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A View From the Top: Risk, Compliance and Financial Management Opportunities

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RiskCure

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AmWINS HEALTHCARE

HCANJ Liability Insurance Program

Employing Advanced Methods of Assessing, Managing and Defending Long Term Care Liability Risk

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HCANJ "RiskCure" Approach

- Using statistical analysis and strategic data collection,
  - RiskCure identifies long term care providers that consistently achieve high levels of clinical and operational performance.
- Working with the Program's Insurance Underwriters
  - RiskCure offers these facilities liability rates that reflect their lower risk.
- Working with PointRight, a nationally recognized provider of data analytics and quality improvement services for long term care providers
  - RiskCure offers tools that provide ongoing analysis of patient data for the purposes of financial, clinical, and risk management.

HCANJ "RiskCure" Product Offerings

- General Liability Coverage – occurrence and claims made
- Professional Liability Coverage – claims made
  - Note: AmWINS does have markets that will write Occurrence
- Ongoing monitoring and risk management services
  - - Accurate MDS assessments and reimbursement
  - - Regulatory compliance
  - - Improved clinical outcomes
  - - Insurance rates and terms that reward preferred risk

"RiskCure"
Exclusive Benefits for HCANJ Members

- Preferred Pricing on Liability Insurance Premiums:
  - All members will receive a discount of between 10% and 25% off of already competitive rates, depending on the risk characteristics of the facility.
  - Discounted pricing on PointRight's industry-leading services including a state-of-the-art, data-driven approach to uninterrupted risk management.
  - Members that purchase analytic services from PointRight will receive up to an additional 6% discount on their insurance premiums.

"RiskCure"
Exclusive Benefits for HCANJ Members

- Higher limits for administrators at no extra cost ($200,000 limit vs. standard limit of $100,000). This is individual protection beyond the coverage provided under the facility limits.
- Increased coverage limits on evacuation reimbursement, public relations coverage and resident loss of property coverage at no additional cost.
- Paperless renewal processing - members will have their insurance renewed without having to fill out applications and provide survey histories.
- Dividend Plan - Once program premium reaches and maintains a level of at least $2 million, members may be able to participate in a dividend plan based on loss experience of the program.

Session Objectives

- Discuss how the implementation of MDS 3.0 has evolved from primarily a data tool to a major resource for risk management, financial and compliance programs.
- Discuss data accuracy issues that impact quality, risk and reimbursement.
- Identify 'key' MDS items that may indirectly or directly affect the risk of litigation or claims.
- Discuss compliance issues that often impact Medicare and Medicaid reimbursement opportunities.
- Present protocols and strategies that may be used to mitigate potential negative outcomes

Introduction

- In October 2010, CMS implemented a new standardized resident assessment instrument called MDS 3.0
- FY2012, new assessment type implemented: Change of Therapy (COT)
- Goals:
  - Improve clinical relevancy and accuracy
  - Improve user satisfaction and efficiency
  - Increase resident involvement "voice"

So What!

- MDS as a principle industry driver
  - Survey and certification
  - Medicare/Medicaid reimbursement
  - Quality Assurance and Improvement
  - Consumer evaluation/Monitoring
- External entities who are directly or indirectly concerned about MDS data quality
  - Office of Inspector General (OIG)
  - General Accounting Office (GAO)
  - Center for Medicare and Medicaid Services (CMS)
  - Fiscal Intermediaries (FI)
  - State Agencies (SA)
  - Others

So What!

- And, more robust compliance and QA/PI regulations were passed as part of the Patient Protection and Affordable Care Act of 2010

The History of RAI

- 1987 Congress passed Omnibus Budget Reconciliation Act (OBRA).
- 1991 All nursing homes were required by HCFA (CMS) to implement the MDS.
- 1992 MDS modified to include additional elements to support development of the Resource Utilization Groups (RUG) reimbursement system. (MDS+).
- 1995 MDS 2.0 was developed. Included items to describe residents receiving post-hospital care.
- 1996 States implemented MDS 2.0.
- 1998 Facility computerization of the MDS was mandated. (June) July 1998 – CMS implements the RUG III Prospective Payment System (PPS) for residents in a Medicare Part A Skilled Nursing Facility stay.
- 1999 CMS establishes the Quality Indicator reporting system.

