2022

NEW YEAR, **NEW WAY**

Viable Solutions for LTC Staffing Shortages

Susan Krall | Chief Strategy Officer
Quality Rehab Management

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Why?

Recent trending headlines surrounding caregiver shortages...

"Industry is bracing for Omicron with 15% fewer workers today than when the pandemic began."

"The departure of 425,000 employees over the past two years has narrowed the bottleneck at nursing homes and other long term care facilities."

"Approximately 58% of the nation's 14,000 nursing homes are limiting admissions."

Objective:

Exploring viable solutions by reallocating resources found within our current rehab department team of specialists.

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Why Rehab?

Quality of Life

Reaching and maintaining the highest possible functional levels in today's Value Based world of Bundles and ISNPs

Publicly reported and monitored results in:

- Obtaining and retaining improved and higher functional and ADL performance scores
- Return to acute
- Successful community discharges

PT/OT and ST areas of education and training:

- Programs designed for service-oriented professionals with education founded in anatomy, neurology and the musculoskeletal system – all focusing on enhanced quality of life, functional independence and safety.

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PT, OT & ST: Education Requirements & Practice Focus Areas

Physical Therapists (PT): Required Doctorate level
Assistant level (PTA): Associate level degree required from an accredited program working under the supervision of a PT

- Physical Therapy is an evidence-based health care profession focused on rehabilitation for individuals of all ages who have medical problems or other health-related conditions that limit their abilities to move and perform functional activities in their daily lives.

Occupational Therapists (OT): Required MS level for new graduates.
Assistant level (COTA): Associate level degree required from an accredited program working under the supervision of an OT

- Treat injured, ill or disable patients through the therapeutic use of everyday activities, helping patients develop, recover, improve and maintain the skills needed for daily living

Speech Language Pathologists (SLP): Masters level degree with a fellowship year requirement (CFY)

- Assisting with communication, hearing and swallowing disorders

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Impact of Rehabilitation on Patient Outcomes and Quality Measures

TABLE 30: Quality Measures Under Consideration for an Expanded Skilled Nursing Facility Value-Based Purchasing Program

Meaningful Measure Area	NQF	Quality Measure
Minimum Data Set		
Functional Outcomes	A2635	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients*
Functional Outcomes	A2636	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients*
Preventable Healthcare Harm	0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)**
Preventable Healthcare Harm	0679	Percent of High Risk Residents with Pressure Ulcers (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Ability to Move Independently Worsened (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)**
Transfer of Health Information and Interoperability	N/A	Transfer of Health Information to the Provider–Post Acute Care *
Medication Management	N/A	Percentage of Long-Stay Residents who got an Antipsychotic Medication**
Medicare Fee-For-Service Claims Based Measures		
Community Engagement	3481	Discharge to Community Measure-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Patient-focused Episode of Care	N/A	Medicare Spending per Beneficiary (MSPB)-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Healthcare-Associated Infections	N/A	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization Measure~
Admissions and Readmissions to Hospitals	N/A	Number of hospitalizations per 1,000 long-stay resident days (Long Stay)**
Patient-Reported Outcome-Based Performance Measure		
Functional Outcomes	N/A	Patient-Reported Outcomes Measurement Information System [PROMIS]-PROMIS Global Health, Physical
Survey Questionnaire (similar to Consumer Assessment of Healthcare Providers and Systems (CAHPS))		
Patient's Experience of Care	2614	CoreQ: Short Stay Discharge Measure
Payroll Based Journal		
N/A	N/A	Nurse staffing hours per resident day: Registered Nurse (RN) hours per resident per day; Total nurse staffing (including RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day**

