SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the patient received during the stay, including spontaneous breathing trial (SBT) for ventilator liberation, intravenous (IV) vasoactive medication, and influenza vaccination status.

O0100. Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs Check all the treatments at admission. For dialysis, check if it is part of the patient's treatment plan.	
↓ **Check all that apply**	
Respiratory Treatments	
☐	**G. Non-invasive Ventilator (BiPAP, CPAP)**
Other Treatments	
☐ ☐	**H. IV Medications** (if checked, please specify below) **H2a. Vasoactive medications** (i.e., continuous infusions of vasopressors or inotropes)
☐	**J. Dialysis**
☐	**N. Total Parenteral Nutrition**
None of the Above	
☐	**Z. None of the above**

Item Rationale

- The treatments, procedures, and programs listed in O0100. Special Treatments, Procedures, and Programs can affect the patient's ability to liberate from invasive mechanical ventilation and/or perform self-care and mobility activities.

Steps for Assessment

1. Review the patient's medical record to determine if the patient received or performed any of the treatments, procedures, or programs during the 3-day assessment period. For dialysis, check if it is part of the patient's treatment plan.

Coding Instructions

Complete only if A0250 = 01 Admission.

Check all that apply.

- Check all treatments, procedures, and programs received or performed by the patient during the 3-day assessment period. For dialysis, check if it is part of the patient's treatment plan. If no items apply during the 3-day assessment period, check Z, None of the above.

Respiratory Treatments

- Check O0100G, Non-invasive Ventilator (BiPAP, CPAP), if the patient has any type of continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP) respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask enables the individual to support his or her own respiration. The BiPAP/CPAP provides enough pressure when the individual inhales to keep his or her airway open, which are unlike ventilators that "breathe" for the individual. This item is coded if the patient puts on or removes his or her own BiPAP/CPAP mask or if the long-term care hospital (LTCH) staff applies it for the patient.

Other Treatments

- Check O0100H, IV Medications, and O0100H2a, Vasoactive Medications (i.e., continuous infusions of vasopressors or inotropes), if the patient received any intravenous vasoactive medications such as vasopressors and inotropes. Examples of vasopressors and inotropes include but are not limited to dobutamine, norepinephrine, milrinone, and dopamine.
- Check O0100J, Dialysis, if the patient undergoes peritoneal or renal dialysis as part of the treatment plan. Record treatments of hemofiltration (intermittent or continuous), Slow Continuous Ultrafiltration (SCUF), hemodialysis, and Continuous Ambulatory Peritoneal Dialysis (CAPD). This item may be checked if the patient performs his or her own dialysis.
- Check O0100N, Total Parenteral Nutrition (TPN), if the patient receives parenteral/IV feeding.

None of the Above

- Check O0100Z, None of the above, if none of the above treatments were received or performed by the patient.

Coding Tips

- Code treatments, programs, and procedures that the patient performed independently or after setup by LTCH staff. Examples may include CAPD and application or removal of BiPAP/CPAP mask.

Examples

1. **Non-invasive Ventilator (BiPAP, CPAP):** Mrs. D is a 68-year-old female with a history of hypertension, morbid obesity, diabetes mellitus (DM), and obstructive sleep apnea (OSA). She was brought to the emergency department unresponsive following 2 days of flu-like symptoms. Her daughter stated that right before she passed out, she had slurred speech and was unsteady on her feet. Mrs. D was admitted to the intensive care unit (ICU) with high blood pressure, renal failure, and a blood sugar level of 352. After Mrs. D spent 3 days in the ICU, she was transferred to the LTCH.

Prior to her acute care admission, Mrs. D has been using her prescribed CPAP device with a mask every night for the past year. While on the medical floor of the acute care hospital, she managed her home CPAP unit. She can turn on her device and place her mask firmly on her face. Mrs. D does require some assistance with filling her humidifier with sterile water and cleaning her mask in the morning.

Coding: O0100G, Non-invasive Ventilator (BiPAP, CPAP), would be checked.

Rationale: Mrs. D has been prescribed a CPAP device and wears the CPAP mask whenever sleeping to manage her sleep apnea.

2. **Non-invasive Ventilator (BiPAP, CPAP):** Mr. G is a 62-year-old former smoker who is diagnosed with chronic obstructive pulmonary disease (COPD). He is dependent on 3 liters per minute of oxygen at home. Mr. G suffers from chronic carbon dioxide (CO2) retention. He was recently prescribed a BiPAP ventilator at night to assist him with eliminating CO2. Mr. G used the BiPAP device until he started to feel congested and had increased sputum production. The symptoms persisted until he was taken to the emergency department. Mr. G was admitted to the ICU requiring intubation and mechanical ventilation for 96 hours. Mr. G recovered and is admitted to the LTCH to optimize his BiPAP settings and receive therapy services to improve his activities of daily living (ADLs). Although Mr. G can use his BiPAP independently, he requires some guidance and coaching to use his BiPAP device properly and consistently.

   Coding: O0100G, Non-invasive Ventilator (BiPAP, CPAP), would be checked.

   Rationale: Mr. G. has been prescribed BiPAP and wears the mask nightly to manage his COPD.

