The DON's Role in Financial Management and how it directly relates to quality of care

- Balancing Quality, Staffing, and the Bottom Line
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Today’s Focus

- • The DON’s influence on the SNF budget
- • How clinical documentation drives reimbursement
- • Staffing strategies for cost control
- • Tying quality outcomes to financial health

But Michelle- there is no regulation stating a DON is responsible for financial management- so why is this my problem?

Because while **CMS regulates care**, the **cost of that care** (staffing, supplies, overtime, PDPM revenue) is controlled operationally by the DON.

Examples:

Regulatory Area	Why It Becomes Financial
Staffing compliance (F-725)	Labor = 60–70% of SNF expenses
Avoiding survey penalties (F-tags)	IJ-level fines can be $10K/day
PDPM documentation (483.20)	Missed comorbidities = lost revenue
Preventing rehospitalization (QRP rule)	Impacts 5-Star + payer contracts
QAPI participation	Required to address "resource use"

Financial awareness helps us preserve the resources we need to care for the residents we serve.

How you control expenses AND improve revenue

- Labor and Staffing management (largest cost driver)
- Nursing supplies and pharmacy spend
- Documentation→ PDPM Revenue/CMI
- Hospitalization reduction
- Survey and Compliance Cost Avoidance

Labor and Staffing Management

- • Approx 62% of SNF budget = labor costs
  - Benefits are approximately 15% of labor costs
- Manage your PPD daily- adjust for census/acuity
- Know your budgeted HPPD target
  - Kansas SNF average PPD was 3.97 compared to 3.85 national average
  - Kansas used a statewide base-period CMI of 1.291 to establish the direct health care cost limit for Medicaid rates effective July 1, 2025.
- Overtime- monitor by person, not by %
  - Keep an eye on your 12-hr shifts- if you are scheduling 3 shifts one week and 4 shifts the next, you are automatically scheduling people into overtime each pay period
  - Track overtime & agency weekly
- Cross train your staff into other positions
- Be creative with your schedule

Nursing Supply Spend

Action	What the DON can do
Set minimum and maximum stock levels	Establish PAR levels based on census, resident needs, delivery schedules, and emergency reserves. Check inventory before ordering.
Standardize commonly used supplies	Work with purchasing and clinical staff to select preferred products. Reduce duplicate brands and sizes while allowing resident-specific exceptions.
Review wound care products and orders	Match dressing type, size, and change frequency to the wound, drainage, manufacturer instructions, and provider order. Request clarification when orders appear inconsistent.
Teach correct product use	Demonstrate how much barrier cream, cleanser, adhesive remover, or dressing material is needed. Include product costs in training.
Reduce expired and unused stock	Rotate supplies by expiration date. Review resident-specific supplies promptly after discharge, treatment changes, or wound healing.
Monitor automatic shipments	Reconcile deliveries with current orders so discontinued catheter, enteral, ostomy, and wound supplies do not continue arriving.
Control emergency purchases	Track rush orders, delivery charges, and purchases outside contracted vendors. Repeated emergencies may indicate an inventory problem.
Audit high-cost items	Review the highest-dollar purchases and investigate unexpected increases in usage or price. Compare equivalent products by cost per treatment.

Nursing Pharmacy Spend

Action	What the DON can do
Cost out high-cost medications before admission	Identify the payer, authorization requirements, facility responsibility, and availability. Coordinate unresolved issues with admissions, pharmacy, and the provider.
Reconcile medications at transitions	Compare hospital discharge orders, prior orders, and current treatment plans. Clarify duplicates, conflicting directions, and missing stop dates.
Follow through on pharmacist recommendations	Track recommendations through provider response and implementation. Federal requirements call for a pharmacist's drug-regimen review at least monthly. Appendix PP
Request review of low-value or unused orders	Flag unused PRNs, duplicate therapies, supplements without a clear ongoing indication, and treatments continued beyond their intended duration. The prescriber determines changes.
Use preferred medications when clinically appropriate	Partner with pharmacy and prescribers on generic and formulary options. Obtain the required authorization before substitutions.
Reduce medication waste	Discuss shorter dispensing quantities for frequently changing regimens. Notify pharmacy promptly of discontinuations, hospital transfers, deaths, and discharges.
Review antibiotic use	Confirm indication and intended duration, and coordinate reassessment with the prescriber and pharmacist. CDC recommends nursing, medical, and pharmacy leadership involvement in stewardship. CDC
Review invoices monthly	Check payer assignment, duplicate charges, discontinued medications, returns and credits, delivery fees, and unexpected price changes.
Evaluate recurring testing and treatment orders	Request individualized provider review of glucose checks and other recurring orders when the results are not informing treatment. Include supply use and nursing time in the discussion.

Bottom line: Know what you have. Order what the residents need. Use products correctly. Stop unnecessary shipments. Verify what You are billed.

Consider a monthly DON report to track progress:

Measure	This Month	Last Month	Target
Nursing supply expense	$	$	$
Nursing supply cost per resident day[1]	$	$	$
Facility-paid pharmacy expense[2]	$	$	$
Pharmacy cost per resident day[1]	$	$	$
Expired/discarded supplies and medications[3]	$	$	$
Rush orders/delivery fees	$	$	$
Outstanding pharmacy credits	$	$	$

Documentation→ Revenue

- Review your 5-day and IPA assessments weekly with MDS to ensure you are capturing NTA points, depression, SLP
- Train yourself and your nurses on PDPM-linked diagnoses
- Require nurse participation in your monthly triple check process (prevents missed codes before they file the claims)
- Daily review of new orders for PDPM qualifiers (IV, suction, wound vac, etc)
- Use an MDS Scrubber

Example: Impact of Change in CMI

Direct Health Care cost center with initial CMI of 1.20.

