



Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Follow Up Webinar for Providers



Section GG

Section M

Section O

February 3, 2016

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Choose your answer before the polling event is closed.
- Scheduled breaks: Short breaks at approximately 2:20 and 3:55 pm.

Polling Question (1)

How many people, including yourself, are in the room attending this webinar?

- 1) 1
- 2) 2
- 3) 3
- 4) 4
- 5) 5
- 6) 6 or more

Agenda

- Welcome and Introduction
- Section GG: Functional Abilities and Goals Part 1
 - Break: approximately 15 minutes
- Section GG: Functional Abilities and Goals Part 2
- Section M: Skin Conditions
- Section O: Special Treatments, Procedures and Programs
- Review of Available Resources
 - Break: approximately 15 minutes
- Questions & Answers
- Wrap Up

Today's Presenters



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Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Follow Up Webinar for Providers



Section GG

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Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Follow Up Webinar for Providers



Section GG: Functional Abilities and Goals

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Section GG: Objectives

- Define items and rating scale included in Section GG: Functional Abilities and Goals.
- Explain intent of Section GG items.
- Discuss coding instructions and needed information for items.
- Practice coding scenario(s) to correctly and accurately code Section GG.

Section GG: Intent

- Items focus on:
 - Prior functioning.
 - Admission and discharge self-care and mobility performance.
 - Discharge goals.
- The admission and discharge self-care and mobility items assess the patient's need for assistance with self-care and mobility activities.

Section GG: Intent (cont.)

- An activity refers to the execution of a task or action by an individual.
- Many patients in LTCHs have self-care and mobility limitations, and most are at risk of further functional decline and complications due to limited mobility.

Section GG: GG0100.

Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities. Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.	
3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. 2. Needed Some Help - Patient needed partial assistance from another person to complete activities. 1. Dependent - A helper completed the activities for the patient. 8. Unknown 9. Not Applicable	↓ Enter Codes In Boxes
	<input type="checkbox"/> B. Indoor Mobility (Ambulation): Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

Applies to Admission Assessment only

Section GG: GG0100

CODING INSTRUCTIONS:

- Complete only if A0250 = 01 Admission.
- **Code 3, Independent**, if the patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help**, if the patient needed partial assistance from another person to complete activities.
- **Code 1, Dependent**, if the helper completed the activities for the patient.
- **Code 8, Unknown**, if the patient's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable**, if the activity was not applicable to the patient prior to the current illness, exacerbation, or injury.

Section GG: GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply

- | | |
|--------------------------|------------------------------------|
| <input type="checkbox"/> | A. Manual wheelchair |
| <input type="checkbox"/> | B. Motorized wheelchair or scooter |
| <input type="checkbox"/> | C. Mechanical lift |
| <input type="checkbox"/> | Z. None of the above |

Applies to Admission Assessment only

Section GG: GG0110

CODING INSTRUCTIONS:

- Complete only if A0250 = 01 Admission.
- **Check all devices that apply:**
 - A. Manual wheelchair
 - B. Motorized wheelchair or scooter
 - C. Mechanical lift
- **Check Z, None of the above,** if the patient did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Section GG: Timeline for “Prior to Admission” Question

QUESTION:

What is the timeframe for "prior to admission"?

Section GG: Timeline for “Prior to Admission” Answer

ANSWER:

“Prior to admission” is the timeframe for items GG0100 Prior Functioning and GG0110 Prior Device Use. The timeframe for “prior to admission” refers to the patient’s functioning and device use immediately before the current illness, injury or exacerbation. If the patient’s episode of care started with an acute care hospital stay followed by an LTCH stay, the patient’s prior functioning would be based on the patient’s status immediately before the illness, injury or event that led to the acute care stay.

Section GG: GG0100 Question

GG0100 Prior Functioning QUESTION:

If a patient had a spinal cord injury 30 years ago and is now admitted for wound care, how do you code GG0100? Would it be based on the 30-year-old injury or the wounds?

Section GG: GG0100 Answer

ANSWER:

In the example, the patient had a spinal cord injury 30 years ago, and is now admitted to an LTCH for treatment of wounds. The item GG0100B. Indoor Mobility/Ambulatory code would be coded based upon his/her need for assistance with indoor ambulation prior to the admission for the wound.

Section GG: GG0100B Question

GG0100B Indoor Mobility QUESTION:

What is the difference between “8, Unknown” and “-” (dash) not assessed/no information?

Section GG: GG0100B Answer

ANSWER:

The clinician should attempt to obtain prior functioning information from the patient, family members or the patient's medical record. If the information is not available from these sources, then code "8, Unknown." If there was not an attempt to obtain this information code a "-" (dash) to indicate not assessed/no information.

Section GG: GG0130. Self-Care (3-day assessment period)

GG0130. Self-Care (3-day assessment period)		
Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).		
CODING: Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. <i>Activities may be completed with or without assistive devices.</i>	1.	2.
	Admission Performance	Discharge Goal
	↓ Enter Codes in Boxes ↓	↓
06. Independent - Patient completes the activity by him/herself with no assistance from a helper.	□ □	□ □
05. Setup or clean-up assistance - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.	□ □	□ □
04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	□ □	□ □
03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.	□ □	□ □
02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.	□ □	□ □
01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.		
If activity was not attempted, code reason: 07. Patient refused 09. Not applicable 88. Not attempted due to medical condition or safety concerns		
		A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment. D. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

Applies to Admission and Planned Discharge Assessments

Section GG: GG0130

	<p>A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.</p>
	<p>B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]</p>
	<p>C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.</p>
	<p>D. Wash upper body: The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.</p>

Section GG: GG0130. Item Rationale

LTCH patients may have self-care limitations on admission. In addition, patients may be at risk of further functional decline during their LTCH stay.

Section GG: GG0130

CODING INSTRUCTIONS:

- Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.
- Code the patient's usual performance for each activity using the 6-point scale:
 - Code "06" for Independent.
 - Code "05" for Setup or clean-up assistance.
 - Code "04" for Supervision or touching assistance.
 - Code "03" for Partial/moderate assistance.
 - Code "02" for Substantial/maximal assistance.
 - Code "01" for Dependent.

