Clinical Indicators & SNF Reimbursement: Driving Outcomes Through IDT Collaboration

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Learning Objectives

By the end of this session, participants will be able to:

1. Identify key clinical and social indicators, including SDOH and chronic disease factors, that contribute to resident complexity in SNF settings.
2. Describe how interdisciplinary team (IDT) collaboration supports accurate capture and communication of clinical and functional status in care planning and documentation.
3. Apply strategies to improve interdisciplinary communication and workflow alignment to ensure documentation accurately reflects resident needs within current payment models, including PDPM, managed care, and value-based purchasing.

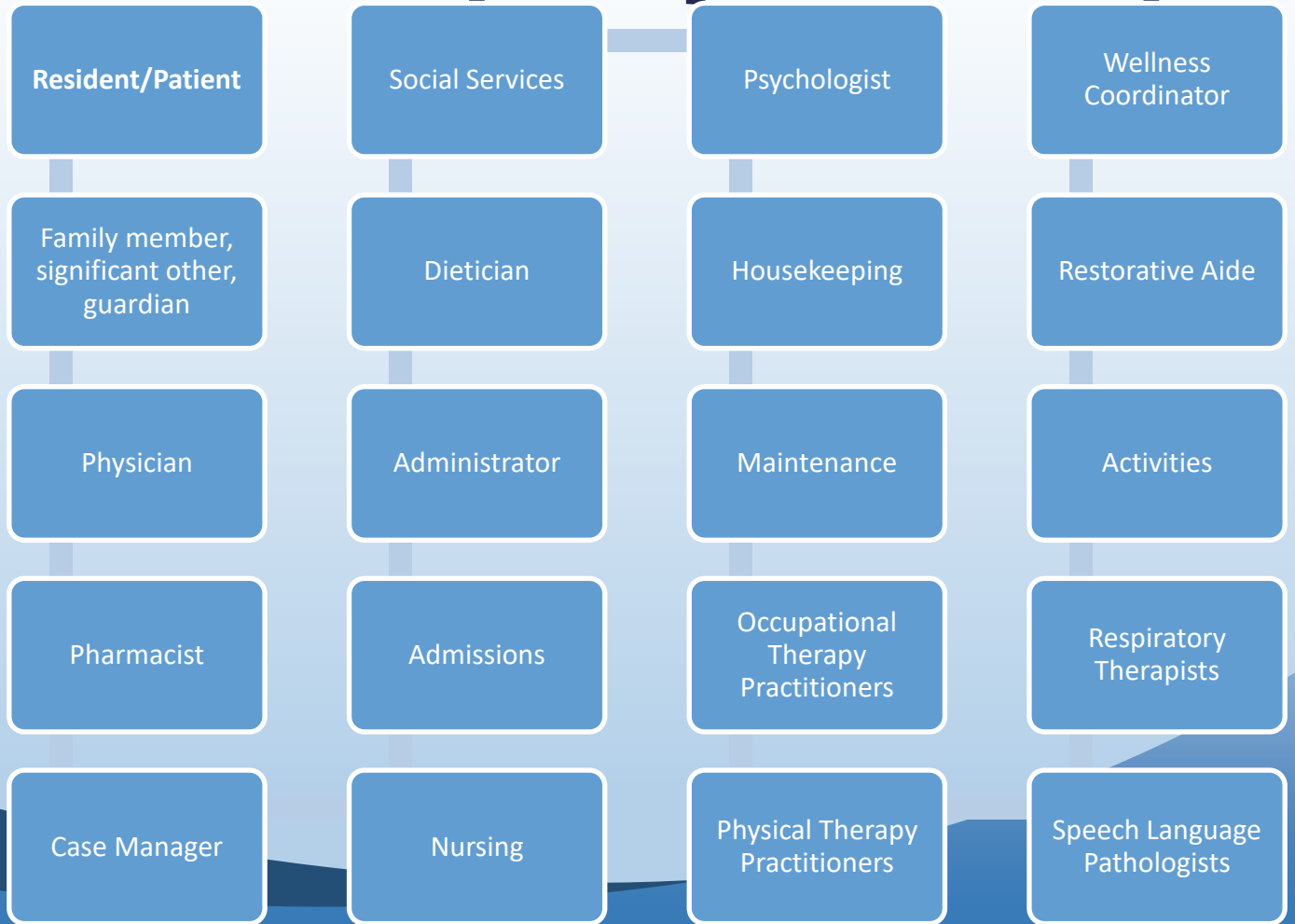
Facility Assessments

- When was the last time that your facility assessment was updated?
- Is there a change in your resident needs?
- Is there a change in your resident diagnosis?
- Does your facility assessment include resident language?

Ethnic, Cultural or Religious Factors

ITEM	FACILITY RESPONSE
Activities	
Food and Nutrition Services	
Languages	
Clothing Preferences	
Access to Religious Services	
Religious-based Advanced Directives	
Other	

Interdisciplinary Partnership



IDT=Where Outcomes Are Won or Lost

- No discipline sees the full picture alone
- Fragmentation increases risk
- Collaboration reduces gaps
- Alignment improves outcomes

F940: Training Requirement
§483.95 Training Requirements

F940
(Rev. 225; Issued: 08-08-24; Effective: 08-08-24; Implementation: 08-08-24)

§483.95 Training Requirements
A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to—

INTENT

Facilities are required to develop, implement, and maintain an effective training program for all staff. Appropriately trained staff can improve resident safety, create a more person-centered environment, and reduce the number of adverse events or other resident complications.

