



# User Manual

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## I. INTRODUCTION

LTRAX™ is a combined data collection tool and outcomes engine built specifically for long-term acute care hospitals. LTRAX merges administrative, clinical, and acute hospital data and extracts patient-centered outcomes in real time. The LTRAX system incorporates pre-admission screening, clinical assessments, and patient satisfaction surveys, along with specific data collection tools for wound and ventilator patients. LTRAX delivers these tools to long-term acute care hospitals using secure, maintenance-free Internet technology.

To subscribe, contact LTRAX representatives at Fleming-AOD at 301-357-8110.

### I.A. About this User Manual

The LTRAX User Manual is a comprehensive but not wholly inclusive document. In some sections of this manual, you will be directed to help documents available on the LTRAX website under the

 **HELP** icons for content not included here. This manual may also include information not found in the help documents available under the  **HELP** icons on the system.

Wherever you see colored text referencing a link or button, the colors indicate the following:

**Teal text** refers to text links on the screen, such as the site navigation links on the left side of the LTRAX Launch Screen.

**BRIGHT BLUE** text in all caps refers to buttons on the screen that are images, such as the **HOME** and **LOG OUT** buttons.

**Orange** text refers to submit buttons, such as the **Enter** buttons that appear in the display options below the assessments tables on the LTRAX Launch Screen.

**Olive text** refers to screens, such as the **LTRAX Launch Screen** and **My Account**. References to items on screens, will appear in *olive italic text*.

### I.B. General Guidelines to Follow when Navigating the LTRAX Website

After you have logged in to LTRAX, you'll see a teal **HOME** button on the left side of the screen below the LTRAX logo and a teal toolbar in the upper right corner of your screen. This toolbar contains the following buttons: **USER MANUAL**, **CONTACT**, and **LOG OUT**.

**HOME** takes you to the LTRAX Launch Screen.

**USER MANUAL** takes you to this user manual online.

**CONTACT** displays contact information for the LTRAX offices.

**LOG OUT** will log you out of the LTRAX system and end your user session.

The left side of your screen displays a set of links that change depending on what part of the site you are on. When you are working on an assessment, the links will appear as tabs with names representing individual sections of the assessment. In other areas of the site, the links are grouped under descriptive headers.

If you have the ability to view patient assessments, you will see tables of assessments on your **LTRAX Launch Screen**. Below those tables, you will see a **List Options** link, which takes you to the **Launch Screen Options** screen. Use **Launch Screen Options** to configure the information displayed in your assessments tables on your **Launch Screen** and the order of the information. For more information on configuring the assessments display options, please refer to [Configuring List Options](#) under the [Assessment Features](#) section of this manual.

**Do not use your web browser's back button.** Most of the pages on this website are dynamic, meaning that every time you click on a link, a fresh set of data is retrieved from the server to create the page. Due to the nature of a database-driven website such as LTRAX, the data used to create each page may change at any time. Each page is set to expire as soon as you move on to the next page. This also enhances security, as expired pages (and therefore, sensitive data) are not cached (saved) on your computer.

If you use your *browser's* back button to revisit a page, you may see a warning message telling you that the last page you visited has expired. To avoid encountering this message, always use the navigation provided on the left side of each page to move around the website. You can always return to your **LTRAX Launch Screen** by clicking **HOME** below the LTRAX logo.

**Always log out when you are through.** For security reasons, it is important to log out of LTRAX when you are finished working on the system or if you are taking a break. If you don't log out of the system, it is still possible to return to the site from your computer and bypass the login screen for up to two hours after the last time you accessed an LTRAX screen. This applies even if you browse to another website. This means that if you leave the site without logging out and then leave your computer unattended, anyone with access to your computer can potentially access LTRAX using your account. Closing your web browser does not log you out of the system. If you log out first, there is no way for anyone else to access the system using your account (unless they know your username and password). For security, make sure you click the **LOG OUT** button in the top navigation bar at the conclusion of every visit or if you step away from your computer.

**Only work in one browser window or tab at a time.** Your web browser can only track one patient record at a time. If you attempt to open multiple patient records in separate browser windows or tabs, you will see a **multiple windows warning** message that will prevent you from opening more than one record simultaneously or visiting the **CMS Transmit File** screen while you have a record open in another tab or window. If you get a multiple windows warning message, you should locate all windows or tabs open to LTRAX, click the **HOME** button on each of those, and then close all but one. If that does not clear the multiple windows warning message, you will need to click the **LOG OUT** button in the top navigation bar and then log in again.

## **I.C. Explanation of the Organization/Facility/Site Hierarchy**

The LTRAX system was designed to accommodate different kinds of hospital organizations through a three-tiered hierarchy of organization/facility/site.

A **facility** is defined by a unique Medicare Provider ID (CMS Certification Number or CCN). One **organization** can own or manage multiple facilities. If your facility belongs to a larger organization that includes other facilities under its umbrella, you can apply the organization/facility hierarchy to those facilities. This allows you to manage user accounts, download data, and view outcomes reports for all facilities from one or more organization administrator accounts; and/or perform the same functions from facility administrator accounts assigned to each facility.

If your facility includes different **sites** that share the same Medicare Provider ID (CCN), you can apply the facility/site hierarchy to those sites and manage user accounts for all sites from one or more facility administrator accounts, and/or manage them from site administrator accounts assigned to each individual site.

If your facility belongs to a larger organization that includes other facilities under its umbrella, and your facility includes different sites, you can apply the full organization/facility/site hierarchy to those facilities and sites. This allows you to view reports, download data, and manage user accounts for all facilities and sites from one organization administrator account, from facility administrator accounts for each facility, and/or from site administrator accounts for each site.

If your facility does not belong to a larger organization with other facilities (or your facility should not be managed from its parent organization), and your facility has only one site, you do not need to consider the hierarchy at all.

The structure of your facility's account with LTRAX is established when the account is created by an LTRAX representative. Please keep this hierarchy in mind when signing up your facility for the LTRAX service and when creating user accounts and assigning privileges.

## I.D. LTRAX Support


If you can't see the website (<http://www.ltrax.com>):

1. Confirm that your computer has a live Internet connection. The easiest way to do this is to check a few other websites. (Note: Do not use internal websites, such as your facility's home page, for this test. These sites may be visible to you from your local network and not the Internet.) If you can't see any websites on the Internet, contact your IT department for assistance.
2. If you can see other websites but can't see [www.ltrax.com](http://www.ltrax.com), email [assistance@ltrax.com](mailto:assistance@ltrax.com) and describe your problem in as much detail as possible. An LTRAX support representative will respond shortly.

If you can see the website but can't log on:

1. Type your facility's Medicare Provider ID (CCN) into the box provided on the login screen and click "Forgot your password?"
2. The contact information for your LTRAX facility administrator(s) will appear. If you are the only LTRAX administrator for your facility, email [assistance@ltrax.com](mailto:assistance@ltrax.com) and include your name and your facility's Medicare Provider ID (CCN) in the message. An LTRAX support representative will respond shortly.

If you have a question while using the website:

1. See if your question is answered in the User Manual. You can search for keywords in the manual by holding down the Ctrl key while pressing the F key on your keyboard and typing your search word into the box that pops up. Then click **Find Next**. You can find all instances of your search word in the manual by continuing to click **Find Next**.
2. If there is a help icon (  ) on the page you are having trouble with, click the icon and a pop-up window will appear. The pop-up window contains information about the screen you are viewing, and your question may be answered there.
3. Search the LTRAX email archive. After you log in, click **Info/Links > Email Archive** on the left side of your screen. This archive is a compilation of all of the emails sent to the LTRAX email list, organized by date.
4. If your question isn't answered in any of the above forums, you can use the LTRAX messaging system to send a message to LTRAX Tech Support. To send a message, please see the instructions for the LTRAX messaging system in the [User Features](#) section of this manual.

If you have a suggestion or request, or you have encountered an error on the site:

1. You can log your suggestion, request, or a description of the error you encountered in the **Enhancement Requests** section of the website. To post new items, please see the instructions concerning enhancement requests in the [User Features](#) section of this manual.

If all else fails:

Call LTRAX support staff at (301) 357-8110.

## II. USER FEATURES

### II.A. Logging In

To log in to LTRAX, you must use a computer that is connected to the Internet. After confirming that you have an Internet connection, open a web browser (Internet Explorer 11 or higher or the latest version of another browser) and point it to [www.ltrax.com](http://www.ltrax.com).

Your browser will be directed to a secure website, and the login screen will appear. Enter your facility's Medicare Provider ID (CCN) and the username and password that were created for you by your facility's LTRAX administrator.

If you have forgotten your username and/or password, type in your facility's Medicare Provider ID (CCN) and then click **Forgot your password?** The contact information for your facility's LTRAX administrator(s) will appear, and you can contact your facility administrator for assistance with logging in.

### II.B. My Account

The **My Account** screen allows you to manage your personal contact information on your user account, as well as customize certain aspects of LTRAX to suit your preference. **My Account** is available when you log in to LTRAX and click the **My Account** link that appears on the left side of your screen.

**Change Password:** An LTRAX password must be at least eight characters long. It must include uppercase and lowercase letters, at least two numbers, and at least one special character (~ ! @ % ^ & \* \_ - + = ` | ( ) { } [ ] : ; " ' < > , . ?). It cannot include any part of your name, your facility's name, or the word "password." LTRAX will immediately prompt you to change your password when you log in for the first time. Passwords cannot be reused. To change your password, click **Change Password**, type your new password into both the password and password confirmation boxes, and click **Update Password**. If your password doesn't match the password confirmation, or if the password is not in the required format, you will receive an error message in red at the top of the screen. If you have entered everything correctly, you will be automatically redirected to a page confirming that your password has been updated.

**Contact Data:** You can edit the contact information on your account to ensure that you can receive LTRAX emails and be contacted by phone if necessary. To update your contact information, click **Contact Data**, enter (or edit) your email address and/or your phone number with extension if applicable, and click **Save**.

**Font Settings:** Due to variances in the way different web browsers, web browser versions, and computer hardware (monitors, video cards, etc.) display font types and sizes, and in consideration of user preference, we've added some display options to allow users to customize the look of their **LTRAX Launch Screen** and other screens. You can control the type and size of the font in which LTRAX appears using the display options settings. From the My Account menu, click **Font Settings**.

**Changing the Font:** Using the font samples displayed on the screen for reference, select the font type and the size you want from the drop-down lists, then click the **Save** button at the bottom of your screen. The screen will refresh, and you will see your font selection applied. Then click **Back** or **HOME** to view your new font display.

**Functional Settings:** This is where you will find any additional customization options for controlling the display and functionality of LTRAX. From the My Account menu, click **Functional Settings**. All of the **Save** buttons on this screen work to save any changes you make, so it doesn't matter which one you click. Current options include:

**Pre-Admission Screening PDF Margins:** This setting allows you to control the size of the margins on the Pre-Admission Screening PDF to allow enough space to affix labels to printed PAS Tool assessments. The default values allow for .5" in all four margins, but you can selectively modify the size of any of the margins. To change a margin, type your desired margin size in inches into the appropriate box and click **Save**.

