Centers for Medicare & Medicaid Services Special Open Door Forum

Long-Term Care Hospital Quality Reporting Program*

November 21, 2013

1:00 p.m. – 2:30 p.m., EST

***Patient Protection and Affordable Care Act, Section 3004(a)**

Affordable Care Act Section 3004(a)

- CMS requires Medicare-Certified Long-Term Care Hospitals (LTCHs) to submit quality data on all patient admissions and discharges.
  - Failure to submit may reduce annual payment update (APU) by 2%.
  - CMS adopted three quality measures for data collection and reporting for Fiscal Year (FY) 2014 and FY 2015, two additional measures for FY 2016, three additional measures for FY 2017, and one additional measure for FY 2018.

LTCH Quality Reporting Program Requirements for FY 2014 Payment Determination

- In the FY 2012 IPPS/LTCH PPS Final Rule, CMS adopted three quality measures:
  - Urinary Catheter-Associated Urinary Tract Infection (CAUTI) Rate per 1,000 Urinary Catheter Days, for Intensive Care Unit (ICU) Patients (NQF #0138)
  - Central Line-Associated Bloodstream Infection (CLABSI) Rate for ICU and High-Risk Nursery (HRN) Patients (NQF #0139)
  - Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)
  - Data collected for October 1 to December 31, 2012, on these three measures affected FY 2014 payment determination

    http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf
  - Data reporting and submission period closed May 15, 2013

IPPS = Inpatient Prospective Payment System

PPS = Prospective Payment System

NQF = National Quality Forum

Measure Name Updates for FY 2013 IPPS/LTCH PPS Final Rule

- In the FY 2013 IPPS/LTCH PPS Final Rule, CMS adopted new measure names (resulting from NQF review of these measures) for the previously finalized three quality measures:
  - Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)
  - Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139)
  - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)

LTCH Quality Reporting Program Requirements for FY 2015 Payment Determination

Per the FY 2012 IPPS/LTCH PPS Final Rule, LTCHs should continue to report data on NQF measures #0138, #0139, and #0678 for FY 2015:

Data collection time frame CY 2013	Submission deadline for data related to FY 2015 payment determination
Q1 (January-March 2013)	August 15, 2013 (revised to August 23, 2013, through subregulatory guidance)
Q2 (April-June 2013)	November 15, 2013
Q3 (July-September 2013)	February 15, 2014
Q4 (October-December 2013)	May 15, 2014

New LTCH Quality Reporting Program Quality Measures for FY 2016 Payment Determination

- In the FY 2013 IPPS/LTCH PPS Final Rule, CMS retained these three quality measures for FY 2016.
- CMS finalized two additional measures for FY 2016:
  - Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)
  - Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)
- http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf

Data Collection Time Frames and Submission Deadlines for FY 2016 Payment Determination

For NQF measures #0138, #0139, and #0678:

Data collection time frame CY 2014	Submission deadline for data related to FY 2016 payment determination
Q1 (January-March 2014)	May 15, 2014
Q2 (April-June 2014)	August 15, 2014
Q3 (July-Sept. 2014)	November 15, 2014
Q4 (October-December 2014)	February 15, 2015

- CMS finalized new quarterly submission deadlines for the quality data submission related to the FY 2016 Payment Determination.
- Beginning in Calendar Year (CY) 2014, submission deadlines will be 45 days after each data collection time frame (in place of the 135 days after each data collection time frame in CY 2013).

Data Collection Time Frames and Submission Deadlines for FY 2016 Payment Determination (continued)

For NQF #0680, in the FY 2014 IPPS/LTCH PPS Final Rule, the CMS-adopted timeline, is as follows:

Data collection time frame	Submission deadline for data related to FY 2016 payment determination
October 1, 2014 (or when the vaccine becomes available) to April 30, 2015	May 15, 2015

- http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Data Collection Time Frames and Submission Deadlines for FY 2016 Payment Determination (continued)

For NQF #0431, in the FY 2014 IPPS/LTCH PPS Final Rule, the CMS-adopted timeline, is as follows:

Data collection time frame	Submission deadline for data related to FY 2016 payment determination
October 1, 2014 (or when the vaccine becomes available) to March 31, 2015	May 15, 2015

- http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Data Submission Requirements for LTCH Quality Reporting Program Quality Measures for FY 2016 Payment Update Determination

- Pressure Ulcer (NQF #0678) and Patient Seasonal Influenza Vaccine (NQF #0680): Submit data using the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set.
- CAUTI (NQF #0138), CLABSI (NQF #0139), and Healthcare Personnel Vaccination (NQF #0431): Submit data to CDC's NHSN.