CMS recognizes that training needs are likely to change over time. Therefore, it is necessary for facilities to have the flexibility to determine training needs based on its facility assessment. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program. The facility is also expected to keep a record of these trainings. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. See §483.71(a) (2)(iv).

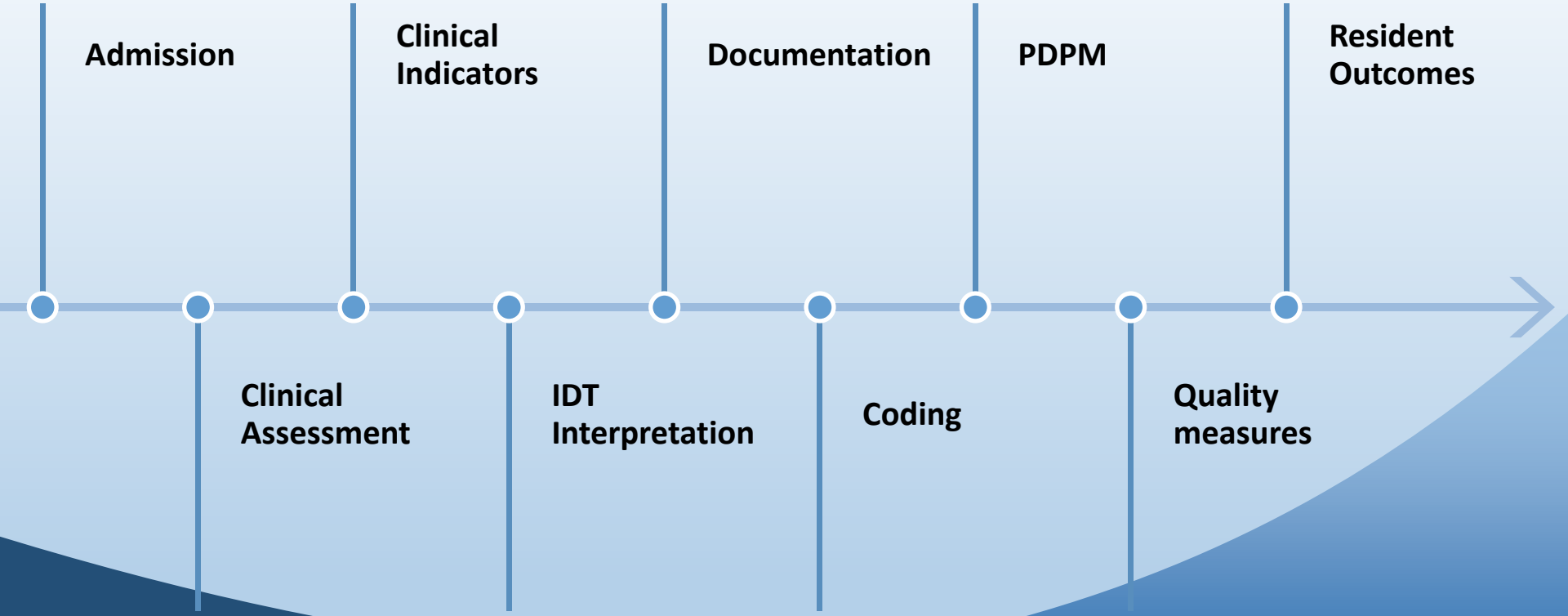
CMS does not propose a specific training mechanism to meet the Training Requirements regulation, and the regulation does not specify that a member of the facility must conduct the training activities. Facilities have the flexibility to work with outside entities to provide facilitated training, computer-based training, self-directed learning, mentoring and/or coaching. CMS encourages facilities to leverage community resources to assist with developing training programs, identifying qualified instructors, identifying training materials, and implementing facility training programs.

Based upon the outcome of a facility assessment, suggestions for additional training topics may include, but are not limited to, advance care planning, cultural competence, end-of-life care, geriatrics and gerontology (i.e., understanding of how human beings change as they grow older), substance abuse, working with young and middle-aged adults, grief and loss, interdisciplinary collaboration, person centered care, specialized rehabilitative therapy, trauma informed care, intellectual disability, mental disorder and quality of life and care.

Every Resident Has a Story

- The question ***isn't*** whether the story exists.
- The question ***is*** whether the entire interdisciplinary team recognizes and communicates it.

A Resident's Journey



ONE RESIDENT. *Hundreds of Decisions.*

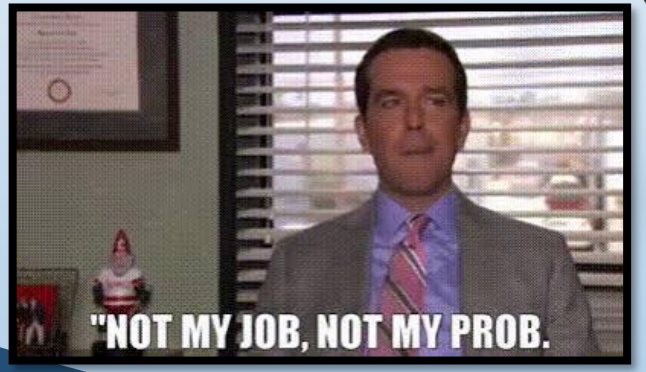
Every decision shapes care. Every observation becomes a clinical indicator.