**Use the Internet Connection Monitor:** The PAS Tool includes an optional Internet connection monitor, which checks the status of your Internet connection at regular intervals and pops up an alert message if your connection is disrupted, offering you an opportunity to avoid data loss by re-establishing a good connection before trying to save or leave the screen. To enable the monitor, check the **Use the Internet Connection Monitor** checkbox and click **Save**.

**Pre-Admission Screening (PAS) Tool Offline Form:** The LTRAX Pre-Admission Screening Tool Offline Form is intended for use only by LTRAX users who are not able to work on PAS Tool assessments online due to limited Internet connectivity. This form stores patient pre-admission screenings, which may contain protected health information, on the user's computer in the Chrome browser database until the user is able to establish a connection to the Internet and upload the screenings to LTRAX. Follow the on-screen instructions in this section of the **Functional Settings** screen to download and install the Chrome web browser and the Offline PAS Tool Form.

**NOTE:** Users will need to download [Chrome](#) to use the LTRAX PAS Tool Offline Form. Users must have the privilege to create pre-admission screenings and/or assessments to upload offline PAS Tools into LTRAX.

## II.C. LTRAX Messaging System (Send Message)

You can communicate with other users at your facility and/or organization through the LTRAX internal messaging system. This system works independent of Internet email and gives you a convenient, centralized, and secure means of communicating about LTRAX and related subjects.

**View Messages:** If you have received any messages through the internal messaging system, a list of those messages appears on your **LTRAX Launch Screen** in a table titled **Messages**. The date the message was sent, the name of the sender, the subject of the message, whether it contains an attachment (an asterisk [\*] indicates that the message includes an attachment, which is usually a patient assessment), and the message status (read or unread) all appear in the table. To read the message, click on any one of those text fields.

If your message includes a patient assessment as an attachment, you can view and edit the assessment from the **Read Message** screen by clicking on either the patient name or **Edit Assessment** on the left side of your screen.

You can reply to a message by clicking **Reply** from **Read Message**. Once you have typed your reply, click **Send Message** to send the message.

You can delete a message either from **Read Message** by clicking **Delete**, or from your **LTRAX Launch Screen** by checking the box next to the message(s) you wish to delete and clicking **DELETE SELECTED**.

**Send Message:** To send a message to another user in your organization, click **Send Message** on your **LTRAX Launch Screen**. A box labeled **Recipients** containing the names of all LTRAX users at your facility will appear. Select the name of the person to whom you are sending the message. To select more than one person, hold down the Ctrl key while clicking on the names. Enter the message subject in the **Subject** box and the text of the message in the **Message** box. The text you type into the subject box will appear as the message subject on the recipient's **LTRAX Launch Screen** when they log in to the system. To send the message to the selected recipients, click **Send Message** at the bottom of the screen. To cancel, click **HOME**.

You can also send a message to LTRAX tech support by clicking [Send Message](#) on your **LTRAX Launch Screen** and selecting **LTRAX Tech Support** as the recipient. These messages are checked regularly by the LTRAX staff.



## II.D. File Transfer (CMS Transmission, Downloads, Uploads)

If you have been granted permission to transfer files from your facility to LTRAX and/or vice versa, you can download your assessment data from and/or upload assessment data to the LTRAX system.

To access the file transfer screens, log in to LTRAX. You will see a header on the left side of your **LTRAX Launch Screen** labeled **File Transfer**. Below that, depending upon your user privileges, you may see links for [CMS Transmit File](#), [Downloads](#), and/or [Uploads](#).

**NOTE:** If you do not see the **File Transfer** header, you will need to contact your facility's LTRAX administrator and ask him or her to adjust your user permissions.

Click [CMS Transmit File](#) to prepare a file of assessments for transmission to CMS. Click [Downloads](#) to access the [Data Download \(Custom Template\)](#) for use in extracting data from LTRAX. Click [Uploads](#) to access the uploads for use in importing data into LTRAX. Currently, the only available upload format is the [PSI Scan Upload](#), used only by LTRAX support staff to upload scanned patient satisfaction surveys.

A brief description of each file is displayed on the downloads and uploads screens, along with a  [HELP](#) icon. You can click the  [HELP](#) icon next to each file description for online instructions. These instructions are also included here for your reference.

### 1. CMS Transmit File

Transmitting assessments to CMS requires that they be uploaded in a specific format to the CMS system. These guidelines cover how to use LTRAX to create these CMS files.

Before creating any files for transmission to CMS, you must first confirm that the facility information on file with LTRAX matches the facility information on file with CMS. This is a one-time process that must be performed by an LTRAX facility administrator for your facility. If the information in the LTRAX system does not match that on file with CMS, you will receive warnings in the transmission report returned by CMS after transmitting your file. If you make any changes to your facility information after creating a CMS transmit file, you will need to re-create the file in order to apply the changes. See the [Facility Settings](#) section of this manual for more information.

Preparation of the CMS file can only be performed by users who have the privilege "User can manage CMS transmission files for assessments belonging to any facility in their organization," or "User can manage CMS transmission files for assessments in their facility," which is assigned by an LTRAX administrator.

**NOTE:** This procedure only creates the file you will be sending. To actually transmit the files, you must use the CMSNet software to connect to the CMS private network, and then use a web browser to perform the upload. For help with the CMSNet software or for questions about your transmissions, please contact QIES Technical Support at (877) 201-4721. For instructions, please refer to the data submission user's guide available on the [CMS Transmit File](#) page of LTRAX, under the [Transmission Instructions](#) link on the left side of the screen.

Creating the file in LTRAX is a multi-step process, with the first step being the selection of assessments to download followed by the actual download of the file containing the assessments to your computer's hard drive.



To begin, click the **CMS Transmit File** link on the left side of the **LTRAX Launch Screen**.

**NOTE:** If you do not see the **CMS Transmit File** link, you will need to contact your facility's LTRAX administrator and ask him or her to grant you the privilege "User can download assessments from their facility."

After clicking on **CMS Transmit File**, follow these steps:

**STEP 1: CONFIRM VALID ASSESSMENTS**

This initial step allows you to choose the assessments you want to send to CMS. The following is an example of what you might see:

**Step 1 Confirm valid assessments**

**Confirm the assessments you wish to include in your transmission file.**

You can include multiple assessments in one CMS transmission file. Select "Confirm" to include an assessment in the download file. Select "Leave" to keep an assessment in Step 1, excluding it from the download file you are creating. Make a selection for each assessment and click "Confirm."

Action	Name	Birth Date	Admit	Discharge	Assess Type
<input type="radio"/> Leave <input checked="" type="radio"/> Confirm	Transmit, CMS	05/05/1955	09/01/2012		Admit

Only complete assessments that have been marked "Xmit: Ready" will appear in Step 1 as available for transmission to CMS. To mark an assessment as "Xmit: Ready," click the **COMPLETE** button on the assessment management (**MGMT**) screen. Once the assessment has passed the LTRAX completion checks and received the status of complete, click the **XMIT: READY** button to mark the record as "Xmit: Ready."

In Step 1, set the action to **Confirm** on all assessments that you wish you place into your CMS transmit file. Set the action to **Leave** on any assessments marked as "Xmit: Ready" that you do not wish to include in your file. This option leaves assessments marked as "Xmit: Ready," and they will remain in Step 1.

Click **Confirm** to perform any actions you've chosen, and proceed to step 2.

**STEP 2: DOWNLOAD CMS ASSESSMENTS FILE**

**Your CMS file has been created.** However, it is stored on the LTRAX server until you download it. The following is similar to what you might see:

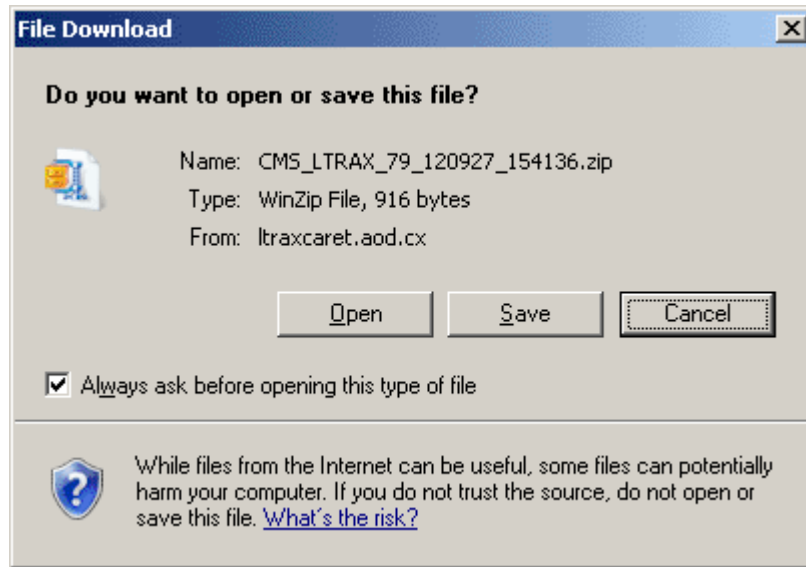
**Step 2 Download CMS Assessments file**