The History of RAI

- 2003 Draft MDS (MDS 3.0) released.
- 2004 CMS establishes the publicly reported enhanced Quality Measures.
- 2005 CMS merges the Quality Indicators and Quality Measures.
- 2006 CMS releases updated Draft MDS 3.0
- 2006 CMS implements 4 new QMs (vaccinations and immunizations).
- 2010 CMS implements and mandates the use of the MDS 3.0 RAI.

General Responses to RAI Implementation

- Multi-disciplinary model
- MDS (RAI coordinator) is judge and jury
- RAI coordinator in organizational hierarchy
  - Report to DON
  - Report to ADM
  - Report to CFO
- Resources
  - Internet/computer access
  - Manual
  - Education/Training
- Dueling documentation systems
- Evolution of data-driven evidence-based clinicians

First Things First

- The RAI process was designed to be an interdisciplinary process
  - help each resident attain and/or maintain their maximum practicable level of functioning and well being.
  - assess residents upon admission, with significant change and annually in order to develop their plan of care.
  - quarterly assessments monitor the resident status and assist in the need for modification to the resident's care plan.
- Failure to comply with current MDS-related regulations can find the facility out of compliance with State and Federal regulations.

F-Tags Related to RAI

- F272 Facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.
- F273 When required, a facility must conduct a comprehensive assessment of a resident within 14 days of admission.
- F274 When required, a facility must conduct a comprehensive assessment of a resident within 14 days of determining a significant change in status has occurred.
- F275 A comprehensive assessment must be completed not less than once every 12 months (366 days).
- F276 A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

F-Tags Related to RAI

- F278 The assessment must accurately reflect the resident's status.
- F279 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.
- F280 The resident has the right to, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.
- F286 A facility must maintain all resident assessment completed within the previous 15 months in the resident's active clinical record (centralized location).
- F287 MDS data must be submitted within CMS established time frames

How are We Doing?

September 2011	
Number of Facilities	13,563
F272	13.1%
F273	0.8%
F274	4.0%
F275	0.7%
F276	3.4%
F278	7.1%
F279	17.8%
F280	8.0%
F286	0.0%
F287	0.4%

Why Did We Change?

- Improve the clinical relevance and accuracy of MDS assessments
- Increase the voice of residents in assessments
  - Emphasizes resident quality of life;
  - Facilitates resident-centered care;
  - Improves accuracy;
  - Is feasible; (80 – 90% "interviewable")
  - For those residents who could not complete interviews, an alternative staff observation assessment was provided.
  - Improves efficiency
- Increase the resident's involvement in the assessment process through direct interview

Giving Residents Voice

- MDS 3.0 interview items were tested to identify the best way to measure the topic in question.
  - Wording and response options have been shown to work in nursing home and other frail populations.
  - Clinicians in other settings already use many of these items.
  - Including structured interview items provides a common language for communication across settings.

Improved Accuracy and Reliability

- MDS 3.0 includes many specific changes designed to improve the accuracy of assessments.
  - Overall, new items were not added unless they represented an improvement over old items.
  - Whenever possible, items or language used in other health care settings was used in order to improve communication across settings

Industry Data Use

- The MDS 3.0 drives clinical care, risk management and reimbursement
- As a risk management tool
  - More comprehensive and detailed with far-reaching corporate compliance implications
  - Areas of resident risk are identified along with assessment items where providers document if and how they addressed this risk
  - Road map for success…or failure

