Session #: 1 (R20)

PEPPER, OSCAR/CASPER, QMs and 5 Star Reports: How to Interpret, Understand and Utilize These Reports for Positive Results

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The Journey Begins…

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Prepare

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4

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5

New Era of Healthcare Quality and Efficiency

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VBP is Around the Corner

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PEPPER

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Government Alignment

- **Government Accountability Office**
  - Medicare Program is at high risk for fraud, waste, and abuse
- **Office of Inspector General**
  - In 2012, 25% of SNF claims were billed in error – Updated Work Plans
  - Monitor COT, Add to FPS, CMS to instruct MAC, RAC to closely monitor SNFs
- **Centers for Medicare and Medicaid Services**
  - In 2013, SNFs were required to have a compliance program

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10

Stake Holders in Performance Measurement

- **US Department of HHS**
  - CMS (*also CMS 5 Star reporting and SNF VBP*)
  - AHRQ
- **MedPAC**
- **GAO**
- **OIG**
- **State Medicaid programs**
- **NQF - NQS initiatives**
- **Affordable Care Act** – driving quality outcomes, performance

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11

PEPPER Data and Rationale

- **Based on OIG report – Initially**
  - CMS and OIG indicate high Medicare expenses could be suggestive of over coding
  - CMS indicates that 20% highest expenses are questionable
  - CMS identifies expenses above the 80% percentile as potential outliers
  - CMS identifies that the bottom 20% of outliers are potential under coding
  - The bottom 20th percentile as outlier may be perceived as evidences of poor Quality of Care

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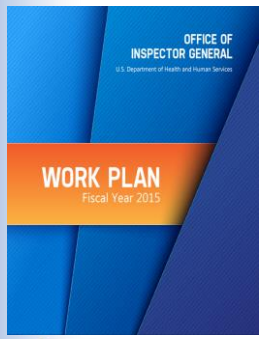
12

OIG



http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Winds-of-Change.pdf

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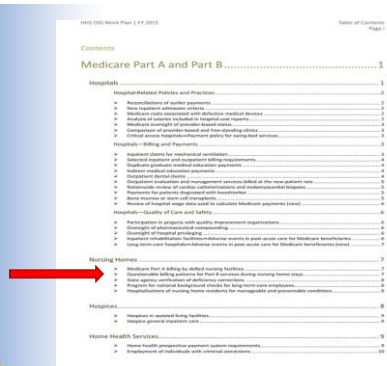
OIG



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OIG

https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2015.pdf

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OIG

HHS Office of Inspector General
Compendium of Unimplemented Recommendations (March 2015

Contents

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Compliance Program

- SNF should conduct regular audits to ensure services provided are necessary and that charges for Medicare services are correctly documented and billed.

- PEPPER
  - Program for
  - Evaluating
  - Payment
  - Patterns
  - Electronic
  - Report
- First available to SNFs in 2013
  - SNF PEPPER Version Q4FY12
- **Next report due on or about April 20, 2015** SNF PEPPER Version Q4FY14

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PEPPER

- Compares SNF to SNF nationally, regional and individually
- 2013 (1st PEPPER) received USPS around 8/30/13
  - *Envelope with red print on the outside*
  - *"Your facility specific PEPPER"*
  - *Many perceived as junk mail*
- 2014 and forward - received electronically

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Potentially Improper Payments

- **PEPPER does not identify the presence of improper payments, but it can be used as a guide for auditing and monitoring efforts.**
- A SNF can use PEPPER to compare its claims data over time to identify areas of potential concern and to identify changes in billing practices.

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19

Facility-Specific Information

- PEPPERs are not available for public release
  - They are released only to CEO, President, or Administrator
- TMF Health Quality Institute, a CMS contractor, produced the report
- TMF provides an access database to MACs, FIs, and Recovery Auditors (RACs)
  - Secured Portal
    - FATHOM or First-look Analysis Tool for Hospital Outlier Monitoring (secured access point)

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20

How To Obtain the PEPPER Report

- SNF Swing-Bed Units
  - Via QualityNet
- Other SNFs
  - Visit PEPPERresources.org
  - Hover over "PEPPER"
  - Select "Secure PEPPER Access"
  - Review Instructions and access portal
- Join the listserv to receive notification when PEPPER reports are available

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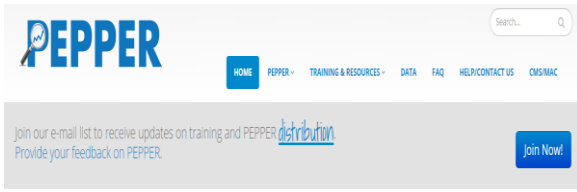
21

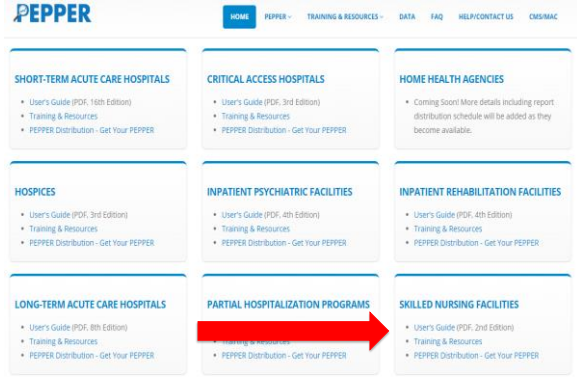


Welcome to PEPPER Resources

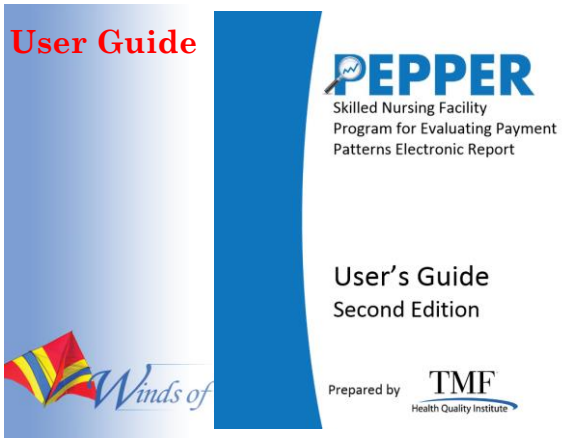
PEPPERResources.org is the official site for information, training and support related to the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments.

Scroll down



User Guide



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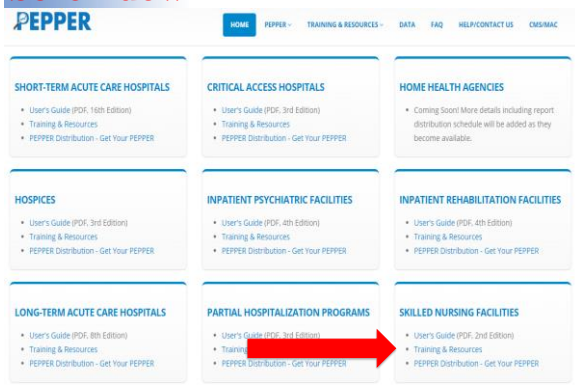
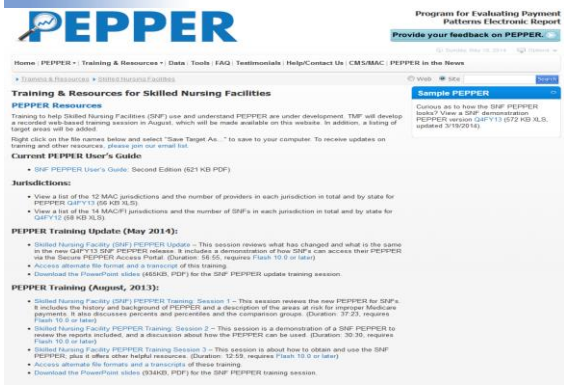


Training and Resources



Training and Resources

PEPPER Training (August, 2013):

- Skilled Nursing Facility (SNF) PEPPER Training: Session 1 – This session reviews the new PEPPER for SNFs. It includes the history and background of PEPPER and a description of the areas at risk for improper Medicare payments. It also discusses percents and percentiles and the comparison groups. (Duration: 37:23, requires Flash 10.0 or later)
- Skilled Nursing Facility PEPPER Training: Session 2 – This session is a demonstration of a SNF PEPPER to review the reports included, and a discussion about how the PEPPER can be used. (Duration: 30:30, requires Flash 10.0 or later)
- Skilled Nursing Facility PEPPER Training Session 3 – This session is about how to obtain and use the SNF PEPPER; plus it offers other helpful resources. (Duration: 12:59, requires Flash 10.0 or later)
- Access alternate file formats and a transcripts of these training.
- Download the PowerPoint slides (934KB, PDF) for the SNF PEPPER training session.

Demonstration PEPPER:

- Demonstration PEPPER version Q4FY13 (572 KB XLS, updated 3/19/2014)

What is PEPPER?

The SNF PEPPER is a report that summarizes a SNF's Medicare claims data in areas that may be at risk for abuse or improper payment. PEPPER compares a SNF's claims data statistics with aggregate statistics for other SNFs in the state, MAC/FI jurisdiction and the nation. SNFs with high billing patterns (at or above the national 80th percentile) are identified as "outliers" and are encouraged to ensure that they are complying with Medicare payment policy, that services provided to beneficiaries are medically necessary and that medical record documentation supports the services that are billed.

PEPPER cannot identify the presence of improper payments; only a review of the medical record can determine whether services are medically necessary and appropriately billed.

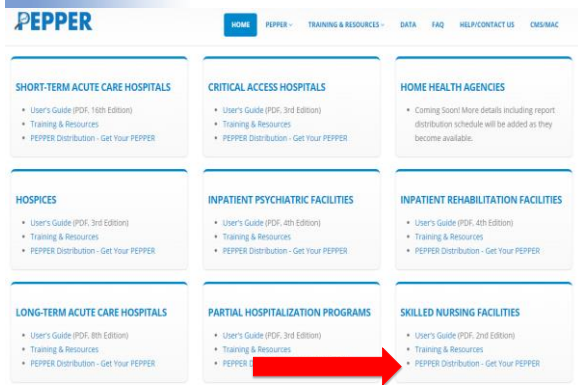
Distribution

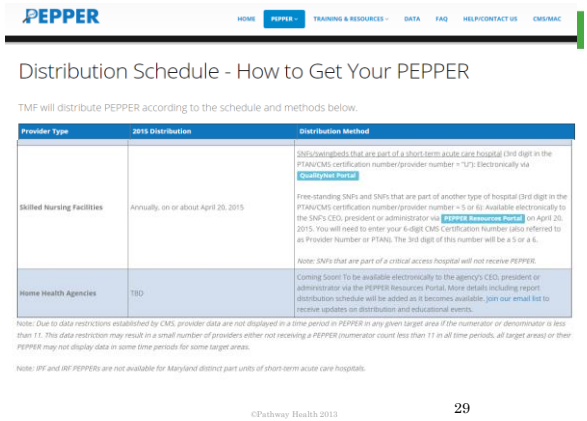
View the distribution schedule.