Functional Outcomes **Long Stay Indicators** **Successful Discharge**

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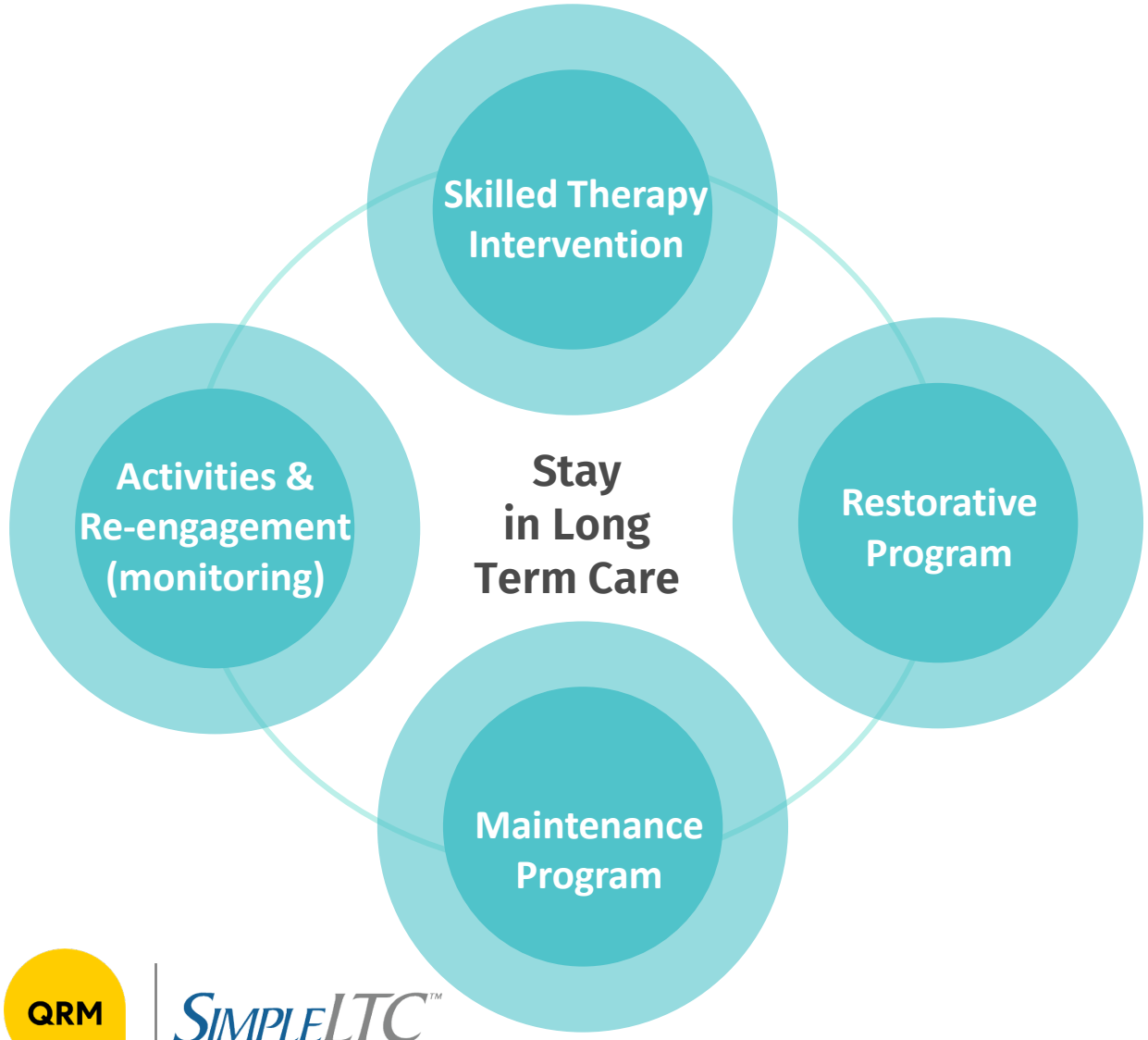
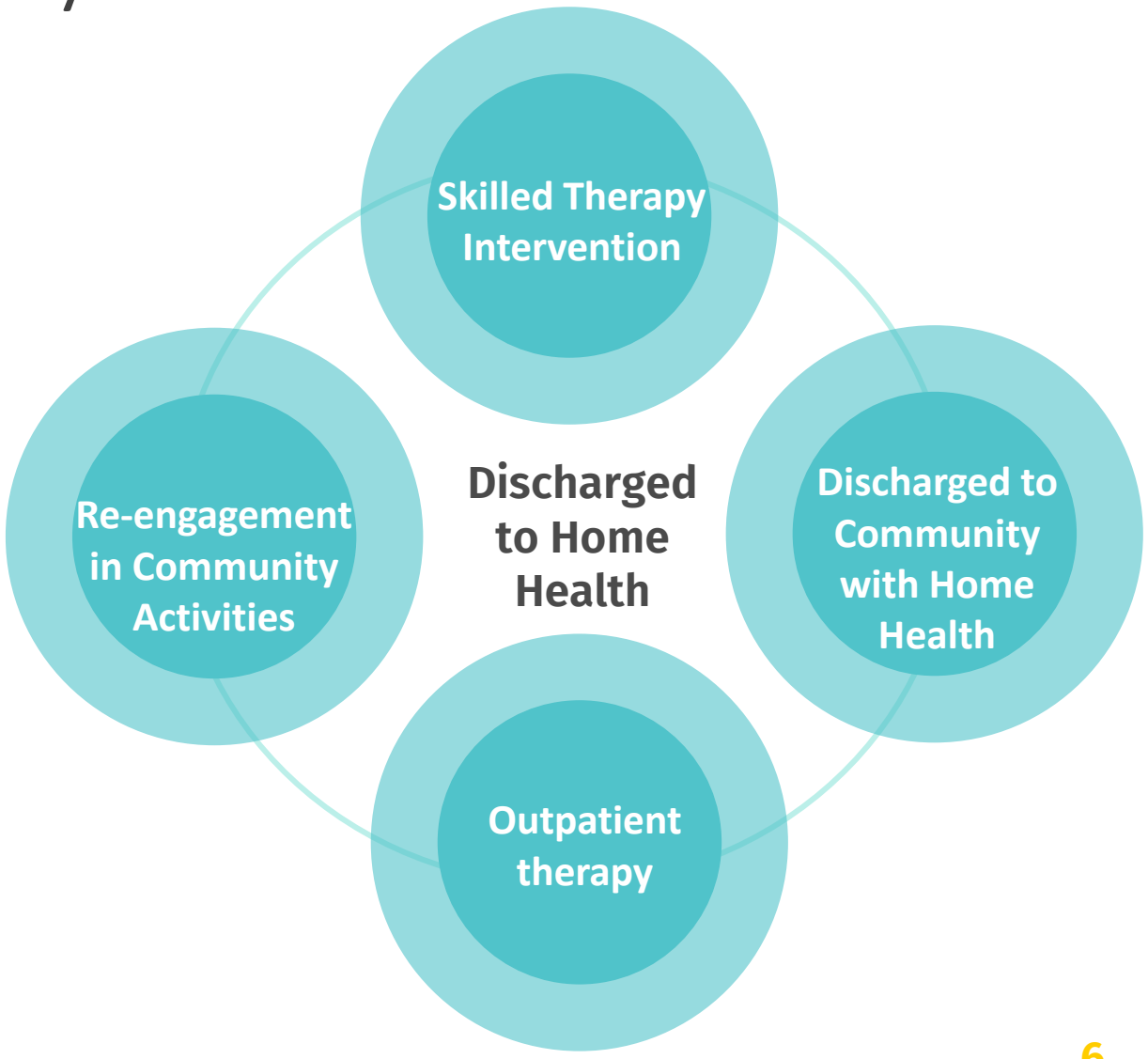
Source: *SimpleLTC*

Continuum Life Cycle of Rehab





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What if?
Rehab Filled Gaps in Key IDT Roles

What if

Rehab coordinated with C.N.A's on assuming responsibilities for bathing, dressing, grooming, eating, and other functional tasks?

What if

Rehab assumed the responsibility of successful restorative programming in collaboration with nursing?

What if

Rehab became the patient care navigator towards successful transitions of care within the continuum?

What if

Rehab owned responsibility for portions of the MDS such as Interviews, prior living settings and assistance?

Why not???

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Poll Question: Why not?

Why are facilities not utilizing therapy in this way?