ONE RESIDENT
At the Center of It All

- Admission
- Hospital Records
- Nursing Assessment
- Therapy Evaluation
- Physician Orders
- Medication Reconciliation
- Nutrition
- Swallowing
- Cognition
- Mood
- Behavior
- Functional Mobility
- ADLs
- Wounds
- Dialysis
- Diabetes
- Obesity
- GLP-1 Use
- Pain
- Falls
- Restorative Nursing
- Care Planning
- Family Interview
- Social History
- Goals of Care
- SDOH / Health Related Social Needs
- Risk Factors

Every decision influences *documentation.* | Every observation influences *care.* | Every discipline contributes to the *resident's story.*

Interdisciplinary Partnership



The Challenge Isn't More Work....
It's More Complexity...

A PERSON
is not a process.

Every resident has a story.
We care for people—not assessments.

IDAHO HEALTHCARE ASSOCIATION

INTERDISCIPLINARY TEAM COMMUNICATION
Bridging the person and the process

- NURSING
- THERAPY
- MDS
- DIETARY
- SOCIAL SERVICES
- ACTIVITIES
- MEDICAL PROVIDER

A PROCESS
is not a person.

A process supports the person.
Good processes drive better outcomes.

THE CONTINUOUS PROCESS

1 ADMISSION → 2 ASSESSMENT → 3 OBSERVATION → 4 COMMUNICATION → 5 DOCUMENTATION → 6 CODING → 7 CARE PLANNING → 8 OUTCOMES

DRIVES WHAT MATTERS

QUALITY MEASURES | PDPM ACCURACY | SURVEY READINESS | VALUE-BASED CARE | BETTER RESIDENT OUTCOMES

A PERSON IS NOT A PROCESS. A PROCESS IS NOT A PERSON.

Excellence happens when the interdisciplinary team connects the two.

People First | Teamwork Always | Idaho Strong | Clinical Integrity | Better Together

A Person Is Not a Process, and a Process is Not a Person: Defining Roles in Patient-Centered Care

- Who is part of your admission process?
- Who is part of the resident care planning process?
- Who is completing MDS Section A: Identification Information?
- Who is completing the BIMS?

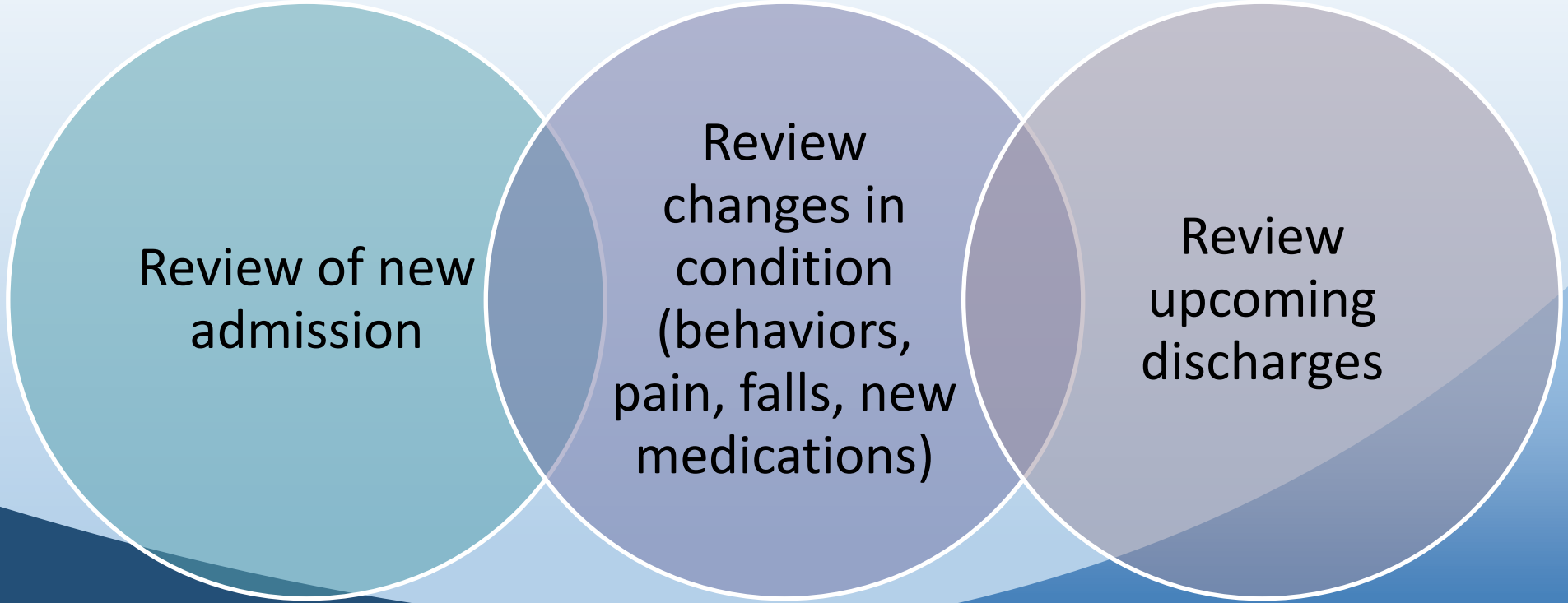
A Person Is Not a Process, and a Process is Not a Person: Defining Roles in Patient-Centered Care

- Who is completing the PHQ 2-9?
- Who is completing MDS Section E: Behaviors?
- Who is completing MDS Section F: Preferences for Customary Routines and Activities?
- Who is responsible for discharge planning?

