performance levels is assigned based on the Brief Interview for Mental Status (BIMS) or the staff assessment for PDPM cognitive level. If neither the BIMS nor the staff assessment for the PDPM cognitive level is complete, then the PDPM cognitive level cannot be assigned and the PDPM case mix group cannot be determined," CMS says.

"This concern was noted by providers and stakeholders," Belt says. "In response to the concern, the issue has been addressed in the early release of the RAI User's Manual v1.17."

On page C-2 of the early release, CMS has added the following (emphasis original):

Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such, **only** in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

"So, assuming this information stays in place with the final release of the Manual, effective Oct. 1, 2019, this concern has been addressed," Belt says. For more on the RAI Manual update, see story, page 64.

The RAI Manual has guidance for conducting the BIMS, beginning on page C-1. If the BIMS cannot be completed, CMS recommends completing a Staff Assessment for Mental Status. "The Cognitive Performance Scale (CPS) is then used to score the patient based on the responses to the Staff Assessment," CMS says.

Evaluate Service Delivery

Take the "patient-driven" aspect of the PDPM at its word and evaluate the patient-focused services that your facility offers as part of patient care. Pay particular attention to your facility's restorative nursing rehabilitation programs, your respiratory therapy service delivery, and the physical therapy and occupational therapy services delivery, Mastrangelo says, and prioritize a keen lookover of all current contractual arrangements.

The NAC is already extremely involved in helping set resident goals, from resident function goals to discharge goals, and those goals ostensibly set up the parameters of care and therapy for each resident's stay in a facility. Taking time now to evaluate all of the systems your facility already has in place should make the transition to PDPM a little bit easier, from making sure each contract for therapy (if it's not in-house) is watertight and reflective of the changes PDPM will bring to really boning up your restorative nursing program.