Schedule is based on 13,140 Medicaid days or 36 Medicaid residents per day.

Medicaid CMI	Medicaid Rate	PPD Change	Annual Change
1.20	$257.24		
1.25	$261.86	$4.62	$60,706
1.30	$266.48	$9.24	$121,413
1.35	$271.10	$13.86	$182,120

Use the guidance from CMS to make the right choices for your ADL documentation

Dependent	**I had to do ALL of the activity for the resident** Or two people are required to assist the resident
Substantial/ maximal assistance	**I had to help with MORE than half of the activity** Or you are doing most of the work in this activity
Partial/moderate assistance	**I had to help with LESS than half of the activity** Or you have to do some of the work for this task
Supervision or touching assistance	**I was present during the activity** Or I had to guide the resident - talking, touching, reminders or directions
Setup or clean-up assistance	**I helped setup or cleanup BEFORE or AFTER the activity. I was NOT there during.** Or the resident ONLY needs you to put things out or clean them up. No instructions, reminders, or directions
Independent	**I was not there before, during or after the activity** Or the resident requires NO reminders, instructions, or support

ADL Score- Accuracy matters!

- How many residents are truly “Independent” based on CMS guidance?
- The CMG of PA1 (0.66 CMI) has a function score of 15-16. But- after education of the aides on how to accurately chart things like supervision or set-up, the ADL score is actually 14- which takes them to PBC1 and the CMI to 1.13.
- The reimbursement for nursing component in KS for a PA1 is $115 (urban) x 0.66(CMI) = $75.90. But a PBC1 is $115x 1.13 (CMI)= $129.95.
  - That’s an additional $54.05 PER DAY or almost $20k/year in reimbursement simply by charting accurately.
  - *slightly lower rate in rural areas

PDPM Related Alerts (5)

Alert ID	Alert Field	Ranking	Alert Message
1009		Potential	Nursing: On this MDS, the nursing category is clinically complex, and the nursing functional score is 6. A nursing score of 0-5 would qualify for a higher nursing category.
1021		Potential	PTOT: On this MDS, the functional score for PT/OT payment is 9 a score of 10 would qualify the MDS for a higher PT/OT Group for PDPM. Ensure the accuracy of section GG.
1061	I6300	Potential	NTA: Consider that shortness of breath was present (J1100) and oxygen was in use (O0110C1b) but no pulmonary condition is coded for Asthma/COPD/Chronic Lung Disease (I6200) or Respiratory Failure (I6300).
1099	K0100	Potential	SLP: This MDS is coded with either Acute Neurologic Condition or SLP-Related Comorbidity. Swallowing Disorder (K0100) and Mechanically Altered Diet (K0520C3) are not present, please verify accuracy of coding as this will affect the SLP component.
1073	N0350B	Potential	Nursing: Diabetes (I2900) is coded and Insulin injections (N0350A) were daily during the observation period; however, Days with Physician Insulin order changes was less than 2 (N0350B). Please check accuracy of days with physician order changes for Insulin.

ICD-10 Diagnosis Codes

MDS Item	ICD-10 Code	Description	OT/PT Group	SLP Group	NTA Score
I0020B	G90.09	✓ Other idiopathic peripheral autonomic neuropathy	Acute Neurologic	Acute Neurologic	
I8000A	G90.09	✓ Other idiopathic peripheral autonomic neuropathy	Acute Neurologic	Acute Neurologic	
I8000B	E66.01	✓ ⊘ Morbid (severe) obesity due to excess calories			1
I8000C	J06.9	⊘ Acute upper respiratory infection, unspecified			
I8000D	B37.2	✓ Candidiasis of skin and nail	Medical Management	Non-Neurologic	
I8000E	E56.9	✓ Vitamin deficiency, unspecified	Medical Management	Non-Neurologic	
I8000F	E87.6	✓ Hypokalemia	Medical Management	Non-Neurologic	
I8000G	H04.123	⊘ Dry eye syndrome of bilateral lacrimal glands			
I8000H	Z79.82	⊘ Long term (current) use of aspirin			
I8000I	L85.3	⊘ Xerosis cutis			
I8000J	R09.89	✓ Other specified symptoms and signs involving the circulatory and respiratory systems	Medical Management	Non-Neurologic	

Section J - Surgical Procedures

J2100	Major Joint Replacement Or Spinal Surgery	Orthopedic Surgery (Except Major Joint Replacement Or Spinal Surgery)	Non-Orthopedic Surgery
0			

PDPM Group Classification

PDPM Rates

HIPPS	Day 1	Day 4
NDPD	813.04	588.18

PT / OT

Group	Code	PT CMI	PT Rate	OT CMI	OT Rate	Function Score
Acute Neurologic	TN	1.40	$94.99	1.42	$89.68	9

Nursing

Code	CMI	Rate	Function Score
CBC1	1.27	$150.20	6

SLP

Group	Code	CMI	Rate	Comp 1	Comp 2
Acute Neurologic	SD	1.38	$34.97	1	0

NTA

Code	CMI	Rate	Score
ND	1.26	$112.43	3

Non Case Mix

Base Rate
$105.91

Survey and Compliance cost avoidance

- Use a survey prep tool to have an organized way to stay on top of survey readiness
  - CMP's can range from $10-$100k + for IJ or higher tags!
  - Denial of payments for new admissions also cost $$ in lost potential revenue- not to mention reputational cost
- Skills fairs! Formalize your nurse competency trainings
  - Preventable rehospitalizations lower 5-Star rating
  - Helps improve reputation in community
- Track F-tag repeat citations in QAPI
  - QAPI programs save money through prevention

- Questions?

References

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- Thank you