A.) Therapy availability / lack of buy in

B.) Lack of RAI expertise / knowledge

C.) Communication and scheduling obstacles

D.) We haven't asked

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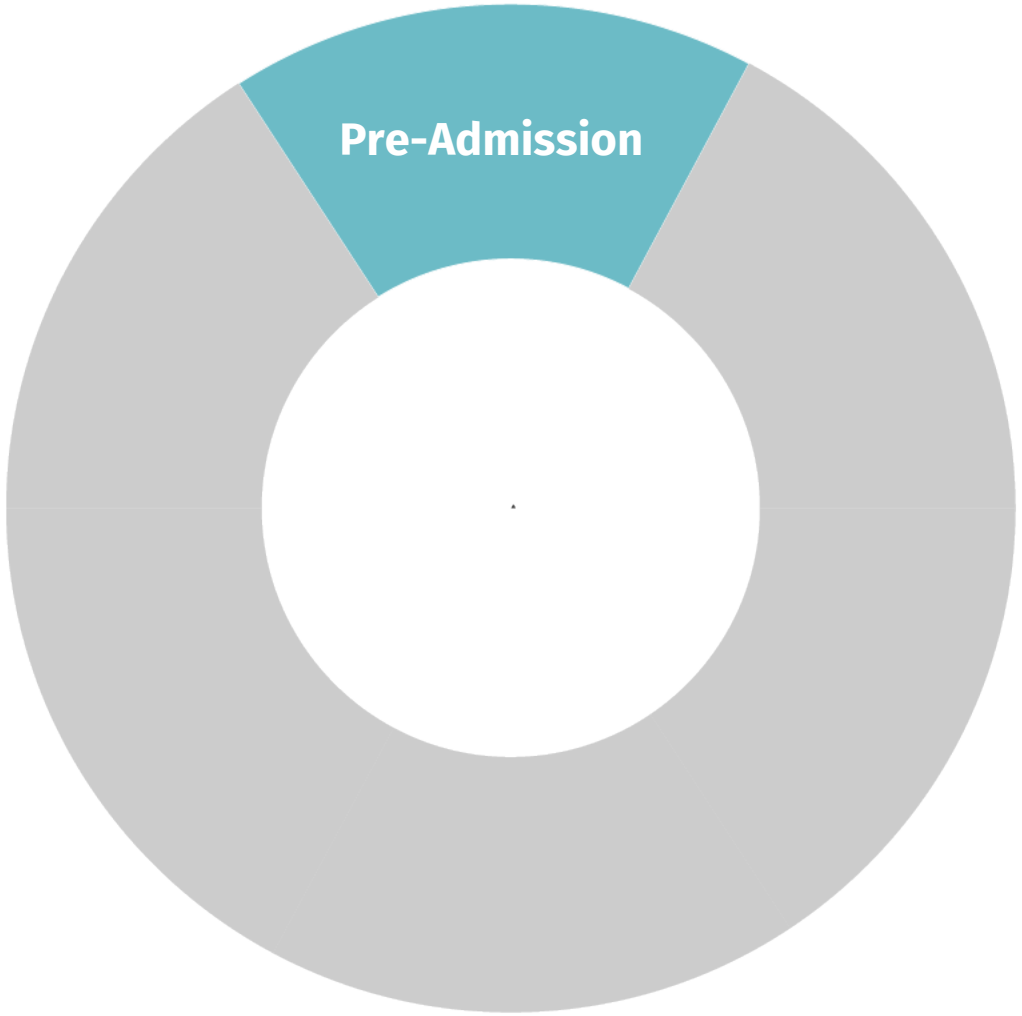


Pre-Admission

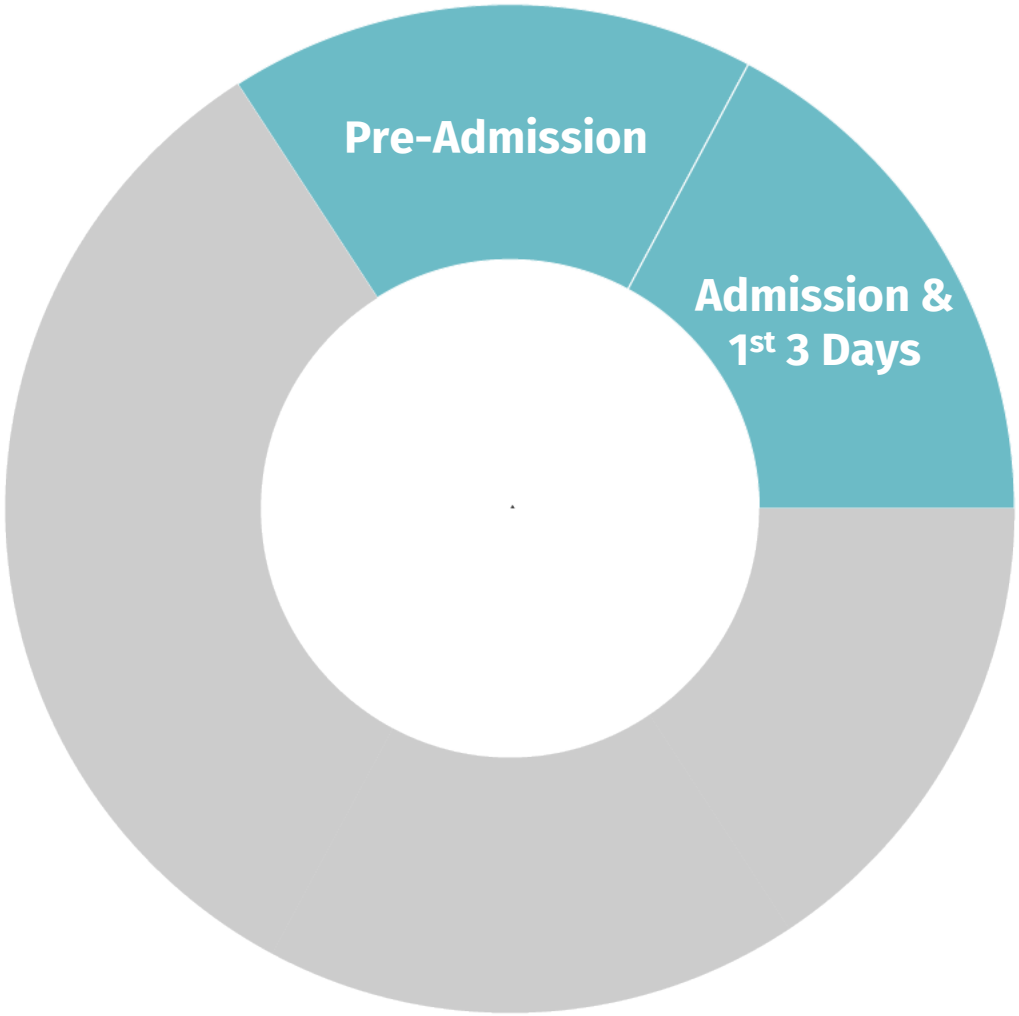
What if rehab could do more throughout the skilled stay?

WHAT IF

...rehab could be an essential part of the PDPM pre-admission process and expected to complete a full medical history review and patient/family interview prior to admission?