LTCH CARE Data Set

- Continue to use the LTCH CARE Data Set Version 1.01 to submit Pressure Ulcer data until June 30, 2014.
- July 1, 2014: LTCHs will being using the LTCH CARE Data Set Version 2.01 to submit quality data to CMS.
  - Please note that while quality data items related to the Patient Season Influenza Vaccine are included in version 2.01 of the LTCH CARE Data Set, providers are only required to respond to these items beginning October 1 of any given year through April 30 of the subsequent year.
- This applies to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under Medicare.
- For information on data collection and submission for these measures, see Chapters 2, 3 and 4 of the LTCH Quality Reporting Program Manual Version 2.0 (Draft), available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html

LTCH Quality Reporting Program Requirements for FY 2017, FY 2018 Payment Determination

- In the FY 2014 IPPS/LTCH PPS Final Rule, CMS adopted four additional quality measures:
  - FY 2017
    - NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF #1716)
    - NHSN Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717)
    - All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Long-Term Care Hospitals
  - FY 2018
    - Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
- http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf
  - NHSN = National Healthcare Safety Network
  - MRSA = Methicillin-resistant Staphylococcus aureus

Data Collection Time Frames and Submission Deadlines for FY 2017 Payment Determination

For NQF measures #0138, #0139, #0678, #1716, and #1717:

Data collection time frame CY 2015	Submission deadline for data related to FY 2017 payment determination
Q1 (Jan.-March 2015)	May 15, 2015
Q2 (April-June 2015)	Aug. 15, 2015
Q3 (July-Sept. 2015)	Nov. 15, 2015
Q4 (Oct.-Dec. 2015)	Feb. 15, 2016

Data Collection Time Frames and Submission Deadlines for FY 2017 Payment Determination (cont'd)

For NQF #0680, in FY 2014 IPPS/LTCH PPS final rule, CMS adopted timeline, as follows:

Data collection time frame	Submission deadline for data related to FY 2017 payment determination
Oct. 1, 2015 (or when vaccine becomes available) to April 30, 2016	May 15, 2016

- http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

Data Collection Time Frames and Submission Deadlines for FY 2017 Payment Determination (cont'd)

For NQF #0431, in FY 2014 IPPS/LTCH PPS final rule, CMS adopted timeline, as follows:

Data collection time frame	Submission deadline for data related to FY 2017 payment determination
Oct. 1, 2015 (or when vaccine becomes available) to March 31, 2016	May 15, 2016

- http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf

LTCH Assessment Submission Entry and Reporting (LASER) Software

- Free, Java-based application for LTCHs to collect and submit data using the LTCH CARE Data Set.
- For further information, select LASER software under the Related Links section on the LTCH Quality Reporting website.
- Information on data collection and submission using the LTCH CARE Data Set is available at:

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html

Reporting LTCH Quality Reporting Program Data through CDC's NHSN

- CDC's NHSN is used as the data submission mechanism for NQF measures CAUTI, CLABSI, and Healthcare Personnel Vaccination.
- Starting in FY 2017, NHSN will also be used as the data submission mechanism for NQF measures MRSA and C. Diff.
- For information on data collection and submission for these measures, see Chapter 5 of the LTCH Quality Reporting Program Manual Version 2.0 (Draft), available for download at http://www.cms.gov/LTCH-Quality-Reporting/

Reporting LTCH Quality Reporting Program Data through CDC's NHSN

- An LTCH must enroll in NHSN as an individual long-term acute-care facility and complete online training modules prior to receiving reporting permissions from NHSN.
  - If you have not yet enrolled your LTCH, contact the CDC's NHSN by e-mail at: nhsn@cdc.gov.
  - FAQs about NHSN enrollment are available on website.

