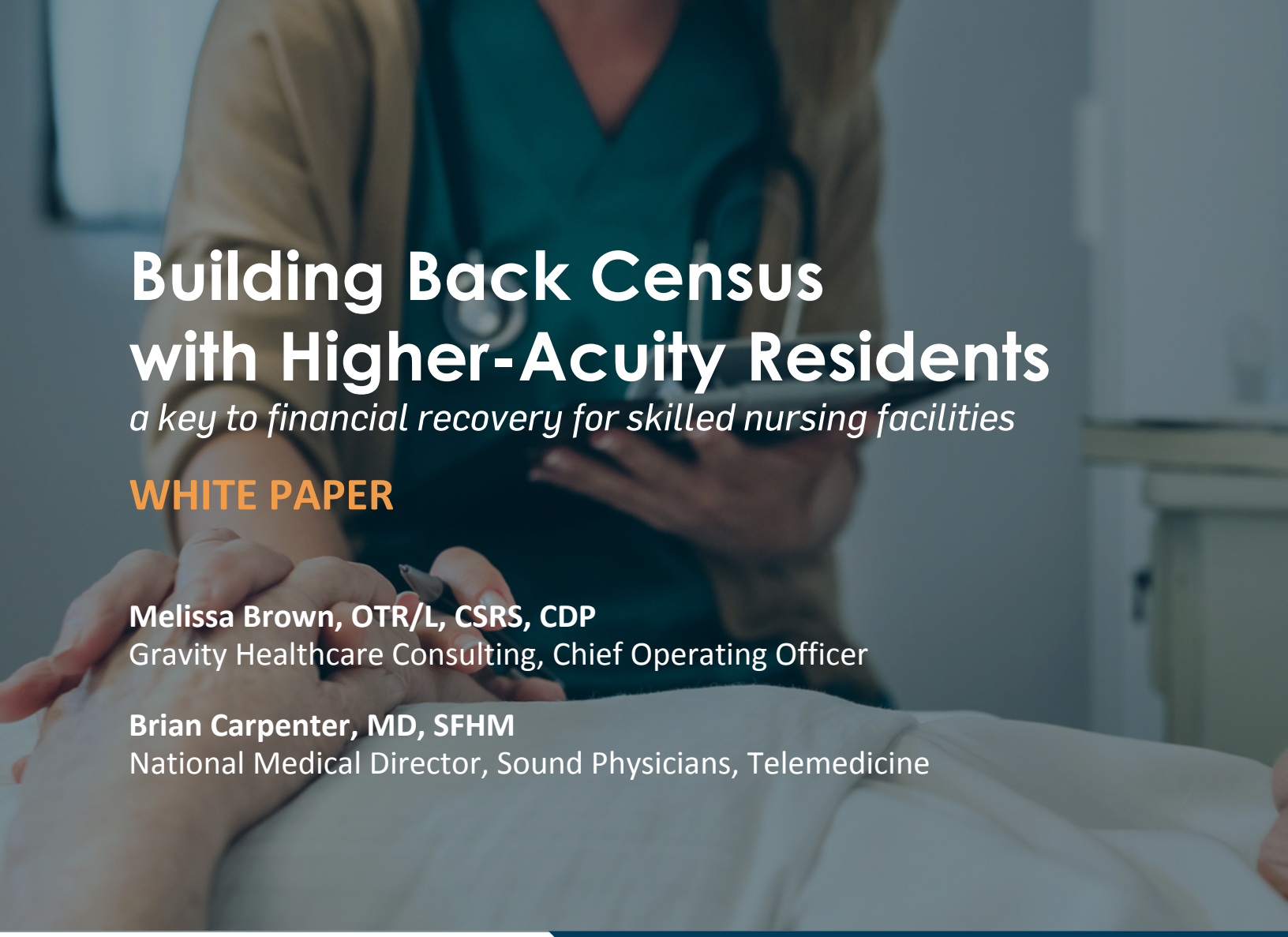

Building Back Census with Higher-Acuity Residents

a key to financial recovery for skilled nursing facilities

WHITE PAPER

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As skilled nursing facilities emerge from the ashes of the COVID-19 nightmare, they are searching for ways to recoup financial losses associated with COVID-19, offset increased costs, and successfully address the reality of vast staff burnout.