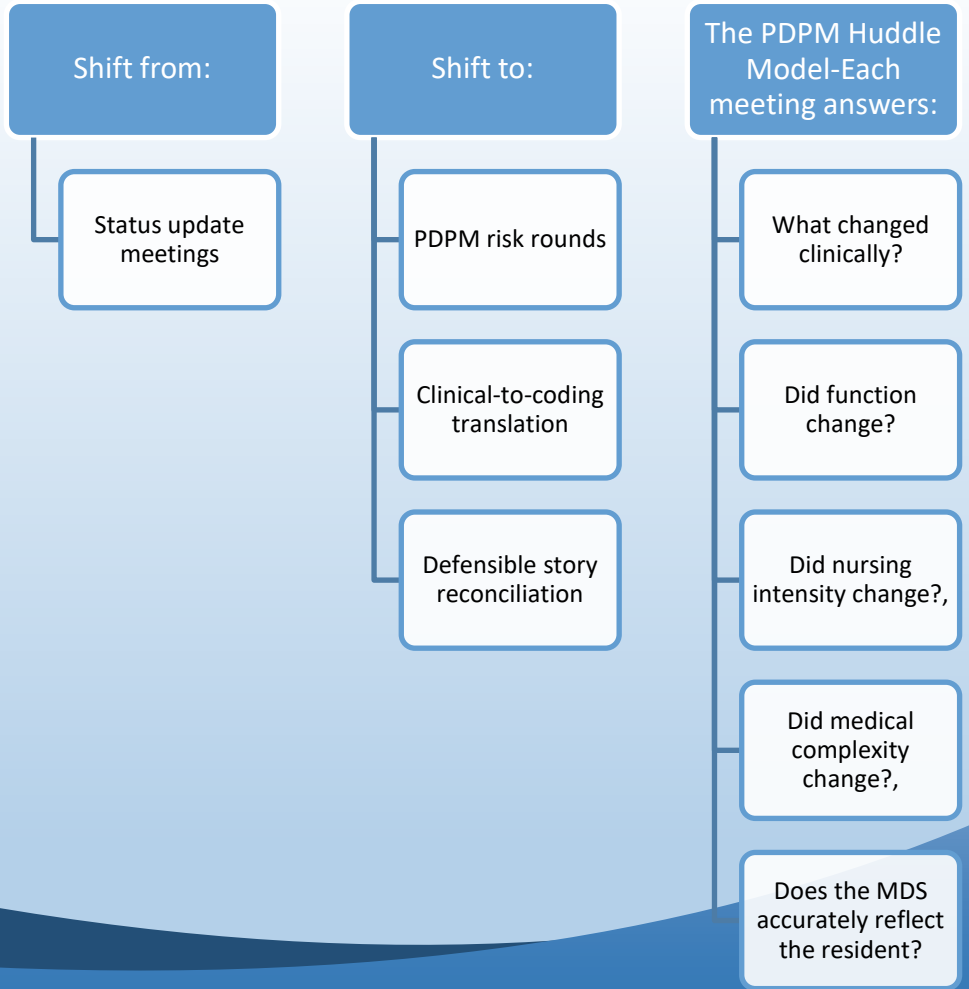
Leveraging Strengths and Addressing Weaknesses in the MDS Process

- Ensuring MDS Accuracy: what systems support accurate MDS completion?
- IDT Collaboration: how do systems facilitate effective interdisciplinary teamwork?
- Patient-Centered Care: what systems ensure a focus on individual resident needs?
- Culturally Competent Care: what systems support culturally sensitive care practices?
- Trauma-informed Care: what systems are in place to provide trauma-sensitive care?
- Evaluating System Effectiveness: are the current systems achieving desired outcomes?

Optimizing Communication within the IDT: Daily Clinical Meetings



The PDPM IDT Huddle Model



IDT Gaps That Compromise PDPM Accuracy and Defensibility

Section GG Misalignment

Problem:	Impact:	IDT Process Breakdown:
• Nursing=usual performance • Therapy=best performance • IDT never reconciles=inaccurate functional score	• Inaccurate case mix group • Inaccurate care planning • Survey risk for inaccurate assessment	• No structured reconciliation between nursing and therapy

Nursing Case-Mix Misalignment

Problem:	Impact:	IDT Process Breakdown:
• Extensive services/depression/behavior needs not fully supported in the documentation • Special care high criteria missed (i.e. SOB while lying flat) • Restorative nursing program not being carried out as ordered	• Lower nursing case-mix group • Survey risk for unmet needs/inaccurate resident acuity	• Nursing care needs not validated