3. **Vasoactive Medications:** Mrs. J was admitted to the LTCH recovering from septic shock and is on invasive mechanical ventilation. Her blood pressure was stable upon admission to the LTCH. On the second day of her hospitalization, Mrs. J's blood pressure decreased to 80/50 and norepinephrine was administered via a central venous catheter to treat her hypotension.

   Coding: O0100H, IV Medications, and O0100H2a, Vasoactive medications, would be checked.

   Rationale: Mrs. J. received norepinephrine, which is a vasoactive medication that was administered through a central venous catheter for hypotension.

4. **Vasoactive Medications:** Mr. L was admitted to the LTCH from an acute care hospital after an acute myocardial infarction. During that admission, it was discovered that he has severe mitral valve regurgitation and was symptomatic for advanced stage heart failure. He is currently receiving intravenous dobutamine via a central venous catheter to enhance his heart's contractility.

   Coding: O0100H, IV Medications, and O0100H2a, Vasoactive medications, would be checked.

   Rationale: Mr. L received intravenous dobutamine, which is a vasoactive medication used for the treatment of heart failure.

5. **Dialysis:** Ms. T has chronic renal failure and receives hemodialysis every 3 days.

   Coding: O0100J, Dialysis, would be checked.

   Rationale: Ms. T's treatment plan includes dialysis.

6. **Dialysis:** Mrs. L. developed acute renal failure related to excessive use of non-steroidal anti-inflammatory drugs for her arthritis. She receives hemodialysis three times per week.

   Coding: O0100J, Dialysis, would be checked.

   Rationale: Mrs. L's treatment plan includes dialysis.

7. **Total Parenteral Nutrition:** Mrs. C has been unable to eat or ingest adequate nutrients since her bowel surgery. Mrs. C receives total parenteral nutrition (TPN) using a peripherally inserted central catheter (PICC line) that infuses her nutrients, 24 hours per day.

   Coding: O0100N, Total Parenteral Nutrition, would be checked.

   Rationale: Mrs. C's treatment plan includes TPN.

8. **Total Parenteral Nutrition:** Mr. Z. was involved in a severe motor vehicle accident that resulted in multiple fractures and internal injuries including his jaw and stomach, leaving him unable to eat. Mr. Z receives TPN via a central venous catheter that infuses his nutrients 24 hours per day.

   Coding: O0100N, Total Parenteral Nutrition, would be checked.

   Rationale: Mr. Z's treatment plan includes TPN.

9. **None of the above:** Mr. D is being treated for a hemorrhagic stroke. He does not require mechanical ventilation, IV vasoactive medications, dialysis, or TPN.

   Coding: O0100Z, None of the above, would be checked.

   Rationale: Mr. D does not require any of the special treatments, procedures, or programs as described above.

O0150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar or Continuous Positive Airway Pressure (CPAP) Breathing Trial) by Day 2 of LTCH Stay

O0150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar or Continuous Positive Airway Pressure (CPAP) Breathing Trial) **by Day 2 of the LTCH Stay**	
Enter Code ☐	**A. Invasive Mechanical Ventilation Support upon Admission to the LTCH** 0. **No, not on invasive mechanical ventilation support** → *Skip to O0250, Influenza Vaccine* 1. **Yes, weaning** → *Continue to O0150B, Assessed for readiness for SBT by day 2 of the LTCH stay* 2. **Yes, non-weaning** → *Skip to O0250, Influenza Vaccine*
Enter Code ☐	**B. Assessed for readiness for SBT by day 2 of the LTCH stay** (Note: Day 2 = Date of Admission to the LTCH (Day 1) + 1 calendar day) 0. **No** → *Skip to O0250, Influenza Vaccine* 1. **Yes** → *Continue to O0150C, Deemed medically ready for SBT by day 2 of the LTCH stay*
Enter Code ☐	**C. Deemed medically ready for SBT by day 2 of the LTCH stay** 0. **No** → *Continue to O0150D, Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?* 1. **Yes** → *Continue to O0150E, SBT performed by day 2 of the LTCH stay*
Enter Code ☐	**D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?** 0. **No** → *Skip to O0250, Influenza Vaccine* 1. **Yes** → *Skip to O0250, Influenza Vaccine*
Enter Code ☐	**E. SBT performed by day 2 of the LTCH stay** 0. **No** 1. **Yes**

Item Rationale

- These data elements document the use of invasive mechanical ventilation support upon admission to the LTCH and the implementation of an SBT by day 2 of the LTCH stay.
- These data elements document the facility's implementation of evidence-based weaning guidelines that occurred as early as is beneficial to the patient during the LTCH patient stay when the patient is assessed as a candidate for weaning upon admission.

Coding Instructions

Complete only if A0250 = 01 Admission.

Complete by day 2 of the LTCH stay (day of admission to the LTCH plus one calendar day).