The Power of Data
Quality, Risk, and Reimbursement Equal Compliance

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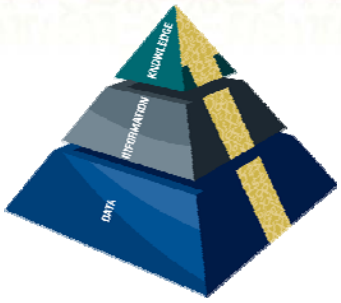
Harness the Power of Your Data



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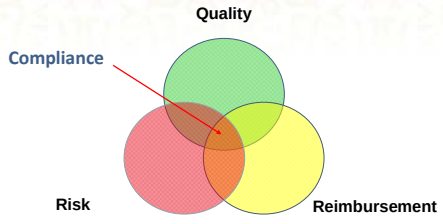
The Compliance Triad



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MDS Quality and Risk

- Key fields on the MDS are easily associated with the 'potential' for risk
- Plaintiff and defense attorneys use the MDS during claim and litigation processes
- Areas such as ADLs, diagnoses and other fields can be used to target residents who might be 'at risk'

MDS Indicators and Litigation Risk

MDS Field	MDS Item	Risk Management Implication(s)
C1600	Acute Onset of Mental Status Change:	May indicate resident change in condition and responsibility for physician/family notification - notification is generally associated with potential claims and litigation
D0200; D0500	Resident Mood Interview/Staff Assessment, thoughts of death or hurting oneself.	Presence of this symptom triggers D0350 D0650, Safety Notification, that places the facility on alert and requires further interventions.
E0900	Wandering .	Presence & Frequency: high risk, litigation area with high monetary awards
G0300A, B, C, D, E	Balance During Transitions and Walking:	Coded as a 1 or 2 may imply high risk for falls and injury
G0600A, B, C	Mobility devices:	Devices are assessed and used a indicated and that the equipment is properly maintained
H0300	Urinary continence	Safety issue since resident urinary incontinence may lead to slips and falls while trying to go to the bathroom
I0200, I0500, I0700, I0900	Anemia, Deep Venous Thrombosis, HTN, PVD, PAD	These specific diagnoses are often associated with 'wrongful death' claims; PVD and PAD are associated with cellulitis and frequently result in limb amputation(s)
I1500	Renal Insufficiency, Renal Failure, or End-stage Renal Disease:	Family expectations often exceed medical outcomes that result in complaints and attorney intervention

MDS Quality and Risk

- Past and current conditions are identified to manage future outcomes for the resident
  - Conditions: diseases, functional strengths and limitations, and weaknesses
  - Resident wishes and participation are actively elicited
  - All are clearly documented

Resident Voice

- "Resident Voice" as expressed through staff interviews is an essential component to MDS 3.0 and represents the most significant change from MDS 2.0
  - Those that completed "Preferred Activity" interview
    - 84% Self
    - 4% Proxy
    - 12% Not Completed
  - Those that completed "BIMS"
    - 90% Self
    - 10% Not interviewable
  - Completing interview is not "getting it right"

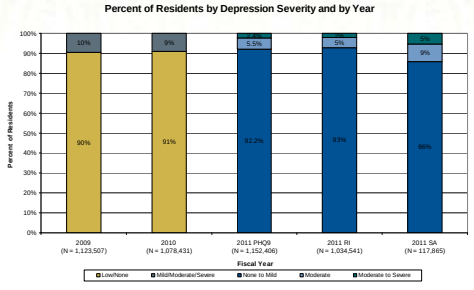
84%

90%

PHQ9 and Depression Severity

- Severity Score:
  - 1-4: minimal depression
  - 5-9: mild depression
  - 10-14: moderate depression
  - 15-19: moderately severe depression
  - 20-27 (30 for staff assessment): severe depression
- When should intervention be initiated?

Depression Scale Change



Depression: Impact on Outcomes

- Depression can be associated with:
  - psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain),
  - decreased participation in therapy and activities (e.g., caused by isolation),
  - decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs])
  - poorer outcomes (e.g., decreased appetite, decreased cognitive status).