NTA Misalignment

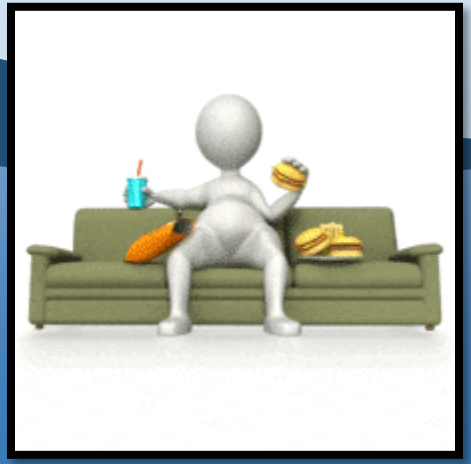
Problem:	Impact:	IDT Process Breakdown:
• High-cost comorbidities identified by therapy or medical record but not communicated to MDS and not supported by nursing documentation	• Missed NTA points • Higher supply costs with no payment offset	• No standardized NTA huddle/process

SLP Comorbidities & Diet/Swallowing Misalignment

Problem:	Impact:	IDT Process Breakdown:
• Diet changes, swallowing safety and documented in nursing/SLP notes and not aligned/captured on the MDS	• Lower SLP case-mix group • Survey risk for inaccurate nutritional and swallowing care plan	• Diet, cognition and swallowing changes not systematically communicated to the MDS coordinator prior to the ARD

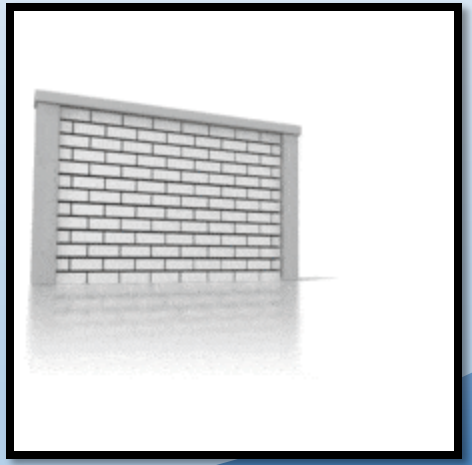
Healthcare Continues to Evolve….

CMS Priorities Continue to Evolve…



Health Equity and SDOH

- SDOH drive disparities
- Structural barriers affect function
- Health equity isn’t another department. It’s the outcome of good interdisciplinary care.



Health Equity: *"Health equity" refers to the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes*.

From the CMS Framework for Health Equity, April 2022, https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity.

Social Determinants of Health (SDOH):

Education Access and Quality:	Health Care Access and Quality:	Economic Stability:	Social and Community Context:	Neighborhood and Built Environment:
• literacy • language • early childhood education • vocational training • higher education	• health coverage • provider availability • provider linguistic and cultural • competency • quality of care • health IT	• employment • income • expenses • debt • medical bills • support	• social integration • support systems • community engagement • discrimination • stress reduction • health IT • nutrition • healthy eating	• housing • transportation • walkability • safety • parks • playgrounds • zip code/geography

Social Determinants of Health

Social Determinant of Health	Clinical/Functional Impact
Food insecurity	Weight loss, malnutrition, wounds, fatigue
Transportation	Missed care, readmissions
Housing instability	Readmissions, falls
Health literacy	Medication errors, readmissions
Social isolation	Depression, functional decline

IDT Roles: Addressing SDOH

Nursing:

- Screen for health-related social needs impacting care and treatment adherence
- Identify barriers affecting symptom management
- Medications and self-care

Social services:

- Assess psychosocial needs
- Caregiver support
- Financial concerns and community resources
- Coordinate discharge planning and connect residents with available services

Dietary:

- Address food insecurities
- Nutritional preferences
- Cultural considerations
- Meal access
- Adapt nutrition plans to support disease management

Therapy:

- Identify functional barriers affecting independence and community participation
- Recommend adaptive equipment and caregiver education

MDS:

- Capture SDOH related factors influencing function and care planning

Resident-Centered Goals

- ✓ Remove barriers to achieving highest practicable level of function
- ✓ Improve health outcomes through individualized, equitable care
- ✓ Support safe transitions and sustained community access
- ✓ Aligned interventions with resident goals, preferences and lived experiences

For Every Resident, The IDT Should Ask:

- ❑ What clinical factors are affecting this resident?
- ❑ What social factors are affecting this resident?
- ❑ How do these factors impact function?
- ❑ What will each discipline do about it?

MAHA Movement-Why it Matters

MAHA-Make America Healthy Again

Why MAHA Matters to Providers:

- ✓ Signals federal and state alignment toward prevention-first care
- ✓ Reinforces nutrition, physical activity, chronic disease management, and behavioral health
- ✓ Supports non-pharmacological, interdisciplinary interventions
- ✓ Aligns with value-based care, quality measures, and cost containment

MAHA-Make America Healthy Again

Compliance and Regulatory Implications:

- ✓ Increased scrutiny on care planning vs. reactive care
- ✓ Expectation for documented IDT coordination
- ✓ Greater focus on outcomes tied to function, falls, pain, and chronic disease
- ✓ Risk if documentation does not support medical necessity and skilled need

IDT Supports Healthy Again Through

Nursing: identifies changes in condition, manages chronic diseases, monitors medication effectiveness and side effects, promotes preventative care, coordinates clinical interventions	**Therapy:** improves strength and endurance, reduces fall risk, promotes independence, preserves muscle mass	**Dietary**: addresses obesity and malnutrition, optimizes protein intake, encourages hydration, monitors unintended weight loss	**Social Services:** identifies barriers to care, addresses food insecurities, supports mental health, connects resident and family with community resources	**Activities:** encourages movement, reduces isolation, supports cognition, creates opportunities for purpose and engagement