LTCH Provider Training

- LTCH Provider training is to be held late winter 2014/early spring 2014. CMS will announce provider training dates.
- All instructional information will be posted on the CMS LTCH Quality Reporting website: http://www.cms.gov/LTCH-Quality-Reporting/

Purpose of Provider Training

- Understand the LTCH Quality Reporting Program requirements related to FY 2015, FY 2016, and FY 2017 annual payment update determinations.
- Discuss new measures finalized in the FY 2014 IPPS/LTCH PPS Final Rule published August 19, 2013.
- Discuss and understand data collection and submission requirements.
- Discuss assessment procedures and coding for LTCH CARE Data Set.
- Learn about additional resources available for assistance.

Resources

- LTCH Quality Reporting Program website and e-mail address:
  - Website: http://www.cms.gov/LTCH-Quality-Reporting/
  - E-mail: LTCHQualityQuestions@cms.hhs.gov
- To receive mailing list notices and announcements about the program, please sign up at
  - https://public.govdelivery.com/accounts/USCMS/subscriber/new
- LTCH Quality Reporting Program Provider Training Slide Decks
  - Training slides from the May 2012 LTCH provider training conference:
    - Part 1: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-Training-Slide-Decks_Part1.zip
    - Part 2: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/LTCH-Training-Slide-Decks_Part2.zip

Resources (continued)

- Operational Guidance for submitting CLABSI, CAUTI, and Healthcare Personnel Vaccination Data to CDC's NHSN:
  - For submitting CLABSI data: http://www.cdc.gov/nhsn/LTACH/CLABSI/index.html
  - For submitting CAUTI data: http://www.cdc.gov/nhsn/LTACH/CAUTI/index.html
  - For submitting Healthcare Personnel Vaccination data: http://www.cdc.gov/nhsn/LTACH/hcp-flu-vac/index.html
  - For submitting C. Diff and MRSA data: http://www.cdc.gov/nhsn/LTACH/mdro-cdi/
  - For assistance with the NHSN enrollment process or questions related to CLABSI, CAUTI, Healthcare Personnel Vaccination, C Diff and MRSA data collection and submissions to NHSN, contact the CDC NHSN help desk at nhsn@cdc.gov

Resources (continued)

- Send questions and comments on technical issues regarding the LTCH CARE Data Set to LTCHTechIssues@cms.hhs.gov
- Address questions regarding access to QIES, LASER submission, and CASPER to QIES Technical Support office at help@qtso.com or by phone at 1-800-339-9313
- Frequently Asked Questions regarding the LTCH Quality Reporting Program are available on the CMS LTCH Quality Reporting website:
  - http://www.cms.gov/LTCH-Quality-Reporting/

QIES = Quality Improvement Evaluation System

CASPER = Certification And Survey Provider Enhanced Reports

1. **I need clarification on the definition of "LTCH." Are these long-term acute care hospitals or long-term care hospitals?**

   A: Long-term care hospitals (LTCHs) and long-term acute care hospitals are different names for the same type of hospital. Medicare uses the term long-term care hospitals. These hospitals are certified as acute care hospitals that treat patients requiring extended hospital-level care, typically following initial treatment at a general acute care hospital. If a hospital is classified as an LTCH for purposes of Medicare payments (as denoted by the last four digits of its six-digit CMS Certification Number [CCN] in the range of 2000–2299), it is subject to the requirements of the LTCH Quality Reporting (LTCHQR) Program.

2. **When is a new LTCH required to being reporting data under the CMS LTCH QRP? According to the current manual: 2.1 Responsibilities of Long-Term Care Hospitals for Completing Assessments: The LTCH CARE Data Set is applicable to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under the Medicare program. It is not applicable to patients receiving services in LTCH units that are not designated as LTCHs under the Medicare program. If I interpret this correctly, the LTCH would start reporting once they have been surveyed by Medicare and received their CCN number and been designated an LTCH, which may not be until a few months until after the hospital opens its doors and begins accepting patients. Is this correct?**

   A: A facility is required to begin reporting quality data to CMS under the LTCHQR Program from the date it is formally designated as an LTCH by CMS. This formal designation happens when a facility receives the CCN from CMS licensing a facility as a Medicare-certified LTCH. The facility will receive notification and the LTCH will be assigned a CCN with the last four digits ranging from 2000-2299, which tells us that they are an LTCH. CMS does not require a facility to report quality data under the LTCH Quality Reporting Program until that time.

