

2016 MDS Training SNF QRP and Casper report overview

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Objective:

- Identify methods to monitor data submission requirements for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
- Discuss how to locate and interpret Minimum Data Set Version 3.0 (MDS 3.0) Final Validation Reports (FVRs)
- Describe useful Certification And Survey Provider Enhanced Reports (CASPER) reports available to SNFs

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SNFs currently submit MDS 3.0 data to CMS through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. **The October 1, 2016 implementation of the SNF QRP will not change requirements related to the submission of MDS 3.0 data through CMS' QIES ASAP system.**

However, in order to collect the standardized data used to calculate SNF QRP measures, an additional MDS submission, the SNF Part A PPS Discharge Assessment, was finalized in the FY 2016 SNF PPS final rule. This discharge assessment includes discharge assessment data needed to inform current and future SNF QRP measures and their calculation.

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SNF Quality Reporting Program Overview - SNF QRP Data Completion Thresholds for the FY 2018 Payment Determination and Subsequent Years:

- Beginning with the FY 2018 payment determination, SNFs must report all of the data necessary to calculate the quality measures on at least 80 percent of the MDS assessments that they submit.
- A SNF is compliant with the QRP if all of the data necessary to calculate the measures has been submitted to fully calculate the quality measures.
- A measure cannot be calculated, for example, when the use of a dash [-], indicates that the SNF was unable to perform a pressure ulcer assessment.

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Where did the Skilled Nursing Facility Quality Reporting Program (SNF QRP) come from?

The IMPACT Act of 2014

- Bipartisan bill was passed; and then signed into law on; 10/6/2014.
- Requires Standardized Patient Assessment Data across Post-Acute Care that will enable:
 - Quality care and improved outcomes
 - Data Element uniformity = (Data Standardization)
 - Comparison of quality and data across post-acute care (PAC) settings.
 - Improved, person-centered goals driven discharge planning
 - Exchangeability of data
 - Coordinated care

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Driving Forces of the IMPACT Act

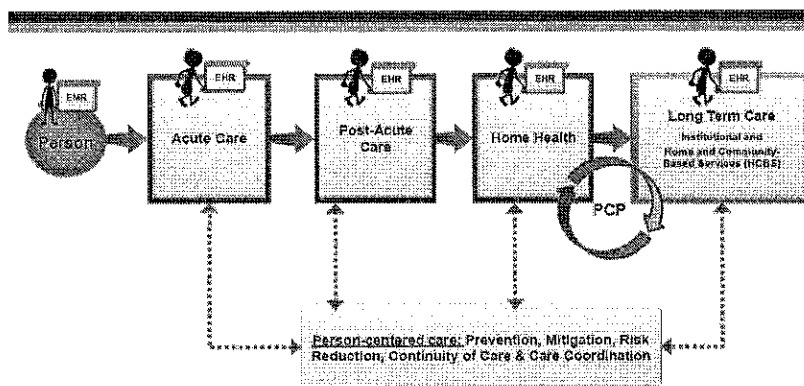
• Why the attention on Post-Acute Care:

- Escalating costs associated with PAC
- Lack of data standards/interoperability across PAC settings
- Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

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Standardization: Ideal State



Information Follows the Person

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SNF QUALITY REPORTING PROGRAM

- In response to the reporting requirements under the Act, CMS established the SNF Quality Reporting Program (QRP) and its quality reporting requirements in the FY 2016 SNF PPS.
- Per the statute, SNFs that do not submit the required quality measures data may receive a two percentage point reduction to their annual payment update (APU) for the applicable payment year.

FOR MORE INFORMATION ON THE SNF QRP, PLEASE VISIT THE WEB PAGE:
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>

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SNF QUALITY REPORTING PROGRAM OVERVIEW QUALITY MEASURES OVERVIEW

- CMS has adopted 3 quality measures for the SNF Quality Reporting Program (QRP) that will be collected beginning on October 1, 2016 For FY2018 and subsequent annual payment update determinations.
- All 3 of these quality measures use assessment data from the MDS.
- Can view the Final Rule at <https://federalregister.gov/a/2015-18950>

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SNF QUALITY REPORTING PROGRAM MEASURES:

NQF MEASURE ID	Measure Title	Data Collection Timeframe	Data Submission Deadline
NQF#0674	Percent of residents experiencing One or More Falls with Major injury (long stay)	10/01/16 - 12/31/16	05/15/2017
NQF#0678	Percent of residents with Pressure Ulcers that are New or Worsened	10/01/16 - 12/31/16	05/15/2017
NQF #2631	Percent of Long-Term Care Hospital patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses function.	10/01/16 - 12/31/16	05/15/2017

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SNF QUALITY REPORTING PROGRAM OVERVIEW:

- A SNF is compliant with the QRP if all of the data necessary to calculate the measures has been submitted to fully calculate the quality measures.
- SNFs must report all of the data on at least 80 percent of the MDS assessments that they submit.
- A measure cannot be calculated, for example, when the use of a dash [-] indicates that the SNF was unable to perform a Pressure ulcer assessment.
- CMS wishes to note that the missing data (e.g., dashes) are very low for SNFs. The calculation of the SNF QRP measures are based on completion of items on a record regardless of whether the stay has been completed.

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SNF QUALITY REPORTING PROGRAM OVERVIEW

- The Annual Payment Update threshold for FY2018 is not based on the final calculation of a quality measure, nor complete stays.
- It is based on the determination of the completion of the items necessary to calculate the measure. The threshold is based on the completion of items on a record regardless of whether the stay has been completed.
- Example: If a resident is admitted on December 20th, and the SNF has completed all items on the resident's 5-Day PPS assessment that is used to calculate the SNF QRP quality measures, then this record would be among those considered compliant.

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SNF QUALITY REPORTING PROGRAM OVERVIEW

- The SNF QRP measures are calculated using the;

5-day PPS for the admission and either the

SNF Part A PPS Discharge or the

OBRA Discharge, depending on which the SNF submits to CMS.

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SNF QUALITY REPORTING PROGRAM OVERVIEW:

- A SNF may request an exception or extension for the SNF QRP within 90 days of the date that the extraordinary circumstances occurred by a written request to CMS's mailbox
- SNFQRPreconsiderations@cms.hhs.gov
- Requests sent through any other channel will not be considered as valid requests for any payment determination.

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SNF QUALITY REPORTING PROGRAM OVERVIEW:

- Public reporting of SNF QRP quality data is scheduled to begin in fall 2018 as per the IMPACT Act, section 1899B(g)(1).
- Public reporting will include a period for review and correction of quality data prior to the public display.
- This data display will include the SNFs performance data, which will initially include data on the 3 quality measures addressed in this presentation.
- Please watch CMS.gov for announcements regarding provider outreach.
- Questions may be submitted by email to: SNFQualityQuestions@cms.hhs.gov

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Check Your Understanding

If a dash [-] is used to code an MDS item that is included in the calculation of a quality measure, that item cannot be used in the calculation of the measure.

1. True
2. False

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Check Your Understanding:

If a SNF provider is unable to submit quality data due to extraordinary circumstances beyond their control (for example, natural, or man-made disasters), they may request an exception or extension.

1. True
2. False

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Check Your Understanding:

A SNF may request an exception or extension for the SNF QRP within 120 days of the date that the extraordinary circumstances occurred.

1. True
2. False

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Understanding MDS 3.0 Technical Information OBJECTIVES

- Explain relationship between Data Submission Specifications (Data Specs) and the Final Validation Report
- Explain the top Fatal and Warning messages
- Explain four CASPER Reports useful in monitoring MDS 3.0 record submission & management

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Data Submission Specifications:

- Current Version in effect October 1, 2016 is 2.00.0
- The Version of the specs in effect for the submitted record depends upon the target date of the record.
- The Specs are posted on the MDS 3.0 Technical Information page on the CMS website:
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHOIMDS30TechnicalInformation.html>

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Data Submission Specifications (cont.)

- ASAP system applies the edits associated to each item submitted in the record.
- Edits are either Fatal or Warning messages
 - If a record encounters one or more fatal edits it is rejected by the ASAP system and the fatal edit message(s) display on the Final Validation Report.
 - If a record encounters no fatal edit, but one or more warning messages, the record is saved in the national database and warning message(s) are displayed on the Final Validation Report.