Section GG: GG0130 (cont.)

KEY CODING QUESTIONS:

- Does the patient need assistance (physical, verbal/ non-verbal cueing, setup/clean-up) to complete the self-care activity?
 - If no, **Code 06, Independent**
 - If yes...
- Does the patient need only setup or clean-up assistance?
 - If yes, **Code 05, Setup or clean-up**
 - If no...

Section GG: GG0130 (cont.)

KEY CODING QUESTIONS (cont.):

- Does the patient need only verbal/non-verbal cueing, or steadying/touching assistance?
 - If yes, **Code 04, Supervision or touching assistance**
 - If no...
- Does the patient need lifting assistance or trunk support with the helper providing *less* than half of the effort?
 - If yes, **Code 03, Partial/moderate assistance**
 - If no...

Section GG: GG0130 (cont.)

KEY CODING QUESTIONS (cont.):

- Does the patient need lifting assistance or trunk support with the helper providing *more* than half of the effort?
 - If yes, **Code 02, Substantial/maximal assistance**
 - If no...
- Does the helper provide *all* of the effort to complete the activity?
 - If yes, **Code 01, Dependent**

Section GG: GG0130 (cont.)

KEY CODING QUESTIONS (cont.):

- Why was the activity not attempted? Code reason:
 - **Code 07, Patient refused**, if the patient refused to complete the activity.
 - **Code 09, Not Applicable**, if the patient did not perform this activity prior to the current illness, exacerbation, or injury.
 - **Code 88, Not attempted due to medical condition or safety concerns**, if the activity was not attempted due to medical condition or safety concerns.

Section GG: GG0130A

Coding Scenario

EATING:

The nurse opens all of Mr. S's cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S's ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

How would you code GG0130A?

Polling Question (2)

How would you code GG0130A?

- 1) 06. Independent
- 2) 05. Setup or clean-up assistance
- 3) 04. Supervision or touching assistance
- 4) 03. Partial/moderate assistance

Section GG: GG0130A

Coding Scenario

CODING: GG0130A. Eating would be coded 05, Setup or clean-up assistance.

RATIONALE: The helper provided setup assistance only prior to the activity.

Section GG: GG0130A

Coding Scenario

EATING:

Mrs. V has had difficulty seeing on her left side since her stroke. During meals, a helper has to remind her to scan her entire meal tray to ensure she has seen all the food.

How would you code GG0130A?

Polling Question (3)

How would you code GG0130A?

- 1) 04. Supervision or touching assistance
- 2) 03. Partial/moderate assistance
- 3) 02. Substantial/maximal assistance
- 4) 09. Not applicable

Section GG: GG0130A

Coding Scenario

CODING: GG0130A. Eating would be coded 04, Supervision or touching assistance.

RATIONALE: The helper provides verbal cuing assistance as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

Section GG: GG0130B

Coding Scenario

ORAL HYGIENE:

Ms. T is recovering from a severe traumatic brain injury and multiple bone fractures. She does not understand how to use oral hygiene items nor does she understand the process of completing oral hygiene. The certified nursing assistant brushes her teeth and explains each step of the activity to engage cooperation from Ms. T; however, she requires full assistance for the activity of oral hygiene.

How would you code GG0130B?

Polling Question (4)

How would you code GG0130B?

- 1) 02. Substantial/maximal assistance
- 2) 04. Supervision or touching assistance
- 3) 01. Dependent
- 4) 88. Not attempted due to medical condition or safety concerns

Section GG: GG0130B

Coding Scenario

CODING: GG0130B. Oral Hygiene would be coded 01, Dependent.

RATIONALE: The helper provides all the effort for the activity to be completed.

Section GG: GG0130C

Coding Scenario

TOILETING HYGIENE: Mr. J is morbidly obese and has several diagnoses, including debility. He requests the use of a bed pan when voiding or having bowel movements and requires two certified nursing assistants to mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene.

How would you code GG0130C?

Polling Question (5)

How would you code GG0130C?

- 1) 04. Supervision or touching assistance
- 2) 02. Substantial/maximal assistance
- 3) 01. Dependent
- 4) 07. Patient refused