Other Resources:

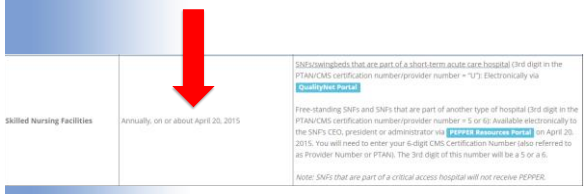
- View a list of the Skilled Nursing Facility target areas (PDF).
- View this slide presentation (PPT file, updated 7-11-2013) on percents and percentiles to help understand the differences between "percent" and "percentile" and how they are used in PEPPER.
- Contact TMF through the Help/Contact Us page to request examples of Triple Check tools from Skilled Healthcare.

Scroll down





NEW - PEPPER Reports!



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30

Required Information for Portal Access

- **6-digit CMS Certification Number**
  - Also referred to as the provider number or PTAN
    - Provider Transaction Access Number
    - Issued when the Medicare contractor approves facility enrollment
  - Not the same as the tax id or NPI number
  - Will have 3rd digit of "5" or "6"
    - Hospital-based swing bed unit PEPPERs, with 3rd digit of "U" are not available on the portal; they are distributed via QualityNet

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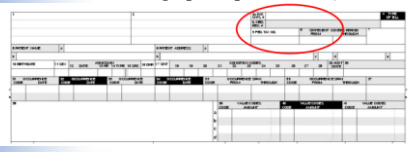
32

Required Information for Portal Access

- **Patient Control Number** (form locator 03a) or Medical Record Number (form locator 03b) from the UB-04 claim of a traditional fee-for-service Medicare beneficiary receiving services during September 2013 ("from" or "through" date between September 1 – 30, 2013 or new date range per April release)



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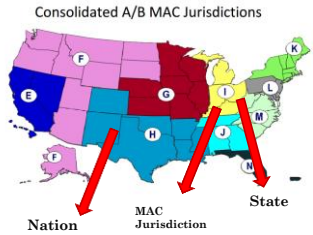
33

Interpret the Individual Reports

SNF PEPPER

- Summarizes Medicare FFS claims data for SNF EOC (see pg 5 of User's Guide)
- Organized in three 12 – month time periods based on fiscal year (FY)
- 3 different comparison groups



SNF PEPPER

Q4FY12 SNF PEPPER

- Statistics for fiscal years 2010, 2011 and 2012
- State comparison group included SNFs in the same state within the same MAC jurisdiction

Q4FY13 SNF PEPPER

- Statistics for fiscal years 2011, 2012, 2013
- State comparison group includes all SNFs in the same state, regardless of whether they are in the same jurisdiction

SNF PEPPER Version Q4FY13

- Episodes of care ending between October 1, 2010, through September 30, 2013
  - Federal fiscal years 2011, 2012, and 2013
  - Remember:
    - 10/1/10 (FY 2011) RUGS III (53) to RUGS IV (66)
    - 10/1/11 (FY 2012) Change of Therapy (COT) Assessments
- An episode of care is created from the UB04 claims submitted by a SNF for each beneficiary
  - A beneficiary could have multiple episodes within this time frame

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37

Six PEPPER Target Areas

- Identified by CMS as being potentially at risk for improper Medicare payments.

Therapy RUGs with High ADLs	•**Numerator**: Days billed of RUGs RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB •**Denominator**: Days billed for all Therapy RUGS •**ADLs**: 11 - 16
Non-Therapy RUGs with High ADLs	•**Numerator**: Days billed SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUGs III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUGs IV •**Denominator**: Days billed for all non-therapy RUGS •**ADLs:** 16-18 in RUGs III; 11 – 16 in RUGs IV
COT Assessment	•**Numerator**: Count of assessments with A! second digit "D" •**Denominator**: Count of all assessments •**Change of Therapy** Assessments started 10/1/11 (FY 2012)
Ultrahigh Therapy RUGs	•**Numerator:** Days billed with RUGs RUX, RUL, RUC, RUB, RUA •**Denominator**: **Days billed for all therapy RUGs** •**Ultra High Criteria:** 720 minutes or more per week, at least 2 therapies, one of the them at least 5 days & the second at least 3 days
Therapy RUGs	•**Numerator:** Days billed for all therapy RUGs •**Denominator**: Days billed for all therapy and non-therapy RUGs
90+ Day Episodes of Care	•**Numerator**: Episodes of care at the SNF with LOS 90+ days •**Denominator**: All episodes of care at the SNF •Maximum 100 days per benefit period

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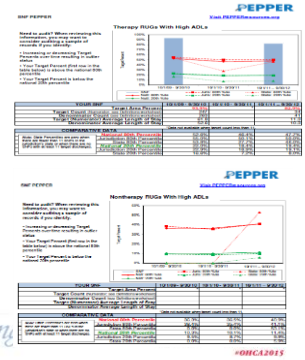
PEPPER Data Restrictions

- Statistics will not display when the numerator or denominator count is less than 11 for a target area in any time period.
  - Some SNFs may not see any data for some target areas or time periods
  - A few SNFs will not have a PEPPER available



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3 Types of Reports

- SNF Compare Report for Q4 FY 2013 (1)
- SNF Target Area Reports for FY 2011, 2012, & 2013 (6)
- Top RUG Reports for FY 2013 (4)
  - SNF
    - All Episodes
    - 90+ Days Episodes
  - Jurisdiction
    - All Episodes
    - 90+ Days Episodes
- April Release will includes historical data/FY 2014

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40

PEPPER Report Comparisons

- 3 Level of Comparisons
  - National
  - State
  - MAC/FI Jurisdiction
- Identify Facility's Target Percent
  - Identify Percentile for each Comparative Group
- Graph Facility in Relationship to Percentiles

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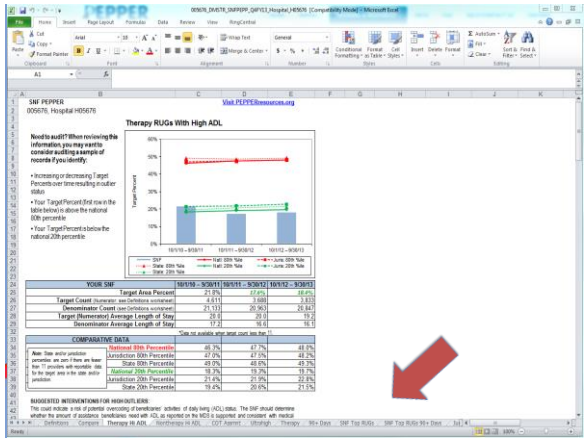
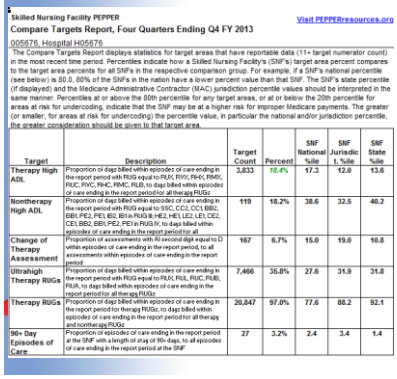
41



1. SNF Compare Targets Report



Skilled Nursing Facility PEPPER — Visit PEPPERresources.org

Compare Targets Report, Four Quarters Ending Q4 FY 2013

005876, Hospital H05676

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target numerator count) in the most recent time period. Percentiles indicate how a Skilled Nursing Facility's (SNF's) target area percent compares to the target area percents for all SNFs in the respective comparison group. For example, if a SNF's national percentile (see below) is 80.0, 80% of the SNFs in the nation have a lower percent value than that SNF. The SNF's state percentile (if displayed) and the Medicare Administrative Contractor (MAC) jurisdiction percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas, or at or below the 20th percentile for areas at risk for undercoding, indicate that the SNF may be at a higher risk for improper Medicare payments. The greater (or smaller, for areas at risk for undercoding) the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Target Count	Percent	SNF National %ile	SNF Jurisdic t. %ile	SNF State %ile
Therapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RUB, to days billed within episodes of care ending in the report period for all therapy RUGs	3,833	18.4%	17.3	12.0	13.6
Nontherapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUG-III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUG-IV, to days billed within episodes of care ending in the report period for all	119	18.2%	38.6	32.5	40.2
Change of Therapy Assessment	Proportion of assessments with RI second digit equal to D within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period	167	6.7%	15.0	19.0	10.8
Ultrahigh Therapy RUGs	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs	7,466	35.8%	27.6	31.9	31.8
Therapy RUGs	Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs	20,847	97.0%	77.6	88.2	92.1
90+ Day Episodes of Care	Proportion of episodes of care ending in the report period at the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF	27	3.2%	2.4	3.4	1.4

- Summarizes Medicare fee-for-service claims data for SNF episodes of care
- Target Count is most recent fiscal year
- 3 Comparison Groups
  - National
  - MAC Jurisdiction
  - State

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Percents vs. Percentiles

- Percent shows SNF score for target area
  - (N/D x 100)
- Percentile shows how SNF's % compares to other SNFs in state, MAC, nation
- PEPPER shows percentage of SNFs with a lower target area percent
- OUTLIERS at risk for improper payment

>80 percentile and **<20 percentile**

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Calculating Percentages

- Target Area Percents are calculated by dividing the numerator by the denominator then multiplying by 100.
  - Example:
    - Numerator count = 20, and
    - Denominator count = 100
    - 20/100 X 100 = 20%
- Target Area Percent is 20%
- This lets the SNF know its billing patterns

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Calculating Percentiles

- **The Percentiles give context by helping a provider understand how it compares to other providers.**
  - Definition of a Percentile:
    - The percentage of providers with a lower target area percent
- To calculate Percentiles for all providers in a comparison group (nation, jurisdiction, or state) the target area percents are sorted from largest to smallest for each time period.
  - Example:
    - If 40% of the providers' target area percents were lower than provider A, then provider A would be at the 40th percentile.