**Click the Download link to download the file(s) to your computer or local network for transmission.**

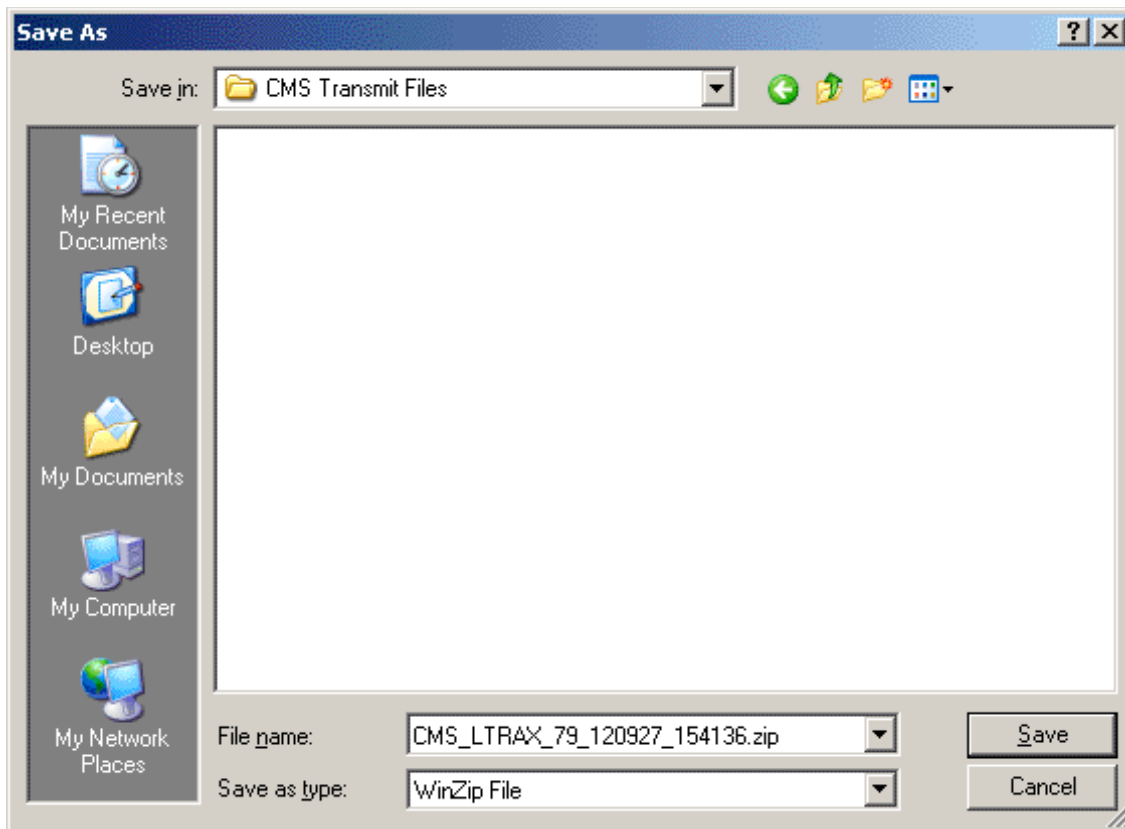
File Name	Date Created	Created by	
CMS_LTRAX_79_120927_154136.zip	09/27/12 03:41 PM EDT	Training, User	<a href="#">Click to download</a>

**\*\*\* After downloading your files, log in to the CMS network and transmit your downloaded file. Then p**

This shows that one file awaits download. By selecting the **Click to download** link, you can save the file to your computer's hard drive. The following is similar to what you might see:



Choose **Save File** and click **OK**. Next, select a destination on your computer's hard drive, change the suggested filename if you wish, and click **Save**. After "CMS\_LTRAX," the default file name includes your facility's Medicare Provider ID (CCN) followed by the file creation date (yymmdd), then the file creation time (hhmmss). If you do not change the filename when you save the file, you won't accidentally overwrite any other downloaded CMS file.



Once you have saved the file, you must access the CMS website using the CMSNet connection to perform the actual transmission. For help with CMSNet and the CMS website, refer to the data submission user's guide available on the **CMS Transmit File** page under the **Transmission Instructions** link on the left side of the screen. You can also reach QIES Technical Support at (877) 201-4721.

At this point, each assessment that has been included in your download file displays the status "xmit: Prepared" on the **LTRAX Launch Screen**. This status identifies those assessments that have been downloaded from LTRAX and should be in transmission to CMS. These assessments are locked and cannot be modified until they have been marked as either accepted by CMS or rejected by CMS in Step 3.

**STEP 3: ACCEPT/REJECT ASSESSMENTS**

After you have transmitted your assessments file to CMS, you should receive a final validation report detailing which assessments were accepted and which ones were rejected, and why. Use the CMS validation report to manually mark each assessment from the file you transmitted as **Accepted** or **Rejected**. At the top of the **CMS Transmit File** page, click **Skip to Step 3**. The following is similar to what you might see:

**Step 3** Accept / Reject Assessments

**Mark each assessment placed in a download file and sent to CMS as Accepted or Rejected.**  
Rejected assessments will be automatically set back to an "incomplete" state for editing and re-transmit.  
Accepted assessments can be corrected and re-transmitted if necessary.

**NOTE:** It is important to process your assessments to accurately reflect their status with CMS, i.e. if a Accepted, mark it Accepted; if it was Rejected, mark it Rejected. Corrections can be made to either.

File 'CMS\_LTRAX\_79\_120927\_154136.zip' created by Training, User on 09/27/12 03:41 PM EDT

Action	Name	Birth Date	Assess Type	Admit Date	Dis
<input checked="" type="radio"/> Leave <input type="radio"/> Rejected <input type="radio"/> Accepted	Transmit, CMS	05/05/1955	Admit	09/01/2012	
<input type="button" value="Update"/>	Set Transmission date to:	<input type="text" value="09/27/2012"/>	<a href="#">&lt;&lt;09/26/2012</a>	<a href="#">&lt;&lt;09/25/2012</a>	<a href="#">&lt;&lt;09/24/2012</a>

For each assessment, select the status that CMS assigned: **Accepted** or **Rejected**. If an assessment was accepted and you need to make some changes and retransmit, you can mark it as **Accepted** and then correct and retransmit it. Marking an assessment as **Rejected** automatically reverts that assessment back to an incomplete state so that the necessary corrections can be made. Once all assessments from a particular download file have been processed, that download file will no longer appear in Step 2.

You may select **Leave** to leave an assessment in Step 3 awaiting processing.

**CMS Transmission Date:** When you mark assessments as accepted by CMS, you have the opportunity to modify the transmission date using the box to the right of the **Update** button to reflect when the assessments were transmitted to and accepted by CMS. If the day that you mark the assessment as accepted is not the date that CMS received and accepted the assessment, you can also edit this date manually for the admission and/or discharge records on the **CMS INFO** tab on the assessment itself.


**NOTE:** If you need to edit and resubmit any assessments, you must create a new download file containing the edited assessments after you have processed those assessments in Step 3 and corrected the errors.

Once you have selected the appropriate status for each assessment, click **Update**. Then click **HOME** to return to the **LTRAX Launch Screen**.

## 2. Data Download (Custom Template)

The Data Download (Custom Template) allows you to select individual fields or groups of fields to include in a file you can download to your computer. It allows you to control the order in which those fields appear in your file. Data fields are grouped by sections based on the LTCH CARE Data Set and LTRAX patient assessment screens. In addition to LTCH CARE data, you can download data from facility custom data fields; the Pre-Admission Screening Tool; vent, wound, and skin (Braden) assessments; and patient satisfaction survey fields in your download file, giving you total control over the structure of your file. File download parameters can be saved as templates for future downloads, and these templates can be shared among users at a facility or organization. Customized data download templates also define the download parameters for hospitals and organizations with automated nightly data downloads. (Please contact LTRAX assistance for more information about automated downloads.)

The files you create are delimited text files that use the delimiter you specify. Each line in a file contains one record, and each record is separated by a carriage return (ASCII 10), with each element in the record separated by your selected delimiter. Depending on the fields you select to download, your data could be delivered in single file or across multiple files that can be downloaded either individually or in a single ZIP file. Please see the **Separate DAT Files**

column in the **File Structure** table in the documentation available under the  icon on the download screen for the list of fields that will download in separate files.

To download your custom template data file, log in to LTRAX and click **Downloads**, then click **Data Download (Custom Template)**. Depending on your user permissions, you may see some or all of the following options for setting your download parameters: Display Facility Templates, Load Saved Template, Select Facility Data to Download, Select and Arrange Data Fields, Choose Search Settings, Choose Settings for Download File, and Save Template for Future Downloads. Saved templates include all download parameters selected when the template was saved.

**NOTE:** If you do not see the **Downloads** or **Data Download (Custom Template)** options, you will need to contact your facility's LTRAX administrator and ask him or her to grant you the privilege "User can download assessments from their facility."

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### DOWNLOAD PARAMETERS

**Display Facility Templates:** This option allows users to view a list of all shared templates at each facility in their organization. Select a facility to display the list of shared templates for that facility.

**NOTE:** The **Display Facility Templates** option is only available to users belonging to an organization that has more than one subscriber facility on LTRAX, and the privilege to download data from multiple facilities can only be assigned by an LTRAX organization administrator.

**Load Saved Template:** This option allows you to load a previously saved template. Users can see templates they have created, plus all templates that have been shared by other users at their facility. To load a template, select the radio button next to the template name and click **Load**. Additionally, users can delete templates they have created by selecting the radio button next to the template name and clicking **Delete**.

**Select Facility Data to Download:** This option allows you to download data for an individual facility or multiple facilities in your organization, or for all facilities in your

organization combined. However, if you select more than one facility or the **All Facilities in Organization** option, your file will not contain facility custom fields.

**NOTE:** The **Select Facility Data to Download** option is only available to users belonging to an organization that has more than one subscriber facility on LTRAX, and the privilege to download data from multiple facilities can only be assigned by an LTRAX organization administrator.

**Select Available Fields:** This box displays all fields available for download, grouped by section. You can select individual fields or entire sections for download. To select an individual field, click on it. To select multiple fields, hold down the Ctrl key while you click on each field name. To select an entire section, click the section name. For example, to grab all of the patient demographic fields, select the section header labeled **Demographic Information (all fields)**. Use the >> button to move selected fields or sections from the **Select Available Fields** box into the **Arrange Selected Fields** box.

Alternately, you can use any of the links above the **Arrange Selected Fields** box as a shortcut to select a group of related data, such as LTCH CARE assessment data or LTCH patient criteria data. Clicking a shortcut link will place all of the grouped data fields into the **Arrange Selected Fields** box.

**Arrange Selected Fields:** This box allows you to arrange the fields in the order in which you want them to appear in your download file. To move a field up or down in the list, click on the field name, then click the up or down arrow to the right of the box. To remove a field from the list, click on the field name and click the X button to the right of the box.

**NOTE:** All records downloaded will include the seven fields that are always displayed at the top of the **Arrange Available Fields** box. Those fields are Provider ID, Assess Unique ID, Assess Type, Last Name, First Name, Birth Date, and Admit Date.

**Records that are currently:** This option refers to the record's current state. For example, if you select **planned discharge**, you will retrieve all available assessment data (admission and discharge) for assessments currently in a planned discharge record state that also meet your other search criteria. If you select **Admit**, you will retrieve all available assessment data for current admission records. However, if you select only **Admit** and you are looking for historic time periods, your search will probably not return any assessments, since presumably those patients would have since been discharged and their assessments would be in a discharge state.

**Payer:** This option controls whether your file will include **Medicare** assessments, **Non-Medicare** assessments, or both. You can select one or both of these options by checking the appropriate boxes. Make a payer selection for each kind of record you are downloading.

**Completion Status:** This option controls whether you will pull **Complete** or **Incomplete** assessments, or both. You can select one or both of these options by checking the appropriate boxes. Make a completion status selection for each kind of record you are downloading. This is only applicable to admission and discharge records.

**Transmission Status:** This option controls whether you will pull assessments that are **Not Accepted by CMS**, **Accepted by CMS**, and/or **Filed**. You can select any combination of these options by checking the appropriate boxes. Make a transmission status selection for each kind of record you are downloading. This is only applicable to admission and discharge records.

**Select A Date Range:** This option enables you to download by a specific date range. The first drop-down allows you to filter for assessments based on date created, last modified,

admitted, discharged, denied on (for denied pre-admissions), transmitted (for assessments that have been marked as accepted by CMS), referred, or screened.