Most facilities want to admit higher-acuity residents because care for these individuals returns higher per diem rates under the Patient-Driven Payment Model (PDPM), often in multiple payment categories. In addition, hospitals are eager to discharge to facilities equipped for a higher level of care. Savvy providers have taken this into account and have started transitioning their care model to focus on higher-acuity residents. But for many skilled nursing facilities, this transition poses challenges, which have only been exacerbated by the pandemic's impact. In particular:

- **Nursing associates lack the confidence or skills to care for higher-acuity residents**
- **Higher-acuity residents have the potential to drive up rehospitalizations, impacting value-based purchasing (VBP) metrics and penalties**
- **The industry is facing insufficient staffing and significant burnout among all categories of care staff**

Developing a solid strategy to mitigate these challenges is a must for skilled nursing facilities that wish to recover from the financial impact of COVID and continue to thrive in the evolving healthcare landscape.

Census Continues to Decline

Nursing facility census has continued to decline over the last decade and COVID-19 has dealt what could be a fatal blow to many, with census dropping even further in 2020, by 9-10%[1] on average. 2020 left communities across the country scrambling over a smaller pool of potential admissions. And while PDPM itself is not to blame for the ongoing census disruption, it is a harbinger of the future of healthcare. In the coming years, only the sickest residents will likely be skilled nursing admissions, with lower-acuity residents utilizing home & community-based services in record numbers.[2]

PDPM Prioritizes Acuity

Before PDPM, a low-acuity resident (admitted with a hip or knee replacement, for example) was often a desirable admission. These residents participated in the most therapy and often qualified for the Rehab Ultra (RU) RUG score, which resulted in a larger payment for the nursing facility. Typically low-acuity residents did not create high ancillary costs because they had few, if any, comorbidities. Now, in the PDPM era, the payment model has shifted. The result is that residents with few clinical indicators yield significantly lower per diem rates.

Additionally, the Centers for Medicare and Medicaid Services (CMS) continue to remove procedures from the CMS Hospital Inpatient-Only (IPO) list. Fee-for-Service (FFS) Medicare patients who would have been a typical skilled nursing candidate just five years ago may no longer be eligible for skilled nursing (e.g., elective knee and hip replacements).
These changes further compound the census challenges facing skilled nursing facilities.

To build back and maintain a robust census, a strategy for higher-acuity patients is paramount.

A Look at How PDPM GG Functional Scores Impact Reimbursement

Based on Acumen's research for CMS[3] and the SNF Proposed and Final Rules for FY2020,[4,5] Section GG parabolically impacts reimbursement for physical therapy (PT) and occupational therapy (OT), paying the highest reimbursement for residents with a PDPM therapy functional score between 10 and 23. But the relationship between Section GG and the nursing PDPM functional score is linear, which means that residents with lower independence for self-care and mobility will yield the highest nursing reimbursement. This outcome is consistent with Acumen's findings that residents with the 10-23 therapy score received the most therapy services, but residents with lower Section GG scores required the most nursing services.

Table 1. Two patients with hip fracture and total hip replacement (THA). Patient #2 with significant comorbidities.

FACTORS IMPACTING REIMBUSEMENT	Patient #1 Low Acuity Hip Fracture with Total Hip Replacement (THA)	Patient #2 High-Acuity Hip Fracture with Total Hip Replacement (THA) with COPD, DM, ESRD
Section GG NSG Functional Score	**13**	**4**
PT / OT / ST Rate	**$252.98** (TC, SA)	**$258.69** (TA, SE)
NSG / NTA Rate	PBC1 = **$134.45** / NF =**$64.63**	HDE2 = **$285.55** / ND = **$119.38**
Typical Length of Stay (LOS)	14 Days	20 Days
Daily per diem (Days 4-20)	**$452.06**	**$663.62**
Total SNF PDPM Reimbursement	**$6,176.62**	**$17,290.86**

Acuity Impacts Nursing / NTA Rates and Reimbursement

Table 1 above compares a "healthy" resident who suffered a hip fracture to a similar resident with the same injury and multiple comorbidities. The differences between therapy and nursing are disparate, meaning that residents in the facility with the lower Section GG Functional Score will yield the highest overall per diem rate for the Skilled Nursing Community.

In other words, with PDPM, Medicare now pays lower rates for more independent residents and higher rates for residents needing complex nursing care.