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46

Risk for Improper Medicare Payments

- Target area percents for all SNFs with reportable data are ordered from highest to lowest.
- The target area percent below which 80% of all SNFs' target area percents fall, is the 80th percentile.
- SNFs whose target percents are at or above the 80th percentile (that is, the top 20%) are considered at risk for improper Medicare payments.

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47

Prioritizing Your Data - QAPI

- Percentile values at or above the 80th percentile
  - **National**
  - Jurisdiction
  - State
- "**Target Count**"
  - If more than one area is at or above the 80th percentile, the one with the higher/est. target count should be given a higher priority than the other(s)

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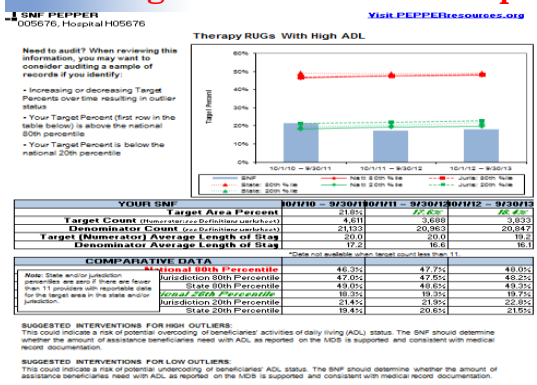
48

One Target Area PEPPER Report



SNF PEPPER
005676, Hospital H05676

Visit PEPPERresources.org

Therapy RUGs With High ADL

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing or decreasing Target Percents over time resulting in outlier status
- Your Target Percent (first row in the table below) is above the national 80th percentile
- Your Target Percent is below the national 20th percentile

YOUR SNF	10/1/10 – 9/30/11	10/1/11 – 9/30/12	10/1/12 – 9/30/13
Target Area Percent	21.8%	*N/A*	*N/A*
Target Count (Numerator/Denominator/Definitions worksheet)	4,611	3,688	3,833
Denominator Count (Denominator/Definitions worksheet)	21,133	20,963	20,847
Target (Numerator) Average Length of Stay	20.0	20.0	19.2
Denominator Average Length of Stay	17.2	16.6	16.1

*Data not available when target count less than 11

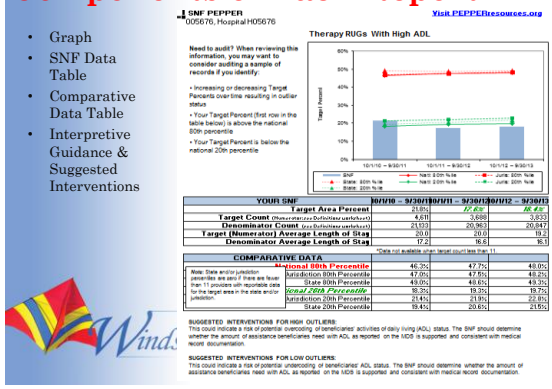
COMPARATIVE DATA				
Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.	National 80th Percentile	46.3%	47.7%	48.0%
	Jurisdiction 80th Percentile	47.0%	47.5%	48.2%
	State 80th Percentile	49.0%	48.6%	49.3%
	National 20th Percentile	18.3%	19.3%	19.7%
	Jurisdiction 20th Percentile	21.4%	21.9%	22.8%
	State 20th Percentile	19.4%	20.6%	21.5%

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS:
This could indicate a risk of potential overcoding of beneficiaries' activities of daily living (ADL) status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

SUGGESTED INTERVENTIONS FOR LOW OUTLIERS:
This could indicate a risk of potential undercoding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

Components of Each Report

- Graph
- SNF Data Table
- Comparative Data Table
- Interpretive Guidance & Suggested Interventions



SNF PEPPER
005676, Hospital H05676

Visit PEPPERresources.org

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	Jurisdiction 80th Percentile	47.0%	47.5%	48.2%
	State 80th Percentile	49.0%	48.6%	49.3%
	National 20th Percentile	18.3%	19.3%	19.7%
	Jurisdiction 20th Percentile	21.4%	21.9%	22.8%
	State 20th Percentile	19.4%	20.6%	21.5%

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS:
This could indicate a risk of potential overcoding of beneficiaries' activities of daily living (ADL) status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

SUGGESTED INTERVENTIONS FOR LOW OUTLIERS:
This could indicate a risk of potential undercoding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

Report Per Target Area

- Identified by CMS as being potentially at risk for improper Medicare payments.

Therapy RUGs with High ADLs	•**Numerator:** Days billed of RUGs RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB •**Denominator:** Days billed for all Therapy RUGS •**ADLs:** 11 - 16
Non-Therapy RUGs with High ADLs	•**Numerator:** Days billed SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUGs III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUGs IV •**Denominator:** Days billed for all non-therapy RUGS •**ADLs:** 16-18 in RUGs III; 11 – 16 in RUGs IV
COT Assessment	•**Numerator:** Count of assessments with AI second digit "D" •**Denominator:** Count of all assessments •**Change of Therapy** Assessments started 10/1/11 (FY 2012)
Ultrahigh Therapy RUGs	•**Numerator:** Days billed with RUGs RUX, RUL, RUC, RUB, RUA •**Denominator: Days billed for all therapy RUGs** •**Ultra High Criteria:** 720 minutes or more per week, at least 2 therapies, one of the them at least 5 days & the second at least 3 days
Therapy RUGs	•**Numerator:** Days billed for all therapy RUGs •**Denominator:** Days billed for all therapy and non-therapy RUGs
90+ Day Episodes of Care	•**Numerator:** Episodes of care at the SNF with LOS 90+ days •**Denominator:** All episodes of care at the SNF •Maximum 100 days per benefit period

Therapy RUGs with High ADLs

Suggested Interventions If At/Above 80th Percentile	Suggested Interventions If At/Below 20th Percentile
Risk of potential over-coding of ADL status Education – orientation, at least quarterly Concurrent audits	Risk of potential under-coding of ADL status Education – orientation, at least quarterly Concurrent audits

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52

90+ Day Episodes of Care

Suggested Interventions If At/Above 80th Percentile	Suggested Interventions If At/Below 20th Percentile
This could indicate the SNF is continuing treatment beyond the point where those services are necessary. Review all documentation to ensure that beneficiaries' continued care is appropriate and they received a skilled level of care. Review plans of care for appropriateness. Assess appropriateness of discharge plans	N/A

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53

SNF Top RUGs Report Example

SNF PEPPER — PEPPERresources.org

SNF Top RUGs

005676 Hospital HQ5676

SNF Top RUGs for All Episodes of Care* (EOC), Most Recent 4 Qtrs.

In Descending Order by Number of RUG Days Billed

Total SNF EOC: 633

RUG Code	Description	Number of RUG Days Billed	% of RUG Days to Total Days	EOC with the RUG Billed to	Average Length of Stay By RUG
RVB	Rehabilitation Very High with ADL 6 - 10	5,522	25.7%	32.8%	20.2
RUB	Rehabilitation Ultra High with ADL 6 - 10	3,951	18.4%	27.0%	17.6
RUA	Rehabilitation Ultra High with ADL 0 - 5	2,733	12.7%	26.3%	12.5
RVA	Rehabilitation Very High with ADL 0 - 5	2,454	11.4%	26.2%	11.3
RVC	Rehabilitation Very High with ADL 11 - 16	1,978	9.2%	11.4%	23.8
RHB	Rehabilitation High with ADL 6 - 10	1,556	7.2%	10.3%	18.1
RHC	Rehabilitation High with ADL 11 - 16	946	4.4%	5.8%	19.7
RUC	Rehabilitation Ultra High with ADL 11 - 16	752	3.5%	5.2%	17.5
RHA	Rehabilitation High with ADL 0 - 5	533	2.5%	5.5%	11.6
RMB	Rehabilitation Medium with ADL 6 - 10	166	0.8%	2.2%	9.2
RMC	Rehabilitation Medium with ADL 11 - 16	157	0.7%	1.7%	15.2
HC1	Special Care High with No Depression and ADL 6 - 10	120	0.6%	1.3%	10.9
LE1	Special Care Low with No Depression and ADL 11 - 16	119	0.6%	0.8%	23.8
LC1	Special Care Low with No Depression and ADL 6 - 10	86	0.4%	0.8%	17.2
HB1	Special Care High with No Depression and ADL 0 - 5	74	0.3%	0.8%	10.6
RMA	Rehabilitation Medium with ADL 0 - 5	69	0.3%	1.0%	8.6
CC1	Clinically Complex with No Depression and ADL 6 - 10	60	0.3%	1.0%	7.5
CB1	Clinically Complex with No Depression and ADL 0 - 5	50	0.2%	0.5%	12.5
RUL	Rehabilitation Ultra High And Extensive Services with ADL 2 - 10	30	0.1%	0.1%	30.0
PC1	Physical Function with or Without Nursing and ADL 6 - 10	29	0.1%	0.8%	5.8
Top RUGs		21,585	99.8%		16.0
All RUGs		21,600	100.0%		15.9

* An episode of care (EOC) is defined as a series of claims from a SNF for a beneficiary where the difference between the "Through Date" of one claim and the "From Date" of the subsequent claim is less than or equal to thirty days. The "From" and "Through" dates in form locator 6 (statement covers period) on the claim identify the span of service dates included in a particular bill; the "From" date is the earliest date of service on the claim.

Note: RUGs will display for which there are a total of at least 11 days billed to the respective RUG during the most recent fiscal year.