**NOTE:** Make sure that when use a date range filter, you filter on a date that will be present in the records you are downloading. For example, if filtering by discharge date, you should not expect to download any pre-admission or admission assessments because those records do not contain discharge dates.

The second drop-down allows you to specify a date range that will be applied to the date type you selected in the first drop-down. Ranges include **All Records**, **Current Day**, **Last # Days** (includes today), **Previous # Days** (excludes today), and a specified date range. Select your date range and one or two boxes will appear to the right of the drop-down so you can enter either your number of days or your start and end dates. If you do not wish to apply a date filter, select **All Records**.

**Include column header in download file?:** This option controls whether your download file will contain a header record with all of the column names. If you want column names in your file, select **Yes**.

**Select Field Delimiter:** This option allows you to specify the character that will separate each individual data element in each record, with the recommended TAB character being the default.

**Share Template:** If you are saving your download options as a template and would like other users at your facility to be able to use your template, select **Yes**. If you want exclusive use of your template, select **No**.

**NOTE:** For organization-level downloaders: If your template includes facility custom data fields from one facility, and you select to use that template to download assessment data at a different facility, the facility custom data fields will be removed from the list of available fields and replaced by any facility custom fields that exist for the facility whose data you are downloading.

**Save Template:** If you wish to save your download options as a template, enter a name for the template into the **Name and Save Template** box and click **Save**. You can overwrite an existing template that you have created by saving a template with the same name. You cannot overwrite a template created by a different user. *You do not need to save a template in order to download a file with the download options you have selected.*

**Download your file:** Make your selections and click **Download**. You will see a list of the parameters you chose and links that say **Change Parameters** and **Create File**. If your file parameters look correct, click **Create File** to create the file, and a link to your file(s) will appear below. If you are downloading data that comes in separate files, you'll see links to each individual file plus a link to a ZIP file that will contain all of the individual files. If you have software that can unzip files, and you are comfortable with using it, you can click on the ZIP file link to download all of the individual files in one easy step. Otherwise, you can click on each file link to download each file separately.

When you click on a link to download a file, you should be prompted to save the file to your computer. You can change the filename if you wish when you save it to your computer. Make a note of where on your computer you save the file so you can find it after your download.

After you've downloaded your file (and unzipped it if necessary), you can refer to the instructions on the **File Downloads** screen for help with importing your file into Excel. Links to the files that you create are available on the custom template download screens for seven days after they were created.

## FILE STRUCTURE

If you specified that your file should include a header record, the first record in the file is the header record containing column names, each separated by your selected delimiter. The fields are included in the order you specified using the *Arrange Selected Fields* box. The facility custom field names listed in the file header are those defined in the *Element Name* box on the **Custom Data Fields Management** screen by an LTRAX facility administrator. See the download specification for other column names.

**NOTE:** If you view your downloaded data using older versions of Microsoft Excel (2003 and prior), the program will limit the allowed columns to 256.

While the individual records generally appear in the order in which they were initially created, this is not guaranteed, so no assumptions should be made regarding order. Null values are not specified by any particular sequence of characters other than having no characters between two delimiters.

All downloaded files contain the seven fields listed in the file specification in red text.

The first value in each record is the Medicare Provider ID (CCN) of the facility to which the record belongs.

The second value in each record is the unique ID assigned to the assessment by LTRAX. This value is numeric and can be used by a facility to uniquely identify each record. If the system that imports the data instead assigns its own ID, the LTRAX unique ID should nonetheless be kept so that after future downloads, duplicate or updated records can be easily identified.

The third value in each record indicates the current state of the assessment: P for pre-admission, A for admission, D for planned discharge, DU for unplanned discharge, DE for expired, and XP/XA/XD/XDU/XDE for deleted assessments of each type.


The complete file specification, including a list of field names with their data types grouped by section of the assessment record, can be found in the documentation available under the

 **HELP** icon at the top of the **Data Download (Custom Template)** screen.

### 3. HCAHPS Upload

Patient satisfaction surveys should be mailed to LTRAX for electronic upload into patient assessments and patient satisfaction reports. The following descriptions of the survey file format and upload process are provided to help you better understand the patient satisfaction service LTRAX provides.

Although individual hospitals should not scan and upload patient satisfaction data into LTRAX, they may opt to enter the data from returned surveys by hand on the **P.S.I.** tab of the patient's assessment. More information about manually entering survey data can be found in the

documentation available via the  **HELP** icon on the **P.S.I.** tab of any patient assessment and in the [LTRAX Patient Satisfaction System](#) section of this manual.

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## IDENTIFYING FIELDS & MATCHING ASSESSMENTS

Each record must contain four types of identifying fields: SurveyType, FacilityID, SurveyID, and DatePrinted.

The first and last field in each record is SurveyType, a one-character value that identifies the survey type. The valid value is:

H: HCAHPS Survey

SurveyType1 is the first field in the record; SurveyType2 is the last field in the record. The value is contained in the barcode that appears in the bottom left corner of each page.

The second field in each record is FacilityID, which identifies the Medicare Provider ID (CCN) for the patient's facility. The value is contained in the barcode on the top left corner of the first printed page of the survey.

The third and second-to-last fields in the record are SurveyID. SurveyID1 is the third field in the record, and SurveyID2 is the second-to-last. The value is contained in the barcode in top right of each page of the printed survey. SurveyID matches the UniqueID of the assessment record in LTRAX.

The fourth field in the record is DatePrinted, which identifies the date of printing but does not necessarily correspond to the month in which the survey will appear in outcomes reports. The value is contained in the barcode in the bottom right corner of the first page of the printed survey.

SurveyID is used to identify the LTRAX assessment to which the survey belongs. This value appears in the record once for each survey page. The redundant SurveyIDs ensure that if printed survey pages are shuffled out of order, the data is rejected, and only correct data is uploaded to the appropriate LTRAX assessment.

SurveyIDs are also used during the upload process to find existing (matching) surveys already saved in the system.

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## FAILED UPLOADS & OTHER ERRORS

The **PSI Scan Upload** uploader performs logic and error checking to ensure that only valid, consistent data is uploaded into LTRAX. There are a few things that may interfere with an upload:

- If any of the printed bar codes have been written over or damaged, it may cause delays by preventing the scanner from reading information necessary for a successful upload.
- If an uploaded survey is found to match a previously uploaded survey (and all fields match), then the survey will not upload with the stated reason, "No difference with previous survey answers."
- If a survey has already been uploaded for a given SurveyID and another survey for that SurveyID is uploaded, the original will be overwritten if the second survey has different answers.
- A blank value may be uploaded for a question as long as the chosen delimiter is used as a placeholder. In this instance, the value saved to the system will be **Not Answered**.
- If a whole survey is blank, then it will fail to upload with the stated reason, "No difference with previously uploaded data."



- If a patient answered multiple values for a single question, the resulting file will contain "Multi" as an answer for the question. However, the question with "Multi" will be saved as **Not Answered**, the same value that is saved when the question is left blank.

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### SURVEY UPLOAD FILE FORMATS

The following examples show what a file could look like when it is uploaded to LTRAX. The first row contains a complete survey, the second a partially filled out survey, the third a blank survey, and the fourth a survey that will not be uploaded.

*H,99,123456,01012014,4,3,3,2,4,3,3,3,4,1,4,1,3,4,1,4,4,3,1,1,9,4,123456,H*

*H,99,234567,01012014,4,3,3,2,4,3,3,3,,,,,1,3,4,1,4,,,1,1,9,4,234567,H*

*H,99,345678,01012014,,,,,,,,,,,,,,,,,,,,,345678,H*

*L,9?9,456789,0?012014,4,3,3,2,4,3,3,3,4,1,4,1,3,4,1,4,4,3,1,1,9,4,567891,H*

**LTRAX Patient Satisfaction Survey Upload File Format**

Name or Survey Question Number	Value	Notes
SurveyType	H	H = HCAHPS Survey, as printed in bar code on lower left corner of survey page 1
FacilityID	xxxxxx	Hospital's Medicare Provider ID (CCN), as printed in bar code on upper left corner of survey page 1
SurveyID	6-7 digits	Survey ID, as printed in bar code on upper right corner of survey page 1
Date	mmddyyyy	Date the survey was printed, as printed in bar code on lower right corner of survey page 1
Q1 - Q3	1-4 or blank	
Q4	0-4 or blank	
Q5 - Q9	1-4 or blank	
Q10	1, 2 or blank	
Q11	1-4 or blank	
Q12	1, 2 or blank	
Q13 - Q14	1-4 or blank	
Q15	1, 2 or blank	
Q16 - Q17	1-4 or blank	
Q18	1-3 or blank	
Q19 - Q20	1, 2 or blank	
Q21	0-10 or blank	
Q22 - Q24	1-4 or blank	
Q25	1-5 or blank	
Survey ID	6-7 digits	Survey ID, as printed in bar code upper right corner of survey page 2
SurveyType	H	H = HCAHPS Survey, as printed in bar code on lower left corner of survey page 2

## II.E. Reports (Outcomes)

If you have been granted access to view Administrative or Clinical Outcomes Reports, you will see the **Reports** header on the left side of your **LTRAX Launch Screen**. Depending on your user privileges, under this header you may see any combination of the following options:

1. [Outcomes](#)
2. [Patient Criteria Report](#)
3. [Referrals Outcomes](#)
4. [HCAHPS Outcomes](#)
5. [Dashboards](#)
6. [Transmissions](#)
7. [HL7 Messages](#)

**NOTE:** In order to access any of the outcomes reports, you must have the appropriate reports viewing privileges. If you cannot access the outcomes reports, contact your facility's LTRAX administrator and ask him or her to grant you the "User can view all Administrative-level reports for their facility" privilege and/or the "User can view all Clinical reports for their facility" privilege. For patient satisfaction outcomes reports only, ask for the privilege "User can ONLY view Patient Satisfaction outcomes reports for their facility."

### 1. Outcomes

To get to the outcomes report menu, from your **LTRAX Launch Screen** click **Outcomes**. The core LTRAX outcomes reports are separated into Administrative and Clinical Report groupings, which are delivered in a four-tiered hierarchy under the **Administrative Drill-Down** and **Clinical Drill-Down** headers. The reports start at the top with the overall Facility Report, and then drill down into the MDC and DRG levels. Users with organization-level reports access will also see links to the Facility Ranking Reports.

1. [Outcomes Reports General Information](#)
2. [Outcomes Reports Inclusion Requirements](#)
3. [Outcomes Reports Drill-Down Levels](#)
  - A) [Facility Ranking](#)
  - B) [Facility Report](#)
  - C) [MDC Report](#)
  - D) [DRG Report](#)
4. [Outcomes Reports Regions](#)
5. [Weighted vs. Unweighted Numbers](#)
6. [Outcomes Reports Measures](#)
  - A) [Administrative Outcomes Measures](#)
  - B) [Clinical Outcomes Measures](#)

## OUTCOMES REPORTS GENERAL INFORMATION


The LTRAX drill-down outcomes reports show you performance measures for your facility for various time periods dating back to the initial release of LTRAX in April 2011, including individual months and calendar year quarters, as well as trailing 30-, 60-, 90- and 180-day, calendar year, and fiscal year periods. Your facility is shown compared to your geographic region and the nation as a whole.