O0150A. Invasive Mechanical Ventilation Support upon Admission to the LTCH

- Code 0, No, not on invasive mechanical ventilation support, if the patient was **not** on invasive mechanical ventilation support upon admission to the LTCH. If coded No, end data collection for O0150. Skip to O0250, Influenza Vaccine.
- Code 1, Yes, weaning, if the patient has any type of electrical or pneumatic closed-system mechanical ventilation device that delivers oxygen to a patient who is unable to support his or her own respiration and for whom weaning attempts **are** expected or anticipated at the time of admission. Patients receiving closed-system ventilation include

those patients receiving ventilation via a tracheostomy and those patients with an endotracheal tube (e.g., nasally or orally intubated). Documentation in support of this item should be recorded and dated by day 2 of the LTCH stay, where day 1 is the day of admission. Continue to O0150B. Assessed for readiness for SBT by day 2 of the LTCH stay.

- Code 2, Yes, non-weaning, if the patient has any type of electrical or pneumatic closed-system mechanical ventilator support device that delivers oxygen to a patient who is unable to support his or her own respiration and for whom weaning attempts are **not** expected or anticipated at the time of admission (e.g., patients who are chronically ventilated in the community or at a facility, or who have progressive neuromuscular disease, such as amyotrophic lateral sclerosis, or irreversible neurological injury or disease or dysfunction, such as high C-2 spinal cord injury). Patients receiving closed-system ventilation include those patients receiving ventilation via a tracheostomy and those patients with an endotracheal tube (e.g., nasally or orally intubated). Documentation in support of this item should be recorded and dated by day 2 of the LTCH stay, where day 1 is the day of admission. If coded 2, Yes, non-weaning, end data collection for O0150. Skip to O0250, Influenza Vaccine.

Complete O0150B-O0150E only if O0150A = 1, Yes weaning.

O0150B. Assessed for readiness for SBT by day 2 of the LTCH stay

- Code 0, No, if the patient was **not** assessed for readiness for SBT by day 2 of the LTCH stay. If coded No, end data collection for O0150. Skip to O0250, Influenza Vaccine.
- Code 1, Yes, if the patient was assessed for readiness for SBT by day 2 of the LTCH stay. If coded Yes, continue to item O0150C, Deemed medically ready for SBT by day 2 of the LTCH stay.

O01510C. Deemed medically ready for SBT by day 2 of the LTCH stay

- Code 0, No, if the patient was **not** deemed medically ready for SBT by day 2 of the LTCH stay. If coded No, continue to item O0150D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?
- Code 1, Yes, if the patient was deemed medically ready for SBT by day 2 of the LTCH stay. If coded Yes, continue to item O0150E. SBT performed by day 2 of the LTCH stay.

O0150D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?

- Code 0, No, if there is no documentation of reason(s) that the patient was deemed medically unready for SBT by day 2 of the LTCH stay. Skip to O0250, Influenza Vaccine.

- Code 1, Yes, if there is documentation that the patient was deemed medically unready for SBT by day 2 of the LTCH stay. Skip to O0250, Influenza Vaccine.

O0150E. SBT performed by day 2 of the LTCH stay

- Code 0, No, if an SBT was not performed by day 2 of the LTCH stay.
- Code 1, Yes, if an SBT was performed by day 2 of the LTCH stay.

Coding Tips

- Day 1 of the LTCH stay is the day of admission to the LTCH.
- Day 2 of the LTCH stay is defined as the second day of the patient's LTCH stay. In other words, it is the day of admission to the LTCH plus one calendar day.
- If item O0150A is marked either "No" or "Yes, non-weaning" then completion of items O0150B through O0150E is not required for the patient. If item O0150A is marked "Yes, weaning," then proceed to item O0150B.
- If item O0150B is marked "No" and items O0150C through O0150E are not required for the patient. Skip to O0250, Influenza Vaccine. If item O0150B is marked "Yes," then proceed to item O0150C.
- The purpose of item O0150D is to identify whether the reason(s) that the patient is deemed medically unready for SBT by day 2 of the LTCH stay is documented by the LTCH by the end of day 2 of the LTCH stay. The specific reason(s) are not required in the assessment.
- For item O0150D, documentation in the medical record indicates explicit physician, registered nurse (RN), or respiratory therapist (RT) documentation of the reason that a patient was not deemed medically ready for SBT by day 2 of the LTCH stay.
- Only one item, either O0150D or O0150E, should be coded. The response to item O0150C determines which one of these items is coded on each patient's assessment.

Examples

1. **Invasive Mechanical Ventilation Support upon Admission to the LTCH:** Mr. M is a 68-year-old male with a history of heart failure. He was admitted to the acute care hospital to undergo a surgical implant of a left ventricular assist device (LVAD). After his surgery, he spent several days in the ICU and received mechanical ventilation for 3 days. He was liberated from the ventilator successfully while in the ICU. Mr. M was transferred to the cardiac step-down unit where he developed pneumonia. He began a course of antibiotic therapy and is now being admitted to the LTCH. His LTCH stay will include the completion of his antibiotic treatment, and daily physical and occupational therapy to increase his strength. He will complete his LVAD training prior to his discharge to home.

   Coding: O0150A would be coded 0, No, not on invasive mechanical ventilation support.
   Rationale: Mr. M is not on invasive mechanical ventilation upon admission to the LTCH.