- FY 2013 (Example)
  - 10/1/12 through 9/30/13
- Total of 2 SNF Reports
  - Top RUGS for the SNF (To the left)
  - Top RUGs for the SNF for episodes of care with 90+days
- Each Report
  - Up to 20 RUG Codes
  - Must have at least 11 days billed to the respective RUG to appear

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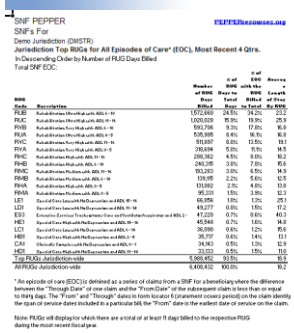
54

Jurisdiction-Wide Top RUGs Report



SNF PEPPER
SNFs For
Demo Jurisdiction (DMSTR)
Jurisdiction Top RUGs for All Episodes of Care* (EOC), Most Recent 4 Qtrs.
In Descending Order by Number of RUG Days Billed
Total SNF EOC:

RUG Code	Description	Number of RUG Days Billed	% of RUG with the Respective RUG Total	# of EOC with the RUG Billed	% of EOC Total	Average Length of Stay for RUG
RUB	Rehabilitation Ultra High with ADLs 11-18	1,572,660	24.5%	34,225	23.2	
RUC	Rehabilitation Ultra High with ADLs 11-18	1,020,029	15.9%	19,351	25.9	
RVB	Rehabilitation Very High with ADLs 4-10	593,706	9.3%	17,815	16.8	
RUA	Rehabilitation Ultra High with ADLs 4-10	535,995	8.4%	16,751	16.8	
RVC	Rehabilitation Very High with ADLs 11-18	511,897	8.0%	13,551	19.1	
RVA	Rehabilitation Very High with ADLs 4-10	319,634	5.0%	11,511	14.5	
RHC	Rehabilitation High with ADLs 11-18	288,362	4.5%	8,915	16.2	
RHB	Rehabilitation High with ADLs 4-10	240,316	3.8%	7,815	15.6	
RMC	Rehabilitation Medium with ADLs 11-18	193,283	3.0%	6,755	14.3	
RMB	Rehabilitation Medium with ADLs 4-10	139,116	2.2%	5,615	12.5	
RHA	Rehabilitation High with ADLs 0-3	131,662	2.1%	4,915	13.8	
RMA	Rehabilitation Medium with ADLs 0-3	95,339	1.5%	3,915	12.3	
LE1	Special Care Level 1 with Pneumonia or ADL 15-18	66,856	1.0%	1,715	25.1	
LDI	Special Care Level 1 with Pneumonia or ADL 11-14	49,277	0.8%	1,515	17.2	
ES3	Extensive Services Tracheostomy Care and Ventilator Dependency or ADL 7-10	47,229	0.7%	1,015	40.3	
HE1	Special Care High with Pneumonia or ADL 15-18	45,540	0.7%	1,615	14.8	
LC1	Special Care Level 1 with Pneumonia or ADL 7-10	36,099	0.6%	1,215	15.6	
HBI	Special Care High with Pneumonia and ADL 0-3	35,717	0.6%	1,415	13.1	
CAI	Clinically Complex with Pneumonia and ADL 0-3	34,963	0.5%	1,215	12.9	
HDI	Special Care High with Pneumonia and ADL 11-14	33,033	0.5%	1,515	11.0	
Top RUGs Jurisdiction-wide		5,960,452	93.5%		16.9	
All RUGs Jurisdiction-wide		6,400,632	100.0%		16.2	

* An episode of care (EOC) is defined as a series of claims from a SNF for a beneficiary where the difference between the "Through Date" of one claim and the "From Date" of the subsequent claim is less than or equal to thirty days. The "From" and "Through" dates in form locator 6 (statement covers period) on the claim identify the span of service dates included in a particular bill; the "From" date is the earliest date of service on the claim.

Note: RUGs will display for which there are a total of at least 11 days billed to the respective RUG during the most recent fiscal year.

PEPPERresources.org

- FY 2013 (Example)
  - 10/1/12 through 9/30/13
- Total of 2 Reports
  - Top RUGS for the Jurisdiction (To the left)
  - Top RUGs for the Jurisdiction for episodes of care with 90+days
- Each Report
  - "Top 20" RUG Codes
  - Must have at least 11 days billed to the respective RUG to appear

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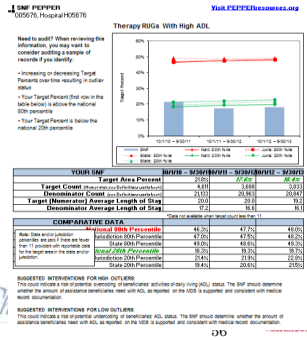
55

How to use the Report

Where does your facility rank?

Red

Green



SNF PEPPER
005676, Hospital H05676
Visit PEPPERresources.org

Therapy RUGs With High ADL

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing or decreasing Target Percents over time resulting in outlier status
- Your Target Percent (first row in the table below) is above the national 80th percentile
- Your Target Percent is below the national 20th percentile

YOUR SNF	10/1/10 – 9/30/11	10/1/11 – 9/30/12	10/1/12 – 9/30/13
Target Area Percent	29.8%	27.4%	27.4%
Target Count (Numerator)	4,481	3,688	3,833
Denominator Count (Days for the jurisdiction's episodes)	21,533	20,963	20,947
Target (Numerator) Average Length of Stay	20.0	20.0	19.2
Denominator Average Length of Stay	17.2	16.6	16.1

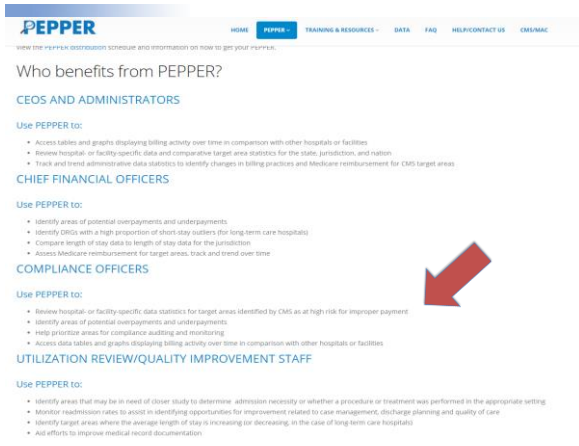
*Data not available when target count less than 11

COMPARATIVE DATA				
Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.	National 80th Percentile	46.3%	47.7%	48.0%
	Jurisdiction 80th Percentile	47.0%	47.8%	48.2%
	State 80th Percentile	49.0%	48.6%	49.3%
	National 20th Percentile	16.3%	16.3%	15.7%
	Jurisdiction 20th Percentile	21.4%	21.9%	22.9%
	State 20th Percentile	19.4%	20.6%	21.6%

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS:
This could indicate a risk of potential overcoding of beneficiaries' activities of daily living (ADL) status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

SUGGESTED INTERVENTIONS FOR LOW OUTLIERS:
This could indicate a risk of potential undercoding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

55



PEPPER
HOME | PEPPER ▾ | TRAINING & RESOURCES ▾ | DATA | FAQ | HELP/CONTACT US | CMS/MAC

View the PEPPER distribution schedule and information on how to get your PEPPER.

Who benefits from PEPPER?

CEOS AND ADMINISTRATORS

Use PEPPER to:

- Access tables and graphs displaying billing activity over time in comparison with other hospitals or facilities
- Review hospital- or facility-specific data and comparative target area statistics for the state, jurisdiction, and nation
- Track and trend administrative data statistics to identify changes in billing practices and Medicare reimbursement for CMS target areas

CHIEF FINANCIAL OFFICERS

Use PEPPER to:

- Identify areas of potential overpayments and underpayments
- Identify DRGs with a high proportion of short-stay outliers (for long-term care hospitals)
- Compare length of stay data to length of stay data for the jurisdiction
- Assess Medicare reimbursement for target areas, track and trend over time

COMPLIANCE OFFICERS

Use PEPPER to:

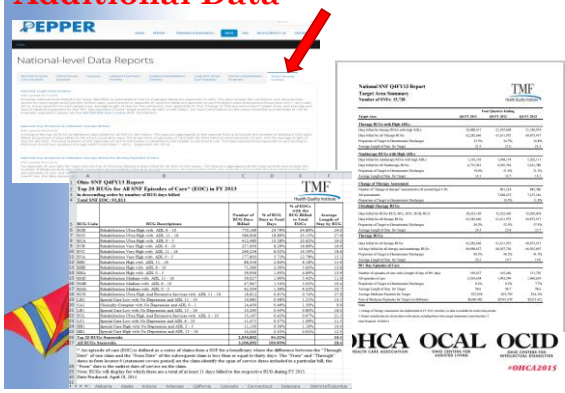
- Review hospital- or facility-specific data statistics for target areas identified by CMS as at high risk for improper payment
- Identify areas of potential overpayments and underpayments
- Help prioritize areas for compliance auditing and monitoring
- Access data tables and graphs displaying billing activity over time in comparison with other hospitals or facilities

UTILIZATION REVIEW/QUALITY IMPROVEMENT STAFF

Use PEPPER to:

- Identify areas that may be in need of closer study to determine admission necessity or whether a procedure or treatment was performed in the appropriate setting
- Monitor readmission rates to assist in identifying opportunities for improvement related to case management, discharge planning and quality of care
- Identify target areas where the average length of stay is increasing (or decreasing, in the case of long-term care hospitals)
- Aid efforts to improve medical record documentation

Additional Data



Internal Leadership Strategies

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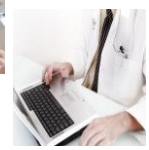
Internal Audits -- QAPI

- Pre-Billing Audits
- Medicare Meeting



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Pre-Billing Audit

- "Clean Claim"
  - A claim that can be processed without obtaining additional information from the provider or a third party
- A focused "Medicare Meeting"
  - Draft UB-04
  - Information confirmed by someone not directly responsible for data
    - Examples: Administrator verifies therapy log for minutes & days
      DON verifies Validation Report
      Billing Office verifies Physician Certifications

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61

Check at Pre-Billing Audit

- Name, HICN, DOB, sex match CWF
- Admission dates & qualifying hospital stay dates
- Copy of Medicare card
- MD orders
- Therapy minutes match Section O of MDS
- MDS submitted & accepted
- RUG & modifiers match
- Correct number of days billed for each MDS
  - Default days
  - Provider liability days
- Physician certifications
- Therapy certifications
- Diagnoses sequenced
- Ancillary charges
- Medicare as Secondary Payer
- **Nursing & therapy documentation**
  - Admission note
  - Weekly note
  - Discharge note/summary
  - Re-instatement note

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62

Other Data Sources

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Internal Sources

- CASPER (QEIS)
  - Reason for Assessment Report (RFA)
- MDS 3.0 Software
  - RUG Reports
  - ADL Reports
- Financial Software
  - Length of Stay

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PEPPER

Summary

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Incorporating PEPPER

1. Who is getting/reviewing PEPPER?
2. What if PEPPER shows problematic areas?
3. How will you conduct reviews?
4. Expectation of ongoing compliance activities and training
5. Remember, "PEPPER is an educational tool…"

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Incorporating PEPPER

1. Obtain Reports (2013 and 2014)
2. Review with internal team
   Red **Green**
3. Prioritize areas for Review
   High Risk for RAC or MAC review
   Opportunities for improvement
4. Conduct Audits (internal/external)
5. Review results at Corporate Compliance and QAPI

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67

Remember….