MAHA-Make America Healthy Again

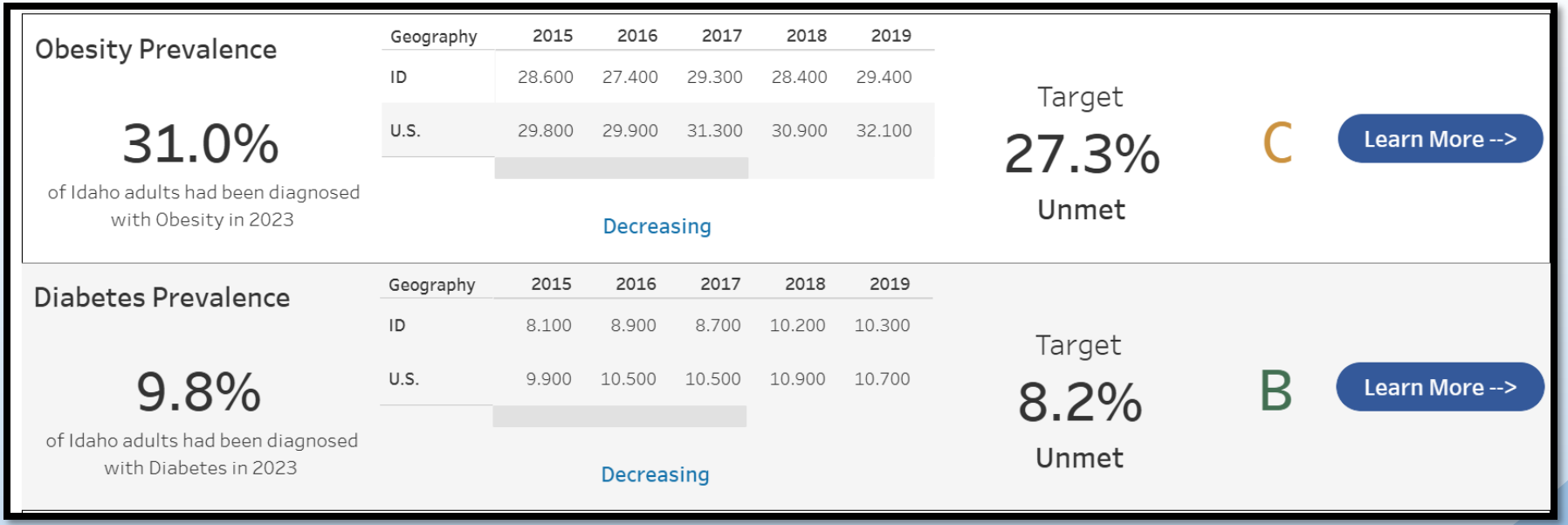
What CMS Cares About:

- ✓ Reduced caregiver burden
- ✓ Increased independence
- ✓ Improved safety in daily routines
- ✓ Decreased reliance on medications
- ✓ Better long-term community living outcomes

CMS Focus:

Diabetes, Morbid Obesity &

GLP-1 Medications



https://www.gethealthy.dhw.idaho.gov/idaho-health-report-card

Adults who have obesity (BMI ≥ 30)

		CI bar length	CI high	CI low	Estimate	Number of Adults
Total	All Adults	3	33	29	31.0	424,168
Sex	Female	5	33	29	31.0	206,840
	Male	4	33	29	30.9	217,328
Age Groups	18-24	8	25	16	20.1	38,542
	55-64	9	40	32	35.8	73,680
	45-54	9	42	33	37.2	69,348
	35-44	8	35	27	30.6	67,081
	25-34	8	36	28	31.9	70,357
	65+	5	34	28	30.8	102,829
Ethnicity	Hispanic	10	42	31	36.2	52,188
	Non-Hispanic	3	32	29	30.2	365,409
Education	K-11th Grade	12	38	26	31.9	37,118
	College Graduate+	5	29	24	25.9	96,767
	Some college credit, but not a degree	6	36	31	33.4	165,333
	12th Grade or GED	6	35	30	32.2	123,229
Income	Less Than $15,000	16	50	34	41.9	20,076
	$15,000-$24,999	11	37	26	31.5	28,621
	$25,000-$34,999	11	42	31	35.9	41,281
	$35,000-$49,999	9	38	30	33.8	56,398
	$50,000-$74,999	8	39	31	34.6	67,239
	$75,000+	5	31	26	28.1	142,278
Employment	Unemployed	17	43	26	34.1	14,795
	Other	5	34	29	31.7	157,790
	Employed	4	33	28	30.4	249,381