3. **Please direct me to the full list of quality measures required for all LTCH facilities.**

   A: For most current information including a list of quality measures adopted for the LTCHQR Program, data collection and submission deadlines for each quality measure, we recommend you to refer to the Fiscal Year (FY) 2014 IPPS/LTCH PPS Final Rule available at http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf (see pages 50853 through 50887, 50959 through 50964, and 51035 through 50136).

   For further details and measure definitions for the three LTCH quality measures—Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138), Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139), and Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678) for

FY 2014 and FY 2015 payment update determination—please refer to the LTCHQR Program Manual V 2.0 (Draft) available for download at http://www.cms.gov/LTCH-Quality-Reporting/ Chapter 1 of the LTCHQR Program Manual V 2.0 (Draft)). We also invite you to visit this Website for updates to specifications for each of these measures that may result from the National Quality Forum's review. For details about NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF #1716) and NHSN Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717) measures for FY 2017 payment update determination, we refer to access Chapter 5 of the CMS LTCHQR Program Manual V 2.0 (Draft) at http://www.cms.gov/LTCH-Quality-Reporting/.

4. Where can I find the definitions for LTCH quality measures?

A: For most current definitions for the current LTCH quality measures, please refer to the LTCHQR Program Manual V 2.0 (Draft) available for download at: http://www.cms.gov/LTCH-Quality-Reporting/ (Chapter 1 of the LTCHQR Program Manual V 2.0 (Draft)). This includes information on Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138), Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139), and Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)—Calendar Year (CY) 2013 data collection for FY 2015 payment update determination. We also invite you to visit this Website for updates to specifications to each measure that may result from the National Quality Forum's review.

For the most current LTCH quality measure definitions for CY 2014 and CY 2015 data collection affecting the FY 2016 and FY 2017 annual payment update determinations, please refer to the LTCHQR Program Manual V 2.0 (Draft) available for download at http://www.cms.gov/LTCH-Quality-Reporting/ (Chapter 1 of the LTCHQR Program Manual V 2.0 (Draft)). This includes information on Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138), Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139), and Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678). It also includes information on Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) and Influenza Vaccination Coverage Among Healthcare Personnel (NQF #431) for CY 2014 and CY 2015 data collection affecting the FY 2016 annual payment update determination, as well as information on NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF #1716) and NHSN Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717) for CY 2015 data collection and affecting the FY 2017 annual payment update determination.

5. **What is the definition for planned discharge?**

   A: A planned discharge is one in which the patient is nonemergently, medically released from care at the LTCH for some reason arranged for in advance (see Appendix A of the LTCHQR Program Manual V 2.0 (Draft) available for download at http://www.cms.gov/LTCH-Quality-Reporting/).

6. **What is the definition for unplanned discharge?**

   A: An unplanned discharge is a transfer of the patient to be admitted to another hospital or facility that results in the patient's absence from the LTCH for longer than 3 calendar days (including the date of transfer); or a transfer of the patient to an emergency department of another hospital in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation, resulting in the patient's absence from the LTCH for longer than 3 calendar days; or the unexpected departure of a patient from the LTCH against medical advice; or the unexpected decision of a patient to go home or to another setting (e.g., to complete treatment in an alternate setting). Unplanned discharges do not include planned transfers to acute-care inpatient hospitals for admission for planned interventions, treatments, or procedures unless the patient does not return to the LTCH within 3 calendar days (see Appendix A of the LTCHQR Program Manual V 2.0 (Draft) available for download at http://www.cms.gov/LTCH-Quality-Reporting/).

7. **If a patient's planned discharge is Friday, but the discharge is delayed until Sunday, what should the assessment reference date (ARD) be?**

   A: The ARD on the Discharge assessment of the LTCH CARE Data Set is the patient's actual discharge date (see Chapter 2 of the LTCHQR Program Manual V 2.0 (Draft)). In the example provided above, it would be Sunday.