Predicting the Probability of a Fall

- Fall history
  - Any fall predicts future falls and risk of injury
- MDS provides the "heads up"
  - Resident has poor balance during transfers
  - Resident has poor balance during toilet transfers
  - Resident has poor balance during walking
- Resident transfers with hands on assistance of 1-2 persons yet balance assessment for transfers indicates no need for assistance (14%)

Data Quality and Pressure Ulcers

- Pressure ulcer prevention and treatment measures
  - Imply a facility's ability to prevent and treat pressure ulcers
  - The absence of these measures indicate poor resident care management and lead to potential complaints regarding quality of life and quality of care
  - 21,779 'at risk' residents did not have prevention measures in place (3%)

Data Quality and Pressure Ulcers

- "No assessment was done to determine pressure ulcer risk"
- Resident is/is not at risk for pressure ulcers
- Worsening pressure ulcer since last assessment
- 4,259 residents of 26,807 residents with venous or arterial ulcers didn't have PVD or PAD (16%)

Data Quality and Pain

- Review medical record to determine if a pain regimen exists.
- Review the medical record and interview staff and direct caregivers to determine what, if any, pain management interventions the resident received during the 5-day look-back period.

Data Quality and Pain

- Goals for pain management for most residents should be to achieve a consistent level of comfort while maintaining as much function as possible.
- Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met.

Data Quality and Pain

- There must be documentation that the intervention was received and its effectiveness was assessed.
- It does not have to have been successful to be counted

Pain Identification and Management

- CMS Quality Measure #0675 for Short Stay residents:
  - *The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency*

Data Quality and MDS Scales

The What and Why of MDS Scales

- Derived from specific fields of the MDS
- Scales are researched and validated to provide clinically relevant information
- Industry tested to ensure accuracy and validity
- Provide a standard of assessment approach for all users

Importance Of MDS Scales

- Assessment uniformity
- Reduce need for duplicative assessments
- Prevent residents from being mislabeled due to non-structured assessment
- MDS 3.0
  - QMQIs entered a "dark" period
    - Role of MDS-based scales

MDS Scales: Describe or Predict

Describe

- **To what degree does the resident have the outcome/condition?**

Predict

- **Will the resident develop the outcome?**

MDS Based Scales

- MDS 3.0 is comprised of a series of descriptive assessment scales
  - Activities of Daily Living (ADLs)
  - BIMS/CPS (Measures Cognition)
  - CAM (Measures Delirium)
  - PHQ-9© (Measures Mood)
  - Pain Scale (Measures Pain)
  - Some of these scales are resident interviews
    - If a resident cannot be interviewed, staff observations are substituted
    - **CMS has found that 70 – 90% of residents can be interviewed, depending upon scale**

MDS Based Scales

- Additional scales (descriptive and predictive) can be derived from MDS, for example
  - Fall Risk (Probability for having a Fall)
  - Frailty Risk (Probability for Death)
  - Hospitalization Scale (Probability of Re-Hospitalization)
  - Pressure Ulcer Risk (Probability for developing a Pressure Ulcer)

MDS 3.0 Predictive Scales

- Use variables (risk factors) that are predictive of an event
- Identify the probability of the event within a specified time period
  - Example: Identifies the probability of an event by the next assessment
- Calculate the probability that an event will occur with a high degree of certainty

MDS Scales as Risk Assessment and Problem Identification Tools

- Acknowledge that the MDS is a holistic and interdisciplinary assessment.
- Reliability and validity of this assessment has been supported.
- Duplicative documentation/scales is not required.
- MDS scales predict or describe many resident conditions.

Compliance and Risk Imperatives: Reimbursement

Why Did This Happen?