Adults ever told they had diabetes

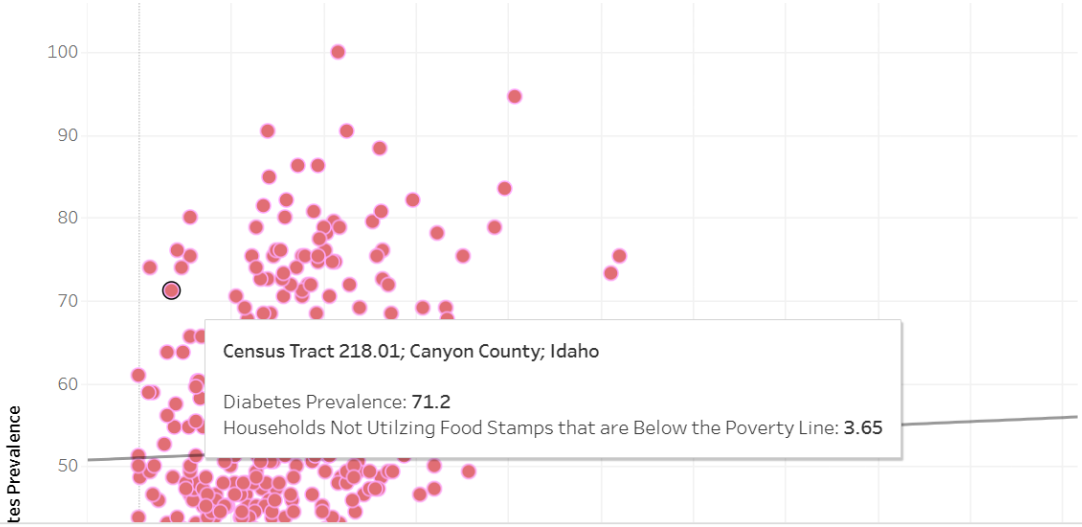
			CI bar length	CI high	CI low	Estimate	Number of Adults
Total	All Adults		2	11	9	9.8	146,844
Sex	Female		3	12	9	10.0	76,277
	Male		2	11	8	9.5	70,567
Age Groups	18-24		3	4	1	2.2	4,776
	25-34	NOTE: estimates with an ..	2	3	1	1.7	4,174
	35-44		3	7	3	4.7	11,451
	45-54		6	14	8	10.8	21,957
	55-64		6	18	12	15.1	33,379
	65+		5	22	17	19.2	68,954
Ethnicity	Hispanic		6	13	8	10.0	17,854
	Non-Hispanic		2	11	9	9.8	128,109
Education	12th Grade or GED		3	10	7	8.2	34,622
	College Graduate+		3	9	7	7.8	30,910
	K-11th Grade		8	19	11	14.6	20,725
	Some college credit, but n..		4	13	10	11.2	60,176
Income	$15,000-$24,999		8	21	12	16.1	16,653
	$25,000-$34,999		6	15	9	11.9	14,881
	$35,000-$49,999		6	14	8	10.5	18,623
	$50,000-$74,999		5	12	7	9.0	18,316
	$75,000+		3	8	6	6.8	35,781
	Less Than $15,000		13	31	17	23.1	12,419
Employment	Employed		2	6	4	5.3	46,958
	Other		4	19	15	17.0	93,350
	Unemployed		12	18	6	10.9	5,312

DIVISION OF PUBLIC HEALTH

Health Outcomes Compared Against Health Related Community Indicators

Click Here for Main Page

Diabetes Prevalence vs. Households Not Utilzing Food Stamps that are Below the Poverty Line



Select a Health Outcome

Diabetes Prevalence

Select a Health-Related Community Indicator

Households Not Utilzing Food Stamps that are Below the Poverty Line

One method for exploring the relationship between health-related community indicators and health outcomes is through a chart known as a scatter plot.

The scatter plots in this section can be used to compare a user selected health-related community measure against a user selected health outcome or behavior. Each circle

CMS Strategy

CMS is Focused On

- Diabetes-related complications
- Morbid obesity and preventable decline
- Falls with major injury
- Readmission and avoidable utilization
- Long-term cost of care

What is Changing

- Expanded Medicare and Medicaid coverage of weight-loss medications (GLP-1)
- Faster weight loss-without guaranteed functional stability

Morbid Obesity Is More Than a Diagnosis

Obesity Influences

- Mobility
- Transfers
- Skin integrity
- Respiratory function
- Diabetes management
- Cardiovascular disease
- Pain
- Quality of life

GLP-1 Medications: What The IDT Must Monitor & Document, Compliance, Safety & Risk Mitigation

The IDT Must Look beyond Weight Loss:

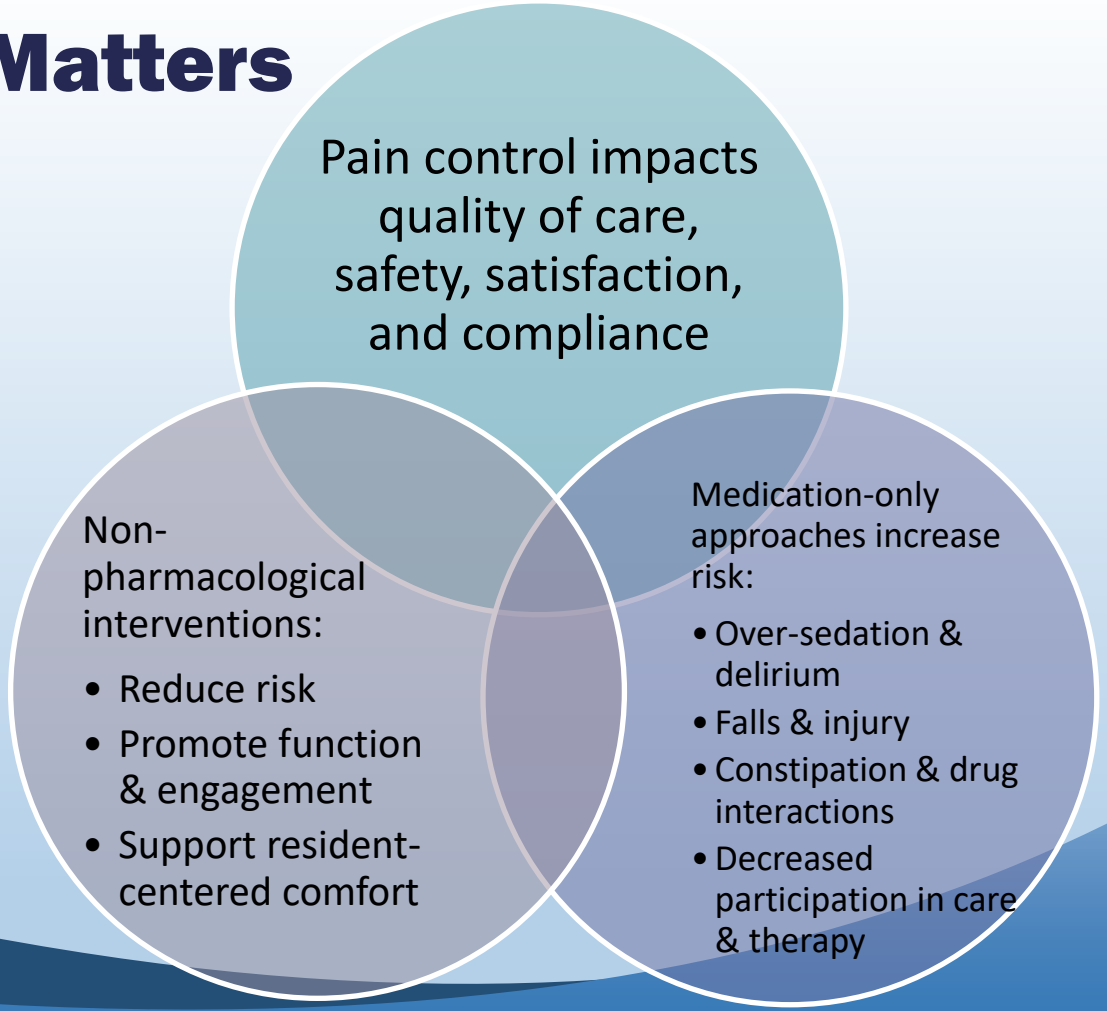
- Rapid weight loss
- Muscle mass loss
- Fatigue and reduced endurance
- Orthostatic hypotension
- Balance changes
- Reduced oral intake
- Dehydration
- Constipation
- Increased fall risk

IDT Roles & Resident-Centered Goals

Nursing:	Dietary:	Therapy:	MDS:	Medical provider:
• Monitor glucose trends • Medication response and adverse effects • Assess for- hypoglycemia, dehydration, skin integrity and GI symptoms	• Optimize- protein, hydration & nutritional intake • Provide resident-centered nutritional education	• Assess changes in strength, endurance, ADLs, swallowing and cognition, • Implement interventions to preserve function and independence during weight loss	• Capture clinical complexity, functional changes and IDT documentation	• Evaluate medication effectiveness & tolerability

Non-Pharmacological Pain Management

Why This Matters



Why An IDT Approach Is Essential

Pain is multidimensional:

- Physical
- Emotional
- Cognitive
- Environmental
- cultural

IDT collaboration ensures:

- Holistic assessment across disciplines
- Accurate pain source identification, especially in dementia
- Integrated, consistent interventions across shifts
- Improved outcomes: mobility, sleep, mood, function
- Regulatory compliance-CMS expects non-pharmacological approaches when clinically appropriate

IDT Roles & Resident-Centered Goals

Why the Solution is NOT "Just a Pill":

- Pain is complex-medications alone are insufficient
- Polypharmacy increases adverse events
- Resident goals & preferences must guide care
- Functional improvement requires active interventions
- Long-term medication reliance does not support sustainable comfort or quality of life

Examples of Non-Pharmacological Strategies:

- **Therapeutic interventions:** exercise, mobility training, positioning, stretching, heat/cold, manual therapy
- **Environmental modifications:** seating, pressure relief, adaptive equipment
- **Behavioral & psychosocial:** reassurance, coping strategies, routine establishment
- **Activities & engagement:** music, social interaction, meaningful activity
- **Relaxation & wellness:** breathing, guided imagery, mindfulness, sleep hygiene
- **Nutrition & hydration support**

IDT Roles & Resident-Centered Goals

Nursing:

- Pain assessment
- Monitoring response
- Change-in-condition communication

Therapy:

- Assess pain's impact on mobility
- Function
- ADLs
- Communication and swallowing
- Implement individualized non-pharmacological interventions
- Educate residents & caregivers on pain management strategies

Social services:

- Emotional support
- Coping strategies
- Mental health screening

Activities:

- Engagement that calms
- Distracts
- Supports function

Dietary:

- Nutrition optimization for healing & inflammation reduction

Medical providers:

- Safe medication management supporting non-pharmacological approaches

Contact Information

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