8. **Can the CMS please clarify whether there is a 72-hour rule or 3-calendar-day rule in the following instances:**

   - **When a patient leaves an LTCH to go to another facility and then returns to the LTCH, for purposes of determining whether to submit a Discharge assessment?**
   - **When a patient dies within 72 hours or 3 days after leaving an LTCH for another facility?**

   A: The 3-day interrupted stay is in accordance with the payment policies that have been established. If the policy states that day 1 of 3 begins on the day of transfer, then that day plus 2 calendar days would dictate the definition of the 3 days. If a patient dies during an interrupted stay, then the LTCH should submit the Expired assessment data set. If the patient dies afterward, the LTCH should have submitted a Discharge assessment data set because the

patient did not return within 3 days. Please note that "72 hours" has been replaced with "3 calendar days" throughout the LTCHQR Program Manual V 2.0 (Draft), available for download at http://www.cms.gov/LTCH-Quality-Reporting/.

9. **If a patient dies during the Assessment Period, should you fill out both Admission and Expired assessments?**

   A: Yes, both an Admission and Expired assessment would be completed. The Assessment Reference Date for the Expired assessment would be the date of death.

10. **A patient came to our facility and was discharged the next day—we assume that patient is exempt from reporting? Do we need to track those cases in some way so that there is no question regarding our full reporting?**

    A: In the example you provide, you state that the patient was discharged the day following their admission to the LTCH. In this instance, the LTCH would be responsible for submitting to the CMS an Admission assessment followed by a planned or unplanned Discharge assessment using the appropriate LTCH CARE Data Set depending on the circumstances surrounding the patient's discharge. For more information regarding planned versus unplanned discharge, consult the LTCHQR Program Manual V 2.0 (Draft), available for download at http://www.cms.gov/LTCH-Quality-Reporting/.

11. **Are all demographic information items required? Are GG0160C (Functional Mobility: Lying to Sitting on Side of Bed); H0400 (Bowel Incontinence); K0200A (Height); and K0200B (Weight) required only for Admission assessments?**

    A: Please refer to the LTCHQR Program Manual V 2.0 (Draft), available for download at http://www.cms.gov/LTCH-Quality-Reporting/. Appendix E provides item-specific guidance on requirements for the completion of the LTCH CARE Data Set. It is extremely important to note that Appendix E is provided to illustrate which items are required, which can be voluntarily submitted, and when each type of LTCH CARE Data Set assessment record should be submitted. Appendix E is not to be used as a replacement for the data submission specifications. For data submission, the LTCH CARE Data Set must follow the LTCH CARE Data Submission Specifications Version 1.00.3 posted on the CMS Website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCHTechnicalInformation.html. According to the specifications of the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), height and weight, diabetes mellitus, peripheral vascular disease/peripheral arterial disease, bowel incontinence, and functional mobility are used as covariates (risk adjustment) to calculate the percentage of patients with pressure ulcers that are new or worsened. Data for these risk adjustment items are derived from the Admission assessment. Therefore, the provider must submit these risk adjustment items on the Admission assessment. These items

are not used in the measure's calculation at discharge and are therefore not required on the Discharge assessment. If providers do not want to provide an actual assessment-based response on these items at the time of discharge, for example, if providers do not provide the functional mobility of the patient, they must enter a default code for some items. The default codes vary according to the data item. Appendix E provides item-specific information on which items are voluntary but require a default code. We refer you to the LTCH CARE Data Submission Specifications V1.00.3 as the primary source for these codes and when they are to be used.

12. Do we report patients with all payer sources for CAUTI, CLABSI, and pressure ulcers for LTCHs, or just patients admitted with Medicare payer source?