PEPPER

is a *roadmap* from the government to help organizations identify potentially vulnerable or improper payments

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68

OSCAR to CASPER!

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OSCAR 3 and 4

- **O**nline **S**urvey **C**ertification **a**nd **R**eporting
- Prior to 10/1/10
- Provided by surveyors at the time of annual survey entrance conference
- OSCAR 3
  - All facility deficiencies from the last 4 years
- OSCAR 4
  - Most recent survey deficiencies and comparisons to state, CMS region, and nation
  - "672" information
- "A roadmap to previous survey issues"

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70

Common Acronyms

- **CASPER**
  - **C**ertification and **S**urvey **P**rovider **E**nhanced **R**eporting System
- **QIES**
  - **Q**uality **I**mprovement and **E**valuation **S**ystem
  - **ASAP**
    - **A**ssessment **S**ubmission and **P**rocessing **S**ystem
- **ASPEN**
  - **A**utomated **S**urvey **P**rocessing **E**nvironment

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71

OSCAR to CASPER

- Implementation of the MDS 3.0 on October 2010,
  - Appendix P of the State Operations Manual was revised.
  - CMS officially changed the terminology of Online Survey Certification and Reporting (OSCAR) to Certification and Survey Provider Enhanced Reporting (CASPER) per S&C letter 10-27
  - CASPER/QEIS are part of a large relational database operating within CMS's Automated Survey Processing Environment (ASPEN)

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72

CASPER DATA Types

- Annual survey
  - Facility is required to submit reports to the State Agencies, these reports are the 802, 671 and 672.
- Accuracy is Key!
- *Reminder* – MDS Focus Surveys!
- CMS – Data Analysis!
  - The administrative purpose of survey data is to support the survey and certification function.
  - Every "institutional" health care provider in the United States that is certified to provide services under either Medicare or Medicaid (or both) is listed in *survey data*.

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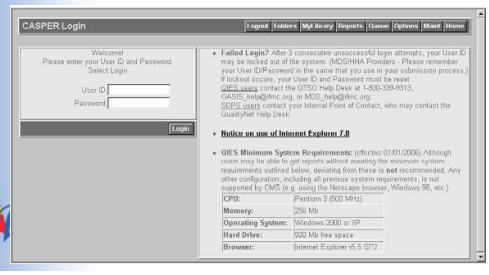
73

Access your CASPER Reports

- **MDS 3.0 Quality Measure Report Manual**
  - Instructions on how to access reports
  - How to interpret your data
  - Survey preparation
  - Surveyors preparation based on your data
  - Quality Improvement activities

CASPER Reports

- Password protected and encrypted
- MDS 3.0 reports are automatically purged after 60 days



CASPER Survey Data

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CASPER Survey Reports

- Survey History
- Complaint Trends
- Life Safety
- F Tags Cited
  - Scope and Severity
- Trend Analysis and Data Accuracy

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77

Identifying Risk

- Compare your data against state, CMS region, and national data to help assess risk of survey deficiencies
  - Facility's own trends
  - State, regional, and national "hot topics"
- Remember:
  - Repeat F Tag citations can lead to stronger penalties!
  - Resident condition data (672) **"outliers"** may be indicative of your unique population, but does facility documentation and policies and procedures support this assumption

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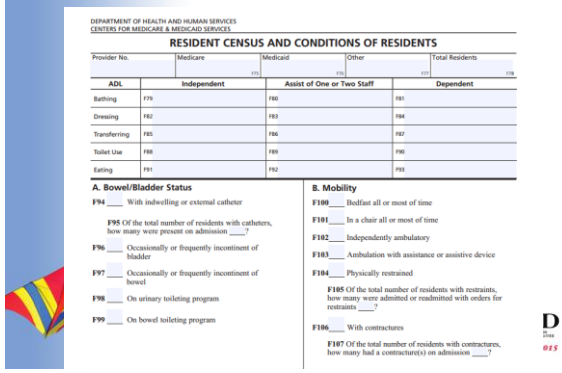
78

CMS 672 Form



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
	F75	F76	F77	F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79	F80	F81
Dressing	F82	F83	F84
Transferring	F85	F86	F87
Toilet Use	F88	F89	F90
Eating	F91	F92	F93

A. Bowel/Bladder Status

F94 ___ With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission ___?

F96 ___ Occasionally or frequently incontinent of bladder

F97 ___ Occasionally or frequently incontinent of bowel

F98 ___ On urinary toileting program

F99 ___ On bowel toileting program

B. Mobility

F100 ___ Bedfast all or most of time

F101 ___ In a chair all or most of time

F102 ___ Independently ambulatory

F103 ___ Ambulation with assistance or assistive device

F104 ___ Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints ___?

F106 ___ With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission ___?

D
015

Facility Response

- Track F Tags, Severity and scope from year to year
  - Annual surveys and Complaint surveys
  - QAPI Monitoring Trends
  - QIS Reports
- Up to Date - 672 and 802 forms
  - MDS software
  - Manual updates with admissions & discharges
  - Increase the frequency of updates within survey window

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CASPER MDS Specific Data

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CASPER

- **C**ertification **a**nd **S**urvey Provider **E**nhanced **R**eports
  - Accessed through the MDS 3.0 submission portal
  - 13 reports are available and the provider can specify the date range for each report
  - qtso.com for Chapter 6 of the QTSO Technical Support Manual

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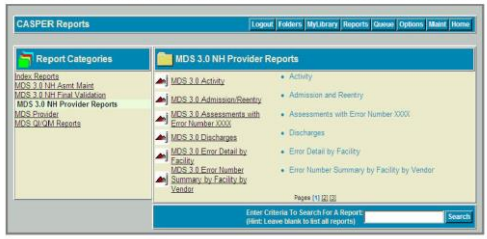
82

CASPER Reports Page

GENERAL INFORMATION

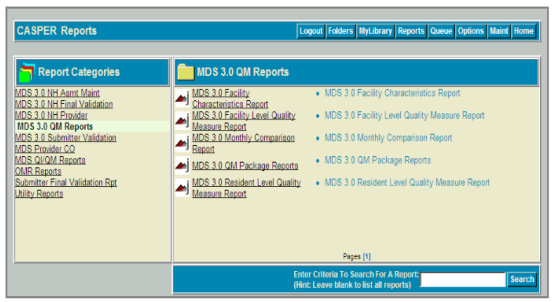
MDS 3.0 Nursing Home (NH) Provider reports are requested on the **CASPER Reports** page (Figure 6-1).

Figure 6-1. CASPER Reports Page – MDS 3.0 NH Provider Reports Category



Data in different Directions

Figure 11-1. CASPER Reports Page – MDS 3.0 QM Reports Category



13 Reports

- MDS 3.0 Activity
- MDS 3.0 Admission/Re-Entry
- MDS 3.0 Assessments with Error Number XXXX
- Discharges
- MDS 3.0 Error Detail by Facility
- MDS 3.0 Error Number Summary by Facility by Vendor
- MDS 3.0 Errors b y Field by Facility
- MDS 3.0 Missing Assessments
- MDS 3.0 NH Assessment Print
- MDS 3.0 Reason for Assessment Statistics
- MDS 3.0 Roster
- MDS 3.0 Submission Statistics by Facility
- MDS 3.0 Vendor List

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85

MDS 3.0 Activity Report

- Lists the accepted assessments, tracking records, and inactivation requests that were submitted by or on behalf of a facility during a specified timeframe.
  - Use to determine workload.
  - Use to determine if record was submitted.
  - Run monthly or more frequently.

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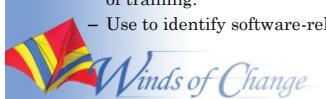
MDS 3.0 Assessments with Error Number XXXX

- Lists the assessments submitted with a specified error for a facility during a specified timeframe.
  - Use to identify assessments with certain fatal errors that were submitted that need to be corrected and resubmitted.
  - Use to determine which assessments were not completed under CMS timing rules (i.e., OBRA quarterly and yearly rules).
  - Use to identify a pattern with coding or an area in need of training.
  - Use to identify software-related errors.



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MDS 3.0 Discharges

- Lists the residents discharged (A0310F = 10, 11, or 12) from a facility during a specified timeframe.
  - When a discharged resident appears on the MDS 3.0 Roster report, use this report to determine if discharge was accepted in the ASAP database.
  - Use to derive a list of all residents discharged since the last survey or other time period.
  - Run monthly or more frequently.

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MDS 3.0 RFA Statistics

- Summarizes for a facility the reasons for assessment for accepted assessments submitted during a specified timeframe.
  - Use to monitor /evaluate workload during an identified timeframe.

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MDS 3.0 Roster

- Lists residents of a facility for whom the latest accepted, federally required assessment is not a Discharge assessment. (A0310F = 10, 11, or 12)
  - Use to determine a list of all current residents at time of survey.
  - Use as a QA tool to ensure all current residents have an entry record and all discharge residents have a discharge record in the ASAP database.

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References$_1$

- Minimum Data Set (MDS) 3.0 Provider User's Guide on the QTSO MDS 3.0 web site at https://www.qtso.com/mds30.html.
- Section 5 contains the error and warning messages.

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References$_2$

- CASPER Reporting User's Guide for MDS Providers at https://www.qtso.com/mds30.html.
- Section 6 contains MDS 3.0 NH provider reports (section 8 is swing bed provider reports).
- Section 7 contains the MDS 3.0 NH final validation report (section 9 is swing bed final validation report).
- Section 10 contains MDS 3.0 submitter validation report.