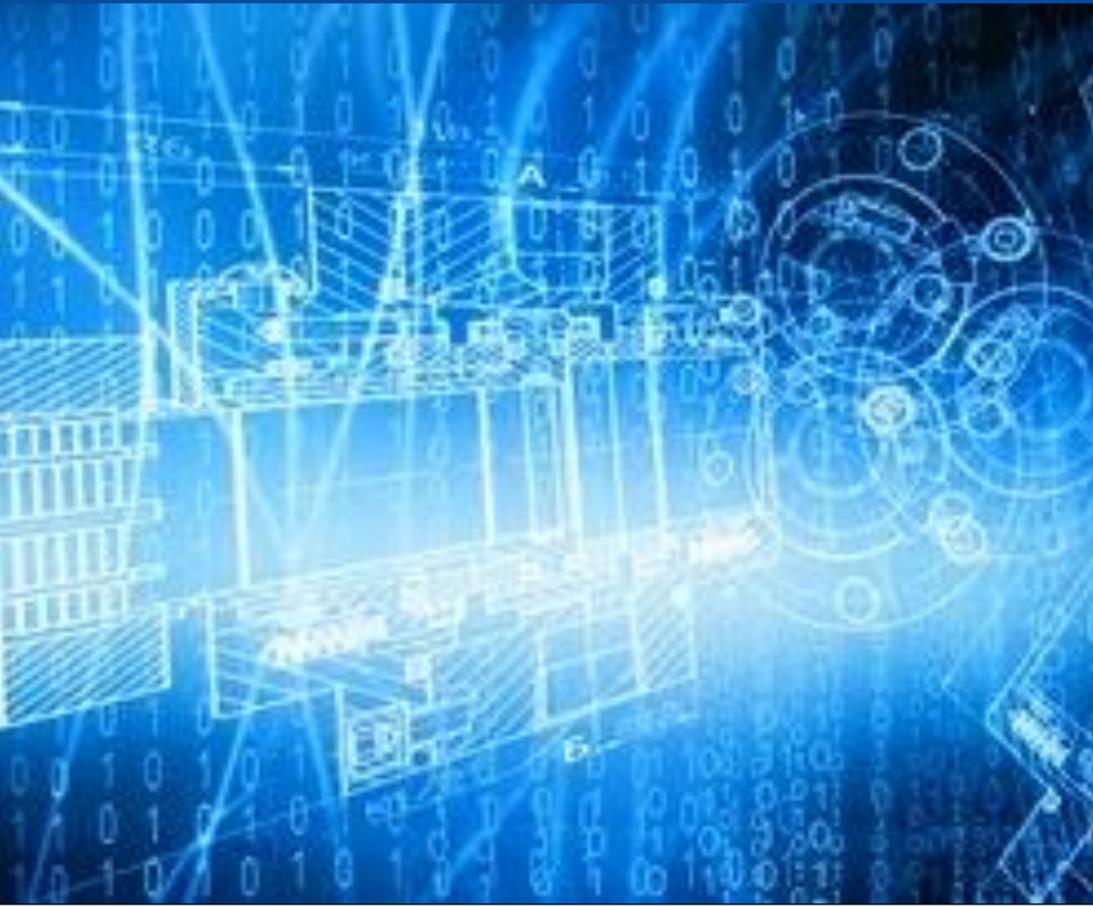
Section GG: GG0130C

Coding Scenario

CODING: GG0130C. Toileting hygiene would be coded 01, Dependent.

RATIONALE: The assistance of two helpers was needed to complete the activity of toileting hygiene.

Break



We will take a short break now. Please refer to the timer on your screen, for when we will promptly reconvene.

If you have a question, please enter it into the chat panel located on the bottom left corner of your screen.

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Follow Up Webinar for Providers



Section GG: Functional Abilities and Goals Part 2

*Anne Deutsch, RN,
PhD, CRRN*



*Tara McMullen,
PhD, MPH*

Section GG: GG0130 and GG0170

Unexpected Discharge Question

QUESTION:

If a patient is discharged unexpectedly, what is coded for Section GG0130 and GG0170: “-” (dash) or 99, etc.?

Section GG: GG0130 and GG0170

Unexpected Discharge Answer

ANSWER:

The self-care and mobility items (GG0130 and GG0170) do not need to be completed at discharge if the patient has an incomplete LTCH stay due to an unexpected discharge. Section GG items are not on the Unplanned Discharge Form or the Expired Form.

Section GG: GG0130 Goals Question

QUESTION:

For GG0130 items, when must the goals be established and entered?

Section GG: GG0130 Goals Answer

ANSWER:

Discharge goals can be established at the time of admission based upon the admission assessment, discussions with the patient and family, the clinician's professional judgment and the clinician's professional standards of practice. This would be completed during the three-day admission assessment period.

Section GG: GG0130 Goals Question

QUESTION:

Please provide some guidance regarding documentation needed to support the discharge goal. What if the goal will clearly not be attainable? Do we need to modify the form?

Section GG: GG0130 Goals Answer

ANSWER:

Discharge goals can be established as the patient's plan of care is developed. At least one functional status goal (Self-Care or Mobility) is reported on the Admission LTCH Care Data Set in order to meet the LTCH Quality Reporting Program requirements. We recognize that goals may change during the course of a patient's LTCH stay; however, the goal coded on the Admission form would not be modified after the admission assessment period.

Section GG: GG0130 Goals Question

QUESTION:

Are we required to create a care plan for Section GG? If we establish a discharge goal, do we need to list the interventions we plan to reach the discharge goal?

Section GG: GG0130 Goals Answer

ANSWER:

Goals should be established as part of the patient's care plan, and the clinician reports at least one goal for one of the items in Section GG0130 or GG0170. The goal provides documentation that a care plan was established. The list of interventions is not reported on the LTCH Care Data Set.

Section GG: GG0130 Goals Question

QUESTION:

Should we code one goal for GG0130 Self-Care and one goal for GG0170 Mobility sections or at least one goal for these two groups of items?

Section GG: GG0130 Goals Answer

ANSWER:

The clinician reports at least one goal for one of the items in GG0130 Self-Care *or* GG0170 Mobility.

Section GG: GG0170. Mobility (3-day assessment period)

GG0170. Mobility (3-day assessment period)

Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).

CODING:
Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

	1. Admission Performance ↓ Enter Code in Boxes ↓	2. Discharge Goal in Boxes ↓	
06. Independent - Patient completes the activity by him/herself with no assistance from a helper.	<input type="text"/>	<input type="text"/>	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back.
05. Setup or clean-up assistance - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.	<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	<input type="text"/>	<input type="text"/>	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.	<input type="text"/>	<input type="text"/>	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.	<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.	<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
If activity was not attempted, code reason:			G. 1. Does the patient walk? 0. No, and walking goal is not clinically indicated → Skip to GG0170Q1. Does the patient use a wheelchair/scooter? 1. No, and walking goal is clinically indicated → Code the patient's Discharge Goal(s) for items GG0170L, I, and K. For Admission Performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter? 2. Yes → Continue to GG0170L. Walk 10 feet
07. Patient refused	<input type="text"/>	<input type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.
09. Not applicable	<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.
88. Not attempted due to medical condition or safety concerns	<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	<input type="text"/>	<input type="text"/>	Q1. Does the patient use a wheelchair/scooter? 0. No → Skip to H0350. Bladder Continence 1. Yes → Continue to GG0170R. Wheel 50 feet with two turns
	<input type="text"/>	<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	<input type="text"/>	<input type="text"/>	RR1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
	<input type="text"/>	<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	<input type="text"/>	<input type="text"/>	SS1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Applies to Admission and Planned Discharge Assessments

Section GG: GG0170. Item Rationale

LTCH patients may have mobility limitations on admission. In addition, patients may be at risk of further functional decline during their LTCH stay.

Section GG: GG0170 (cont.)