A: For the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), the LTCH CARE Data Set applies to all patients receiving inpatient services in a facility certified as a hospital and designated as an LTCH under Medicare. Data collection using the LTCH CARE Data Set applies regardless of a patient's age, diagnosis, length of stay, or payment/payer source (Chapter 2, Section 2.1 of the LTCHQR Program Manual V 2.0 (Draft)). For the Catheter–Associated Urinary Tract Infection(CAUTI) Outcome Measure (NQF #0138 and Central Line–Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139), each LTCH must submit data for these measures on all patients from all inpatient locations, regardless of payer source (Chapter 5, Section 5.1 of the LTCHQR Program Manual V 2.0 (Draft) available for download at http://www.cms.gov/LTCH-Quality-Reporting/).

13. None of our patients had pressure ulcers, CAUTI, or CLABSI during the April 1, 2013, through June 30, 2013, reporting period. Do we need to submit data on pressure ulcers, CAUTI, and CLABSI to comply with LTCHQR Program for this quarter?

A: Compliance with the LTCH Quality Reporting Program requires submission of quality data, irrespective of whether your patients have pressure ulcers, CAUTI or CLABSI. An LTCH is required to submit "no event" for the Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138) and Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139) for the months of April 1, 2013, through June 30, 2013, to the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN). Further, your LTCH is required to submit an LTCH CARE Data Set (Admission, Discharge [unplanned or planned], Expired assessments) for all patients, irrespective of their pressure ulcer status, to the CMS. Please refer to the LTCHQR Program Manual V 2.0 (Draft), available for download at http://www.cms.gov/LTCH-Quality-Reporting/ (Chapter 5 [for details on submission of CAUTI and CLABSI data] and Chapter 3 [for details on submission of Pressure Ulcer data]). Starting in CY 2015, this information will also apply to the NHSN Facility-Wide Inpatient Hospital-Onset MRSA

Bacteremia Outcome Measure (NQF #1716) and NHSN Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* (CDI) Outcome Measure (NQF #1717). Please refer to the LTCHQR Program Manual V 2.0 (Draft) for further information about these two measures.

14. What do we do if a pressure ulcer worsens during the first 3 days of the patient's admission to the LTCH? How do we code the wound?

A: The patient skin condition reflected in the Admission assessment data set should match with the patient's Admission assessment for the purposes of determining if a pressure ulcer was present on admission (POA). A wound determined to be POA would specifically need to be "on admission." Thus, if a POA wound worsened during the first 3 days, the Admission assessment record should capture the wound's stage at admission based on the Admission skin assessment.

15. On Day 2 of the 3-day assessment period, a pressure ulcer was assessed as unstageable. On Day 5, the wound was debrided and assessed as a Stage 3. On Day 24, the day of discharge, the wound was assessed as a Stage 4. How would this scenario be coded on the Admission and Discharge Assessment?

A: On the Admission assessment, the pressure ulcer would be coded as unstageable and POA. On the Discharge assessment, it would be coded as a Stage 4, worsened, not POA. This is because the first time the pressure ulcer was able to be numerically staged after debridement, it was staged as a Stage 3, then it subsequently increased in numerical staging (worsened) to be a Stage 4 prior to discharge (see Chapter 3, Section M, of the LTCHQR Program Manual V 2.0 (Draft)).

16. We entered an admit on a patient who went to another facility for 5 days; the patient had zero wounds when he left us. The patient was not discharged from our facility; he was on bed-hold. Upon return from the other facility, he had two significant pressure ulcers that remained until discharge. How do we report wounds at discharge that were not caused by our facility but will appear to be?

A: Thank you for your inquiry. In the scenario you outline, if a patient returns to the LTCH after more than 3 calendar days at another hospital/facility/location, a planned or unplanned Discharge assessment should be completed depending on the circumstances surrounding the patient's discharge (in addition to an Admission assessment). Further, when the patient "returns" to the LTCH after a stay of 3 calendar days at another hospital/facility/location, a new Admission assessment should be completed. For the purpose of the LTCHQR Program, this admission would be considered a "new" admission and the date for this admission to the LTCH should be used as the Admission Date. For this patient, you will also complete a planned or unplanned Discharge assessment depending on the circumstances surrounding the

patient's discharge. Please consult the LTCHQR Program Manual V 2.0 (Draft) available for download at http://www.cms.gov/LTCH-Quality-Reporting/.