2. **Invasive Mechanical Ventilation Support upon Admission to the LTCH:** Ms. K is a 32-year-old female who is being discharged from the acute care hospital after an acute episode of respiratory failure secondary to pneumonia. Ms. K is diagnosed with cystic fibrosis and has had recurrent respiratory infections over the course of 6 months. Ms. K was intubated in

the emergency department and transferred to the ICU, where she was treated for her pneumonia. After several failed attempts to wean and extubate, Ms. K underwent surgery for placement of a tracheostomy tube. She remains fully ventilated and is being transferred to the LTCH for weaning. Ms. K is admitted to the ventilator weaning unit where she is anticipated to liberate from mechanical ventilation; this is recorded in her discharge summary as well as in her care plan upon her admission to the LTCH.

Coding: O0150A would be coded 1, Yes weaning.

Rationale: Ms. K is on invasive mechanical ventilation upon admission to the LTCH, and it was documented in her care plan that she is anticipated to liberate from mechanical ventilation.

3. **Invasive Mechanical Ventilation Support upon Admission to the LTCH:** Mr. P is admitted to the LTCH after receiving treatment at an acute care facility secondary to a myasthenic crisis. While in the emergency department, he was placed on a mechanical ventilator to manage his elevated partial pressure of carbon dioxide (PaCO2) levels. Mr. P has a tracheostomy tube in place from a prior admission to an acute care facility due to recurrent aspiration pneumonia. During this stay in the ICU, he had several failed attempts to liberate from mechanical ventilation. Given his history of myasthenia gravis and his recurrent aspiration pneumonias with subsequent need for tracheostomy tube, he is unlikely to fully liberate from mechanical ventilation. His discharge summary indicates that he is expected to require nocturnal ventilation on discharge from the LTCH.

   Coding: O0150A would be coded 2, Yes, non-weaning.

   Rationale: Mr. P is on invasive mechanical ventilation upon admission to the LTCH; however, he is unlikely to fully liberate from mechanical ventilation due to his condition.

4. **Assessed for readiness for SBT by day 2 of the LTCH stay:** Mr. J is a 24-year-old male who transferred to the ventilator unit at the LTCH for weaning and physical therapy to increase his endurance. He is approximately 6 weeks status post a bone marrow transplant and is deconditioned due to chronic shortness of breath that does not allow him to perform most ADLs independently. His current admission to the acute care facility was due to acute respiratory distress; he was admitted to the ICU with a diagnosis of idiopathic pneumonia syndrome. During his ICU stay, he suffered several failed attempts to liberate from mechanical ventilation.

   On admission to the LTCH he was receiving full mechanical ventilation through a tracheostomy tube. There is documentation in his admission summary and his LTCH care plan that he is anticipated to liberate from mechanical ventilation. The LTCH physician orders the weaning protocol that requires assessment for SBT by day 2 of the LTCH stay.

   Mr. J is expected to wean from mechanical ventilation. He was not assessed on day 2 of his LTCH stay due to a clinical change in his condition. His assessment for readiness for SBT occurred on day 4 of the LTCH stay due to 48 hours of severe nausea, vomiting, and diarrhea, which temporarily increased his shortness of breath and exacerbated his deconditioned status. Due to his high respiratory rate and a decrease in his blood pressure, he did not meet criteria for assessment for SBT.

Coding: O0150B would be coded 0, No, the patient was not assessed for SBT by day 2 of the LTCH stay.

Rationale: Mr. J was assessed for readiness for SBT on day 4 of the LTCH stay due to a clinical change in his condition that did not allow him to be assessed by day 2 of his LTCH stay.

5. **Assessed for readiness for SBT by day 2 of the LTCH stay:** Ms. T is a 32-year-old female with cystic fibrosis. She was discharged from the ICU to the ventilator weaning unit at the LTCH. She was admitted to the ventilator weaning unit yesterday afternoon. Her night was stable, she was comfortable on her new ventilator, and she is eager to begin her weaning trials. Her care plan includes weaning trials and assessment for SBT on day 2 of her LTCH stay. Ms. T was assessed for SBT trial on the day after her admission to the LTCH, which is day 2 of her LTCH stay.

   The LTCH uses evidence-based criteria to assess a patient's readiness to perform the SBT. Her assessment included but was not limited to the following: her pneumonia is resolving, her gas exchange is adequate on positive end-expiratory pressure (PEEP) of 5 centimeters of water (cmH2O) and fraction of inspired oxygen (FiO2) of 40%, she is hemodynamically stable, she has a rapid shallow breathing index (RSBI) < 105, and she has the capacity to breathe spontaneously.

   Coding: O0150B would be coded, Yes, the patient was assessed for SBT by day 2 of the LTCH stay.

   Rationale: Ms. T was assessed for SBT trial on the day after her admission to the LTCH, which is day 2 of her LTCH stay.

6. **Deemed medically ready for SBT by day 2 of the LTCH stay:** Mrs. F is admitted to the LTCH with a diagnosis of hypercarbic hypoxemic respiratory failure secondary to a COPD exacerbation brought on by flu-like symptoms. While Mrs. F was in the ICU, she required intubation and mechanical ventilation. Mrs. F was extubated twice and was placed on non-invasive ventilation (NIV) immediately following both extubations. Both attempts at NIV led to elevated PaCO2 levels and respiratory distress, which required re-intubation and ventilation. After the second failed attempt to liberate her from mechanical ventilation, she underwent a procedure to insert a tracheostomy tube. She has been stable in the ICU and transferred to the LTCH early this morning. The acute care referral and the attending physician notes from the ICU state that she is expected to wean off mechanical ventilation.