CODING INSTRUCTIONS:

- Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.
- Code the patient's usual performance for each activity using the 6-point scale:
 - Code "06" for Independent.
 - Code "05" for Setup or clean-up assistance.
 - Code "04" for Supervision or touching assistance.
 - Code "03" for Partial/moderate assistance.
 - Code "02" for Substantial/maximal assistance.
 - Code "01" for Dependent.

Section GG: GG0170

	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back.
	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
	F. Toilet transfer: The ability to safely get on and off a toilet or commode.

Applies to Admission and Planned Discharge Assessments

Section GG: GG0170H1. Does the Patient Walk?

	<input type="checkbox"/>	<p>H1. Does the patient walk?</p> <p>0. No, and walking goal is not clinically indicated → Skip to GG0170Q1. Does the patient use a wheelchair/scooter?</p> <p>1. No, and walking goal is clinically indicated → Code the patient's Discharge Goal(s) for Items GG0170I, J, and K. For Admission Performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?</p> <p>2. Yes → Continue to GG0170L. Walk 10 feet</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.</p>	
<input type="checkbox"/> <input type="checkbox"/>	<p>J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.</p>	
<input type="checkbox"/> <input type="checkbox"/>	<p>K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.</p>	

Applies to Admission and Planned Discharge Assessments

Section GG: Two or More Helpers Question

QUESTION:

If a patient requires two helpers and participates in an activity to some extent, should the code used be “01, Dependent” or “02, Substantial/maximal assistance”?

Section GG: Two or More Helpers

Answer

ANSWER:

Code “01, Dependent” if the patients requires assistance from two or more helpers to complete the activity, even if the patient participates in completing part of the activity.

Section GG: Patient Refusal Question

QUESTION:

If a patient refuses to attempt an activity because he does not feel safe completing the activity, would the correct code be “07, Refused” or “88, Not attempted due to medical condition or safety concerns”?

Section GG: Patient Refusal Answer

ANSWER:

The clinician would make a judgement about whether there is a safety concern or not. If the clinician agrees with the patient's concern that there is a medical or safety concern, code "88, Not attempted due to medical condition or safety concerns."

Section GG: Use of Mechanical Lift Question

QUESTION:

How to you code transfers if 2 helpers are required for use of a mechanical lift and patient does some of effort?

Section GG: Use of Mechanical Lift

Answer

ANSWER:

When two helpers are required for the patient to complete the activity, code “01, Dependent”, regardless of whether the patient assists with any portion of the activity. If a mechanical lift is used, and the assistance of 2 or more helpers is needed, code “01, Dependent”.

Section GG: Setup or Clean Up Question

QUESTION:

What are some examples of setup or clean up assistance?

Section GG: Setup or Clean Up Answer

ANSWER:

Here are some examples:

1. Sit to Lying: The helper places the bedrail in the upright position and the patient uses the bedrail to move from a sitting position to a lying position.
2. Chair/Bed-to-Chair Transfer: The helper places the patient's wheelchair next to the patient's bed and moves the wheelchair footrests out of the way so that patient can transfer into the wheelchair safely without supervision, cueing or physical assistance.
3. Chair/Bed-to-Chair Transfer: The helper provides a slide board to the patient and the patient uses the slide board to transfer from his bed to his wheelchair. The helper does not provide any supervision, cueing or physical assistance.

Section GG: GG0170E

Coding Scenario

CHAIR/BED-TO-CHAIR TRANSFER:

Mr. L had a stroke and is not currently able to walk. He uses a wheelchair for mobility. When Mr. L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position, and locks the brakes so that Mr. L can transfer into the wheelchair safely. Mr. L had been observed several other times to determine any safety concerns, and it was documented that he transfers safely without the need for supervision. Mr. L transfers into the wheelchair by himself (no helper) after the certified nursing assistant leaves the room.

How would you code GG0170E?

Polling Question (6)

How would you code GG0170E?

- 1) 06. Independent
- 2) 05. Setup or clean-up assistance
- 3) 04. Supervision or touching assistance
- 4) 03. Partial/moderate assistance

Section GG: GG0170E

Coding Scenario

CODING: GG0170E. Chair/bed-to-chair transfer would be coded 05, Setup or clean-up assistance

RATIONALE: Mr. L is not able to walk, so he transfers from his bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Mr. L transfers safely and does not need supervision or physical assistance during the transfer.

Section GG: GG0170I

Coding Scenario

WALK 10 FEET: Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once the nurse has donned her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker with only touching assistance provided toward the last half of her 10-foot walk.

How would you code GG0170I?

Polling Question (7)

How would you code GG0170I?

- 1) 06. Independent
- 2) 04. Supervision or touching assistance
- 3) 03. Partial/moderate assistance
- 4) 01. Dependent

Section GG: GG0170I

Coding Scenario

CODING: GG0170I. Walk 10 feet would be coded 04, Supervision or touching assistance.

RATIONALE: The helper provided touching assistance for the patient to complete the activity of walk 10 feet. Assistance getting from a sitting to standing position is not coded as part of the Walk 10 Feet item.

Section GG: GG0170Q1. Does the Patient Use a Wheelchair/Scooter?

	<input type="checkbox"/>	Q1. Does the patient use a wheelchair/scooter? 0. No → Skip to H0350. Bladder Continence 1. Yes → Continue to GG0170R. Wheel 50 feet with two turns
<input type="checkbox"/> <input type="checkbox"/>		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	<input type="checkbox"/>	RR1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
<input type="checkbox"/> <input type="checkbox"/>		S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	<input type="checkbox"/>	SS1. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Applies to Admission and Planned Discharge Assessments

Section GG: Wheelchair Use Question

QUESTION:

For GG0170Q1, if a patient is paraplegic and remains in bed during the three day assessment period, should the item be coded as “0. No” even though he will use a wheelchair by discharge?

Section GG: Wheelchair Use Answer

ANSWER:

If the patient does not use a wheelchair during the admission assessment period, code “0, No” for the item GG0170Q1. *Does the Patient Use a Wheelchair/Scooter?* at the time of admission. If the patient uses a wheelchair or scooter at the time of discharge, code “1, Yes” for this item at the time of discharge.