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COMMON TYPES OF FATAL ERRORS

- Duplicate submissions
- Submission authority issues
- User Errors: Invalid or Incorrect data entered
- Ignored software edits
- Software Errors - where the software doesn't conform to the requirements

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COMMON TYPES OF WARNING MESSAGES:

- Timing errors - not submitted timely
- Sequencing errors - submitted out of order
- Resident or Provider Information Mismatch - one or more resident identifying items contained different data than the most current
- Data for the resident in the national resident table.

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TOP 10 ERRORS

4,894,473 errors returned for MDS 3.0 records submitted during Quarter 4-2015 and Quarter 1-2016.

- #1 -1031 Resident Information Mismatch; Must verify the new information entered is correct.
- #2 -1032 Resident Provider Updated
- #3 -3616b Incorrect RUG Logic Version (Logic Version Settings are not correct; contact software vendor)
- #4 -3616a Incorrect HIPPS/RUG Value: (RUG parameters in software are not set correctly)
- #5 -3749a Assessment Completed Late
- #6 -3808 Section S not completed or missing data.
- #7 -3810d Record Submitted Late
- #8 -3749e Care Plan Completed Late
- #9 -3749d Admission Assessment Completed Late
- #10 -1007 Duplicate Assessment of previously accepted record (Fatal and will be rejected) 162,711 records with this error.

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MDS 3.0 NH Provider Reports that can help troubleshoot

- **Final Validation Report** - Identifies whether record is accepted or rejected and the first step to monitoring whether your facility is meeting the *SNF QRP reporting requirements*.
- **Activity Report**
- **Missing OBRA Assessment Report** – should be *blank*
- **Roster Report**

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Final Validation Report (cont.)

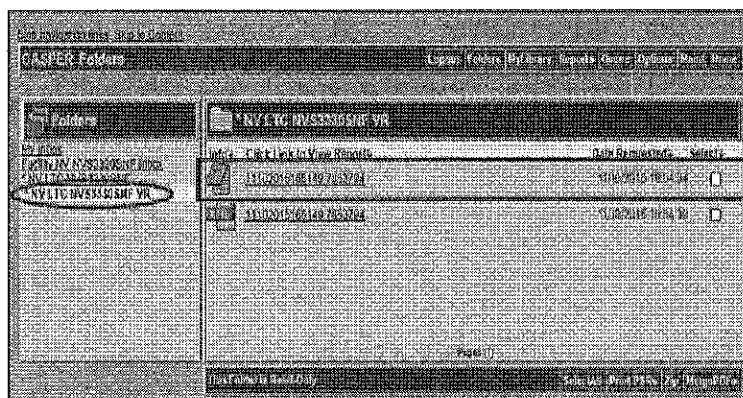
- New on FVR for Oct; 2016 =

A0310H: Part A PPS Discharge Assessment

- Will be automatically deleted after 60 days. Providers should print or save the FVR before it is automatically deleted.

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Final Validation Report is placed in
 Facility's CASPER shared Validation Report folder

- Created within 24 hours following submission
- Provides feedback about each record processed
 - Accepted or rejected
 - Error messages (Can look up the error message Edits in the Data specs to identify the problem

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Final Validation Report

Record: 1		Accepted
Asmt ID: 107621113		Name: [REDACTED]
Res_Int_ID: 35508365		SSN: [REDACTED]
A0200: 1	A0310A: 01	Medicare Num: [REDACTED]
A0310B: 99	A0310C: 0	A0050: NEW RECORD
A0310D: A	A0310E: 1	Target Date: 10/17/2016
A0310F: 99	A0310G: A	
A0310H: 1		Attestation Date (X1100E):
Item Subset Code: NC		Data Spec Version #: 2.00
XML File Name:		SG_TC0350_Step 1_Fed NC.XML
MDS 3.0 Item(s):		A0310A, Submission Date, V0200C2, A0050
Item Values:		01, 11/05/2016, 10/17/2016, 1
Message Number:		-3810C WARNING
Message:		Record Submitted Late: The submission date is more than 14 days after V0200C2 on this new (A0050 equals 1) comprehensive assessment (A0310A equals 01, 03, 04, or 05).