Using this pre-admission information, the rehab team could:

- Establish individualized DC plan upon admission
- Determine prioritized goals for safe transition
- Identify essential and prioritized disciplines upon admission
- Allocate appropriate resources at the right time
- Share patient specific information with the IDT members



Admission & 1st 3 Days

What if rehab could do more throughout the process?

WHAT IF

...rehab owned GG?

Ownership includes collecting and completing the MDS Section GG per the RAI manual guidelines for the:

- Initial Medicare Assessment
- IPA if indicated
- PPS Discharge Assessments

When rehab owns GG, they understand which functional skills need to improve & who should address it. With this information, they will focus on essential GG functional activities to facilitate optimal outcomes

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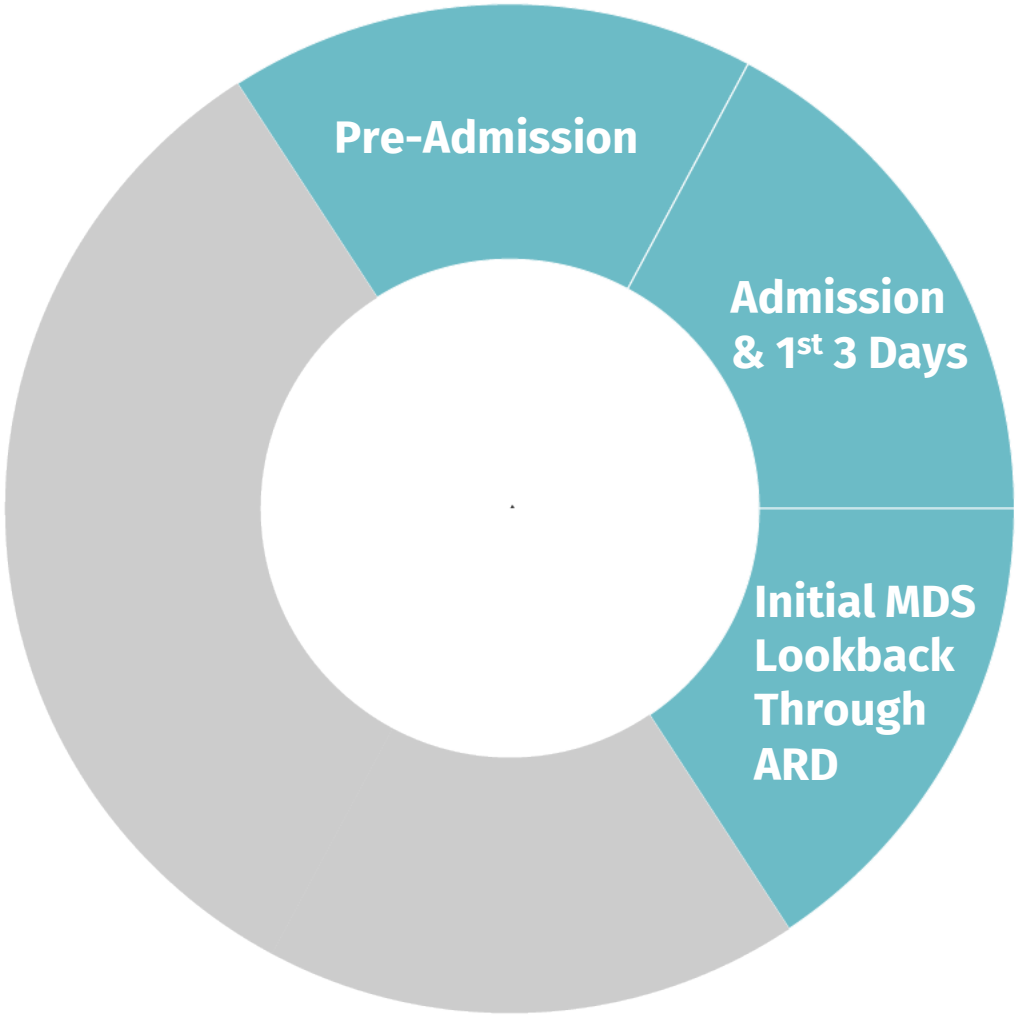

Initial Medicare Assessment Lookback through ARD

What if rehab could do more throughout the process?

WHAT IF

...rehab could own more responsibility in gathering, reporting on and reviewing items impacting successful rehab outcomes such as:

- Cognitive impairment
- Depression
- Signs and symptoms of swallowing disorders
- Active co-morbidities and conditions
- Changes in condition

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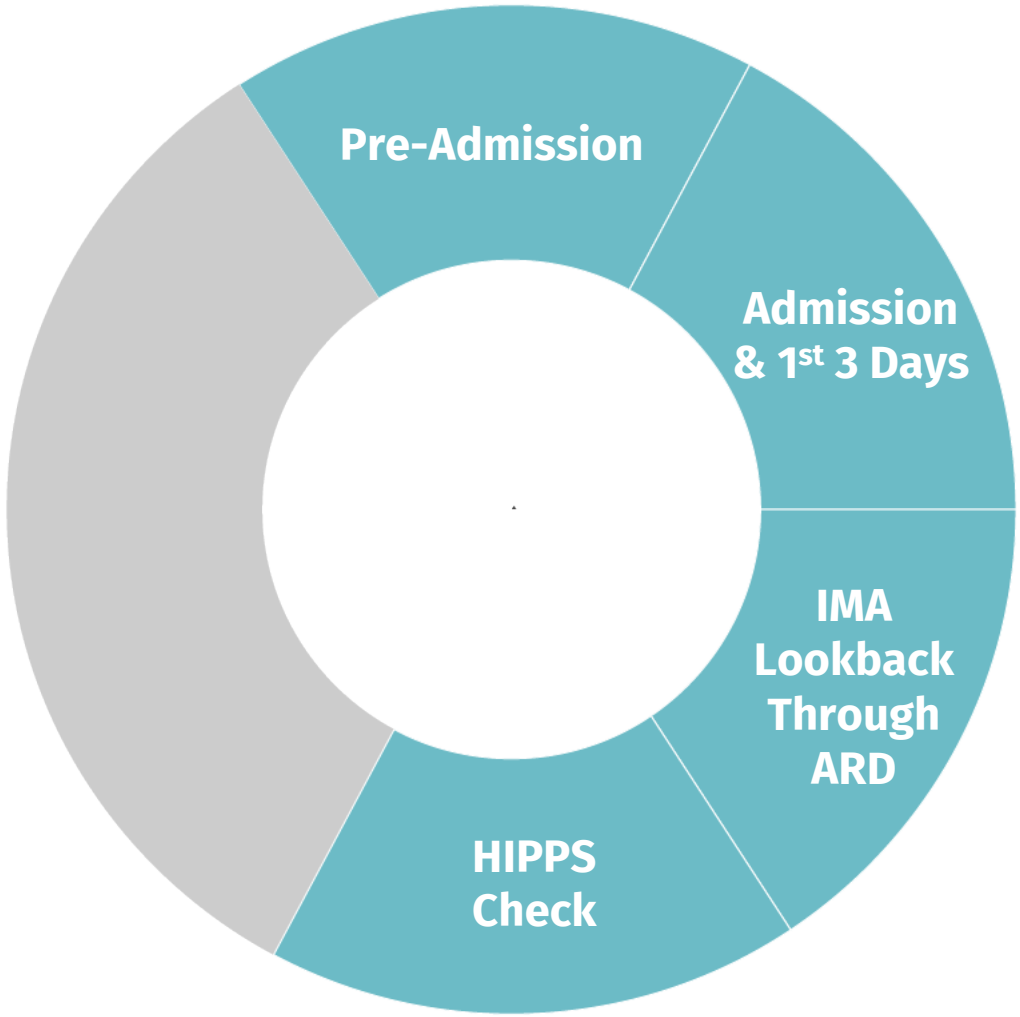