Drop-down menus at the top of the drill-down reports screens allow you to select different time periods, payers, and regions. Records are included in a time period based on varying dates depending upon the measure. For example, *Admissions in Sample* counts the number of patients admitted during the selected time period based on the admission date, while *Discharges in Sample* counts the number of patients discharged during the time period based on discharge date, and *Referrals* counts the total number of referrals based on either admission date or date denied, depending on the status of the record. See the [Outcomes Reports Measures](#) section below for information on individual measures.

The Medicare payer selection only includes assessments where Medicare (traditional fee-for-service) was chosen as a payer. Non-Medicare includes all other payers and records where payer was omitted.

Many of the comparisons include “weighted” and “unweighted” national and regional numbers. The weighted numbers are benchmarks that use DRGs to volume-adjust national or regional patterns to exactly match the case mix in your facility. For this reason, the weighted numbers give you a more accurate picture of how your facility compares to other facilities in the nation and your region.

The drill-down reports are updated nightly. A time stamp at the top of the report indicates the last time the reports were generated.

Some reports are available as PDF documents. On reports where this is available, near the top of the report screen is a  **PRINT PDF** button that you can click to open a new window displaying a PDF version of the report. You can then click the print icon in the new window to print your report.

**NOTE:** This requires Adobe Reader software. If you don't already have Reader installed on your computer, you can get the latest version from the [Adobe website](#).

Some reports are also available as an Excel spreadsheet. On reports where this is available, near the top of the report screen is an  **OPEN/EXCEL** button that you can click to either open the comma separated (.csv) file as an Excel spreadsheet or save the .csv file to your computer.

We suggest that national and regional benchmarks not be heavily relied upon for periods of less than 90 days, regardless of the time period you select.

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## OUTCOMES REPORTS INCLUSION REQUIREMENTS

In order to be included in the LTRAX outcomes reports, all records must meet the following minimum standards:

**Referral-based measures:** These are measures under the *Referrals* heading in the Administrative Outcomes Reports. In order to be included in these measures, a record must have at least one pre-admission screening, along with an admission date or a denial date.

**Admission-based measures:** These are measures under the *Admissions* heading in the Administrative Outcomes Reports. In order to be included in these measures, a record must have an admission date.

**Discharge-based measures:** These are all measures in the Administrative Outcomes Reports other than referrals and admissions measures. These are also all measures in the Clinical Outcomes Reports. In order to be included in these outcomes measures, a record must be marked accepted by CMS. For records that predate the LTCH Quality Reporting Program, records must have a discharge date, a valid discharge DRG, and a discharge destination (or expired). Records with discharge DRGs 998 (Principal Diagnosis Invalid as Discharge Diagnosis) and 999 (Ungroupable) are excluded from outcomes.

See the [Outcomes Reports Measures](#) section below for more information on individual measure requirements.

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## OUTCOMES REPORTS DRILL-DOWN LEVELS

### Facility Ranking

Under the Administrative or Clinical Drill-Down Reports menu, click **Facility Ranking**. For users belonging to organizations with more than one facility in LTRAX, the Facility Ranking Report allows you to display any individual outcomes measure to compare all facilities in your organization. A measures drop-down at the top of the report table lets you select the measure to display. The privileges "User can view all Administrative-level reports for all facilities in their organization (includes all facilities)" and "User can view all Clinical reports for all facilities in their organization (includes all facilities)" control access to the Facility Ranking Reports.

In addition to the *Facility*, *Region/Org*, and *Time Period* drop-downs available on the other reports screens, the Facility Ranking Report also includes a *Detail Level* drop-down that lets you view measures for all of your facilities at the facility level or at the DRG-MDC or DRG level. If you select anything other than *Facility* in the *Detail Level* drop-down, a second drop-down appears for you to select your detail category.

For most measures, you will see organization variance and national variance percentages. Variances are calculated by subtracting the organization or nation value from the facility value and then dividing by the organization or nation measure value.

To change the sort order of the report table, click on the column header for the column by which you want to sort the report. Clicking on the header once will sort the report in ascending order by that value. Clicking on the header a second time will sort the report in descending order. A lightly shaded background identifies the sort column.

**Facility Report**

Under the Administrative or Clinical Drill-Down Reports menu, click **Facility Report**. Your Facility Report displays all available measures for all patients in your facility for your selected time period with national and regional benchmarks.

**MDC Report**

Under the Administrative or Clinical Drill-Down Reports menu, click **MDC Report** to view the Major Diagnostic Category Report menu. On the left side of the screen is a list of the MDCs with counts of facility admissions and discharges for the selected time period and payer. Click on an MDC to view facility, national, and regional comparisons of all available measures for the selected MDC.

On the right side of the MDC Report menu screen is a list of all available measures. Click on a measure to view facility, national, and regional data for that measure for each MDC. From this screen, you can click on an MDC to jump directly to the report of all measures for that MDC.

**DRG Report**

Under the Administrative or Clinical Drill-Down Reports menu, click **DRG Report** to view the Diagnosis-Related Group Report menu. On the left side of the screen is a list of DRGs with counts of facility admissions and discharges for the selected time period and payer. This list only includes DRGs for which there were facility admissions and/or discharges. Click on a DRG to view facility, national, and regional comparisons of all available measures for the selected DRG.

On the right side of the DRG Report menu screen is a list of all available measures. Click on a measure to view facility, national, and regional data for that measure for each DRG containing facility data for the selected time period and payer. Check the **Show all DRGs** checkbox at the top of the screen to view the facility, national, and regional data for the selected measure for each DRG containing national data for the selected time period and payer. From this screen you can click on a DRG to jump directly to the report of all measures for that DRG.

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**OUTCOMES REPORTS REGIONS**

Regions are defined as the nine U.S. Census Regions, as follows:

**Outcomes Reports Regions**

Region	State
New England	Connecticut Maine New Hampshire Rhode Island Vermont
Middle Atlantic	New Jersey New York Pennsylvania

**Outcomes Reports Regions (Continued)**

Region	State
South Atlantic	Delaware Florida Georgia Maryland North Carolina South Carolina Virginia Washington DC West Virginia
East North Central	Illinois Indiana Michigan Ohio Wisconsin
East South Central	Alabama Kentucky Mississippi Tennessee
West North Central	Iowa Kansas Minnesota Missouri Nebraska North Dakota South Dakota
West South Central	Arkansas Louisiana Oklahoma Texas
Mountain	Arizona Colorado Idaho Montana Nevada New Mexico Utah Wyoming
Pacific	Alaska California Hawaii Oregon Washington

**WEIGHTED VS. UNWEIGHTED NUMBERS**

Some measures offer “weighted” and “unweighted” calculations. Unweighted numbers are the raw (unadjusted) values of the indicated measures. Weighted calculations adjust the national and regional values to match the case mix at your facility. Weighted measures minimize the effect of case mix when comparing your facility to the nation or your region.

Weighted numbers are created by calculating the average value for each DRG for the nation and region for a given measure, then volume-adjusting the averages to match the actual case mix volumes at your facility.

For example, we calculate the weighted discharge destinations as follows: For each DRG, we count the number of discharges to a given destination for the nation and region and

divide by the number of discharges to all destinations for the nation and region. This gives us the national and regional rates for each discharge destination and DRG. These rates are multiplied by the count of discharges from the facility for the same destination and DRG. The results of these multiplications are summed over all DRGs and divided by the count of all discharges for the facility, giving us the volume-adjusted rates for each discharge destination for the nation and the region.

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## OUTCOMES REPORTS MEASURES

### Administrative Outcomes Measures

#### Referrals

##### **Referrals**

The count of pre-admission assessments during the selected time period (based on admission date for successful conversions or denial date for denied referrals), excluding the rescreening of Medicare patients readmitted to continue an interrupted stay.

##### **Referral Conversions**

The count and percentage of pre-admission assessments that were converted to admissions during the selected time period (based on admission date), excluding the readmission of Medicare patients continuing an interrupted stay.

##### **Highest Referral Percentage**

The highest percentage of admissions referred from a single facility during the selected time period (based on admission date).

##### **Top Referring Facility**

The name of the referring facility with the highest number of admissions during the selected time period (based on admission date).

#### Admissions

##### **Admissions in Sample**

The number of admissions during the selected time period (based on admission date). The readmissions of Medicare patients experiencing interrupted stays are not counted as admissions.

##### **Ventilator Weaning Admissions**

The count and percentage of ventilator patients admitted during the selected time period deemed appropriate candidates for weaning, as indicated by "Yes" in answer to **OO100F3. Invasive Mechanical Ventilator: weaning** on the **VENT** tab. This measure displays for admissions April 1, 2016, and later.

##### **30-Day Readmissions**

The count and percentage of patients readmitted within the period starting the day after discharge through the end of the 30-day readmission window monitored for CMS quality reporting in All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (NQF #2512) and Potentially Preventable 30-Days Post-Discharge Readmission Measure for Long-Term Care Hospital Quality Reporting Program. The CMS 30-day readmission window ends 31 days after discharge. It begins on day 2 after discharge, where day 1 is the day after the patient's discharge date.



Patients appear in the selected time period based on readmission date. This measure excludes the readmission of Medicare patients to continue an interrupted stay.

### Patient Days

The total number of days all patients were present in the facility during the selected time period (based on admission date and discharge date, or admission date and the last day of the time period if discharge date is not entered). A patient is counted as present in the facility for the day if he or she stayed over midnight. This measure is adjusted to subtract days when a patient is absent from the facility, regardless of whether the days away count toward the patient's length of stay. (See **Average Length of Stay** below for more information.)

### Bed Days

The number of facility beds multiplied by the number of days in the selected time period. A facility's bed count can be configured by users with LTRAX facility administrator privileges.

### Occupancy Rate

Percent of filled bed days during the selected time period, calculated as bed days divided by patient days. (See **Bed Days** and **Patient Days** above for more information.)

## LTCH Quality Reporting Program

### Incomplete Stays

The percentage and count of visits — in which a visit is represented by an LTCH CARE Admission Assessment and its corresponding Discharge Assessment — in which the patient did not complete the expected course of care.