Resident Information

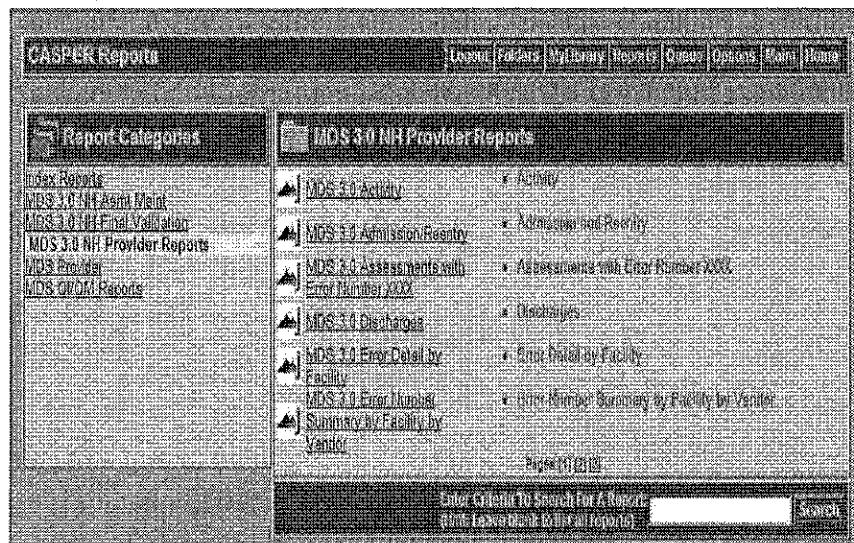
Record Information

Error Information

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CASPER Reports: Activity Report



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CASPER Reports: Activity Report

This report lists the accepted assessments, tracking records, and inactivation requests that were submitted by a facility during a specified timeframe.

User specific on activity of work

From mm/dd/yyyy to mm/dd/yyyy

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CASPER Reports: Missing OBRA Assessment Report

- A list of the residents for whom the target date of the most recent OBRA assessment (other than discharge or death record) is more than 138 days prior to the run date.
- If no OBRA assessments can be displayed then the latest PPS assessment will be displayed.
- You want this report to be blank.

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CASPER Reports: Missing OBRA Assessment Report

Run Date: 04/26/2011 Page 12 of 12

**CASPER Report
(NV) MDS 3.0 Missing OBRA Assessment**

Nursing Home
Facility ID: NY012125NF
Facility Name: TORREY PINES CARE CENTER
Facility City:

Resident Identifiers:					Last Record Identifiers:		
Resident Internal ID	Resident Name	SSN	Date of Birth	Gender	OBRA A0310A	PPS A0310B	Target Date
17779112	RETEST10114, SUBMITTER	████████	04/26/1968	M	99	08	10/11/2010
17779080	RETEST10117, SUBMITTER	████████	04/28/1968	M	99	06	10/11/2010
17779078	RETEST10121, SUBMITTER	████████	12/01/1965	F	99	07	10/11/2010
17779079	RETEST10122, SUBMITTER	████████	12/01/1965	F	99	07	10/11/2010
17779111	RETEST10127, SUBMITTER	████████	11/09/1931	M	99	07	10/11/2010
17760730	WALDORF, NURSINGHOME	████████	12/01/1965	F	00	07	10/11/2010

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

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CASPER Reports: MDS 3.0 Roster Report

- A list of residents currently in the facility. Only as current as the most recent assessments submitted
- A good check source to compare Resident Internal ID #'s with the Resident's ID # seen on the Validation Report and/or the Missing assessment report.
- *If 2 different Resident Int ID's are found for the same resident on this comparison then a duplicate ID has been created.*

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CASPER Reports: MDS 3.0 Roster Report

Run Date: 12/28/2011

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CASPER Report (NV) MDS 3.0 Roster

