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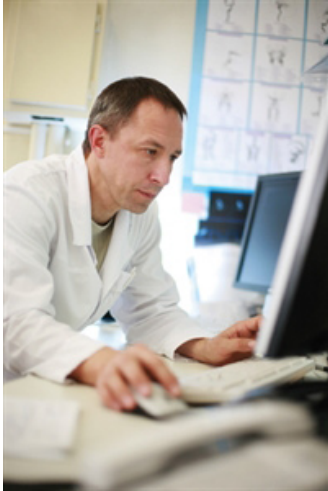
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March to MDS

John Andrews
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Autumn 2008 it's right around the corner, but in terms of the Minimum Data Set 3.0 implementation, it's right around the corner.

The Centers for Medicare & Medicaid Services recently announced the Oct. 1, 2009, implementation date for its new version of MDS, the system governing Medicare and Medicaid reimbursements.

Proponents say the updated format is a quantum leap forward in the collection, processing and dissemination of resident data.

That represents a critical step in the government's plan to nudge the healthcare industry toward a national electronic medical record.

The most drastic changes with MDS 3.0 include:

- A new resident interview process that adds time to the data collection procedure and creates new challenges for staff gathering the data
- Five-day look-back periods
- New measurements for pressure ulcers and pain
- Changes to the resource utilization groups
- Shorter submission timelines

CMS procedural instructions for MDS 3.0 still lie ahead. Draft specifications are due to be released in March 2008 followed by a revision in December 2008 or January 2009, with final specifications set to be released in February 2009. Along the way, long-term care providers are expected to create and follow their own preparedness timelines, assessing their capabilities for implementation and responding accordingly. Information technology specialists say those facilities in need of an automation makeover can't spare a minute in terms of preparation. "The industry began with MDS 2.0 at electronic transmission in 1999 and we still see facilities that haven't effectively mastered it," said Jim Shearon, clinical operations consultant for Pittsburgh, PA-based Vocollect Healthcare Systems. "To completely change the database is going to have a tremendous impact on the facilities. Within that reality, two years doesn't sound like a lot of time."

Time to get going

If they haven't already, facilities need to take action soon because the implementation date appears to be firm, said Dan Cobb, chief technology officer for Ozark, MO-based HealthMEDX.

"We have to assume that CMS' timeline will happen as planned," he said. "They communicated that software specifications will be available nine to 12 months in advance of the deadline. This is a tight timeline, but feasible as long as the specs do not vary significantly from the information available today and if states are consistent in their implementation. I believe most systems will be ready." Which ones will be ready depends squarely on each facility's information technology infrastructure. And as Cobb observes, "the long-term care industry in general has a low level of adoption around IT." Even so, he contends "since all nursing homes send MDS 2.0 assessments electronically, they should be equipped to do so with MDS 3.0."

Carrie O'Connell, vice president of clinical development for Farmingdale, NJ-based Health Care Software shares Cobb's view that the industry is in varying degrees of IT adoption.

"The state of readiness with regard to IT covers a wide spectrum, from facilities embracing technology that includes vast infrastructure to those with only the essentials," she said. "Providers should assess their current MDS solution and determine if theirs can lead the MDS 3.0 implementation."

At this point, even those facilities that are under-equipped for the transition have adequate time to bring themselves up to speed, O'Connell said.

"For procrastinators, a first great step would to identify the facility's point person to gather and disseminate MDS 3.0 information," she said. "Review the official implementation plan and timeline and mark all essential dates on the calendar to ensure all developments are discussed with the team."

'Perfect transition time'

Having an adequate IT platform is a good foundation for MDS 3.0, experts agree, but they caution that no one should get too comfortable with their current situation.

“Even if facilities are properly equipped, few are using the automated features available to them today,” said Sue Lewis, RN, clinical product director for Milford, OH-based Accu-Med Services. “The best preparation would be to automate more processes, even using their existing software. The 80/20 rule applies where 80% of users only use 20% of their software’s capability.”

For those that are still documenting on a paper MDS, Lewis says 2008 “is a perfect transition time” to evaluate hardware, infrastructure and networks.

“Few facilities have hardware available that more than a few staff can access,” she said. “Clinicians need to be entering MDS directly to effectively use all the software tools provided for efficiency, accuracy and consistency of the medical record.”

To be sure, evaluating current workflow processes is a critical task for facilities to perform during the transition, adds Leah Klusch, founder and executive director of the Alliance (OH) Training Center. “Automating a bad process is not a good solution,” she said. “The facilities must ask themselves, for example, if it really makes sense to replace a manual system like paper with a manual data entry system. They may need to shop around for an IT system that facilitates workflow changes, drives higher efficiencies and improves reimbursements and communication while reducing paperwork.”

Federal regulators clearly are “driving the industry toward adoption of an electronic medical record,” says Tim Quarberg, vice president of sales and marketing for software provider Optimus EMR Inc. “CMS is looking for more automated processes and efficiencies built into the processes.”

Prudent planning

Although providers are being given nearly two years to prepare for MDS 3.0, the new format has been in the works already for four years. Still, a gradual switchover period is necessary due to the enormous scope of the project, said Bill Caldwell, president and CEO of Jackson, MS-based American HealthTech.

“Without question, this is the largest industry change since the MDS and prospective payment system began over a decade ago,” he said. “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.”

Purchasing and installing the appropriate equipment is certainly one of the major challenges involved in the MDS 3.0 project. Sources say the most prudent approach is to devote sufficient time toward finding and working with the right vendor.

“The MDS can make or break a facility financially and includes major legal and regulatory liabilities,” Lewis said. “Providers need to look for systems that accommodate the MDS workflow, provide audits and analysis of the MDS prior to submission and assure corresponding accuracy with their supporting documentation. The MDS also needs to integrate with the care

planning process to cue staff for accurate care planning consistent with the MDS.”

The MDS initiative also will bring about dramatic procedural change for organizations, which means extensive re-training of staff – a task Caldwell sees as a daunting undertaking.

“Staff will have to leave behind what has become second nature to embrace a new set of terms, definitions and facility policies,” he said. “They’ll need to learn the new rules of the game to ensure that the providers are 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.”

All need training

To accurately capture the information to support MDS 3.0, all users need education on the new resident-centered assessment tool, O’Connell adds.

“The challenge is to effectively relay this new but familiar information to the entire team so that each user understands the process, the vital role they play and that these changes may impact the daily assessment process, dialogue and documentation for each resident,” she said. “The key will be the ability to provide a supportive environment with collaboration from all team members – including management – to work together to find the processes that work best for the facility.”

Most sources said they believed that CMS has set a reasonable deadline for completing the MDS 3.0 logistical cycle and that failures most likely will be due to the squandering of precious time from excessive procrastination.

“The way providers approach this next series of major changes – starting with MDS 3.0 – could very well determine their future viability,” Caldwell said. “As one might imagine, there’s a direct parallel among the software vendor community. There is a legitimate level of uncertainty in the industry about whether vendors can 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 now is critical to success.”

MDS 3.0 timetable:

Oct. 25, 2007 – Official announcement of MDS 3.0 rollout dates
March 2008 – Release of MDS Crosswalk
December 2008/early 2009 – Draft version to be revised
February 2009 – Final specifications to be released
Oct. 1, 2009 – Full implementation

Source: CMS, 2007