Section GG: Summary

- Section GG assesses the need for assistance with self-care and mobility activities.
- Knowledge of the patient's functional status prior to the current event could inform treatment goals.

Questions?

Please enter your questions into the chat panel located in the lower left corner of your screen.

Questions will be answered at the conclusion of the training



Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Follow Up Webinar for Providers



Section M: Skin Conditions

*Teresa M. Mota, BSN, RN,
CALA, WCC*

Section M: Objectives

- Review Intent of Section M.
- Explain and clarify different aspects of pressure ulcer coding based on select questions received during and after the November 2015 LTCH QRP Provider Training.
- Practice coding scenario(s) to correctly and accurately code Section M.

Section M: Intent

- Document the presence, appearance, and change of pressure ulcers.
 - Pressure ulcers are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Section M: Other Wounds/Ulcers

- Arterial, venous, diabetic ulcers, and ulcers at end-of-life (a.k.a. Kennedy Ulcers) are **not** reported in Section M on the LTCH CARE Data Set.
- These are not reported in Section M because the etiology of these ulcers is different from the etiology of a typical pressure ulcer as defined.

Section M: Staging Definitions

- Staging definitions are adapted from 2007 National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer guidelines.
- There are some slight differences between the 2007 and current NPUAP guidelines.
- LTCHs are to follow the guidelines set forth in the LTCH CARE Data Set Manual to complete the LTCH CARE Data Set; but can use current NPUAP guidelines in clinical documentation.

Section M: Present on Admission

- The phrase, “present on admission” means as close to the actual time of admission as possible.
- Therefore, the initial skin assessment conducted as close to the time of admission as possible is what should be used to complete the pressure ulcer staging items on Admission.
- If there are discrepancies related to pressure ulcer coding on admission, these discrepancies should be rectified prior to entering information on the LTCH CARE Data Set.

Section M: M0300B2-G2

Discharge Assessment: Present on Admission

CODING INSTRUCTIONS:

- Completed only if A0250 = 10 Planned discharge or 11 Unplanned discharge.
- **Enter the number** of pressure ulcers that were present on admission (see instructions starting on M-4 under **Steps for Completing M0300A-G, Step 3: Determine “Present on Admission”**).
- **Enter 0**, if no pressure ulcers were noted at the time of admission.

Section M: M0300 Coding Scenario

A patient arrives at the LTCH on Day 1, a clinical skin assessment is completed on admission, with no pressure ulcers identified. On Day 3, while bathing the patient, a Stage 2 pressure ulcer was noted on the patient's sacrum and documented in the patient's medical record. The patient was discharged with a Stage 2 pressure ulcer 8 days later.

How would you code M0300 on the Admission and Discharge Assessments?

Polling Question (8)

How would you code M0300B1, Number of Stage 2 pressure ulcers on the Admission Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Polling Question (9)

How would you code M0300B1, Number of Stage 2 pressure ulcers on the Discharge Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Polling Question (10)

How would you code M0300B2, Number of these Stage 2 pressure ulcers present on the Discharge Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 3
- 4) Code as 0

Section M: M0300 Coding Scenario

ANSWERS:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	Code as 0	Code as 1
M0300B2, Number of these Stage 2 pressure ulcers present on admission		Code as 0

Section M: M0300 Coding Scenario

CODING:

- **M0300B1 is coded as 0** on the Admission Assessment.
- **M0300B1 is coded as 1** on the Discharge Assessment.
- **M0300B2 is coded as 0** on the Discharge Assessment.

RATIONALE: Even though the patient had a Stage 2 pressure ulcer identified on Day 3 of the LTCH stay, only those pressure ulcers that were present as close to the time of admission are coded on the Admission Assessment.

Section M: M0300 Coding Scenario

A patient enters the LTCH with a Stage 2 pressure ulcer. On Day 2 of the patient's stay, the wound is reassessed as a Stage 3 pressure ulcer. The wound does not heal by the time of discharge, 2 weeks later.

How would you code M0300 on the Admission and Discharge Assessments?

Polling Question (11)

How would you code M0300B1, Number of Stage 2 pressure ulcers on the Admission Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 3
- 4) Code as 0

Polling Question (12)

How would you code M0300B1, Number of Stage 2 pressure ulcers on the Discharge Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Polling Question (13)

How would you code M0300B2, Number of these Stage 2 pressure ulcers present on the Discharge Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Polling Question (14)

How would you code M0300C1, Number of Stage 3 pressure ulcers present on the Discharge Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 3
- 4) Code as 0

Polling Question (15)

How would you code M0300C2, Number of Stage 3 pressure ulcers present on the Discharge Assessment?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 3
- 4) Code as 0

Section M: M0300 Coding Scenario

ANSWERS:

Item	Admission Assessment	Discharge Assessment
M0300B1, Number of Stage 2 pressure ulcers	Code as 1	Code as 0
M0300B2, Number of these Stage 2 pressure ulcers present on admission		Code as 0
M0300C1, Number of Stage 3 pressure ulcers		Code as 1
M0300C2, Number of these Stage 3 pressure ulcers present on admission		Code as 0

Section M: M0300 Coding Scenario

CODING:

- **M0300B1 is coded as 1** on the Admission Assessment.
- **M0300B1 and M0300B2 are coded as 0** on the Discharge Assessment.
- **M0300C1 is coded as 1** on the Discharge Assessment.
- **M0300C2 is coded as 0** on the Discharge Assessment.

RATIONALE: The Stage 2 pressure ulcer was present on admission, and even though the wound developed a deeper level of tissue damage during the 3-day assessment period, the initial stage of the pressure ulcer is captured because it reflects the patient's skin assessment at the time of admission.

Section M: M0800

M0800. Worsening in Pressure Ulcer Status Since Admission	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on admission. If no current pressure ulcer at a given stage, enter 0	
Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4
Enter Number <input type="text"/>	D. Unstageable - Non-removable dressing
Enter Number <input type="text"/>	E. Unstageable - Slough and/or eschar
Enter Number <input type="text"/>	F. Unstageable - Deep tissue injury

Applies to the Admission, Planned Discharge, and Unplanned Discharge Assessment.