A patient's visit is considered an incomplete stay if any of the following occur:

- The patient discharged with an LTCH CARE Unplanned or Expired Discharge
- The patient discharged to any of the following locations, as recorded in **A2110. Discharge Location** on the **DISCHG** tab:
  - 04 - Hospital emergency department
  - 05 - Short-stay acute care hospital (IPPS)
  - 06 - Long-term care hospital (LTCH)
  - 08 - Psychiatric hospital or unit
  - 12 - Discharged against medical advice
- The patient stayed less than 3 days

**Incomplete Stays** is shown as a percentage of discharge assessments transmitted during the selected time period.

### On-Time Transmission (Admission and Discharge)

The percent and count of admission and discharge assessments marked accepted by CMS that were transmitted to CMS on time. Each assessment must have a recorded transmission date to be included in these transmission measures. "On time" is defined in the [LTCH QRP Manual](#) as follows:

Admission assessments are considered "on time" if the original date accepted by CMS falls on or before the earliest of the following dates:

- Assessment completion date + 7 calendar days, or
- Admission assessment reference date + 12 calendar days, or
- Admission date + 14 calendar days

Discharge assessments are considered "on time" if the original date accepted by CMS falls on or before the earliest of the following dates:

- Assessment completion date + 7 calendar days, or
- Discharge assessment reference date + 12 calendar days, or
- Discharge date + 12 calendar days

### **Complete QRP Data**

The combined percent and count of admission and discharge assessments Accepted by CMS with complete quality data. Medicare requires that 80% of assessments submitted during a calendar year contain all required quality data for an LTCH to avoid a reimbursement penalty in the subsequent fiscal year.

### **Incomplete QRP Data (Admission and Discharge)**

The percent and count of admission and discharge assessments marked accepted by CMS that lack LTCH Quality Reporting Program (QRP) data. The completion requirements for these assessments were overridden, enabling transmission to CMS with incomplete QRP data.

## **Discharges**

### **Discharges in Sample**

The number of discharges during the selected time period (based on discharge date). The transfers of Medicare patients who later return to continue interrupted stays are not counted as discharges.

**NOTE:** Unless otherwise specified in the measure description, Administrative Outcomes measures that follow **Discharges in Sample** have been adjusted to consider two or more assessments as a single record for Medicare patients who experienced interruption(s) in stay. For more information about how LTRAX handles interruptions for Medicare patients, please see [Interruptions in Stay/Leave of Absence \(LOA\)](#).

### **Average Length of Patient Stay**

The average length of patient stay during the selected time period (based on discharge date). Interruptions in stay are subtracted from a patient's length of stay as follows:

- Program interruptions of three or fewer days are subtracted for non-Medicare patients.
- Program interruptions of three or fewer days are subtracted for Medicare patients who transfer to a location other than a short stay acute hospital (IPPS), inpatient rehabilitation facility or unit (IRF), or skilled nursing facility (SNF).

- Program interruptions of four or more days are subtracted for Medicare patients who transfer to the following locations and return during the relevant time period:
  - Short stay acute hospital (IPPS) = 4 to 9 days
  - Inpatient rehabilitation facility or unit (IRF) = 4 to 27 days
  - Skilled nursing facility (SNF) = 4 to 45 days

### Average Age

The average patient age at admission for patients discharged during the selected time period.

### Gender

The counts and percentages of male and female patients discharged during the selected time period.

### Case Mix Index (CMI)

The average Medicare Severity Long-Term Care Diagnosis Related Group (MS-LTC-DRG) payment weight for patients discharged during the selected time period. Higher numbers indicate higher average acuity. Payment weights for MS-LTC-DRG are available from the [CMS PC Pricer website](#).

### Wound Patients

The count and percentage of wound patients discharged during the selected time period. A patient must have at least one wound assessed on the **WOUNDS** tab to be counted in this measure.

### Ventilator Patients

The count and percentage of mechanical ventilation patients discharged during the selected time period. To be counted in this measure, an assessment done during the patient's stay must have "Yes" saved for **00100F3. Invasive Mechanical Ventilator: weaning** or **00100F4. Invasive Mechanical Ventilator: non-weaning** on the **VENT** tab when the assessment has an admission date of April 1, 2016, or later. Assessments with admission dates prior to April 1, 2016, must have data of any kind saved on the **VENT** tab. LTCH Prospective Payment System

### Short Stays

The count and percentage of discharges during the selected time period that qualify as a short stay under CMS regulations. CMS defines a short stay as a length of stay up to and including five-sixths the average length of stay for the patient's MS-LTC-DRG.

For Medicare patients experiencing an interruption in stay; three or fewer days at a short stay acute hospital (IPPS), inpatient rehabilitation facility or unit (IRF), or skilled nursing facility (SNF), count toward the patient's length of stay. Days at other transfer destinations, and interruptions of four or more days, do not count toward the length of stay for Medicare patients. For non-Medicare patients, all days away from the facility do not count toward the patient's length of stay.

### Interrupted Stays

The count and percentage of patients discharged within the selected time period who had a qualified interruption in stay. A patient is considered to have

had an interruption in stay if **A2500. Program Interruptions** on the **DISCHG** tab is answered **yes**, or the patient is a Medicare patient who transferred to any of the following destinations and readmitted within the designated time span described below. For more information about how LTRAX handles interruptions for Medicare patients, please see [Interruptions in Stay/Leave of Absence \(LOA\)](#).

- Short stay acute hospital (IPPS) = 4 to 9 days
- Inpatient rehabilitation facility or unit (IRF) = 4 to 27 days
- Skilled nursing facility (SNF) = 4 to 45 days

### **Discharge Location**

#### **Discharge Destination Categories**

The percentage and count of patients discharged to one of a group of discharge settings during the selected time period, with weighted (case mix-adjusted) and unweighted national and regional comparisons. For more information on the weighted calculations, please see the [Weighted vs. Unweighted Numbers](#) section above.

**NOTE:** Some discharge destinations are grouped into more than one category.

The categories are defined as follows:

**Community Discharges:** Patients discharged to any of 1 - **Community residential setting**; 2 - **Long-term care facility (LTC)** (only if Pre-Hospital Living Setting was Long-Term Care); 10 - **Hospice**; or 12 - **Discharged against medical advice**, as recorded for **A2110. Discharge Location** on the **DISCH** tab.

**Lower Level of Care Discharges:** Patients discharged to any of 1 - **Community residential setting**; 2 - **Long-term care facility (LTC)**; 3 - **Skilled nursing facility (SNF)**; 7 - **Inpatient rehabilitation facility (IRF)**; or 9 - **ID/DD facility**, as recorded for **A2110. Discharge Location** on the **DISCH** tab.

#### **Discharge Destination**

The percentage and count of patients discharged to each discharge setting during the selected time period, with weighted (case mix-adjusted) and unweighted national and regional comparisons. For more information on the weighted calculations, please see the [Weighted vs. Unweighted Numbers](#) section above.

### **Clinical Outcomes Measures**

#### **Discharges in Sample**

The number of discharges during the selected time period (based on discharge date). The transfers of Medicare patients who later return to continue interrupted stays are not counted as discharges.

**NOTE:** Unless otherwise specified in the measure description, Administrative Outcomes measures that follow **Discharges in Sample** have been adjusted to consider two or more assessments as a single record for Medicare patients who experienced interruption(s) in stay. For more information about how LTRAX handles interruptions for Medicare patients, please see [Interruptions in Stay/Leave of Absence \(LOA\)](#).

### Average Length of Patient Stay

The average length of patient stay during the selected time period (based on discharge date). Interruptions in stay are subtracted from a patient's length of stay as follows:

- Program interruptions of three or fewer days are subtracted for non-Medicare patients.
- Program interruptions of three or fewer days are subtracted for Medicare patients who transfer to a location other than a short stay acute hospital (IPPS), inpatient rehabilitation facility or unit (IRF), or skilled nursing facility (SNF).
- Program interruptions of four or more days are subtracted for Medicare patients who transfer to the following locations and return during the relevant time period:
  - Short stay acute hospital (IPPS) = 4 to 9 days
  - Inpatient rehabilitation facility or unit (IRF) = 4 to 27 days
  - Skilled nursing facility (SNF) = 4 to 45 days

### Average Age

The average patient age at admission for patients discharged during the selected time period.

### Gender

The counts and percentages of male and female patients discharged during the selected time period.

### Case Mix Index (CMI)

The average Medicare Severity Long-Term Care Diagnosis Related Group (MS-LTC-DRG) payment weight for patients discharged during the selected time period. Higher numbers indicate higher average acuity. Payment weights for MS-LTC-DRG are available from the [CMS PC Pricer website](#).

## **PRESSURE ULCERS: ADMISSION TRANSMISSIONS**

### Admission Transmissions

The percent and count of admission assessments transmitted to CMS during the selected time period (based on admission date).

### **Pressure Ulcers Assessed**

The percent and count of admission assessments transmitted to CMS with complete Skin data.

### **Pressure Ulcers Not Assessed**

The percent and count of admission assessments transmitted to CMS with incomplete Skin data.

"Incomplete" is defined as:

- a) **M0210** = Yes, but no counts of pressure ulcers stage 2, 3, or 4 were entered on **SKIN (M0300 B1, C1, D1)**, or

b) **M0210** = unspecified (i.e., not answered)

### **Admission Transmissions with Pressure Ulcers**

The percent and count of admission records transmitted to CMS where pressure ulcers were present, shown as a total and broken down by stage. Because this is a count of records with pressure ulcers and not a sum of pressure ulcers at each stage, some records may contain multiple pressure ulcers at different stages. Therefore, the sum of counts by stage may exceed the total displayed under **Any**. Only records where the count for at least one stage of pressure ulcer is greater than zero are included in the **Any** group.

## **PRESSURE ULCERS: DISCHARGE TRANSMISSIONS**

### **Discharge Transmissions**

The percent and count of discharge records transmitted to CMS during the selected time period, shown as a total and broken down by type (planned, unplanned, and expired), with weighted and unweighted national and regional comparisons (based on discharge date).

### **Planned & Unplanned Discharge Transmissions**

**Pressure Ulcers Assessed:** The percent and count of planned and unplanned discharge records transmitted to CMS with complete Skin data.

**Pressure Ulcers Not Assessed:** The percent and count of planned and unplanned discharge records transmitted to CMS with incomplete Skin data.

“Incomplete” is defined as:

- a) **M0210** = Yes, but no counts of pressure ulcers stage 2, 3, or 4 were entered on **SKIN (M0300 B1, C1, D1)**, or no counts of new/worsened pressure ulcers were entered on **SKIN (M0800 A, B, C)**; or
- b) **M0210** = unspecified (i.e., not answered)

### **Planned & Unplanned Discharge Transmissions with Pressure Ulcers**

The percent and count of planned and unplanned discharge records transmitted to CMS where pressure ulcers were present, shown as a total and broken down by stage. Because this is a count of records with pressure ulcers and not a sum of pressure ulcers at each stage, some records may contain multiple pressure ulcers at different stages. Therefore, the sum of counts by stage may exceed the total displayed under **Any**. Only records where the count for at least one type of pressure ulcer is greater than zero are included in the **Any** group.