HIPPS Check

What if rehab could do more throughout the process?

WHAT IF

...rehab could identify and alert the MDS coordinator of an incorrect case mix group (CMG) assignment by simply reviewing the HIPPS code with the MDS coordinator by no later than day 8?

Understanding the CMG and corresponding HIPPS codes captured requires patient specific functional and clinical knowledge, PDPM component criteria and services received through written and verbal communication

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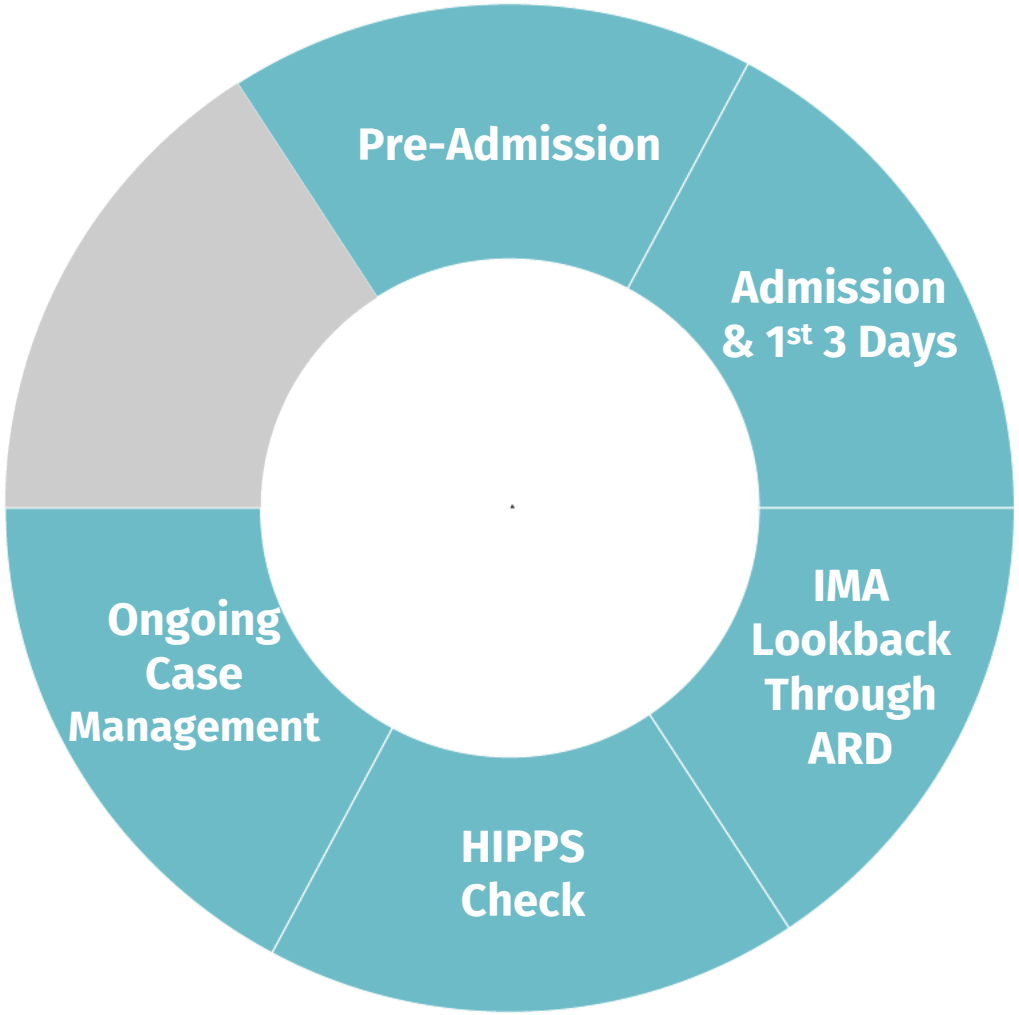

Ongoing Case Management

What if rehab could do more throughout the process?

WHAT IF

...could own all aspects of physical and intellectual wellbeing that directly influence a successful discharge focused on reducing rehospitalizations, patient satisfaction, & positive functional outcomes?

Ownership means knowing current support provided and delivery of care for all functional self care and mobility such as bathing, dressing, toileting, grooming, eating, transferring, walking, etc.

Rehab utilizes this information to appropriately progress patients through the continuum at the right time for the right level of care