   Mrs. F was assessed for readiness for SBT on the day she was admitted to the LTCH. Mrs. F did not pass her SBT assessment. Her assessment included evidence-based guidelines to assess her readiness to perform SBT. It was noted in the medical record by the RT that Mrs. F had significant auto PEEP levels and breath stacking. The physician ordered her applied PEEP to be increased to a level above the acceptable high range for readiness to perform SBT.

   Coding: O0150C would be coded, No, the patient was not deemed medically ready for SBT by day 2 of the LTCH stay.

   Rationale: Mrs. F did not pass her SBT assessment.

7. **Deemed medically ready for SBT by day 2 of the LTCH stay:** Ms. K is a 32-year-old female with cystic fibrosis. She was discharged from the ICU yesterday and admitted to the

ventilator weaning unit at the LTCH. She had a stable first night and transitioned from the ICU ventilator to the LTCH ventilator without issue. She understands that she passed the SBT criteria and is medically stable and ready to transition to spontaneous breathing via a trach mask. The RN and RT coordinated the trial for SBT to begin when Ms. K is finished with her routine morning care.

Coding: O0150C would be coded, Yes, the patient was deemed medically ready for SBT by day 2 of the LTCH stay.

Rationale: Ms. K passed the SBT criteria and is medically stable and ready to transition to spontaneous breathing via a trach mask.

8. **Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?** Mr. O is admitted to the LTCH from the ICU at the acute care facility. Mr. O suffered a cervical spine, C4/C5, injury following a diving accident. He was intubated at the scene and transferred to the acute care facility and surgical ICU. He is status post cervical spine surgery. His course in the ICU was stable, but he did require bedside surgery for a percutaneous tracheostomy after a failed trial to extubate. He was eventually liberated from mechanical ventilation while in the ICU. From the ICU, he was transferred to the surgical floor with a tracheostomy tube in place receiving oxygen and humidification. While on the surgical floor, he was found unresponsive with agonal breathing and hypoxemia in the setting of secretions plugging his trach tube. He was placed back on mechanical ventilation in the ICU. Mr. O is now admitted to the LTCH ventilator weaning unit. It is documented in his discharge summary that he is anticipated to liberate from mechanical ventilation prior to discharge from the LTCH. The discharge summary also states that due to his inability to manage his secretions, he may not be a candidate for tracheostomy decannulation. It is also documented in Mr. O's admission care plan that he is expected to liberate from mechanical ventilation prior to discharge from the LTCH.

   Mr. O was deemed medically unready for SBT when he was assessed on the day after admission to the LTCH. There is no documentation in the medical record why Mr. O was medically unready for SBT by day 2 of the LTCH stay.

   Coding: O0150D would be coded No, there is no documentation in the medical record that indicates that the patient was deemed medically unready for SBT by day 2 of the LTCH stay.

   Rationale: There is no documentation in the medical record stating why Mr. O was medically unready for SBT by day 2 of the LTCH stay.

9. **Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?** Mrs. F is admitted to the LTCH with a diagnosis of hypercarbic hypoxemic respiratory failure secondary to a COPD exacerbation brought on by flu-like symptoms. While Mrs. F was in the ICU, she required intubation and mechanical ventilation. Mrs. F was extubated twice and was placed on NIV. Both attempts at NIV led to elevated PaCO2 levels, which lead to her being re-intubated and placed on mechanical ventilation. After the second failed attempt to liberate her, she underwent a procedure to insert a tracheostomy tube. She was admitted to the LTCH

yesterday and is expected to wean off mechanical ventilation as documented in her admission care plan.

Mrs. F was assessed for readiness for SBT on the day of her admission to the LTCH. Mrs. F did not pass her SBT assessment. Her assessment included evidence-based guidelines to assess her readiness to perform SBT. It was noted in the medical record by the RT that Mrs. F had significant auto PEEP levels and breath stacking. The physician ordered her applied PEEP to be increased to a level above the acceptable high range for readiness to perform SBT. The treatment plan is to increase her bronchodilator treatments and to stop her steroid taper. The physician order and the documentation of breath stacking and significant auto PEEP are documented in the medical chart.

Coding: O0150D would be coded 1, Yes, there is documentation in the medical record that indicates that the patient was deemed medically unready for SBT by day 2 of the LTCH stay.

Rationale: There is documentation in the medical chart on why Mrs. F was medically unready for SBT by day 2 of the LTCH stay.

10. **SBT performed by day 2 of the LTCH stay:** Ms. M is an 82-year-old female admitted to the LTCH with a diagnosis of non-small cell lung cancer. After a successful pneumonectomy procedure, she was transferred to the surgical ICU. While in the ICU, she required high levels of oxygen to maintain normal oxygen saturations. She eventually required intubation and ventilation for respiratory distress. Mrs. M's course was then complicated by the development of acute respiratory distress syndrome (ARDS). She was treated for ARDS and slowly improved over the course of 2 weeks; during this 2-week period she underwent a procedure to place a tracheostomy tube. Yesterday she was discharged to the LTCH, where she was admitted to the ventilator weaning unit. It is documented in her care plan that she is expected or anticipated to liberate from mechanical ventilation prior to discharge.