### **New or Worsened Pressure Ulcers**

The percent and count of planned and unplanned discharge records transmitted to CMS with new or worsened pressure ulcers as identified on the **SKIN** tab in questions **M0800 A, B, and C**. Because this is a count of records with pressure ulcers and not a sum of pressure ulcers at each stage, some records may contain multiple pressure ulcers at different stages. Therefore, the sum of counts by stage may exceed the total displayed under **Any (Stages 2, 3, or 4)**.

## **INFLUENZA VACCINATION — Patients Assessed and Appropriately Given the Seasonal Influenza Vaccine (NQF #0680)**

### **Flu Season Vaccination Patients**

The count of patient visits — where a visit is represented by an LTCH CARE Admission Assessment and its corresponding Discharge Assessment — that overlap the influenza vaccination season and include a discharge within the same year's influenza season. The influenza season begins July 1 and ends June 30. The influenza vaccination season begins Oct. 1 and ends Mar. 31. For example, the 2015-16 influenza season began July 1, 2015, and ended June 30, 2016. The 2015-16 influenza vaccination season began Oct. 1, 2015, and ended Mar. 31, 2016.

*Flu Season Vaccination Patients* excludes patients younger than six months old during the flu vaccination season. For time periods before April 1, 2016, the count also excludes expired patients. This measure displays for discharges July 1, 2014, and later.

*Flu Season Vaccination Patients* is also shown as a percentage of discharge transmissions for the selected time period, excluding expired discharges in time periods prior to April 1, 2016.

### **Assessed and Appropriately Vaccinated**

The count and percentage of *Flu Season Vaccination Patients* whose admission and/or discharge assessment shows the patient was vaccinated for the most recent influenza season, was offered and declined the vaccine, or was ineligible due to medical contraindication(s). If a patient's visit overlaps more than one flu vaccination season, the measure will look only to the discharge assessment for the patient's flu vaccine status.

Patients assessed and appropriately vaccinated appear in one of the measure's three subcategories. If a patient's admission and discharge assessments both qualify the patient as assessed and appropriately vaccinated, the patient's discharge assessment is used to assign the patient to a subcategory.

#### **Vaccinated**

The count and percentage of *Flu Season Vaccination Patients* vaccinated for the current influenza season. The patient may have been vaccinated inside the facility (**00250A. Did the patient receive the influenza vaccine in this facility for this year's influenza vaccination season? = "Yes"**) or outside the facility (**00250C. If influenza vaccine not received, state reason = "2. Received outside of this facility"**).

#### **Offered and Declined**

The count and percentage of *Flu Season Vaccination Patients* who were not vaccinated because they declined the vaccine (**00250C. If influenza vaccine not received, state reason = "4. Offered and declined"**).

#### **Contraindicated**

The count and percentage of *Flu Season Vaccination Patients* who were not vaccinated due to medical contraindication(s) (**00250C. If**

influenza vaccine not received, state reason = "3. Not eligible - medical contraindication").

### **FALLS — Patients Experiencing One or More Falls with Major Injury (NQF #0674)**

#### **Falls with Major Injury**

The count of visits — where a visit is represented by an LTCH CARE Admission Assessment and its corresponding Discharge Assessment — in which the patient had one or more falls that resulted in a major injury.

*Falls with Major Injury* is shown as a percentage of discharge assessments transmitted during the selected time period. The calculation excludes visits for which the occurrence of falls (**J1800. Any falls since admission?**) was not coded, or for which a fall occurred (**J1800** = "Yes") but **J1900. Falls with Major Injury** was not coded. This measure displays for discharges April 1, 2016, and later.

### **FUNCTIONAL ASSESSMENT — Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)**

#### **Functional Assessment and Care Plan: Observed Score**

The percentage and count of visits — where a visit is represented by an LTCH CARE Admission Assessment and its corresponding Discharge Assessment — in which the patient had a complete functional assessment and at least one functional goal, indicating a care plan that addresses function.

A complete functional assessment for patients without *Incomplete Stays* requires all functional items below be coded at admission and discharge. Patients with *Incomplete Stays* need only have functional items coded at admission (see [Incomplete Stays](#) above for more information). All patients need at least one functional goal. This measure displays for discharges April 1, 2016, and later.

#### **GG0301. Self-Care**

- A. Eating
- B. Oral Hygiene
- C. Toileting Hygiene
- D. Wash Upper Body

#### **GG0170. Mobility**

- A. Roll left and right
- B. Sit to lying
- C. Lying to sitting on side of bed
- D. Sit to stand
- E. Chair/bed-to-chair transfer
- F. Toilet transfer
- I. Walk 10 feet (if patient is walking)
- J. Walk 50 feet with 2 turns (if patient is walking)
- K. Walk 150 feet (if patient is walking)
- R. Wheel 50 feet with 2 turns (if patient uses a wheelchair or scooter)
- RR. Type of wheelchair (if patient uses a wheelchair or scooter)
- S. Wheel 150 feet (if patient uses a wheelchair or scooter)
- SS. Type of wheelchair (if patient uses a wheelchair or scooter)

#### **BB0700. Expression of Ideas and Wants**



**BB0800. Understanding Verbal Content****C1610. Confusion Assessment Method**

- A & B. Acute Onset & Fluctuating
- C. Inattention
- D. Disorganized Thinking
- E1 & E2. Altered Consciousness

**H0350. Bladder Continence****FUNCTIONAL ASSESSMENT — Cross-Setting Application of Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)****Cross-Setting Functional Assessment and Care Plan: Observed Score**

The percentage and count of visits — where a visit is represented by an LTCH CARE Admission Assessment and its corresponding Discharge Assessment — in which the patient had a complete functional assessment and at least one functional goal, indicating a care plan that addresses function.

The cross-setting application of the functional assessment and care plan measure is calculated in the same manner as the [LTCH-specific measure](#) but uses a subset of data. For the cross-setting application, a complete functional assessment for patients without *Incomplete Stays* requires all functional items below be coded at admission and discharge. Patients with *Incomplete Stays* need only have functional items coded at admission (see [Incomplete Stays](#) above for more information). All patients need at least one functional goal. This measure displays for discharges April 1, 2016, and later.

**GG0301. Self-Care**

- A. Eating
- B. Oral Hygiene
- C. Toileting Hygiene

**GG0170. Mobility**

- B. Sit to lying
- C. Lying to sitting on side of bed
- D. Sit to stand
- E. Chair/bed-to-chair transfer
- F. Toilet transfer
- J. Walk 50 feet with 2 turns (if patient is walking)
- K. Walk 150 feet (if patient is walking)
- R. Wheel 50 feet with 2 turns (if patient uses a wheelchair or scooter)
- RR. Type of wheelchair (if patient uses a wheelchair or scooter)
- S. Wheel 150 feet (if patient uses a wheelchair or scooter)
- SS. Type of wheelchair (if patient uses a wheelchair or scooter)

**VENTILATOR PATIENT MOBILITY — Change in Mobility Among Patients Requiring Ventilator Support (NQF #2632)****Invasive Ventilator Admissions**

The percentage and count of patients admitted on invasive mechanical ventilation, both weaning and non-weaning, as identified by "Yes" saved in either **00100F3. Invasive Mechanical Ventilator: weaning** or **00100F4. Invasive Mechanical Ventilator: non-weaning** on the **VENT** tab. This

measure is shown as a percentage of discharge transmissions for the selected time period and displays for discharges April 1, 2016, and later.

### **Ventilator Mobility Patients**

The percentage and count of invasive ventilator patients eligible for inclusion in the mobility change calculations.

Ventilator Mobility Patients must be admitted on invasive mechanical ventilation (see [Invasive Ventilator Admissions](#) above) but are excluded from the mobility measure if any of the following are true:

- The patient experienced an incomplete stay. (See [Incomplete Stays](#) above.)
- The patient was younger than 21 at admission.
- The patient discharged to hospice.
  - **A2110. Discharge Location**
- The patient was in a coma, was in a persistent vegetative state, had complete tetraplegia, or had locked-in syndrome.
  - **B0100. Comatose**
  - **I5101. Complete Tetraplegia**
  - **I5460. Locked-In State**
  - **I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain**
- The patient had a progressive neurological condition.
  - **I5200. Multiple Sclerosis**
  - **I5250. Huntington's Disease**
  - **I5300. Parkinson's Disease**
  - **I5450. Amyotrophic Lateral Sclerosis**
- The patient was independent at admission on all mobility items used to calculate the mobility change measure. Such patients have 6 - "Independent" coded for all of the following items on the LTCH CARE Admission Assessment:
  - **GG0170A. Roll left and right**
  - **GG0170B. Sit to lying**
  - **GG0170C. Lying to sitting on side of bed**
  - **GG0170D. Sit to stand**
  - **GG0170E. Chair/bed-to-chair transfer**
  - **GG0170F. Toilet transfer**
  - **GG0170J. Walk 50 feet with two turns**
  - **GG0170K. Walk 150 feet**

This measure is shown as a percentage of *Invasive Ventilator Admissions*, and it is displayed for discharges April 1, 2016, and later.

### **Average Ventilator Patient Admission Mobility**

The average mobility score of Ventilator Mobility Patients at admission.

Mobility is coded on a scale of 1 to 6, with 1 indicating dependence and 6 indicating independence. Average mobility is calculated by adding the coded value for each included mobility item and dividing by the number Ventilator Mobility Patients.

**Average Ventilator Patient Admission Mobility** can range from 8, indicating all patients are dependent on all items at admission, to 47, indicating all patients are nearly independent on all items at admission. Patients coded as independent on all included mobility items are excluded from this measure (see [Ventilator Mobility Patients](#) above).

Mobility items left blank or coded as 7 ("patient refused"), 9 ("not applicable"), or 88 ("not attempted due to medical condition or safety concerns") are recoded as 1 ("dependent") for purposes of calculating average mobility.

**Average Ventilator Patient Admission Mobility** uses the following items from the LTCH CARE Admission Assessment. This measure displays for Discharges April 1, 2016, and later.

- **GG0170A. Roll left and right**
- **GG0170B. Sit to lying**
- **GG0170C. Lying to sitting on side of bed**
- **GG0170D. Sit to stand**
- **GG0170E. Chair/bed-to-chair transfer**
- **GG0170F. Toilet transfer**
- **GG0170J. Walk 50 feet with two turns**
- **GG0170K. Walk 150 feet**

#### **Average Ventilator Patient Discharge Mobility**

The average mobility score of Ventilator Mobility Patients at discharge.

Mobility is coded on a scale of 1 to 6, with 1 indicating dependence and 6 indicating independence. Average mobility is calculated by adding the coded value for each included mobility item and dividing by the number Ventilator Mobility Patients.

**Average Ventilator Patient Discharge Mobility** can range from 8, indicating all patients are dependent on all items at discharge, to 48, indicating all patients are independent on all items at discharge. Mobility items left blank or coded as 7 ("patient refused"), 9 ("not applicable"), or 88 ("not attempted due to medical condition or safety concerns") are recoded as 1 ("dependent") for purposes of calculating average mobility.