- Claims data for the first 8 months for FY 2011 show therapy utilization changed drastically from prior to October 1, 2010
  - CMS referenced an OIG study of SNF payments during the first 6 months of FY 2011 as validation
    - Concurrent therapy almost disappeared (<5%)
    - There was a significant increase in individual and group therapy
    - Individual therapy was being provided only during the look-back period
- Result was overpayment rather than required budget neutrality

Case Mix Hierarchy Change

- **FY2011**
  - Top 19 RUG levels included 16 Rehab RUG categories
  - All Rehab+Extensive, RUA-C and RVA-C and RHC
- **FY2012**
  - Top 19 RUG levels included 14 Rehab RUG categories
  - All Rehab+Extensive and RUA-C and RVC and RHC
  - RVB and RVA are replaced by HE2 and HD2 in the top 19 groups

Reimbursement Risk Points

- New final rule impact
  - ARD window changes
  - COT
  - EOT-R
  - Group Therapy
- Appropriate therapy delivery based upon resident condition

Reimbursement Risk Points: ARD Window Change

- Reduced ARD window on the front end and back end
- OBRA MDS will most likely need to combine with the Medicare 5-day

Reimbursement Risk Points: COT

- MDS COT item set new item: A0310 C4 and X0600 C 4.
- Requires continuous monitoring of therapy level based on a 7 day window that starts with the last scheduled/unscheduled MDS ARD
- Required whenever the intensity of therapy, based on the reimbursable therapy minutes (RTM), changes to such a degree that it no longer reflects the RUG classification and payment based on the most recent MDS used for Medicare payment

Reimbursement Risk Points: COT

- Payment for the COT starts the **first day of the COT observation period**
- COT is mandatory if the RTM decrease/change from the billed RUG, and, optional, if there is a RUG increase

Reimbursement Risk Points: COT

- Payment implications:
  - Payment for the COT starts the **first day of the COT observation period**
  - Example:
    - 30-day ARD, 10/30/11
    - COT evaluation windows: 11/6/11, 11/13/11, **11/20/11**
    - COT MDS completed on 11/20/11 for a lower RUG
      - **Reimbursement retros back to the day after the last COT eval period started, 11/14/11**

Reimbursement Risk Points: EOT-R

- MDS EOT item set will be revised to contain new items, O0450A and O0450B
- May be completed when therapy stops for no more than 4 days and resumes on the 5th day after the last day of therapy on the EOT MDS
- Resident must resume therapy services at the **same RUG level** as they were before the EOT break

Reimbursement Risk Points: EOT-R

- Payment implications:
  - Paid at the calculated non-therapy RUG-IV group starting the day following the last day therapy services were provided through the day before the therapy was resumed
  - Payment at the appropriate therapy RUG will resume as of the resumption of therapy date noted in O0450B of the MDS.

Reimbursement Risk Points: Group Therapy

- Allocation of group minutes:
  - When group therapy is performed, the minutes would be allocated among the 4 residents in the group
  - 1 hour of group time provided = 15 min/resident
  - CMS may allocate all group minutes at 25% of total time regardless of the number of residents in the group

State Based RUG Reimbursement Systems

- Over 34 states use some type of a case mix system for Medicaid reimbursement
- Options: RUG 66, 53, 44, 34 are the primary systems in place currently
- Medicare versus Medicaid systems
  - Many nursing categories often have a higher CMI assigned
  - System pays higher rates based upon chronic dependencies and nursing care

State Based RUG Reimbursement Systems

- States often had 'add-on' incentives, none in New Jersey
- Use combinations of Medicare and Medicaid to derive the rate per day

Key Areas for Medicaid Systems

- Depression split
  - PHQ-9© interviews are key
    - Noted reduction in mood indicators with MDS 3.0
- Restorative Nursing programs
  - Follow RAI guidance
  - Train ALL nursing staff in restorative processes
  - Develop and maintain easy to use documentation tools (automated or not)

Key Areas for Medicaid Systems

- Therapy opportunities
  - Identify early resident decline for appropriate therapy intervention
  - Develop partnership with therapy that includes programs that discharge residents into a formal restorative nursing program
  - Incorporate therapy screening into the interdisciplinary process for care planning