M0800: Item Rationale

- This item documents whether skin status, overall, has worsened since the Admission Assessment. To track increasing skin damage, this item documents the number of new pressure ulcers (that is, the ulcer was not present at admission) and whether any pressure ulcers have increased in numerical stage (that is, were documented at a lesser stage at admission). Such tracking of pressure ulcers is consistent with good clinical care.

Section M: M0800 Coding Scenario

A patient is admitted to the LTCH with a Stage 2 pressure ulcer. The ulcer develops a deeper level of tissue damage, exposing muscle, and is staged as a Stage 3 pressure ulcer during the stay. The wound bed subsequently covers with slough, and is identified as an unstageable pressure ulcer. The patient discussed his discharge plan with the LTCH and decided to go home with home health services and receive wound treatment at a local wound care clinic. On discharge, the patient record notes that wound debridement was not performed on the Stage 3 pressure ulcer at the LTCH and would be performed at the wound clinic.

How would you code M0800 on the Admission and Discharge Assessments?

Section M: M0800 Coding Scenario

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 1	Code as 0
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Code as 0
M0300F1 , Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar		Code as 1
M0300F2 , Number of these unstageable pressure ulcers that were present upon admission		Code as 0

Polling Question (16)

How would you code M0800A, Worsening in Pressure Ulcer Status Since Admission – Stage 2?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 3
- 4) Code as 0

Polling Question (17)

How would you code M0800B, Worsening in Pressure Ulcer Status Since Admission – Stage 3?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 3
- 4) Code as 0

Polling Question (18)

How would you code M0800C, Worsening in Pressure Ulcer Status Since Admission – Stage 4?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Polling Question (19)

How would you code M0800D, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Polling Question (20)

How would you code M0800E, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Polling Question (21)

How would you code M0800F, Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury?

- 1) Code as 1
- 2) Code as 2
- 3) Code as 0
- 4) Skip

Section M: M0800 Coding Scenario

ANSWERS:

Item	Admission Assessment	Discharge Assessment
M0300B1 , Number of Stage 2 pressure ulcers	Code as 1	Code as 0
M0300B2 , Number of these Stage 2 pressure ulcers that were present upon admission		Code as 0
M0300F1 , Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar		Code as 1
M0300F2 , Number of these unstageable pressure ulcers that were present upon admission		Code as 0
M0800A , Worsening in Pressure Ulcer Status Since Admission – Stage 2		Code as 0
M0800B , Worsening in Pressure Ulcer Status Since Admission – Stage 3		Code as 0
M0800C , Worsening in Pressure Ulcer Status Since Admission – Stage 4		Code as 0
M0800D , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Non-removable dressing		Code as 0
M0800E , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Slough and/or Eschar		Code as 1
M0800F , Worsening in Pressure Ulcer Status Since Admission – Unstageable - Deep tissue injury		Code as 0

Section M: M0800 Coding Scenario

CODING:

- **M0300B1 is coded as 1** on the Admission Assessment.
- **M0300B1 and M0300B2 are coded as 0** on the Discharge Assessment.
- **M0300F1 is coded as 1** on the Discharge Assessment.
- **M0300F2 is coded as 0** on the Discharge Assessment.
- **M0800E is coded as 1** on the Discharge Assessment.

RATIONALE: The Stage 2 pressure ulcer that was present on admission further evolved to a Stage 3 pressure ulcer during the LTCH stay and covered over with slough prior to discharge. The ulcer was not debrided prior to the patient's discharge.

Section M: Summary

- Section M documents the presence, appearance, and change of pressure ulcers.
- No other types of ulcers/wounds are captured in Section M.
- LTCH CARE Data Set v 3.00 uses staging definitions adapted from the NPUAP 2007 pressure ulcer guidelines.
- Present on admission refers to status of the ulcer as documented on the skin assessment closest to the time of admission and is collected at both Admission and Discharge.

Section M: Summary (cont.)

- Worsening in pressure ulcer status refers to a change in overall skin status since admission where either a new pressure ulcer is identified since admission, or the status of a pressure ulcer has changed (that is, has worsened) since admission.
- Reading the LTCH CARE Data Set Manual including the Intent, Rationale, Coding Instructions and working through scenarios is the best way to fully understand coding in this, or any section.

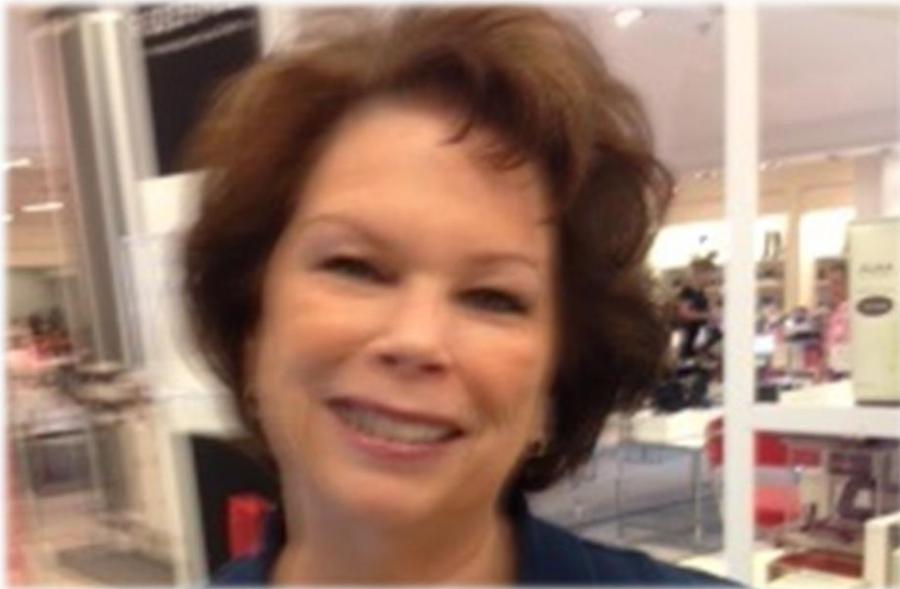
Questions?