17. A patient admitted without a pressure ulcer, sent to acute care hospital for a procedure, and returned less than 24 hours later now has a pressure ulcer. How do we report this on the LTCH CARE Data Set?

A: For the purpose of the LTCHQR Program, if a pressure ulcer developed during the time when the patient is away from an LTCH and in an acute care hospital for a stay of less than 3 calendar days (considered less than a 3-day interrupted stay) and if an Admission assessment was not completed on this patient prior to sending the patient to acute care hospital for a procedure, please code this at a stage you assess when the patient returns to the LTCH. This will be included on the Admission assessment. If this pressure ulcer is present at the time of discharge, it should be recorded on the Discharge assessment.

18. Does the LTCH CARE Data Set require the signature of a registered nurse?

A: No. The CMS has removed the language surrounding and requirement for a registered nurse's signature for the submission of the LTCH CARE Data Set's submission (see Chapter 3, Section Z, of the LTCHQR Program Manual V 2.0 (Draft) available at http://www.cms.gov/LTCH-Quality-Reporting/). This does not, however, mean that any staff member may assess a patient. We ask that your facility refer to its own policies surrounding patient assessments as well as any state laws surrounding this issue.

19. Should the signature sections be completed and held at the hospital? If so, how long should they be kept?

A: The CMS will not be receiving the signatures from the LTCH CARE Data Set, Section Z, items Z0400 and Z0500. We will receive the submission date. We strongly suggest that you retain what you submit to the CMS, including Section Z, according to your facility and state regulations and requirements surrounding maintenance and storage of patient records. Facilities should comply with their policies pertaining to electronic signatures, should they require them.

20. What is the NHSN? What measures are submitted through NHSN?

A: The CDC's National Healthcare Safety Network (NHSN) is used as the data submission mechanism for Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138), Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139, and Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431). Starting in FY 2017, NHSN will also be used as the data submission mechanism for NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF

#1716) and NHSN Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717). LTCHs must enroll in NHSN and complete online training modules prior to receiving reporting permissions from NHSN. For more information on data collection and submission, please refer to Chapter 5 of the LTCHQR Program Manual V 2.0 (Draft) available at http://www.cms.gov/LTCH-Quality-Reporting/.

21. Does CMS pull data from CDC NHSN?

A: Currently, CDC NHSN submits Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138) and Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (NQF #0139) data for LTCHs to the CMS via QualityNet. Starting in CY 2015, NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF #1716) and NHSN Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717) LTCH data will also be pulled from the NHSN and sent to the CMS.

22. What are the quarterly submission deadlines for the FY 2015 and FY 2016 Payment Determinations?

A: The submission deadlines for CY 2013 quarterly data for three measures (Percent of Residents or Patients with Pressure Ulcers [NQF #0678], Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure [NQF #0138], and Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure [NQF #0139]) that will impact the FY 2015 payment update determination are 135 days after each data collection time frame. For CY 2014 and CY 2015 quarterly data for five measures (Percent of Residents or Patients with Pressure Ulcers [NQF #0678], Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure [NQF #0138], Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure [NQF #0139], Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) [NQF #0680], and Influenza Coverage Among Healthcare Personnel [NQF #0431]) that will impact the FY 2016 and FY 2017 payment update determinations, the CMS finalized quarterly submission deadlines in the FY 2014 Inpatient Prospective Payment System (IPPS)/LTCH Prospective Payment System (PPS) Final Rule. Starting in CY 2015 and affecting the FY 2017 payment update determination, data will also be required for MRSA [NQF #1716] and *C. difficle* [NQF #1717] Measures. Beginning in CY 2014, submission deadlines will be 45 days after each data collection time frame (in place of the 135 days after each data collection time frame in CY 2013). We refer providers to slides 7, 8, and 9 of this November 21, 2013, Special Open Door Forum's presentation materials for measure-specific submission deadlines.

23. Is it public information to ask for the pressure ulcer statistics that were reported by a particular CMS provider for the period that began with October 2012 or is this information somehow private?

A: We refer you to page. 50883 of the FY 2014 IPPS/LTCH PPS Final Rule section titled "Public Display of Data Quality Measures for the LTCHQR Program" published on August 19, 2013 and available at http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf for current information.