Review Process

- Is there a process in place to review the MDS prior to the ARD window lookback period?
  - Grand Rounds
  - Resident Review
  - Daily Rounds

Essentials for Reimbursement

- DOCUMENTATION is key
- EDUCATION is essential
- VALIDATION is imperative
- INTER-DISCIPLINARY approach is key, essential AND imperative

Compliance: Systems and Internal Controls

OIG Work Plan for FY2012

- **Nursing Home Compliance Plans (New)**
  - We will review Medicare- and Medicaid-certified nursing homes' implementation of compliance plans as part of their day-to-day operations and whether the plans contain elements identified in OIG's compliance program guidance. We will assess whether CMS has incorporated compliance requirements into Requirements of Participation and oversees provider implementation of plans.
  - Section 6102 of the Affordable Care Act requires nursing homes to operate a compliance and ethics program, containing at least 8 components, to prevent and detect criminal, civil, and administrative violations and promote quality of care.
  - The Affordable Care Act requires CMS to issue regulations by2012 and SNFs to have plans that meet such requirements on or after 2013.
  - OIG's compliance program guidance is at 65 Fed. Reg. 14289 and 73 Fed. Reg. 56832. (OEI; 00-00-00000; expected issue date: FY 2013; new start; Affordable Care Act)

OIG Compliance Guidance for Nursing Homes

- Original notice published in 3/16/2000 Federal register
  - Provided voluntary guidance and not binding standard for nursing facilities
- OIG supplemental guidance issued to nursing facilities on 9/30/2008
  - Provided voluntary guidelines to assist nursing facilities in identifying significant risk areas and in evaluating and, as necessary, refining ongoing compliance efforts

OIG Compliance Guidance for Nursing Homes

- OIG identified 3 broad risk areas
  - Quality of Care
  - Submission of accurate claims
  - Federal Anti-kickback Statute

OIG Compliance Guidance for Nursing Homes

- Quality of Care
  - Sufficient Staffing
  - Comprehensive Resident Care Plans
  - Medication Management
  - Appropriate use of psychotropic medications
  - Resident safety
    - Promoting Resident Safety
    - Resident Interactions
    - Staff Screening

OIG Compliance Guidance for Nursing Homes

- Submission of accurate claims
  - Proper Reporting of Resident Case-Mix by SNFs
  - Therapy Services
  - Screening for excluded individuals and entities
  - Restorative and personal care Services

OIG Compliance Guidance for Nursing Homes

- Federal Anti-Kickback Statute
  - Free Goods and Services
  - Service Contracts
    - Non-Physician Services
    - Physician Services
  - Discounts
    - Price Reductions
    - Swapping
  - Hospices
  - Reserved Bed Payments

OIG Compliance Guidance for Nursing Homes

- Self-reporting requirements
  - Identify credible evidence of misconduct from any source
  - Report to the appropriate federal and state authorities
    - Report within a reasonable period of time
    - Report no longer than 60 days after the evidence is found

Why Have Corporate Compliance Programs

- Gives you a better view of your own operations, quality and performance;
- Gives you a systematic way to measure/enforce compliance; and,
- A corporate compliance program evidences your commitment to your residents/customers/payers, including Medicare, Medicaid and insurance programs

Compliance Program Requirements

- Establish standards and procedures capable of reducing criminal, civil and administrative violations
- Assign individual overall responsibility to oversee compliance
- Communicate program to employees and other agents
- Take steps to achieve compliance

Compliance Program Requirements

- After identification of a problem, take steps to prevent further problems
- Periodically, reassess compliance to identify needed changes
- Mandatory compliance: March 26, 2013!

Blueprint for Compliance Programs

- Compliance officer/committee;
- Effective lines of communication;
- Creation and retention of records;
- Effective training and education;
- Compliance as part of employee performance;
- Internal auditing and monitoring;
- Responding to violations and corrective action; and
- Assessing effectiveness of your program; policies, procedures and code of conduct.