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Quality Measures

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Purpose of QMs

Provide the public, information about:

- quality of care at nursing homes
  - assist in choosing a nursing home
- care at a nursing home where they or family members already live
- to facilitate discussions with nursing home staff regarding the quality of care

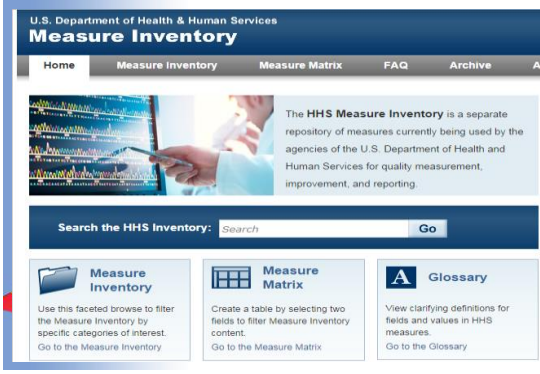
Provide data to the nursing home to help them in their quality improvement efforts

- *CMS.gov*

94

All Quality Measures

Measure Inventory for QMs



Summary of QMs

- 18 MDS 3.0-based
  - 5 short-stay
  - 13 long-stay
- 4 surveyor-only long-stay measures
- National and state benchmarks used for comparison purposes
  - National benchmarks used for ranking purposes (percentiles)
  - Surveyors are directed to focus on any QM at the 75th percentile or greater

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97

MDS 3.0-Based Short Stay QMs

1. Self-report moderate to severe pain
2. Have pressure ulcers that are new or worsened*
3. Newly received an anti psychotic medication
4. Were assessed and appropriately given the seasonal influenza vaccine
5. Were assessed and appropriately given the pneumococcal vaccine

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98

MDS 3.0-Based Long Stay QMs

1. Experienced one or more falls with major injury
2. Self-report moderate or severe pain*
3. Are *high risk* residents with pressure ulcers
4. Were assessed and appropriately given the seasonal influenza vaccine
5. Were assessed and appropriately given the pneumococcal vaccine

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99

MDS 3.0-Based Long Stay QMs

6. • Have a urinary tract infection
7. • Are *low risk* residents and lose control of bowel or bladder
8. • Have/Had a catheter inserted and left in the bladder*
9. • Were physically restrained
10. • Have an increased need for help with daily activities

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100

MDS 3.0-Based Long Stay QMs

11. • Lose too much weight
12. • Have depressive symptoms
13. • **Received an antipsychotic medication**

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101

MDS -Based Survey Only QMs

1. • Prevalence of falls
2. • Prevalence of psychoactive medication use, in the absence of psychotic or related conditions
3. • Prevalence of antianxiety/hypnotic Use
4. • Prevalence of behavior symptoms affecting others

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102

Quality Measure Definitions

http://www.medicare.gov/nursinghomecompare/search.html

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Target Date

The event date for an MDS record

- Entry Tracking Form
  - Entry date at A1600
- Discharge Assessment or Death in Facility Tracking Form
  - Discharge date at A2000
- All other Assessments
  - ARD at A2300

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104

Target Period

The span of time that defines the QM

- *e.g.*, a calendar quarter

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105

Admission & Re-Entry

Admission

- Has never been admitted before ***OR***
- Has been in this facility previously and is returning after a discharge return not anticipated ***OR***
- Has been in this facility previously and was discharged return anticipated and is returning more than 30 days after discharge

Re-Entry

- Discharged return anticipated ***AND***
- Returned to the facility within 30 days of discharge

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106

Stay

The period of time between a resident's entry into a facility and either a discharge or the end of the target period, whichever comes first

- A set of contiguous days in a facility
- Start of stay = either an admission or re-entry
- End of stay = discharge, death in facility record or the end of the target period

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107

Episode

A period of time spanning one or more stays

- Begins with an Admission Entry
- Ends with
  - Discharge return not anticipated **OR**
  - Discharge return anticipated but did not return within 30 days of discharge **OR**
  - A death in facility tracking record **OR**
  - The end of the target period

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108

CDIF: Cumulative Days in Facility

Total number of days within an episode during which the resident was in the facility

- May contain one or more stays
- Only days in the facility count
- Outside days (home, hospital, etc.) do not count
- Entry day is counted, but discharge day is not unless it is the same day as entry
- Counting stops with the last record in the target period if that record is a discharge assessment or a death in facility record **OR** if the end of the period is reached, whichever is earlier

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109

Short Stay and Long Stay

Short Stay

- An episode with CDIF less than or equal to 100 days as of the end of the target period

Long Stay

- An episode with CDIF greater than or equal to 101 days as of the end of the target period

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110

Selecting the Resident Samples

Step 1 - All residents whose latest episode either ends during the target period or is ongoing at the end of the target period

Step 2 - For each latest episode that is selected, the CDIF is computed

Step 3

If CDIF is less than or equal to 100 days, resident included in short stay sample

If CDIF is greater than or equal to 101 days, resident is included in the long stay sample

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111

Risk Adjustment

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What Is Risk Adjustment?

- Risk adjustment refines quality measure rates to better reflect the prevalence of problems that facilities should be able to address
  - Why?
    - To ensure comparisons across facilities are "fair" and not skewed by the presence of special populations
- **Example:** If a facility has more short-stay residents with diabetes, their expected rate for pressure ulcers is higher than the average facility. Therefore, "to level the playing field," their rate will be adjusted downward.

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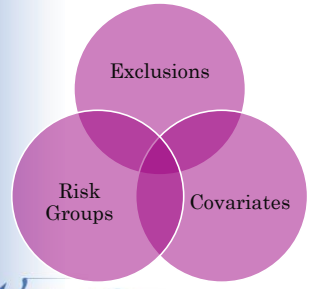
113

Three Types of Risk Adjustments



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114

Exclusions

Example - Percentage of long-stay residents who are receiving antipsychotic drugs

Exclusions – residents with schizophrenia, Tourette's Syndrome, Huntington's Disease

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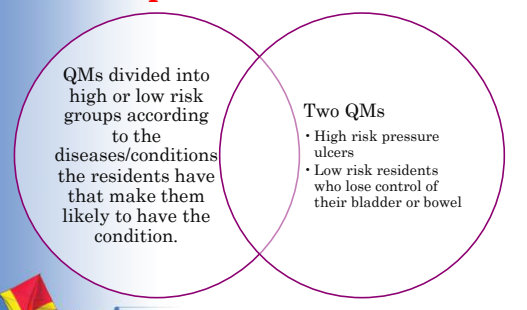
115

Risk Groups



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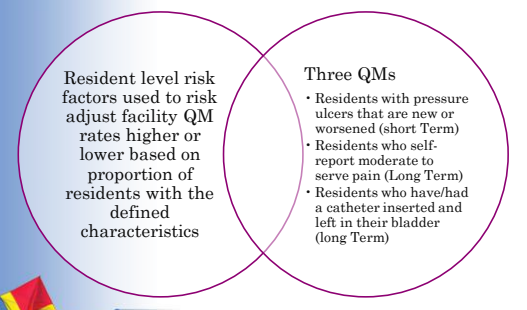
116

Covariates



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117

Covariate Effect on Pain QM

Higher Risk Adjusted Rate

Expect lower rate if there are fewer cognitively intact residents reporting (or staff not identifying) pain	**Expect** higher rate if there are more cognitively intact residents reporting more pain

Lower Risk Adjusted Rate

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118

Quality Measure Reports

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CASPER

Figure 11-1. CASPER Reports Page – MDS 3.0 QM Reports Category

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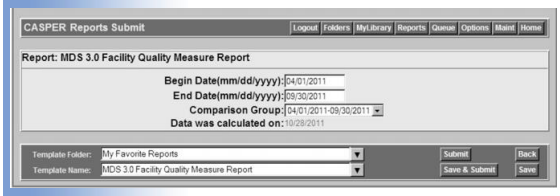
120

QM Report Access



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CASPER – QM Reports

- Three reports
  - Facility Quality Measure Report
  - Resident Level Quality Measure Report
  - Monthly Comparison Report
- Reports default to a 6-month reporting period ending with the most recently ended month
  - Users may change the dates of the reporting period manually

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Facility Quality Measure Report

- Displays
  - Each QM
  - Numerator and denominator used for the calculation for each QM
  - Facility percentage
  - Comparison of facility score with all facilities in state and nation
- Assists to identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process

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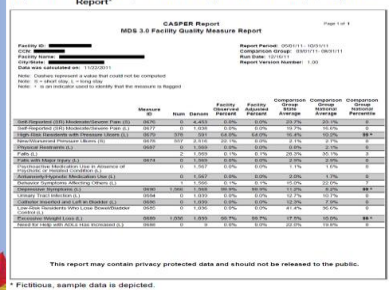
Example - QM Report

Figure 11-3. CASPER Reports Submit Page - MDS 3.0 Facility Quality Measure Report*



CASPER Report
MDS 3.0 Facility Quality Measure Report

This report may contain privacy protected data and should not be released to the public.

* Fictitious, sample data is depicted.

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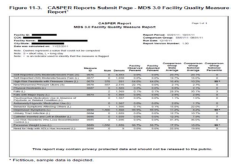
Facility QM Report

- Upper Left
  - Facility ID information
  - Date data was calculated
    - Data is calculated weekly
- Upper Right
  - Report Period – Period of time covered by the report
  - Comparison Group – Data calculated monthly with two-month delay
  - Run Date – Date the report was accessed by the facility



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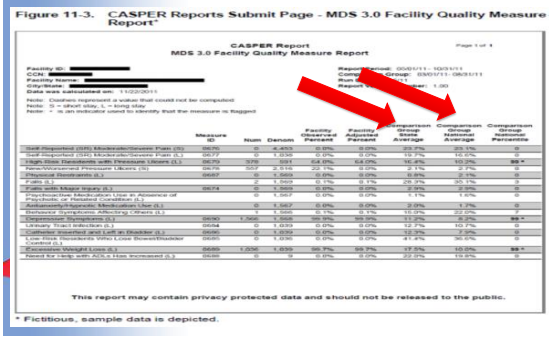
Facility QM Report

Comparison Group State and National Average

Figure 11-3. CASPER Reports Submit Page - MDS 3.0 Facility Quality Measure Report*



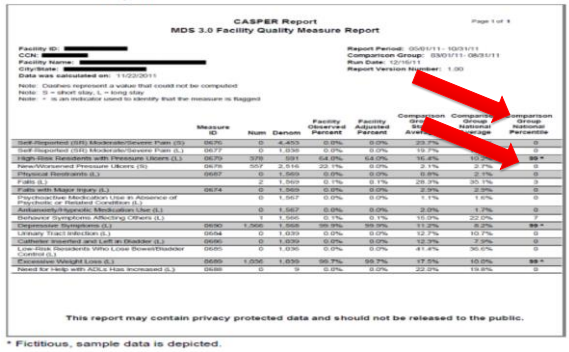
CASPER Report
MDS 3.0 Facility Quality Measure Report

This report may contain privacy protected data and should not be released to the public.

* Fictitious, sample data is depicted.

Facility QM Report

Figure 11-3. CASPER Reports Submit Page - MDS 3.0 Facility Quality Measure Report*



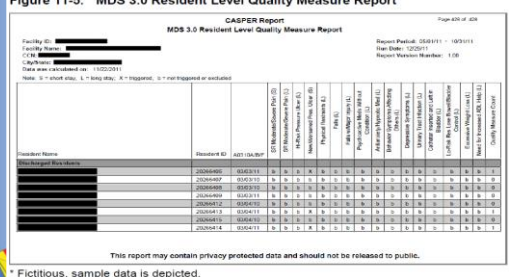
CASPER Report
MDS 3.0 Facility Quality Measure Report

This report may contain privacy protected data and should not be released to the public.