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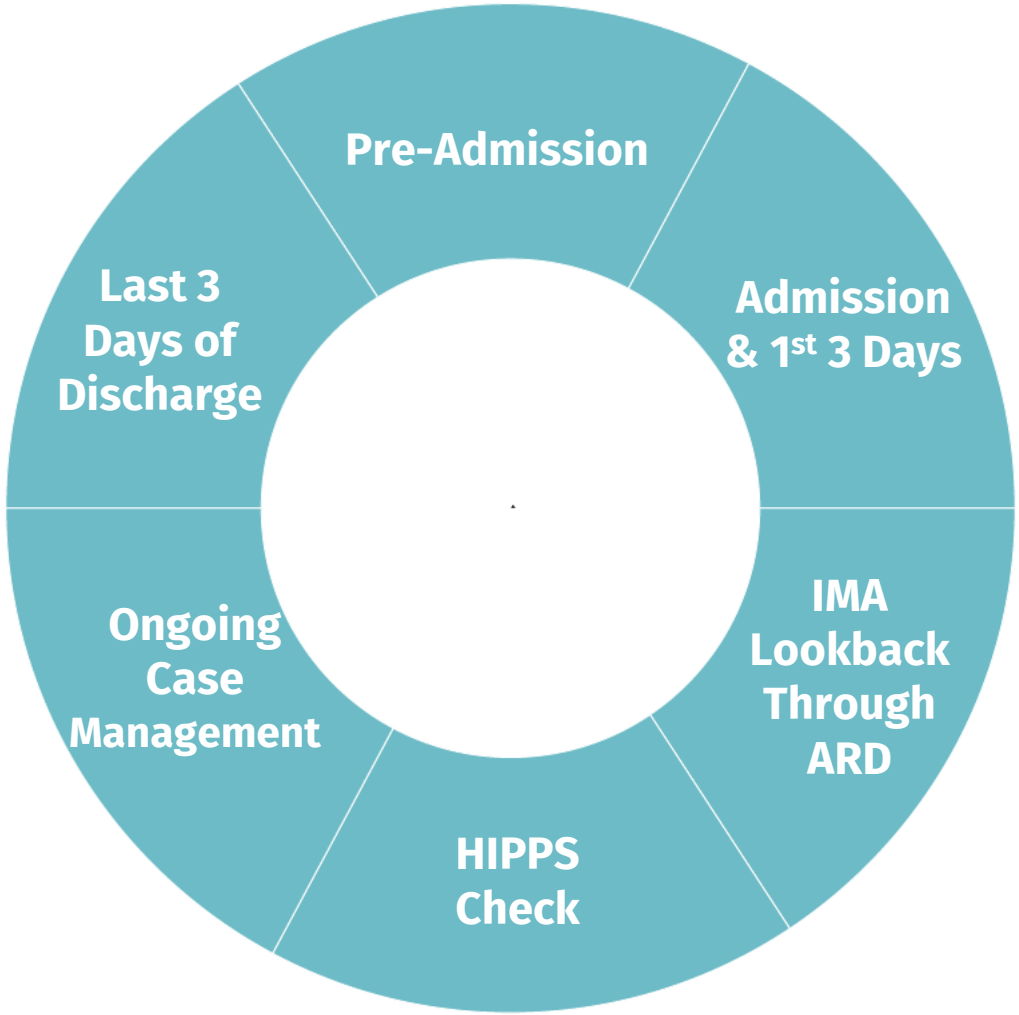

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Last 3 Days of Discharge

What if rehab could do more throughout the process?

WHAT IF

...rehab could facilitate and own successful discharge/ transition coordination with the IDT, supporting patient & caregiver engagement and education while reducing risk of rehospitalization

Ownership means rehab begins discharge planning and preparation on day 1 with patient & caregiver education and training supporting a realistic, mutually agreed upon discharge plan shared with the IDT throughout the stay

Rehab schedules onsite and/or remote home visits to identify and address barriers to a successful discharge

Rehab schedules dc GG assessments to gather the last 3 days of usual self care and mobility performance

Why this is **medically necessary, skilled & reimbursable**

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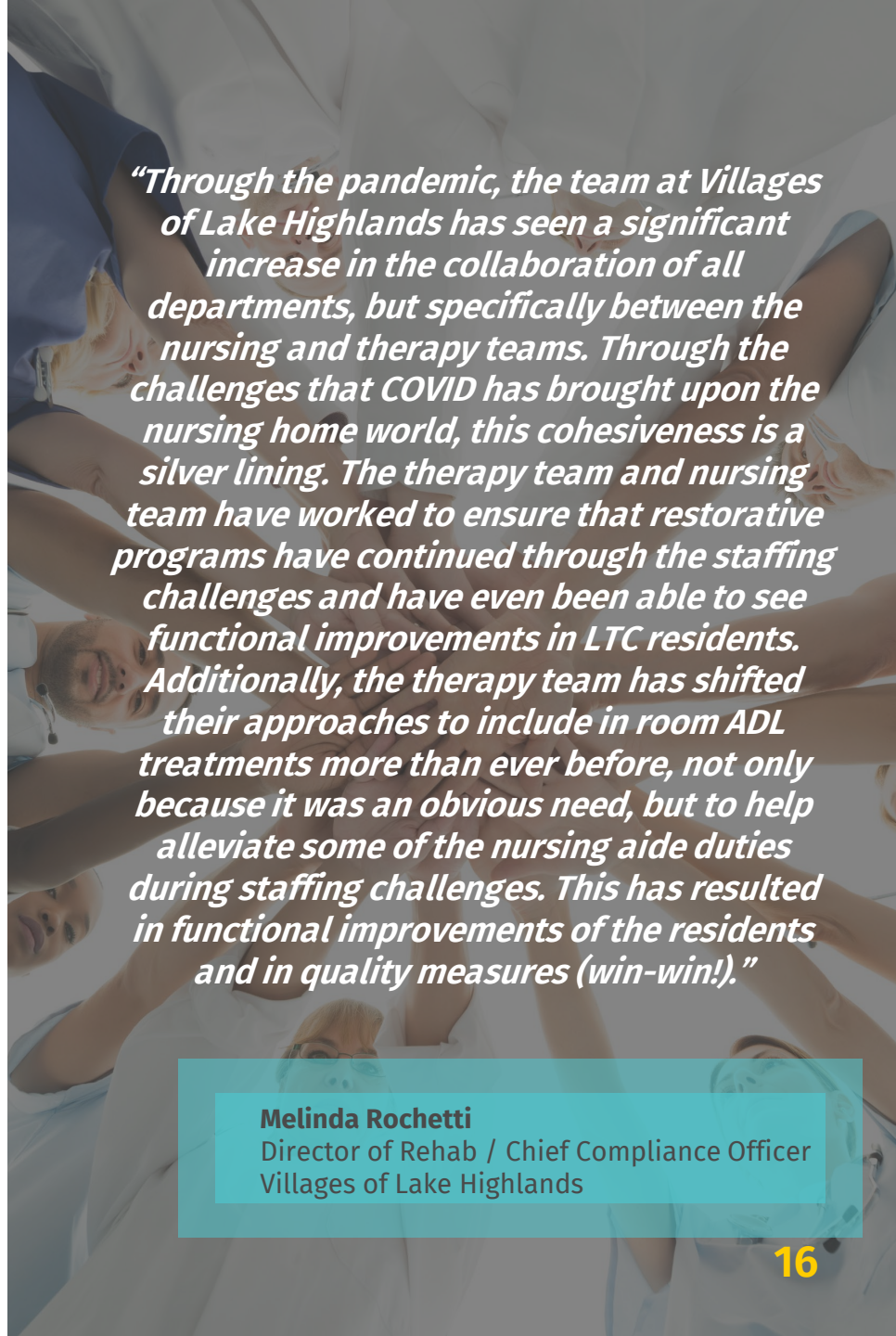
Example: New Skilled (PDPM) Admission – skilled and reimbursable rehab includes:

- Identification of prior level of independence and support requirements will be utilized to establish rehab appropriate goals (MDS Section A – Identification Information)
- Patient preferences for customary routines and activities for establishment of patient centered, individualized treatment strategies (MDS Section F - functional task preferences for prioritized goal setting and treatment plans)
- Prior home environment and what is required for return to next level of care utilized for rehab goal setting, care plan development, effective DC planning and caregiver education (MDS Section GG - Prior Functional levels)
- Establishment of baseline upon admission to set expected patient outcomes and goals (GG goals)
- Assessment of changes in condition impacting expected goal achievement and outcomes (IPA – Interim Payment Assessment)

Making it Happen

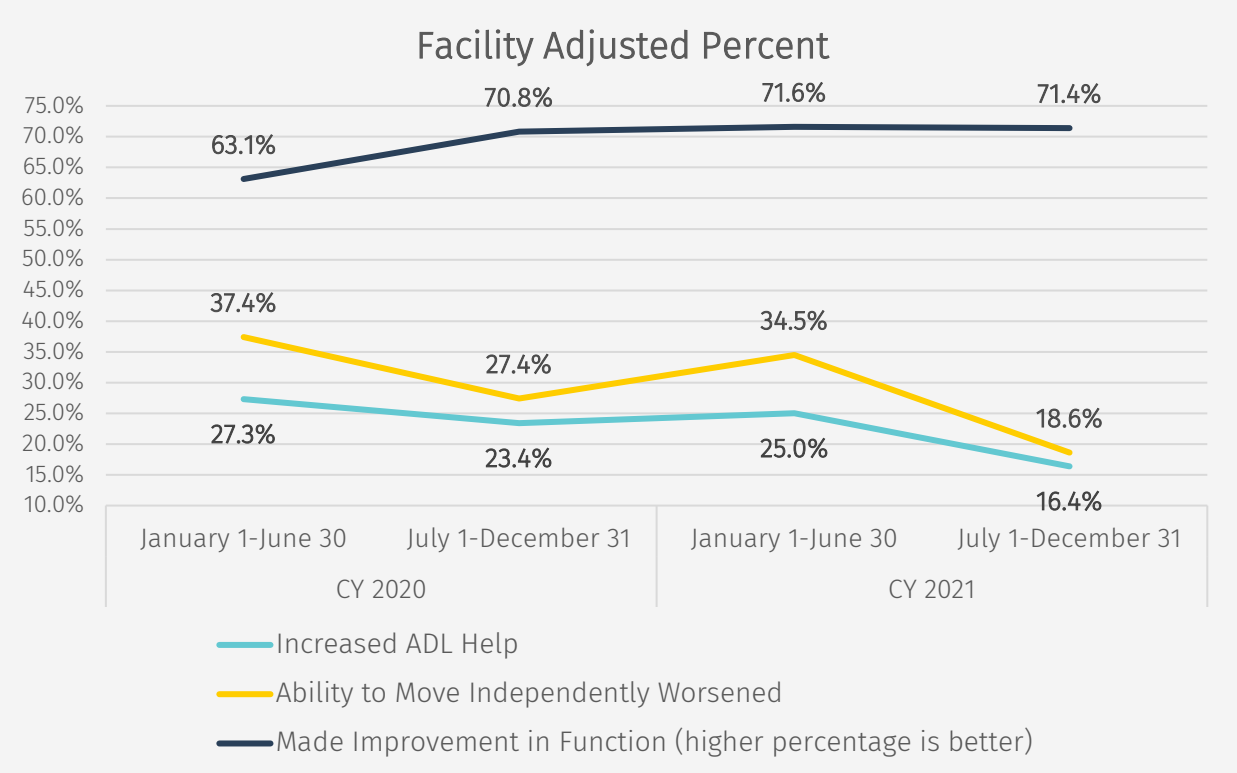
- Collaboration between Nursing and Therapy
- Education and training on MDS: A, F, GG, G, K, D PHQ-9, C-BIMS, Q
- Communication system between Therapy and MDS



"Through the pandemic, the team at Villages of Lake Highlands has seen a significant increase in the collaboration of all departments, but specifically between the nursing and therapy teams. Through the challenges that COVID has brought upon the nursing home world, this cohesiveness is a silver lining. The therapy team and nursing team have worked to ensure that restorative programs have continued through the staffing challenges and have even been able to see functional improvements in LTC residents. Additionally, the therapy team has shifted their approaches to include in room ADL treatments more than ever before, not only because it was an obvious need, but to help alleviate some of the nursing aide duties during staffing challenges. This has resulted in functional improvements of the residents and in quality measures (win-win!)."

Melinda Rochetti
Director of Rehab / Chief Compliance Officer
Villages of Lake Highlands

Recognizing Results: Patient Care Coordination



	CY 2020		CY 2021	
	1/1 – 6/30	7/1 – 12/31	1/1 – 6/30	7/1 – 12/31
Increased ADL Help	27.3%	23.4%	25.0%	16.4%
Ability to Move Independently Worsened	37.4%	27.4%	34.5%	18.6%
Made Improvement in Function	63.1%	70.8%	71.6%	71.4%

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Recognizing Results:
Patient Care Coordination

- Person centered delivery of care
- Improved carry over of therapy skills
- Improved Accuracy in the MDS data
- Most important – enhanced patient satisfaction and successful transitions