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Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Follow Up Webinar for Providers



*Section O: Special
Treatments, Procedures,
and Programs*

*Terry Kahlert Eng, PhD,
RN*

Section O: Objectives

- Focus on O0250, Influenza Vaccine items
- Review influenza season and influenza vaccination season (IVS) definitions
- Discuss coding instructions for completing these items in and outside of IVS
- Practice coding scenario(s) to correctly and accurately code Section O

Section O: O0250. Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.	
Enter Code <input type="checkbox"/>	<p>A. Did the patient receive the influenza vaccine in this facility for this year's influenza <u>vaccination</u> season?</p> <p>0. No → Skip to O0250C. If influenza vaccine not received, state reason</p> <p>1. Yes → Continue to O0250B. Date influenza vaccine received</p>
	<p>B. Date influenza vaccine received → Complete date and skip to Z0400. Signature of Persons Completing the Assessment</p> <p><input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Month Day Year</p>
Enter Code <input type="checkbox"/>	<p>C. If influenza vaccine not received, state reason:</p> <p>1. Patient not in this facility during this year's influenza vaccination season</p> <p>2. Received outside of this facility</p> <p>3. Not eligible - medical contraindication</p> <p>4. Offered and declined</p> <p>5. Not offered</p> <p>6. Inability to obtain influenza vaccine due to a declared shortage</p> <p>9. None of the above</p>

Applies to the LTCH CARE Data Set V 3.00 Admission, Planned Discharge, Unplanned Discharge, and Expired Assessment

Section O: 00250

- **Influenza Season** is July 1 – June 30
- **Influenza Vaccination Season (IVS)** is October 1- March 31
 - Current Influenza Vaccination Season is October 1, 2015 (or when the influenza vaccine became available) through March 31, 2016
- **LTCHs are encouraged to vaccinate patients outside the IVS if patient has not been vaccinated**
 - Vaccine is usually available in September and generally does not expire until late Spring
 - Will not count toward the quality measure, but benefits the patient

Section O: 00250. Quality Measure

Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680)

- Includes all patients in the LTCH 1 or more days during the IVS:
 - Admitted and/or discharged during current influenza vaccination season; or
 - Admitted before and discharged after current influenza vaccination season
- Based on a LTCH stay (day of admission to day of discharge/expired)
 - To be included in QM, patients must have a discharge/expired assessment
 - Influenza vaccine status based on admission and/or discharge/expired assessments

Section O: 00250A

CODING INSTRUCTIONS:

For patients with assessment dates within the influenza vaccination season.

Did the **patient receive the influenza vaccine in this facility** for this year's influenza vaccination season?

- **Code 0, No**, if the patient did not receive the influenza vaccine in this facility (LTCH) during this year's influenza vaccination season.
 - Continue to 00250C. If influenza vaccine was not received, state reason.
- **Code 1, Yes**, if the patient received the influenza vaccine in this facility (LTCH) during this year's influenza vaccination season.
 - Continue to 00250B. Date Vaccine Received.

Section O: 00250C

CODING INSTRUCTIONS IF 00250A IS 0, NO (*influenza vaccine not received*):

- **Code 1, Patient not in this facility during this year's influenza vaccination season**, if the patient was not in the facility during this year's influenza vaccination season.
- **Code 2, Received outside of this facility**, if the patient received an influenza vaccination in another setting (e.g., physician office, health fair, grocery store/pharmacy, hospital, fire station, etc.) during this year's influenza vaccination season.
- **Code 3, Not eligible—medical contraindication**, if the influenza vaccination was not received because of medical contraindications, including, but not limited to: allergic reaction to eggs or other vaccine component(s), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination. However, the patient should be vaccinated if contraindications end.

Section O: 00250C (cont.)

CODING INSTRUCTIONS IF 00250A IS 0, NO (*influenza vaccine not received*):

- **Code 4, Offered and declined**, if the patient or responsible party or legal guardian has been informed of what is being offered and chooses not to accept the influenza vaccine.
- **Code 5, Not offered**, if the patient or responsible party or legal guardian was not offered the influenza vaccine.
- **Code 6, Inability to obtain vaccine due to a declared shortage**, if the influenza vaccine was unavailable at the facility due to declared vaccine shortage. However, the patient should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year.
- **Code 9, None of the above**, if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

Section O: 00250 Coding Scenario

Ms. B received the influenza vaccine at an LTCH on January 15. She was discharged to a hospital and returned a week later to the same LTCH.

How would you code 00250 for first and second stay?

Polling Question (22)

How would you code O0250A?

- 1) Code 1, Yes
- 2) Code 0, No

Polling Question (23)

How would you code O0250B?

- 1) 1-30-16
- 2) 1-15-16
- 3) 1-10-16
- 4) Skip

Polling Question (24)

How would you code O0250C?

- 1) 2. Received outside the facility
- 2) 3. Not eligible
- 3) 9. None of the above
- 4) Skip

Section O: 00250 Coding Scenario

ANSWERS:

- 00250A would be coded **1, Yes**.
- 00250B would be coded **01-15-2016**.
- 00250C would be **skipped**.

RATIONALE: On Ms. B's discharge assessment for the first stay, 00250A should be coded 1, Yes, because she did receive the influenza vaccine in the LTCH during the influenza vaccination season. Enter the date she received the vaccine, 01-15-2016, in 00250B.

The same answers should be provided for 00250A and 00250B for the admission assessment and discharge assessment associated with Ms. B's second stay at the LTCH.

Section O: 00250 Coding Scenario

Mr. D was admitted to an LTCH on October 5. The shipment of the influenza vaccine to the LTCH was delayed, and not available before Mr. D was discharged on October 11.

How would you code 00250?

Polling Question (25)

How would you code O0250A?

- 1) Code 1, Yes
- 2) Code 0, No

Polling Question (26)

How would you code O0250B?