    Ms. M was assessed on the day of admission and determined to be medically ready for SBT. However, due to inconsistent communication among the healthcare team, Ms. M did not perform the SBT until the third day of her LTCH stay.

    Coding: O0150E would be coded 0, No, if an SBT was not performed by day 2 of the LTCH stay.

    Rationale: Ms. M did not perform the SBT until day 3 of her LTCH stay.

11. **SBT performed by day 2 of the LTCH stay:** Ms. K is a 32-year-old female with cystic fibrosis. She was discharged from the ICU yesterday and admitted to the ventilator weaning unit at the LTCH. She was assessed for readiness for the SBT on the morning of her second day at the LTCH. She passed the criteria for the SBT and was deemed medically ready to perform the SBT. Ms. K completed her morning routine and was placed on the SBT using a trach mask. Ms. K tolerated the tracheostomy mask wean for 45 minutes.

    Coding: O0150E would be coded 1, Yes, if an SBT was performed by day 2 of the LTCH stay.

    Rationale: Ms. K performed SBT on day 2 of her LTCH stay.

O0200. Ventilator Liberation Rate

O0200. Ventilator Liberation Rate	
Enter Code ☐	**A. Invasive Mechanical Ventilator: Liberation Status at Discharge** **0. Not fully liberated at discharge** (i.e., patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge) **1. Fully liberated at discharge** (i.e., patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge) **9. NA** (code only if the patient was non-weaning or not ventilated on admission [O0150A=2 or 0 on Admission Assessment])

Item Rationale

- To determine the facility's rate of discontinuation of invasive mechanical ventilation, known as weaning or liberation, which is associated with improved patient health outcomes.

Coding Instructions

Complete only if A0250 = 10 Planned Discharge or 11 Unplanned Discharge.

O0200A. Invasive Mechanical Ventilator: Liberation Status at Discharge

- Code 0, Not fully liberated at discharge, if the patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge.
- Code 1, Fully liberated at discharge, if the patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge.
- Code 9, NA, if this item does not apply. This code only applies if the patient was non-weaning or not on invasive mechanical ventilation support on admission (O0150A = 2 or 0 on Admission Assessment).

Coding Tips

- For patients to be considered fully liberated, patients should not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge and upon discharge.

Examples

1. **Invasive Mechanical Ventilator: Liberation Status at Discharge:** Mrs. F was admitted to the LTCH with a diagnosis of hypercarbic hypoxemic respiratory failure secondary to a COPD exacerbation. While Mrs. F was in the ICU, she underwent two attempts to wean fully from the ventilator and had two unsuccessful trials of BiPAP post extubation. She was admitted to the LTCH with the expectation of fully liberating from invasive mechanical ventilation.

Despite several attempts to wean her from the ventilator she was unable to maintain normal PaCO2 levels for greater than a few hours. She remained fully ventilated until the time she was discharged to the acute care facility with sepsis.

Coding: O0200a would be coded 0, Not fully liberated from mechanical ventilation at discharge.

Rationale: Mrs. F was not fully liberated from mechanical ventilation at discharge.

2. **Invasive Mechanical Ventilator: Liberation Status at Discharge:** Ms. K is a 32-year-old female who is being discharged from the LTCH to a skilled nursing facility. She was admitted to the ventilator weaning unit after her ICU stay at an acute care hospital. Ms. K is diagnosed with cystic fibrosis complicated by multiple, recurrent respiratory infections and had a tracheostomy tube placed while at the acute care hospital after she failed several attempts to liberate from mechanical ventilation. While at the LTCH, Ms. K successfully liberated from mechanical ventilation. Ms. K will be discharged to a skilled nursing facility for tracheal decannulation, she has not required invasive mechanical ventilation for at least 2 consecutive calendar days immediately prior to this discharge.

   Coding: O0200A would be coded 1, Fully liberated at discharge.

   Rationale: Ms. K did not require invasive mechanical ventilation for at least 2 consecutive calendar days immediately prior to discharge and was fully liberated at discharge.

3. **Invasive Mechanical Ventilator: Liberation Status at Discharge:** Mr. G was diagnosed several years ago with amyotrophic lateral sclerosis (ALS), he has been managing his respiratory system adequately using a non-invasive ventilator. Over the past 2 months it has become increasingly difficult for him to maintain ventilation using a non-invasive ventilator in the home without developing pneumonia and atelectasis. He was recently admitted to the ICU at an acute care hospital for elective surgery to receive a tracheostomy tube and subsequently be placed on full invasive mechanical ventilation. After his 3-day stay in the ICU, he was stable on appropriate ventilator settings and transferred to the LTCH to prepare his family and caretakers to care for his needs in the home setting.

   Coding: O0200A would be coded 9, this patient was admitted as non-weaning on admission.

