



## Looking Ahead to MDS 3.0

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*The following comments were recently submitted at the request of one of the industry trade publications. Since it would not be likely to see all of our comments make it through the editing process, we wanted to share this fuller version with you.*

### **1. Are there any surprises from CMS regarding the procedural instructions and implementation timetable?**

Obviously, there are details that have not been published yet. However, at this early stage, there are a couple of looming things to watch for:

- The most glaring issue of concern with the timeline at this point is that the STRIVE data analysis extends through 2009. This means that RUGs variations could continue past the Final MDS 3.0 Specs of February 2009.
- As has been proven historically with any regulatory change of this magnitude, there will most certainly be changes all the way up to the go-live point. That means that providers must stay up to date on the developments. But even more critically, software companies must keep pace with the changes as they come and marshal the critical resources necessary to deliver the final results in time for the ultimate go-live date.

### **2. What aspects of the provider's operation will be most affected by MDS 3.0 and how?**

The bottom line is that every position and process that the MDS touches (Nurse Aides, RNs, DONs, Activity Directors, Therapists, Dietary, Care Planning, Billing, Admissions, etc.) will be impacted. The heaviest impact will be for Assessment Coordinators.

Many processes will change as a result of MDS 3.0. Some key changes include:

- Provider staff must re-learn which MDS items are associated with RAPs, RUGs, and QMs as well as learn new terminology associated with MDS 3.0.
- Care planning and documentation guidelines will need to be reevaluated.
- Survey preparation processes and procedures will require adjustments.
- The interviews of the residents are new and may require extra training and coordination. The interviews will also add time to the data collection effort while the look back period and filing deadlines are both shrinking.

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## **What are the most drastic changes providers will face?**

MDS 3.0 has been a long time coming. Without question, this is the largest industry change since the MDS and PPS began over a decade ago. The MDS is not merely a form for input, it is an integrated system of processes that begin before a resident is admitted. Then, it plays a role in every part of the resident's clinical and financial journey even beyond discharge.

The most drastic changes with MDS 3.0 include:

- New Resident interview process
  - This will add time to the data collection processes and create new challenges for the staff gathering this data.
- 5-day look-back periods
- New measurements for pressure ulcers and pain
- Changes to RUGs
- Shorter submission timelines

Facilities located in case mix states that borrow reimbursement calculations from the federal RUGs standards may face even more challenges because of the delays in finalization. A facility's worst nightmare would be to have to continue sending MDS 2.0 for their state's Case Mix program while sending MDS 3.0 for CMS. It would be very beneficial for these providers to start working now with their state associations to insure that their state is responsive to the federal changes too.

Providers need to also be aware that MDS 3.0 will be the first step in a bigger plan. E-RAPs will eventually change the current RAP process to go far beyond an initial set of triggers and care plan meeting. Electronic signatures and electronic health records will also be an integral part of the data that flows in and out of the RAI and care planning process.

### **3. What changes will be the most challenging?**

Preparation in changing forms and processes and training staff will be a challenge. Maintaining quality and maximum reimbursement during implementation is an even bigger challenge. Staff will have to leave behind what has become second nature to embrace a new set of terms and definitions and facility policies. They'll need to learn the new rules of the game to ensure that the provider is adequately paid for the services they render, and they'll need to adapt to the new form quickly to avoid inconsistent coding that might hide a quality issue for the resident.

### **4. Providers have the better part of two years to get everything in order, which initially sounds like a long time. I suspect, however, that upon closer inspection that the wheels need to start turning now (sort of like steering an ocean liner). Let's go through the preparation process in increments -- what should providers' first priorities be and how do they methodically get their ducks in a row so that they are fully ready by Oct. 1, 2009?**

1. Step one should be to evaluate your current MDS software vendor. (There's an entire section on this later.) If you are concerned that your current vendor's track record could put your transition at risk, you should make the switch before the chaos of the actual change. In short, if you don't think your vendor can help you make this major transition, you would be far better off changing to a more proven software company now rather than during a time when your primary focus should be on a new set of MDS rules.
2. Form a team to learn how the MDS 3.0 changes impact your organization. This team should communicate information with all areas of your organization that need to be aware of changes related to MDS 3.0.
3. Review current processes and software systems to identify and document risks.
4. Assess your software vendor's modification roadmap so that you can better appreciate the system transition and re-education challenge you will be facing. Ask specifically about how your automated processes and data will transition to MDS 3.0. Evaluate and streamline processes for quality and efficiency improvement.