* Fictitious, sample data is depicted.

Resident Level QM Report

Figure 11-5. MDS 3.0 Resident Level Quality Measure Report*



CASPER Report
MDS 3.0 Resident Level Quality Measure Report

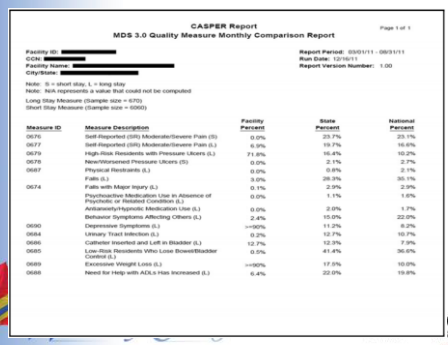
This report may contain privacy protected data and should not be released to public.

* Fictitious, sample data is depicted.

Resident Level QM Report

- Identifies all residents, active and discharged, included in the QM calculations
  - They are the residents in the numerator of the calculations
- Also indicates which QMs triggered for each resident
- Important tool that facilitates detailed record reviews of residents in the numerator of a QM for use in QA/QI activities and survey process

Monthly Comparison Report



CASPER Report
MDS 3.0 Quality Measure Monthly Comparison Report

Page 1 of 1

Facility ID: [redacted]
CCN: [redacted]
Facility Name: [redacted]
City/Brone: [redacted]

Report Period: 03/01/11 - 08/31/11
Run Date: 12/16/11
Report Version Number: 1.00

Note: S = short stay, L = long stay
Note: N/A represents a value that could not be computed
Long Stay Measure (Sample size = 670)
Short Stay Measure (Sample size = 6060)

Measure ID	Measure Description	Facility Percent	State Percent	National Percent
0676	Self-Reported (SR) Moderate/Severe Pain (S)	0.0%	25.7%	23.1%
0677	Self-Reported (SR) Moderate/Severe Pain (L)	6.9%	19.7%	16.6%
0679	High-Risk Residents with Pressure Ulcers (L)	71.8%	16.4%	10.2%
0678	New/Worsened Pressure Ulcers (S)	0.0%	2.1%	2.7%
0687	Physical Restraints (L)	0.0%	0.6%	2.1%
	Falls (L)	3.0%	28.3%	35.1%
0674	Falls with Major Injury (L)	0.1%	2.9%	2.9%
	Psychoactive Medication Use in Absence of Psychotic or Related Condition (L)	0.0%	1.1%	1.6%
	Antianxiety/Hypnotic Medication Use (L)	0.0%	2.0%	1.7%
	Behavior Symptoms Affecting Others (L)	2.4%	15.0%	22.0%
0690	Depressive Symptoms (L)	>=90%	11.2%	8.2%
0684	Urinary Tract Infection (L)	0.2%	12.7%	10.7%
0686	Catheter Inserted and Left in Bladder (L)	12.7%	12.3%	7.9%
0685	Low-Risk Residents Who Lose Bowel/Bladder Control (L)	0.5%	41.4%	36.6%
0689	Excessive Weight Loss (L)	>=90%	17.5%	10.0%
0688	Need for Help with ADLs Has Increased (L)	6.4%	22.0%	19.8%

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130

Monthly Comparison Report

- Summarizes comparison of facility's performance to state and national averages
- Made available to the public on NHC
- Not included
  - Long-stay QMs with denominator ≤ 30
  - Short-stay QMs with denominator ≤ 20
  - High-triggered percentages

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131

How To Use the CASPER Reports

- State and National comparison group data are calculated monthly on the first day of the month.
  - Data calculation is delayed by 2 months in order to allow for submission of late and corrected assessments.
- Your QM data is calculated weekly for the assessments submitted since the previous week's data calculation

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132

How To Use The Data

- Strong programs of Performance Improvement (QAPI)
  - Continuous monitoring of key aspects of key systems
  - Correlate related QM scores with each other for clues to causative factors
  - Identify and correct problems before they become trends
  - Individual accountability for key systems – put someone in charge of the system
- Quality Management is Key

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133

MDS Excellence

- Misunderstandings about coding definitions can be disastrous
  - QM scores are derived from MDS data
  - Inaccurate coding can result in misleading Quality Measure scores
  - Inaccurate MDS coding can result in inappropriate resident care

MDS 3.0

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134

Educate on Coding the MDS

- ADLs (Section G)
  - Rule of 3, ADL algorithm
- Pressure Ulcers (Section M)
  - No back-staging, definition of worsening pressure ulcer
- Influenza Vaccine (Section O)
  - Capturing vaccine from season just ended when new season hasn't started yet
- Restraints (Section P)
  - Code only if the device meets the definition of daily restraint
- Urinary Tract Infection (Section I)
  - Definition is very specific; code only if definition is met

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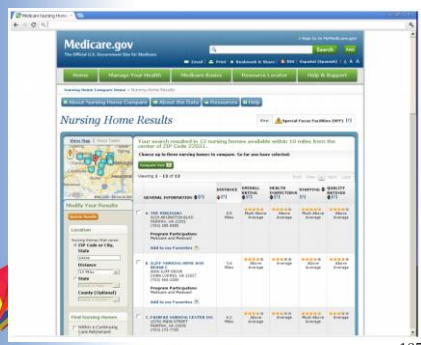
135

The Five Star Rating System

Five Star Ratings



Nursing Home Compare Website

- http://www.medicare.gov/NHCompare
- Each nursing home participating in Medicare and/or Medicare is a assigned an overall rating between one and five stars
  - 5 Stars = Much above average*
  - 1 Star = Much below average*

* Compared to other nursing homes in the state

Three Categories

- 1 – 5 stars assigned to each category

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139

Five Star Timeline

December 2008
Five-Star Nursing Home Quality Rating System added to Nursing Home Compare site

August 2014
New York Times Article "Medicare Star Ratings Allow Nursing Home to Game the System"

October 2014
CMS announced upcoming changes in the data used to calculate Staffing and additional QMs

February 2015
Announcement, Preview, and Implementation of Five-Star Quality Rating System changes

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140

Five-Star Basics

Help consumers make meaningful distinctions among high-performing and low-performing nursing homes

Help nursing homes identify areas for improvement

- CMS.gov

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141

Update

February 12, 2015, CMS announced changes to the Five Star Rating System on the Nursing Home Compare website -

- impacts how CMS assigns stars for both Staffing and Quality Measure components
- impact a skilled nursing facility's Overall Five Star Rating.
- The changes became public information February 20, 2015.

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142

Download and Learn


Design for *Nursing Home Compare* Five-Star Quality Rating System:

Technical Users' Guide

February 2015

CMS

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/usersguide.pdf

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143

Five-Star Components

Health Inspections Rating	• Measures based on outcomes from State health inspections • Number, scope, and severity of deficiencies during the most recent 36 months • Standard and substantiated complaint surveys
Staffing Rating	• Measures based on nursing home staffing levels • RN hours PPD, RN + LPN + NA hours PPD • Case mix adjusted
Quality Measures Rating	• Measures based on resident-level quality measures (QMs) • Use data from the MDS • Use a portion of the publically reported QMs
Overall Nursing Home Rating	• Composite Rating • 5 step process

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144

Health Inspections Rating

(a.k.a., Survey Component)

No changes as a result of the February 2015 changes announced by CMS

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145

Health Inspections

Last 3 Years	Standard Surveys and Complaint Surveys
Health Inspections	
Most Recent Survey Findings Are Weighted More Than the Prior 2 Years	Most Recent Year = 50% 2 Years Ago = 1/3 3 years Ago = 1/6

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146

Health Inspections Score

Severity	Isolated Scope	Pattern Scope	Widespread Scope
Immediate jeopardy to resident health or safety • * = 20 points if status of deficiency is "past noncompliance" • () = Substandard Quality of Care (SQC)	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 point (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 points	B 0 points	C 0 points

Weights for Repeat Visits

Revisit Number	Noncompliance Points
1	0
2	50% of health inspection score
3	70% of health inspection score
4	85% of health inspection score

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148

Weighted Deficiency Score

- Lower score = Fewer deficiencies and revisits
- More recent surveys are weighted more heavily than earlier surveys
  - Most recent period (Cycle 1) assigned a weighting factor of ½
  - Previous period (Cycle 2) assigned a weighting factor of 1/3
  - Second prior survey (Cycle 3) assigned a weighting factor of 1/6
- Weighted time period scores are then summed to create the survey score

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149

Compare Within A State

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150

Cut Points

- Re-calibrated every month
  - Relatively constant distribution within the state
- Rating for a given facility is held constant until there is a change in the weighted health inspection score for that facility
  - New health inspection
  - Complaint investigation resulting in citations
  - 2nd, 3rd, or 4th re-visit
  - Informal Dispute Resolutions (IDR)
  - "Aging" complaint deficiencies
    - Based on a calendar year

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151

Staffing

RN Hours/Resident/Day	Total Staffing (RNs, LPNs, CNAs) /Resident/Day
Staffing	
Staffing Data Submitted by the Facility at Time of Standard Survey	Adjusted Based Upon Resident Acuity (RUG-IV CMIs)

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152

Staffing Rating

The method of calculating 3 Star and 4 Star ratings changed as a result of the February 2015 changes announced by CMS

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153

Staffing

- There is considerable evidence of a relationship between nursing home staffing levels and resident outcomes.
- The CMS Staffing Study found a clear association between nurse staffing ratios and nursing home quality of care, identifying specific rations of staff to residents below which residents are substantially higher risk of quality problems.