- 1) 10-05-15
- 2) 10-11-15
- 3) 10-12-15
- 4) Skip

Polling Question (27)

How would you code O0250C?

- 1) 1. Patient not in this facility during this year's influenza vaccination season
- 2) 6. Inability to obtain influenza vaccine due to declared shortage
- 3) 9. None of the above
- 4) Skip

Section O: 00250 Coding Scenario

ANSWERS:

- 00250A would be coded **0, No.**
- 00250B would be **skipped.**
- 00250C. If influenza vaccine not received, state reason. Code **9, None of the above.**

RATIONALE: During Mr. D's stay the vaccine was not available. Only use the above coding sequence due to a delay in the shipment of the vaccination, not in the case of a declared shortage of the influenza vaccine. In the case of a declared shortage, code 6, Inability to obtain influenza vaccine due to a declared shortage.

Section O: Summary

- **Influenza Season** is July 1 – June 30
- **Influenza Vaccination Season (IVS)** is October 1- March 31
 - Current Influenza Vaccination Season is October 1, 2015 (or when the influenza vaccine became available) through March 31, 2016
- Code O00250A as follows if the **patient received the influenza vaccine in this facility** for this year's influenza vaccination season:
 - **Code 0, No**, if the patient did not receive the influenza vaccine in this facility (LTCH) during this year's influenza vaccination season.
 - Continue to O0250C. If influenza vaccine was not received, state reason.
 - **Code 1, Yes**, if the patient received the influenza vaccine in this facility (LTCH) during this year's influenza vaccination season.

Questions?

Please be sure to enter your questions into the chat panel.

Questions will be answered at the conclusion of the training.



Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Follow Up Webinar for Providers



Available Resources

*Terry Kahlert Eng, PhD,
RN*

LTCH QRP Resources

- LTCH QRP Website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html>
- General inquiries regarding quality measures: LTCHQualityQuestions@cms.hhs.gov
- Inquiries regarding technical issues regarding the LTCH CARE Data Set: LTCHTechIssues@cms.hhs.gov

LTCH QRP Resources

- Inquiries regarding access to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, LTCH Assessment Submission Entry and Reporting (LASER), and Certification And Survey Provider Enhanced Reports (CASPER): help@qtso.com, 1-800-339-9313
- Inquiries regarding the CDC's National Healthcare Safety Network (NHSN): nhsn@cdc.gov

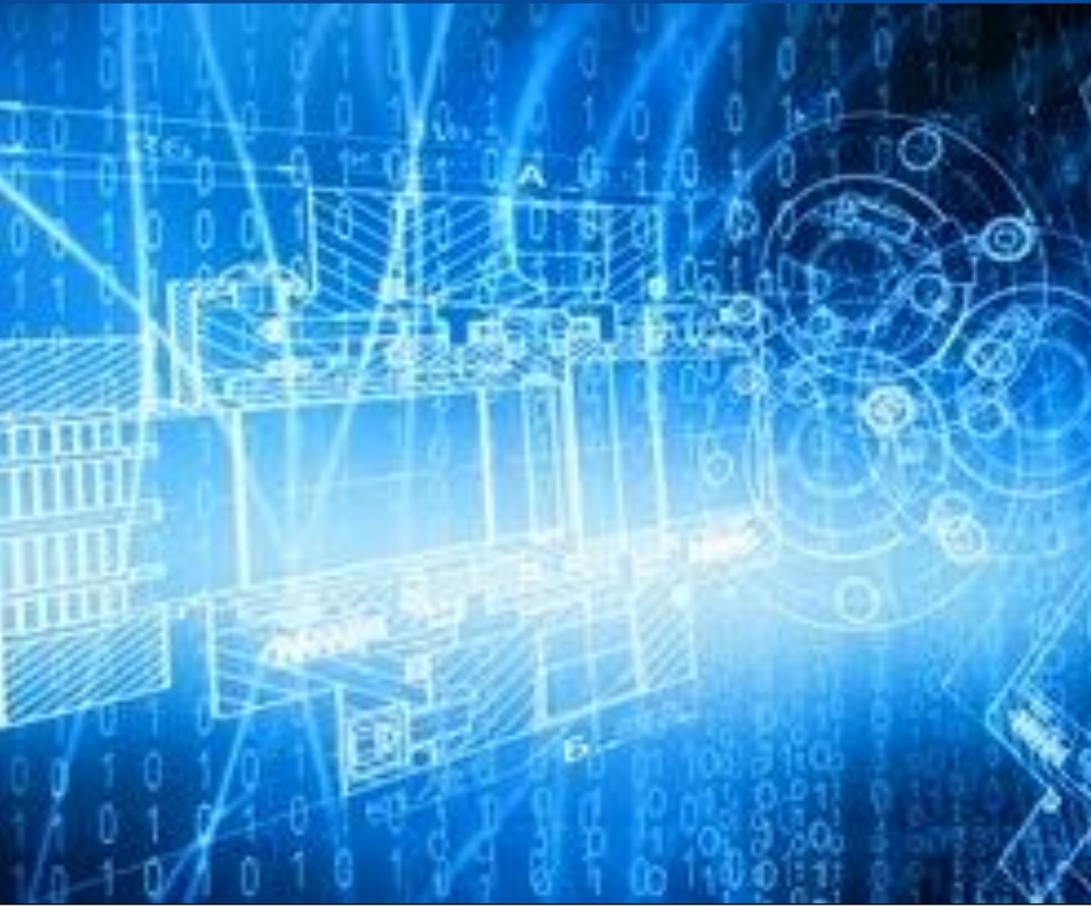
Questions?

Please be sure to enter your questions into the chat panel.

Questions will be answered right after the break!



Break



We will take a short break now. Please refer to the timer on your screen, for when we will promptly reconvene.

If you have a question, please enter it into the chat panel located on the bottom left corner of your screen.

Questions & Answers

Please enter your questions into the chat panel.

The chat panel is located on the bottom left corner of your screen.



Wrap-Up



Thank you for attending!

Enjoy the rest of your day!