LTCH Quality Reporting Program
& LTCH CARE Tool
LTCH Quality Reporting Program

- What is it?
- How does it work?
- What does it mean for facilities?
- What does it mean for the industry?
LTCH Quality Reporting Program

- Is a feature of the 2010 Patient Protection & Affordable Care Act
  - Mandates quality reporting for LTCHs, IRFs & Hospice
- Brings post-acute care in line with mandates already in place for acute care
LTCH QRP: Purpose

- Improve quality
- Improve safety
- Minimize healthcare-associated infections (HAIs) & adverse events
- Improve coordination of care
- Create more person- and family-centered care
• LTCH QRP requires LTCHs to submit patient data to CMS for the first time
• Data collection begins Oct. 1
• Data collected on *all patients*, regardless of payer
• Penalty for not participating is a 2 percentage point reduction in annual Medicare payment update
• Affects payment beginning fiscal year 2014 (October 2013)
Beginning Oct. 1, LTCHs will be required to collect and submit data for 3 measures:

1. **Patients with pressure ulcers**
   that are new or have worsened

2. **Catheter Associated Urinary Tract Infection**
   (CAUTI)

3. **Central Line Catheter-Associated Bloodstream Infection** (CLABSI)
Pressure Ulcers: percent of patients with one or more stage 2-4 pressure ulcers that are new or have worsened

- LTCH patients tend to be medically complex with functional limitations, sometimes severe.
- Pressure ulcers can lead to serious, life-threatening infections.
- Pressure ulcers are an increasingly common secondary diagnosis across all settings.
CMS developed the LTCH CARE Data Set:

- Patient assessment instrument
- Collects documentation for pressure ulcers, selected pressure ulcer risk factors, patient demographics, and provider attestations
- Admission, Planned Discharge, Unplanned Discharge, and Expired assessments
- Submit electronically to CMS
- Used for all patients, regardless of payer
**HAIs: Rationale**

**CAUTI** (*catheter-associated urinary tract infection*)
- Medical severity & common comorbidities of LTCH patients make catheters common
- Most common healthcare-associated infection
- Largely preventable

**CLABSI** (*central line-associated bloodstream infection*)
- Patients come to LTCHs from ICUs or step-down units with central lines in place, or have them inserted at the LTCH
- Largely preventable
CMS piggybacked on the CDC’s National Healthcare Safety Network

- Definitions and reporting requirements conform to CDC, with minor alterations to make the measures better fit LTCHs
- CDC will report quarterly information to CMS
- LTCHs already participating in NHSN may have to change account settings
CMS proposed the following additional measures for data collection beginning Jan. 1, 2014:

- LTCH CARE Data Set
  - % patients assessed and appropriately given the seasonal influenza vaccine
  - % patients assessed and properly given the pneumococcal vaccine
  - Ventilator bundle
  - Restraint rate per 1,000 patient days

- NHSN
  - Influenza vaccination coverage among healthcare personnel

- Participation required for full payment update in fiscal year 2016 (Oct. 1, 2015)
Things We Don’t Know

• Mandated public reporting of quality data
  ▪ Subject to its own rulemaking
  ▪ Details and timing not yet determined
Things We Do Know

• First data collection mandate for LTCHs
• This is just the beginning.
  ▪ CMS has already announced 5 new measures to be collected beginning Jan. 1, 2014.
• Data collection allows LTCHs to monitor performance, offering the potential to improve outcomes.
• Facilities will need to integrate data collection into regular workflow.
• Pre-Admission Screening
• Complete assessment system with built-in LTCH CARE data collection
  ▪ Integrated checks for compliance with CMS rules
  ▪ Easy-to-use screens
  ▪ Electronic transmission to CMS
• Patient Satisfaction System
• Workflow for new data collection
• Referrals Outcomes generated from Pre-Admission Screening data
• Patient Satisfaction Reports generated from three unique surveys
• Outcomes reports for internal quality auditing
  ▪ Administrative outcomes for management support
  ▪ Clinical outcomes for program evaluation
  ▪ Intensive focus on wound and ventilator patients
• How do we compare in discharging patients to a lower level of care?
  - **MEASURE**: Discharge to Lower Level of Care
  - **COMPARE TO**: National numbers adjusted for case mix
  - **FOR DISCHARGES**: Last 180 Days, with All Payers

<table>
<thead>
<tr>
<th></th>
<th>Facility</th>
<th>Weighted National</th>
</tr>
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<tbody>
<tr>
<td><strong>Facility Level</strong></td>
<td>65.75%</td>
<td>64.97%</td>
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<tr>
<td><strong>MDC 4 - Respiratory Patients</strong></td>
<td>63.16%</td>
<td>61.81%</td>
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<tr>
<td><strong>DRG 207 - Respiratory Diagnosis w/ ventilator support 96+ hours</strong></td>
<td>41.67%</td>
<td>48.62%</td>
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• Do we successfully mitigate the risk of patients developing pressure ulcers?
  - **MEASURE**: Hospital Acquired Pressure Ulcers
  - **COMPARE TO**: National numbers adjusted for case mix
  - **FOR DISCHARGES**: Last 90 Days, with All Payers

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<thead>
<tr>
<th></th>
<th>Facility Level</th>
<th>Weighted National</th>
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<tbody>
<tr>
<td><strong>Facility Level</strong></td>
<td>13.51%</td>
<td>5.01%</td>
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- Compared with others with an identical case mix, our overall rate is higher.
• **Who is getting pressure ulcers?**
  - View broken down by **risk at admission**:

<table>
<thead>
<tr>
<th>Braden Scale for Predicting Pressure Sore Risk©</th>
<th>Severe</th>
<th>High</th>
<th>Moderate</th>
<th>Mild</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>53%</td>
<td>3%</td>
<td>27%</td>
<td>7%</td>
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- **Find out which Mild Risk patients are developing pressure ulcers:**
  - They fall into the following Diagnosis-Related Groups:
    - 464 - Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC
    - 540 - Osteomyelitis w CC
    - 592 - Skin ulcers w MCC
    - 637 - Diabetes w MCC
First industry-wide data set could...
  - Improve care through standardized outcomes.
  - Better illustrate the need for long-term acute care in the post-acute spectrum.

Payment penalties begin Oct. 1, 2013.
LTRAX provides outcomes-focused intelligence to guide executive management and support quality care.