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Resources

- MDS & RAI Manual
- AP News
- Washington Post

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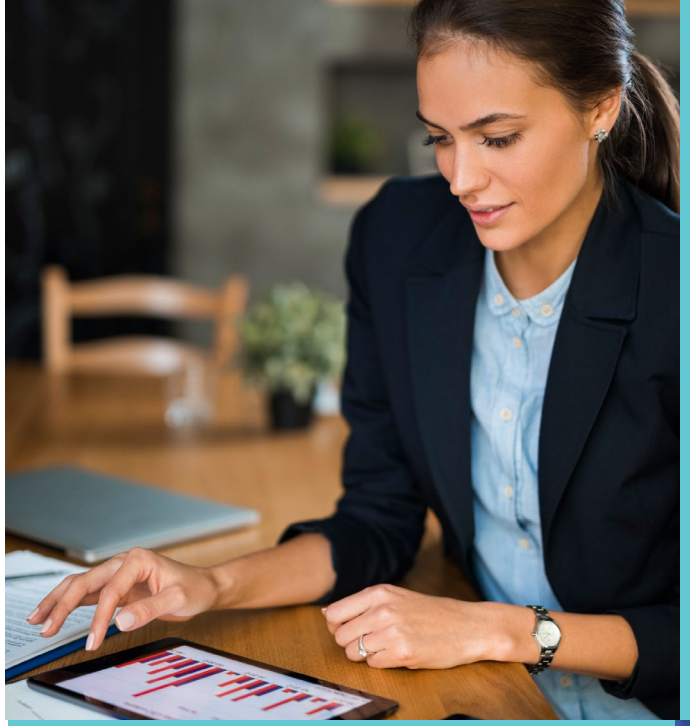
Quality Rehab Management

All-inclusive In-House Rehab Management Services

- Recruitment Services
- Operational Management
- Clinical Programming
- Clinical Reimbursement
- ADR Guidance
- Interdisciplinary Education
- Data Analysis



Supporting facilities in **30 states**

A model that **maximizes resources** and **improves outcomes**

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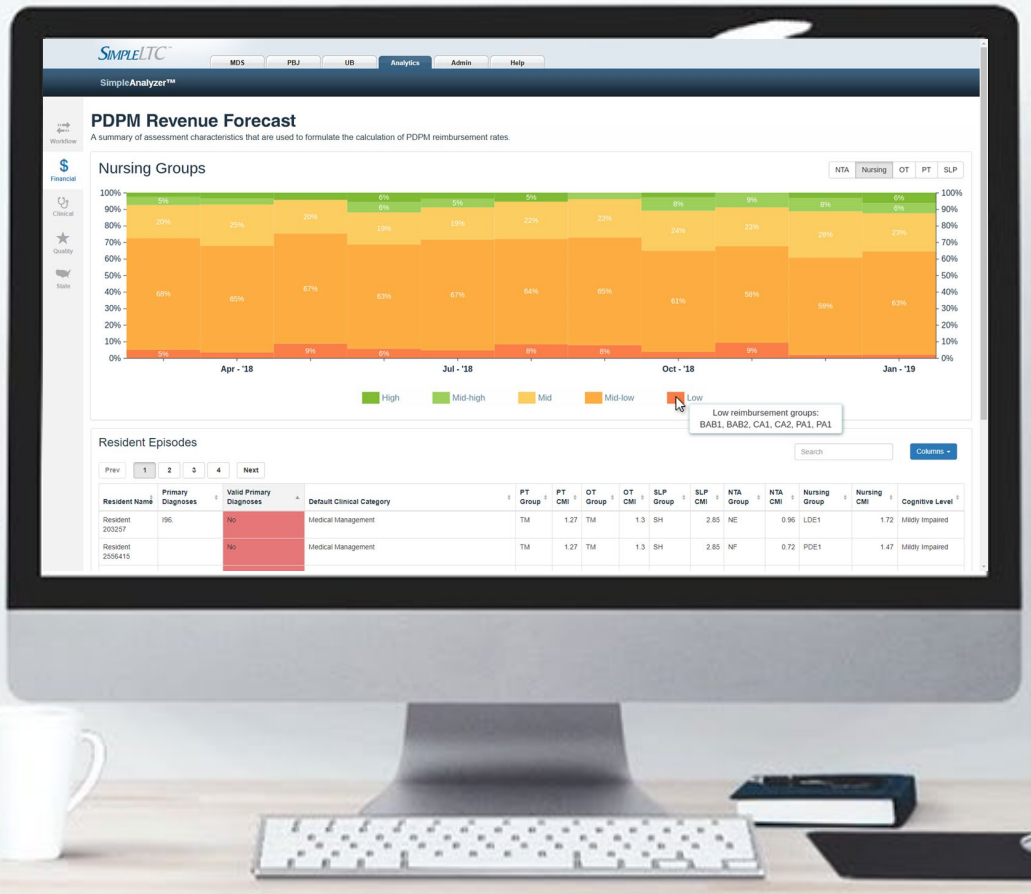

SimpleAnalyzer™

MDS analytics

Real-time quality metrics

Pre-transmission scrubbing

PDPM performance tools

Five-Star insights

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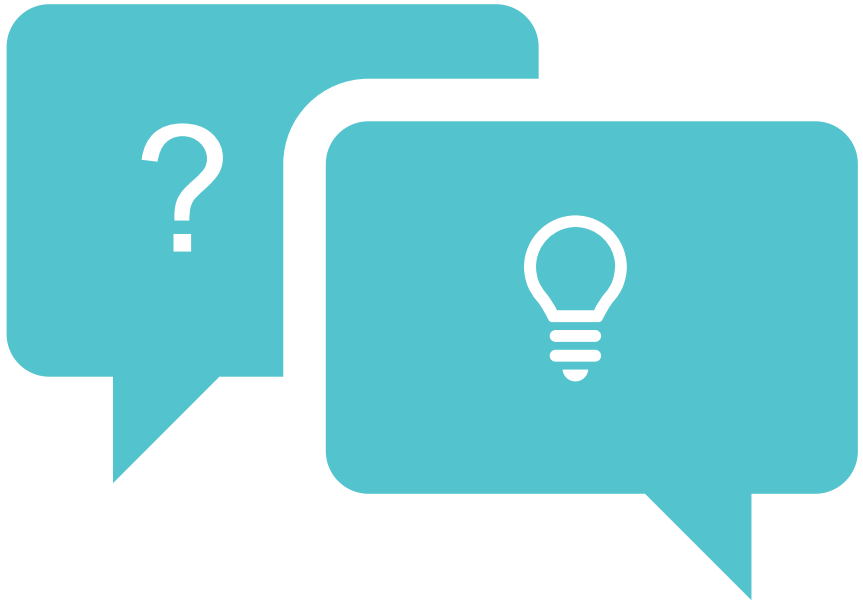
Questions & Answers

Please use the Q&A button to submit your questions.



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Thanks for attending!

Session recording, handouts & resources available at:

https://www.simpleltc.com/staffing-shortages

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