Nursing Home

Facility ID: NV60008NF

Facility Name: MOUNTAINVIEW CARE CENTER AT BOULDER CITY

Facility City: BOULDER CITY

Date of Last Facility Production Submission: 8/1/11 3:41 PM

Resident Internal ID	SSN	Resident Name	DOB	Gender/ Race/Ethnicity	ISO A0310A/A0310B A0310C/A0310F	Target Date	Submission Date	Admission Date	Admission Type
17763875		OKAMII,		F	NC	05/05/11/95	07/09/2011	09/01/2011	Admission
17763876		OKAMII,		F	NC	01/01/13/99	11/01/2010	09/01/2011	Admission
17763877		OKAMII,		F	NC	02/09/10/99	02/01/2011	09/01/2011	Admission
17763878		OKAMII,		F	NC	03/01/13/99	08/22/2011	09/01/2011	Admission
17763879		OKAMII,		F	NC	01/07/12/99	07/10/2011	08/29/2011	Admission
17763880		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763881		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763882		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763883		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
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17763960		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763961		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763962		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763963		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763964		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763965		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763966		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763967		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763968		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763969		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763970		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763971		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763972		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763973		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763974		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763975		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763976		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763977		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763978		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763979		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763980		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763981		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763982		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763983		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763984		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763985		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763986		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763987		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763988		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763989		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763990		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission
17763991		OKAMII,		F	NC	01/07/12/99	07/10/2011	07/16/2011	Admission

Common Scenarios':

- I have these people on my Missing Assessment Report and I know I did their discharge.
- I have a BC1 on my case mix report for this resident and the records were submitted.
- I have the same resident that keeps showing up on our Roster and I don't know why. They are discharged.



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Common Scenarios': (cont.) Steps to work through

1. Run the Validation report for the week or time frame you last submitted for this resident. Search the pdf for the resident and look at the warnings or fatals. Right down the Int. Res ID. (may answer your question and can stop here)
2. If not, then run your Roster & Missing Assessment report's. They will show the last MDS assessment that CMS has for that Resident's Int. ID - if you compare resident Int. IDs on these 2 reports, and they are different, then a duplicate ID has been created.



Did you run the Validation Report for the timeframe you submitted the record(s)?

Did you identify a duplicate Resd ID?

What are the two Resd Int IDs and what legal document was viewed to verify?

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Common Scenarios': (cont.)

3. Make it a habit to run a Validation report every week or routinely and save in a folder to review.
4. In the (pdf.), Validation report file you can search:
 - by error codes (1031 and 1027);
 - term 'fatal'
 - Residents Name or social security #
5. Proactive monitoring approach and you would be aware of potential problems ahead of them becoming;

Late Assessments or Duplicate Resident Int. Ids. Most Can be corrected early with data entry modifications and/or submission after corrections made.



Did you run the Validation Report for the timeframe you submitted the records?

Did you identify any duplicate Resc IDs?

What are the two Resc Int Ids and what less document was viewed to verify?

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CASPER Report Retention Information

System-generated MDS 3.0 NH Final Validation Report

- Deleted after 60 days

-System-generated MDS 3.0 SB Final Validation Report

- Deleted after 60 days

-MDS 3.0 Facility and Resident QM Preview Reports

- Available to nursing home-based SNFs only

• **Effective November 1, 2016, the retention time period for these reports will change from 230 days to 90 days**

-MDS 3.0 Nursing Home QM Five Star-Rating Preview Reports

- Available to nursing home-based SNFs only
- Deleted after 90 days

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Technical Resources:

- MDS 3.0 Provider User's Guide
- CASPER Reporting User's Guide

-Available in the following locations:

- 'Welcome to the CMS QIES Systems for Providers' web page
- MDS 3.0 User Guides & Training page on the QIES Technical Support Office (QTSO) website:

<https://www.qtso.com/mdstrain.html>

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Technical Resources (cont.) Provider User Guide

Comprehensive list of all MDS 3.0 errors that could occur during record processing is contained in Section 5, Error Messages

–Section 5 is one section available in the MDS 3.0 Provider User's Guide

- Refer to Section 5 while reviewing the final validation report
- Contains detailed information about each MDS 3.0 error, including the message number and message description; type of error (Fatal or Warning); explanation about why the error occurred, and steps that should be taken to correct the error

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Technical Resources (cont.)

MDS 3.0 Data Submission Specification

-Available on MDS 3.0 Technical Information page on the CMS website <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html>

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You may email questions to:

Jonelle.thompson@la.gov

Call: MDS Helpline 1-800-261-1318

LTC Nursing Homes PM/Louisiana State RAI Coordinator

LDH/Health Standards Section

Michael Mire

Michael.Mire@la.gov

LTC Nursing Homes PM/Louisiana State Automation Coordinator

LDH/Health Standards Section

Training and Resource information can be found on the Louisiana MDS Health Standards web page:

<http://www.dhh.louisiana.gov/index.cfm/directory/detail/731>

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