As this example illustrates, Nursing and Non-Therapy Ancillary (NTA) per diem rates make the largest impact on the overall per diem rate. The additional clinical indicators (COPD, DM, ESRD) of the second patient raise the Case Mix Group (CMG) from the lowest category to the second-highest category (Nursing CMG = HDE2). Just a few NTA points from the comorbidities increase the NTA CMG from an NF to ND. These changes increase the per diem by $211.56 per day, which amounts to $11,114 over the entire skilled stay.

Nurses May Need More Clinical Support

Nursing associates often report they lack the confidence or skills to care for higher acuity residents. After years of focusing on healthier residents, many veteran nurses may not feel comfortable with the changing patient population. Less experienced associates may have very little experience in their careers caring for patients with complex medical needs. Staff who are uncomfortable caring for higher acuity residents are concerned about causing unnecessary medical complications and worry that they cannot get clinical advice in real-time as needed.

Utilizing ancillary physician services via telemedicine can boost these associates' confidence to manage a higher acuity resident's evolving clinical picture effectively. At the same time, this camaraderie within the healthcare team helps reduce anxiety and improve the onsite nursing team's clinical skills.

Higher-Acuity Patients Could Lead to More Hospital Readmissions

Accepting discharged patients with higher acuity and more complex medical needs potentially opens the door for returns to acute (RTAs), interrupted stays, and penalties, all of which can negate the financial gains from higher acuity CMGs, and impact quality scores. To avoid these losses, facilities should proactively enact a strategy to identify and manage residents at high-risk for a return to the hospital. Additionally, staff should follow clinical protocols to identify changes in condition and treat residents in place whenever possible.

In the middle of the night, the emergency room often becomes the default solution for nurses facing a change in condition. Utilizing an ancillary physician service via telemedicine is one way to support more treatment in place. If a transfer is needed, tele-hospitalist physicians may manage the transfer to ensure the timely and appropriate use of resources and arrange for a safe return to the facility as soon as possible. Adding an additional layer of physician support at night has been shown to improve the management of higher acuity residents by identifying and diagnosing acute conditions, delivering appropriate interventions at the facility, and reducing avoidable returns to the hospital emergency department (ED).

Studies in which expert panels have reviewed SNF and hospital records have rated 45% to 68% of transfers back to the ED as potentially avoidable.

Table 2. Reduction in hospital readmissions at a 72-bed facility in Ohio after implementing a tele-hospitalist program.

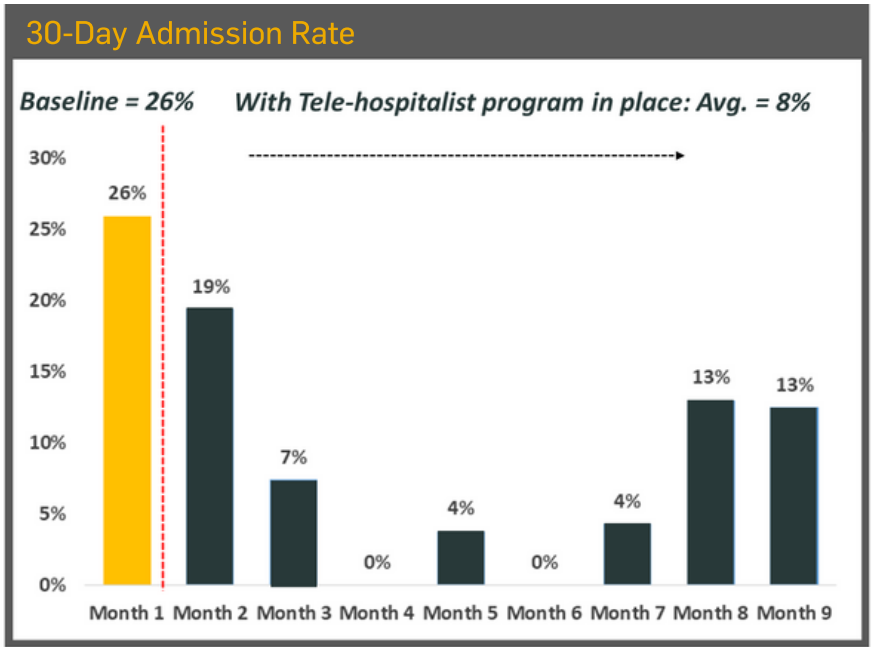

Table 2 above illustrates the impact ancillary physician support can deliver to reduce unnecessary hospital readmissions. In this particular program, nurses had on-demand access to tele-hospitalists staffed for the facility from 5 pm to 8 am M-F and 24-hour access on weekends.