Systems and Internal Controls: MDS Data Quality

- External auditing of MDS records
  - Manual review has merits but limited only to selected sample
  - Automated auditing of all assessments prior to state submission has proven most efficient
    - Assure balanced approach by third party auditor
    - Most major MDS software providers have interface with several auditing providers

Auditing and Monitoring

- Specifically what are we auditing and monitoring (i.e., what are the specific issues we are looking for in this part of our auditing/monitoring process)?
- What specific sources of information will we examine to find that information?
- What will we do with the information we obtain?

Systems and Internal Controls: Reimbursement

- Financial Management
  - Establish a solid tracking mechanism that visually reminds staff of the changes for every PPS assessment completed
- Explore software solutions with your vendors
- Work with therapy vendors/staff

CMS Certification Letter: April 8, 2011

- **Affordable Care Act**: CMS is to establish QAPI standards & provide technical assistance to nursing homes on the development of best practices in order to meet such standards.
- **QAPI Prototype**: Will be tested in a small nursing home demonstration project conducted by an independent contractor in the summer of 2011.
- **New QAPI Regulation:** In addition to the existing QAA regulation at 42 CFR, Part 483.75(o), CMS will promulgate a new QAPI regulation.

Quality Assurance/Performance Improvement

- The provider must take reasonable steps to achieve compliance with its standards, such as by ***utilizing monitoring and auditing systems…***
- QA/PI will be in the forefront for all systems – risk, reimbursement and compliance
- Proactive systems versus reactive systems will be the 'name of the game'

Quality Assurance/Performance Improvement

- Again, data is the key
  - Track, trend, analyze and target key outcome areas that embrace resident care, reimbursement and risk
- Detection and prevention techniques
  - Automation
  - Data collection methods
- Functioning multi-disciplinary teams

Quality Assurance/Performance Improvement Benefits

- Helps to maintain an appropriate standard of care
- Continuously evaluates the facility's systems
- Identifies issues and concerns related to risk, quality and reimbursement
- Designs a systematic approach that corrects and prevents inappropriate practices

Final Thoughts

High-quality data
- What does it mean to have data quality or a "valid" dataset?
- Reliability and Validity of the dataset
- Validity and Reliability
  - Validity is considered to be the degree to which the tool measures what it claims to measure
  - Reliability is the consistency of a set of measurements or of a measuring instrument, often used to describe a test
  - Reliability doesn't imply validity

Sufficient volume
- Is volume an issue?
- Access?

Final Thoughts

- OIG Workplan 2011

"We will review CMS's oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid…We will also review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data."

Final Thoughts

> Success requires strategies that incorporate extensive data and analysis to model and predict the consequences of alternative actions and guide executive decision-making.

Adapted from Thomas H. Davenport et. al. "Competing on Analytics" May 2005

Final Thoughts

- Start with valid data
  - demographics
  - who, what, when, where, frequency counts
- Move to information
  - add comparison groups
  - diagnostic groups, trending, aggregations. outliers, etc
- Conclude with knowledge
  - Predictive analytics
  - Multiple data sources

The Future……

- What impact can analytics make in your organization's future?
- Analytics is a tool that turns data into knowledge. With advanced analytics, comprehensive data resources and clinical and research expertise, providers can guide decisions that increase profitability, reduce risk, improve quality of service and operate more efficiently in a cost-effective manner – ***"even when CMS changes the rules"!***

Conclusions

- MDS 3.0 impacts clinical, regulatory, and financial processes and outcomes within the nursing facility
- There are both internal and external users of this data, along with positive and negative consequences
- Development of strategies to respond effectively while minimizing the risk of potential negative consequences begins with an awareness of the magnitude of this dataset and inherent challenges and weakness
- Compliance and Quality Improvement programs will be elevated to new levels of importance during the next several years

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