   Rationale: Mr. G is on invasive mechanical ventilation but was determined to be non-weaning on admission due to his condition.

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 ☐

A. Did the **patient receive the influenza vaccine in this facility** for this year's influenza vaccination season?
0. **No** → *Skip to O0250C, If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O0250B, Date influenza vaccine received*

B. Date influenza vaccine received → *Complete date and skip to Z0400, Signature of Persons Completing the Assessment*

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If influenza vaccine not received, state reason:
1. **Patient not in this facility during this year's influenza vaccination season**
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

Item Rationale

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional Influenza A outbreak can result in up to 60% of the population becoming ill, with 25% of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.
- The Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccinations for all persons aged 6 months and older in the United States.[2]

DEFINITION

INFLUENZA VACCINATION SEASON[1]
The influenza vaccination season is defined as beginning October 1 of the current year, or when the influenza vaccine becomes available (whichever comes first), through March 31 of the following year.

Steps for Assessment

1. Review the patient's medical record to determine whether an influenza vaccine was received in the LTCH for this year's influenza vaccination season. If the patient's vaccination status is known, proceed to coding O0250A.

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1 Please refer to FY 2015 IPPS/LTCH PPS Final Rule at http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf, pages 50289-50290.

2 Kim, D.K., Riley, L.E., Harriman, K.H., Hunter, P., Bridges, C.B.: Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older — United States, 2017. MMWR Morb Mortal Wkly Rep. 66:136–138, 2017. DOI: http://dx.doi.org/10.15585/mmwr.mm6605e2.

2. If the patient did not receive the influenza vaccine in the LTCH, ask the patient if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. Please also review (when available) the patient's medical record from previous setting(s) (e.g., short-stay acute care hospital medical records). If the patient's influenza vaccination status is still unknown, proceed to the next step.
3. If the patient is unable to answer, then ask the same question of the responsible party, legal guardian, or primary care physician. If vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, please refer to the standards of clinical practice to determine whether to administer the vaccine to the patient and proceed to coding O0250A.

Coding Instructions for O0250A, Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season?

Complete only if A0250 = 01 Admission; A0250 = 10 Planned Discharge; A0250 = 11 Unplanned Discharge; or A0250 = 12 Expired.

- Code 0, No, if the patient did not receive the influenza vaccine in this facility (LTCH) for this year's influenza vaccination season. Proceed to O0250C. If influenza vaccine was not received, state reason.
- Code 1, Yes, if the patient received the influenza vaccine in this facility (LTCH) for this year's influenza vaccination season. Continue to O0250B, Date influenza vaccine received.

Coding Instructions for O0250B, Date influenza vaccine received

- Enter the date that the vaccine was received by the patient in your LTCH. Do not leave any boxes blank.
- If the month contains only a single digit, fill in the first box of the month with "0." If the day contains only a single digit, fill in the first box of the day with "0."
  - For example, January 7, 2018, should be entered as 01-07-2018.
  - October 6, 2018, should be entered as 10-06-2018.
- A full 8-character date is required. If the date is unknown or the information is not available, a single dash (–) needs to be entered in the first box.

Coding Instructions for O0250C, If influenza vaccine not received, state reason

If the patient has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A = 0), code the reason from the following list:

- Code 1, Patient not in 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 or precautions, including, but not limited to, severe allergic reaction to egg protein 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 or precautions end.
- 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.

Coding Tips and Special Populations

- If the influenza vaccination was administered to a patient for the current influenza season at the time of or prior to admission, then that information should be reflected on the patient's discharge assessment.
- Influenza can occur at any time, but most influenza occurs from October through May. However, patients should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.

- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) Web site. This Web site provides information on influenza activity and has an interactive map that shows geographic spread of influenza: http://www.cdc.gov/flu/weekly/fluactivitysurv.htm http://www.cdc.gov/flu/weekly/usmap.htm.
- Facilities can also contact their local health department Web site for local influenza surveillance information.
- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, if a declared influenza vaccine shortage occurs in your geographical area, patients should still be vaccinated once the facility receives the influenza vaccine.
  - Information regarding vaccine shortages can be obtained from the CDC: http://www.cdc.gov/vaccines/vac-gen/shortages/.
- Facilities should follow current ACIP recommendations to inform standards of practice and applicable patients.
- Annual influenza vaccination of all persons aged 6 months or older continues to be recommended.
- If the patient was in the facility one or more days during the influenza vaccination season and was assessed, and where appropriate, received the influenza vaccination for the current influenza season, report that information on the LTCH CARE Data Set, regardless of whether the patient was admitted or discharged during or outside the influenza vaccination season.
- For item O0250A, code 1, Yes, for vaccines given to patients in the facility one or more days during the influenza vaccination season.
- For item O0250A, 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 vaccine in the LTCH.

Examples

1. Mrs. J received the influenza vaccine in this LTCH during this year’s influenza vaccination season, on October 2, 2017.

   Coding: O0250A would be coded 1, Yes; O0250B would be coded 10-02-2017; and O0250C would be skipped.

   Rationale: Mrs. J received the vaccine in the facility on October 2, 2017, during this year’s influenza vaccination season.