Document the new processes and procedures, train to those processes and have everything in order to implement.

#### **5. What would you tell the procrastinators out there?**

There is no time to waste. MDS 3.0 is coming, and it will significantly impact your organization! The larger your organization is, the more advance work there is to do.

While it's overly obvious to most providers, the prospect of not being ready for MDS 3.0 will threaten two of the most important pillars of a provider's operation: managing quality and maximizing reimbursement.

And finally, a farther reaching risk of procrastination is that MDS 3.0 is not the only major initiative headed our way. Our industry is facing unprecedented changes over the next several years with electronic medical records, interoperability and, of course, more creative reimbursement schemes. Providers who wait to react at the last minute literally might be putting the long term viability of their organizations in danger.

#### **6. How would you assess the state of readiness with regard to IT systems in nursing homes? Are they properly equipped?**

CMS has been making great efforts to move the current MDS 2.0 submission to broadband and hopefully the plans to use portals for data submission as part of this whole new world of data sharing. Nursing homes will need to gear up. Due to the shortened look-back and submission timelines, bedside computing and real-time data access solutions like American HealthTech's Smart Charting will be essential. IT infrastructure at many facilities will need to be upgraded. And in many cases corporate offices will require better real time access of consolidated data as well.

## **7. What should providers be looking for when selecting a software system?**

The MDS is core to any good SNF software system. So the magnitude of this particular change will require an enormous focus from your software company to be both effective and on time with its delivery. Ability to focus – that’s the primary thing providers need to assess in a vendor during this current season. And here are some things to look for:

- Is the vendor staffed well enough to handle MDS 3.0 and the other major changes coming right behind it? One tell-tale sign might be that they have a pattern of lagging behind with product enhancements. Do they in fact have a master plan to help you map out your automation strategy to meet all the challenges you’ll be facing, and can they deliver on it?
- Does the vendor support multiple product versions? If so, then one of two problems will be felt by the customer base:
  - 1. The magnitude of MDS software change effort is multiplied directly by the number of versions they support; or
  - 2. The software company will be distracted as they try to force their legacy customers to upgrade to the ‘new’ version that they don’t currently use.
- Was the vendor’s clinical software originally written to integrate fully with their billing software? If not, then new data exchange issues brought on by MDS 3.0 could quite possibly make the transition more cumbersome for them and buggy for you. Will new or additional manual reconciliation processes be required to tie the new MDS software together with the old billing?
- Outside the product challenges, is the vendor’s company generally stable? Have they grown too fast in recent months to effectively focus on implementing such a significant update? Are they distracted with external pressures of financial issues or corporate reorganizations that could force them to take their eye off the ball during such a critical season of industry change?

Asking some of the questions above should help providers better understand the various software system offerings and the companies behind them as well. American HealthTech is undistracted by any of the issues above.

## **8. How can an organization help its staff adjust to the new landscape?**

- Map out a clear transition plan and publish it for all stakeholders to see
- Start early. Take what you have now and identify what is different and how you will need to address the changes.
- Perform mock assessments utilizing the new processes and evaluate the differences.
- Review staff restructuring requirements for efficiency and quality improvement

## **9. What will MDS do to reimbursement rates? How do organizations compensate?**

It is assumed that the new look-back periods will remove some of the current extensive services that are captured on admission which has the potential to reduce reimbursement.

To compensate the organization can:

- Review and adjust admission analysis process to provide quality care and to maximize payment.
- Ensure that data collection is accurate and that procedures are well documented.
- Retain a knowledgeable MDS coordinator who can handle the change.
- Select a software vendor who can meet the timelines and provide a stable product. That product should include an accurate new RUGs analysis tool with direct integration to the billing module to maintain your critical cash flow during this time of great change.

## **10. How confident are you that the industry will be ready at the deadline?**

If history holds true, the larger provider chains will embrace this change and manage its implementation better than the rest of the provider population. After all, they simply have more resources to throw at it. For the rest of the provider community, the way they approach this next series of major changes – starting with MDS 3.0 - could very well determine their future viability. As one might imagine, there's a direct parallel among the software vendor community. Providers are expressing concern even now that some software vendors will not be able to meet the very real challenges ahead. With proper focus, both providers and their software vendors can be ready by the deadline. However, starting to prepare right now is critical to success.

**Contact us or call 1-800-489-2648, ext 1051 today, and let us show you how we can help.**