After implementing the tele-hospitalist program to support the nursing staff, the skilled nursing facility's 30-day hospital readmission rate dropped from over 25% to an average of 8%.

Success Depends on Establishing Appropriate Clinical Protocols

To reduce unnecessary hospital readmissions, skilled nursing facilities must also develop and follow appropriate clinical protocols for at-risk residents. This should include additional monitoring, especially during the first few days at the facility. If an ancillary physician group supports the facility via telemedicine, they should also develop a clinical program that supports established workflows with consistent communication in partnership with onsite staff. Adding additional rounding, which can be completed in person or by a tele-hospitalist, can also support improved outcomes for residents at risk of readmission.

Table 3. Estimated annual fiscal impact of tele-hospitalist services for a 100 bed SNF.

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Facilities Need Accurate PDPM Reimbursement

Incomplete documentation can result in lost reimbursement revenue and can set the stage for a potential audit. Thorough documentation that leads to appropriate reimbursement takes collaboration from the entire interdisciplinary team. In addition to supporting higher acuity residents' clinical needs, ancillary tele-hospitalists who are appropriately trained in ICD-10 coding can drive accurate reimbursement under PDPM. Telemedicine video technology allows the remote physician to conduct a full examination and accurately document secondary diagnoses, increasing reimbursement for Nursing and NTA, and sometimes Speech Therapy (ST). As seen in Table 3 above, increasing just one resident's NTA CMG per month would have an annual impact of $7,884.

Tele-hospitalists can positively impact revenue in a variety of ways, including documentation to support appropriate and accurate PDPM reimbursement. A 100-bed facility could conservatively see a revenue increase of $118,474.

Staff Burnout Must Be Addressed

Burnout is impacting healthcare workers across all specialties and settings.[6] Communities nationwide are struggling with the worst staffing crisis in recent decades. The reported increase in staff burnout from COVID-19 is causing more and more healthcare workers to seek new avenues of employment. Nursing homes have been disproportionally impacted by the pandemic, struggling[7] with higher mortality rates and fewer allocated resources than their acute care peers.

Recruiting, staffing, and maintaining qualified workers for skilled nursing and long-term care facilities has become increasingly difficult. Providing a supportive and empowering environment for the care team, especially those who work after-hours, is essential. Nightshift nurses are more vulnerable, with nurses reporting hesitation to reach out to an on-call physician in the middle of the night. Delays in care often result in the resident being unnecessarily transferred to the hospital. Leveraging an ancillary tele-hospitalist group for on-shift coverage gives nurses immediate access to the physician who can attend to the patient via video technology within minutes, reducing medical errors and avoidable hospital readmissions.

Both nurses and residents report higher satisfaction when a tele-hospitalist is available to see and immediately treat the resident.[8]

Research before the COVID-19 pandemic showed that over 50% of physicians working in post-acute care in the US experienced at least one symptom of burnout.[9] Supporting SNF physicians and medical directors with ancillary tele-hospitalist coverage reduces the negative impacts of being on-call 24/7. The chance to unplug and recharge when not on shift also helps minimize medical errors and has even been reported to improve care delivery at the bedside.

Conclusion

Skilled Nursing Facilities are seeking practical and powerful strategies to propel their recovery through and beyond COVID-19. Leveraging ancillary physician services via telemedicine allows skilled communities to target and successfully care for residents with increased acuity while promoting functional outcomes and reducing avoidable rehospitalizations.

This ancillary physician support during evenings, weekends, and holidays empowers frontline associates and alleviates burnout for physicians and nurses alike. This support can result in increased reimbursement for the SNF community and improved quality of life for residents and the healthcare team.

ABOUT THE AUTHORS

Melissa Brown is the Chief Operating Officer with Gravity Healthcare Consulting. An Occupational Therapist with over 15 years of experience across the health care spectrum, Melissa, specializes in skilled nursing and long-term care settings. A self-described "PDPM Nerd" Melissa has studied over 3,500 pages of regulations and guidance from CMS to supply providers with key strategies and analysis for success under the payment model, while always striving for excellence in care. She has served as a clinical liaison and compliance officer for several rehabilitation services companies and is the host of the Gravity Healthcare Hacks Podcast. She specializes in strategizing through regulatory changes and burdens to help communities provide outstanding clinical care while achieving operational success.
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