Kramer AM, Fish R. "The Relationship Between Nurse Staffing Levels and the Quality of Nursing Home Care." Chapter 2 in Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report. Abt Associates, Inc., Winter 2001

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154

Staffing Data Source

- **Annual Survey**
  - **CMS-671 Form**
    - RN Hours (F41, F39, and F40)
      - RNs, DON, RNs with administrative responsibility
    - LPN Hours (F42)
      - LPNs/LVNs
    - Nurse Aide Hours (F43, F44, and F45)
      - CNAs, Aides in training, Medication aides/technicians
    - Includes facility employees, organization (agency) contract employees, or an individual contract
    - Does not include "private duty" hired by resident
  - **CMS-672 Form**
    - Resident Census (F78)

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155

Calculations

Reported Hours	Expected Hours	Adjusted Hours
Data on Form 672 converted to FTEs	Sum the nursing times from the STRIVE study connected to each RUGS-III category/census	National Average Hours as of April 2012 Total nursing staff RNs
HRD Calculated Hours per Resident Day calculated for each discipline/census/14 days	RUGS-III 53 group version STRIVE = Staff Time and Resource Intensity Verification	Adjusted Hours = Reported Hours/Expected Hour X National Average Hours

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156

National Average Hours (April 2012)

Type of Staff	National Average Hours per Resident per Day
Total Nursing Staff (Aides + LPNs + RNs)	4.0309
RNs	0.7472

The 2 staffing measures are given equal weight in calculating the Staffing Rating
- RN
- Total Nursing Staff

Percentile cut points were determined using the data available as of December 2011

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157

Staffing Cut Points and Rating 2015

RN Rating	RN Hours	Total Nursing Rating & Hours	Total Nursing Rating & Hours	Total Nursing Rating & Hours	Total Nursing Rating & Hours	Total Nursing Rating & Hours
		1	2	3	4	5
		<3.262	3.262 – 3.660	3.661 – 4.172	4.173 – 4.417	>/= 4.418
1	<0.283	1 star	1 star	2 stars	2 stars	3 stars
2	0.283 – 0.378	1 star	2 stars	3 stars	3 stars	3 stars
3	0.379 – 0.512	2 stars	3 stars	3 stars	4 stars	4 stars
4	0.513 – 0.709	2 stars	3 stars	4 stars	4 stars	4 stars
5	>/= 0.710	3 stars	3 stars	4 stars	4 stars	5 stars

158

Impact of the Change

- Staffing Rating
  - Drop in the number of SNFs achieving 4 stars
  - Increase in the number of SNFs achieving 3 stars
  - No changes in the number of SNFs achieving 1, 2 or 5
- Overall Star Rating
  - SNFs that drop from 4 to 3 stars on staffing component will lose 1 star from previous overall rating

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159

Quality Measures Component

- Derived from the MDS 3.0
- 18 QMs are reported on the Nursing Home Compare Website
- 9 of the 18 have been used to calculate the Quality Measure Rating
- 2 more of the 18 have been added to the calculation of the Quality Measure Rating

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160

Quality Measures as of 02/20/2015

Long Stay QMs
ADL Decline
Catheters (Risk Adjusted)
Falls with Injury
High Risk Pressure Ulcers
Pain (Risk Adjusted)
Physical Restraints
UTIs
Use of Antipsychotics

Short Stay QMs
Pressure Ulcers (Risk Adjusted)
Pain
Use of Antipsychotics

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161

Points Are Assigned to Each QM

	OLD System	NEW System
# of QMs	9 QMs	11 QMs
Points for Each QM	0 to 100	20 to 100
Total Score Range	0 to 900	225 to 1100
Reset Cut Points	2009 Distribution	2013 Q3 or Q4 Distribution
1 Star	11%	15%
2 Stars	18%	20%
3 Stars	24%	20%
4 Stars	31%	20%
5 Stars	16%	25%

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162

QM Cut Points

QM Star Rating	OLD QMs Cut Points	NEW QMs Cut Points
1 Star	0 – 355	225 – 544
2 Stars	356 – 435	545 – 629
3 Stars	436 – 507	630 – 689
4 Stars	508 – 615	690 – 759
5 Stars	616 - 900	760 – 1,100

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163

QM Scoring

- All 11 QMs have equal weight
- Points are assigned by various methods
  - Quintiles (5 Groups)
    - Long Stay ADL worsening, pressure ulcers, catheters, UTIs, pain, injurious falls
    - Short Stay pain
  - 0% = 100 Points
    - Long Stay physical restraints > 0% sorted into 2 groups and assigned 20 or 60 points respectively
    - Short Stay pressure ulcers > 0% sorted into 3 groups and assigned 25, 50, or 75 points respectively
  - Antipsychotic Medications – New Methods

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164

Antipsychotic Med QM Scoring

- Long Stay
  - 5 Groups
    - Top 10% receive 100 points
    - Bottom 20% receive 20 points
    - Middle 70% divided into 3 groups and receive 40, 60, or 80 points respectively
- Short Stay
  - 0% = 100 points
  - Bottom 20% receive 20 points
  - Remaining divided into 3 groups and receive 40, 60, or 80 points respectively

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165

Impact of New QM Calculations

- Quality Measures Component –
  - SNFs are dropping their ratings from 5, 4, 3 or 2 stars
  - Increase in the number of SNFs achieving 1 Star
- Overall Five Star rating
  - Drop from 5 to 4 stars on their QM component will lose 1 star from their overall rating
  - SNFs that drop from 3 or 2 stars to 1 star on their QM component will lose 1 or 2 stars from their overall rating
  - SNFs will lose 2 or more stars if their antipsychotic rates are very high
  - Some SNFs will gain a star if their antipsychotic rates are very low

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166

Quality Measures Component

Two Quality Measures were added to the current 9 QMs

Point calculation technique and cut points for each star level were re-scaled as a result of February 2015

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167

Overall Nursing Home Rating

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Five-Star Components

Health Inspections Rating	• Measures based on outcomes from State health inspections • Number, scope, and severity of deficiencies during the most recent 36 months • Standard and substantiated complaint surveys
Staffing Rating	• Measures based on nursing home staffing levels • RN hours PPD, RN + LPN + NA hours PPD • Case mix adjusted
Quality Measures Rating	• Measures based on resident-level quality measures (QMs) • Use data from the MDS • Use a portion of the publically reported QMs
Overall Nursing Home Rating	• Composite Rating • 5 step process

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169

5 Steps to Overall 5 Star Rating

1. • Start with the health inspection five-star rating.
2. • Add one star to Step 1 if staffing rating is four or five stars and greater than the health inspection rating
   • Subtract one star if staffing is one star.
   • The overall rating cannot be more than five stars or less than one star.
3. • Add one star to Step 2 if quality measure rating is five stars.
   • Subtract one star if quality measure rating is one star.
   • The overall rating cannot be more than five stars or less than one star.
4. • If the health inspection rating is one star, then the overall quality rating cannot be upgraded by more than one star based on the staffing and quality measures.
5. • If the nursing home is a Special Focus Facility (SFF) that has not graduated, the maximum overall quality rating is three stars.

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170

What Might Change the Rating?

- New data
  - New survey, complaint surveys, revisits, IDRs
  - Timing of updates not standard
- "Aging" data
  - Complaint surveys are assigned to a calendar year
  - When it ages into a prior period, it receives less weight in the scoring process
- When previously unavailable RUG data becomes available, the staffing rating will be recalculated
- Quality Measure data quarterly updates
  - Mid-month January, April, July, and October

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171

Implications of New vs. Old

Survey Component	• None
Staffing Component	• A bit more difficult to get a 4 Star
Quality Measures Component	• Some SNFs will see a drop from 5, 4, 3, or 2 Stars • More SNFs will achieve a 1 Star rating
Overall Nursing Home Rating	• SNFs that drop Staffing from 4 to 3 Stars will lose 1 Star • SNFs that drop QMs from 5 to 4 Stars will lose 1 Star, that drop from 3 or 2 to 1 Stars will lose 1 or 2 Stars.

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172

Additional Data Resources

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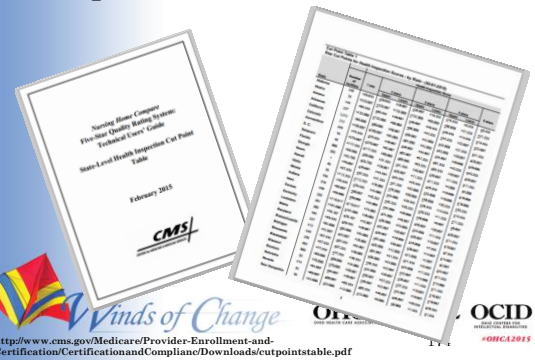
Updated "Cut Points"



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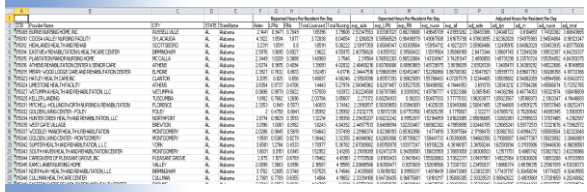
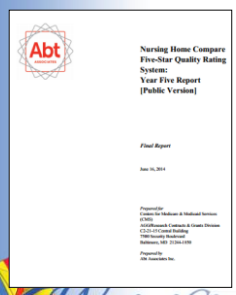
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/cutpointstable.pdf

Individual Facility Staffing Data



http://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandCompliance/FSQRS.html

5 Star Performance



Nursing Home Compare Five-Star Quality Rating System: Year Five Report [Public Version]

Final Report

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/NHC-Year-Five-Report.pdf

More Changes are Coming !

2015 and 2016 Updates

Positioning for VBP!

- Additional Quality/Performance Measures
  - Re-hospitalizations
  - Discharge back to community
  - Staffing turnover and retention
  - Other measures from IMPACT act
- Alternative methods for obtaining actual staffing
- Increased scrutiny of MDS 3.0 during surveys
- SNF Ranking
- SNF Performance Score!

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178

Leadership Strategies

- Available in the facility's shared folders on CMS' QIES website
  - (Same way you got to CASPER)
  - Allow provider to see quality measure percent values prior to being posted on NHC
- QM values for the most recent quarter
- Check Nursing Home Compare at least monthly
- Know Your Data!
- Always pre-view your star ratings from CMS on QIES

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179

Leadership Thoughts

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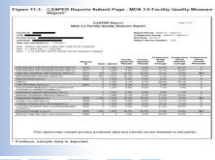
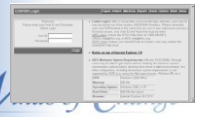
Data Driven Decisions



PEPPER



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181

Leadership and Data

- Determine Quality Profile: Assess Organization Data
- Review Internal Processes: Optimize Data
- Establish an Information Agenda for Planning
- Plan to handle "bad" or "inaccurate" data – "GIGO"
- Leadership today – Data Driven Decisions!

Your data is key to positive outcomes

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Implementation and Innovation For Sustainability

Preparation
Operational Readiness Assessment
Services
Internal Systems
Team composition
Increase clinical competencies
Validation and benchmark data
Excellent outcomes – quality and financial

Evaluate, reposition, partner and implement

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183

Thank You

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