2. Ms. A received the influenza vaccine in the LTCH on February 5, 2018, during this year’s influenza season. This patient transferred to an acute care facility on February 10 because of a medical emergency. The patient was then readmitted to the same LTCH on February 20. The patient did not receive the influenza vaccination during the second LTCH stay because she had already received it during the previous LTCH stay. The patient is discharged home on March 1, 2018.

Coding: **February 5 to February 10 stay:** O0250A would be coded 1, Yes; O0250B would be coded 02-05-2018; and O0250C would be skipped. **February 20 to March 1 stay:** O0250A would be coded 1, Yes; O0250B would be coded 02-05-2018; and O0250C would be skipped.

Rationale: Ms. A received the vaccine in the facility on February 5, 2018, during this year's influenza vaccination season. This date is reported on both assessments.

3. Mrs. B was admitted on March 31, 2018, was vaccinated in the LTCH on April 5, 2018, and was discharged April 15, 2018.

   Coding: O0250A would be coded 1, Yes; O0250B would be coded 04-05-2018; and O0250C would be skipped.

   Rationale: Mrs. B was vaccinated for the current (2017–2018) influenza vaccination season. The vaccination items should be completed for Mrs. B even though she was discharged after the influenza vaccination season. Mrs. B was in the facility for one or more days during the influenza vaccination season.

4. Mr. R did not receive the influenza vaccine in the LTCH during this year's influenza vaccination season because of his known allergy to egg protein.

   Coding: O0250A would be coded 0, No; O0250B would be skipped; and O0250C would be coded 3, Not eligible-medical contraindication.

   Rationale: Allergy to egg protein is a medical contraindication to receiving the influenza vaccine; therefore, Mr. R did not receive the vaccine.

5. Mrs. T was hospitalized during the influenza vaccination season. She had previously received the influenza vaccine at her doctor's office during this year's influenza vaccination season. Her doctor provided documentation of Mrs. T's receipt of the vaccine to the LTCH to place the documentation in Mrs. T's medical record. He also provided documentation that Mrs. T was explained the benefits and risks for the vaccine prior to administration.

   Coding: O0250A would be coded 0, No; O0250B would be skipped; and O0250C would be coded 2, Received outside of this facility.

   Rationale: Mrs. T received the influenza vaccine at her doctor's office during this year's influenza vaccination season.

6. Ms. M was hospitalized at the LTCH after a severe traumatic brain injury in May 2018 and discharged in August 2018. She did not receive the influenza vaccine during this hospitalization.

   Coding: O0250A would be coded 0, No; O0250B would be skipped; and O0250C would be coded 1, Patient not in facility during this year's influenza vaccination season.

   Rationale: Ms. M did not receive the influenza vaccine as she was not in the facility during the influenza vaccination season.

7. Mr. N was offered the influenza vaccine during his LTCH hospitalization beginning in February 2018. Mr. N refused the influenza vaccine asserting that whenever he has received it in the past it always gave him the flu. Despite the staff providing education that the influenza vaccine does not cause the flu, Mr. N still refused to take it.

   Coding: O0250A would be coded 0, No; O0250B is skipped; and O0250C would be coded 4, Offered and declined.

   Rationale: Mr. N did not receive the influenza vaccine. He was offered the vaccine, but refused to take it.

8. Mr. L was admitted to the LTCH comatose after an intracerebral bleed. His family requests that he receive an influenza vaccine during his hospitalization. The nurse explains that there is currently a declared shortage of influenza vaccine and that Mr. L will receive a dose when the facility obtains more vaccine. Mr. L is discharged prior to the LTCH receiving additional doses of the influenza vaccine. He is encouraged to ask his primary care physician about receiving the vaccine following discharge from the LTCH.

   Coding: O0250A would be coded 0, No; O0250B would be skipped; and O0250C would be coded 6, Inability to obtain vaccine due to a declared shortage.

   Rationale: Mr. L did not receive the influenza vaccine because there was no influenza vaccine available due to a declared shortage.

9. Mrs. T was admitted on Friday evening to the LTCH during this year's influenza vaccination season. Mrs. T's acute care medical records were checked and there was no record of her having received the influenza vaccine. The patient and her family decided that Mrs. T was to be discharged and transferred to another LTCH facility on the following Tuesday. The patient was never offered an influenza vaccination.

   Coding: O0250A would be coded 0, No; O0250B would be skipped; and O0250C would be coded 5, Not Offered.

   Rationale: Mrs. T did not receive the influenza vaccine because she was never offered the influenza vaccine during her LTCH stay.

10. Mr. F was admitted to the LTCH on April 1, 2018. It is the LTCH's policy to vaccinate patients through the end of May. The patient is vaccinated in the LTCH on April 14, 2018, and was discharged April 15, 2018.

    Coding: O0250A would be coded 1, Yes; O0250B would be coded 04-14-2018; and O0250C would be skipped.

    Rationale: Mr. F was vaccinated for the current (2017–2018) influenza season. The vaccination items should be completed for Mr. F even though he was not in the LTCH for one or more days during the influenza vaccination season. Patients should be offered the vaccine after the influenza vaccination season if consistent with facilities' policies. Mr. F would not be included in the quality measure as his stay was outside the influenza vaccination season.

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