**Average Ventilator Patient Discharge Mobility** uses the following items from the LTCH CARE Planned Discharge Assessment. This measure displays for Discharges April 1, 2016, and later.

- **GG0170A. Roll left and right**
- **GG0170B. Sit to lying**
- **GG0170C. Lying to sitting on side of bed**

- **GG0170D. Sit to stand**
- **GG0170E. Chair/bed-to-chair transfer**
- **GG0170F. Toilet transfer**
- **GG0170J. Walk 50 feet with two turns**
- **GG0170K. Walk 150 feet**

### **Average Ventilator Patient Change in Mobility**

The average change in mobility among Ventilator Mobility Patients from admission to discharge.

This measure is calculated by subtracting the ***Average Ventilator Patient Admission Mobility*** from ***Average Ventilator Patient Discharge Mobility***. A positive number indicates an improvement in mobility by discharge, and a negative number indicates a worsening in mobility by discharge.

This measure corresponds to the facility observed score calculated for Change in Mobility Among Patients Requiring Ventilator Support (NQF #2632). It displays for discharges April 1, 2016, and later.

## **VENTILATORS**

### **Ventilator Patients**

The count and percentage of mechanical ventilation patients discharged during the selected time period. To be counted as a patient in this measure, an assessment done during the patient's stay must have "Yes" saved for **00100F3. Invasive Mechanical Ventilator: weaning** or **00100F4. Invasive Mechanical Ventilator: non-weaning** on the **VENT** tab when the assessment has an admission date of April 1, 2016, or later. Assessments with admission dates prior to April 1, 2016, must have data of any kind saved on the **VENT** tab.

### **Chronic Ventilator Patients**

The count and percentage of ventilator patients deemed chronic ventilator patients and, therefore, inappropriate candidates for weaning.

Patients are deemed chronic ventilator patients if an assessment done during the patient's stay has "Yes" saved for **00100F4. Invasive Mechanical Ventilator: non-weaning** on the **VENT** tab when the assessment has an admission date of April 1, 2016, or later. Assessments with admission dates prior to April 1, 2016, qualify patients as chronic ventilator patients if "yes" is saved for the question ***chronic vent -- weaning inappropriate*** on the **Vent Admission Assessment**.

A patient will be deemed a ventilator weaning patient instead of a chronic ventilator patient if at any time during the stay an assessment shows the patient was considered a weaning candidate.

**NOTE:** A patient may be counted as both a chronic ventilator patient and a terminal wean patient.

### **Terminal Wean Patients**

The count and percentage of ventilator patients for whom “Terminal Wean” has been selected as the *Vent Weaning Goal* on an assessment during the patient’s stay. A patient will be deemed a ventilator weaning patient instead of a terminal wean patient if at any time during the stay an assessment shows the patient was considered a weaning candidate.

**NOTE:** A patient may be counted as both a chronic ventilator patient and a terminal wean patient.

### **Ventilator Weaning Patients**

The count and percentage of ventilator patients eligible for weaning. This measure excludes chronic ventilator patients and terminal wean patients from the count of ventilator patients. (See [Ventilator Patients](#), [Chronic Ventilator Patients](#), and [Terminal Wean Patients](#) above for more information.)

### **Weaning Succeeded**

The count and percentage of ventilator weaning patients whose final weaning outcome before discharge was “liberated”.

### **Weaning Failed**

The count and percentage of ventilator weaning patients whose final weaning outcome before discharge was “weaning failed or ended,” “patient expired,” or “liberated and returned to the vent after liberation.” Subsets show itemized counts for each of the failure categories.

**NOTE:** When identifying a patient’s final weaning outcome, LTRAX will look to the final assessment in the patient’s stay and, if it contains multiple wean assessments, order wean records by *Weaning Start Date*. Wean assessments missing a *Weaning Start Date* may be ignored when calculating outcomes.

### **Reason for Failed Wean**

The count and percentage of patients who fell into each category of reason that weaning failed or ended.


### **Ventilator Status at Discharge**

The count and percentage of ventilator patients grouped by ventilator status at discharge, as identified on the ventilator discharge of the last assessment in the stay.

## **2. Patient Criteria Report**

The LTRAX Patient Criteria Report offers a real-time analysis of LTCH criteria patients and site neutral patients at your hospital. The Patient Criteria Report can be viewed by users with privileges to view outcomes reports on LTRAX.

The report updates dynamically, instantly reflecting the addition of new admissions, new discharges, and new or updated information used in LTRAX patient criteria analysis. Each patient’s criteria analysis and results can be viewed on the **METRICS** tab of the

assessment. A full explanation of the LTRAX three-part criteria test can be found by clicking the  **HELP** icon on the **METRICS** tab of any patient assessment.

**IMPORTANT:** LTRAX uses information recorded in the LTCH CARE Data Set and supplementary assessment questions to assign a criteria status to each patient. Medicare draws information from short-term acute care (IPPS) and long-term acute care (LTCH) hospital claims to determine whether an LTCH should be reimbursed at LTCH patient rates or site neutral patient rates. Because LTRAX and CMS draw from different sources of data, the two analyses may differ. For more information about Medicare's implementation of LTCH patient criteria, please see the fiscal year 2016 IPPS & LTCH prospective payment [proposed and final rule](#).

In order to appear in the Patient Criteria Report, the patient's admission assessment must have a recorded admission date. A Medicare patient with two or more sets of LTCH CARE assessments during an interrupted stay will appear only once in the Patient Criteria Report.

## REPORT FILTERS

Use the report filters to determine the parameters of your desired report. Click **Refresh** to display the report with the updated selections.

**Facility:** Use this drop-down menu to generate a Patient Criteria Report for all facilities in your organization or a single selected facility.

**NOTE:** This drop-down menu shows only for users at multi-facility organizations with organization-level access to LTRAX reports.

**Patients:** Use this drop-down menu to select the admission status of patients appearing in the report: admitted but not discharged, admitted, discharged, or all patients.

**Patient Type:** Use this drop-down menu to select the patient type appearing in the report: LTCH criteria, site neutral, unknown (criteria status still undetermined), or all patients.

**Payer:** Use this drop-down menu to select the payer category: Medicare, Medicare Advantage, or non-Medicare.

**NOTE:** A patient with multiple payers that include Medicare or Medicare Advantage may appear in more than one payer category.

**Time Period:** The time period fields allow you to choose the assessments included in the report based on admission and/or discharge dates. Enter start and end dates for the desired date range. The date range defaults to the past 30 days.

**NOTE:** LTRAX began collecting data for patient criteria analysis beginning July 1, 2014. Patients admitted before July 1, 2014, may not have enough data to enable full criteria analysis. This report will be most accurate and complete for patients admitted on or after July 1, 2014.

## REPORT OUTPUT

### Summary

The **Summary** table of the report shows the number and percentage of patients who fall into each category:

**LTCH Criteria Patients:** Patients who met the LTCH patient criteria test.

**Site Neutral Patients:** Patients who failed the LTCH patient criteria test.

**Unknown:** Patients for whom LTRAX has insufficient information to determine criteria status.

## Patients

The **Patients** table of the report displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the report is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

For your selected facility, patients, patient type, and date range, the report displays the following information. The Patient Criteria Report returns a line for each patient stay.

**Patient Name:** The patient's name (recorded as LTCH CARE items **A0500A** and **A0500C** on **ID/PAY**).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item **A0900** on **ID/PAY**).

**Admitted:** The patient's admission date (recorded as LTCH CARE item **A0220** on **ADMIT**).

**Discharged:** The patient's discharge date (recorded as LTCH CARE item **A0270** on **DISCHG**); an in-house patient will show a blank in this column.

**Patient Type:** The patient's criteria status if LTRAX has determined the patient to be an LTCH criteria or site neutral patient; a patient whose criteria status is unknown will show a blank in this column.

**NOTE:** This information will also be reflected on the **METRICS** tab of the patient assessment.

**Payer:** the payer(s) recorded on the patient's admission or discharge assessment (recorded as LTCH CARE item **A1400** on **ADMIT**).

**NOTE:** Admission payers will display for a patient with an admission date and no discharge date saved to the assessment. Discharge payers will display for a patient with a discharge date saved to the assessment.

**Admitted From:** The setting the patient was admitted from (recorded as LTCH CARE item **A1802** on **ADMIT**).

**ICU/CCU Days:** The number of midnights the patient stayed at the ICU or CCU at the referring facility (recorded in the **Referring Facility ICU/CCU Stay** section on **ADMIT**).

**Vent 96+ Hours:** The patient's use of 96+ hours of ventilator services (recorded in the **Secondaries** area on **MEDICAL**).

**Discharge DRG:** The patient's Discharge DRG (as recorded in the DISCH. column for Diagnosis-Related Group on **MEDICAL**).

**Facility:** The name of the facility where the patient was admitted.

**Provider ID:** The Medicare Provider ID (CCN) of the facility where the patient was admitted.

## 3. Referrals Outcomes

LTRAX **Referrals Outcomes** give users with outcomes reports privileges the ability to view denial, admission, and referral trends for their hospitals. The data for the reports come from denied pre-admission assessments and admission assessments that began as pre-admission assessments. Unlike the **Administrative** and **Clinical Outcomes Reports**, the **Referrals Outcomes** are generated in real time, and the reports immediately update as pre-admission assessments are admitted or denied. To get to **Referrals Outcomes** from your **LTRAX Launch Screen**, click **Referrals Outcomes**.

The reports include a set of filters that you can use to view outcomes for your date range by selected referring facility, referring physician, evaluator, payer, denial reason, admitted instead location, MDC, and/or DRG. Because none of the fields on a pre-admission assessment are required, the reports only include assessments when a value is present. For that reason, total denials, admissions, and referrals may differ across the tables displayed on **Referrals Outcomes** if some assessments lack a value used in a particular table. For example, an assessment without a recorded referring physician will not be included in the **Referrals by Referring Physician** table.

Denied assessments are included in a date range based on the date a pre-admission was marked denied, while admissions are included based on the admission date entered on an admission assessment that began as a pre-admission.

The reports display the data both numerically and graphically and are available at the facility, MDC, DRG, and denied patient levels.

### REPORT FILTERS

Use the filters available at the top of each **Referrals Outcomes** screen to narrow or adjust the display according to your needs. Use the **RESET** button to set all filters back to "All" and set the date range to the three month period ending today.

**Facility:** This drop-down lets users with organizational level outcomes privileges select a facility in the organization for viewing. It will appear only for users with organizational access to outcomes reports.

**Site:** This drop-down lets users at facilities with multiple locations under the same Medicare Provider ID (CMS Certification Number or CCN) filter referral reports by building.

**Referring Facility:** This drop-down lets you select from your custom list of referring facilities. If your facility has not configured a custom data field drop-down called **Referring Facility**, this filter will not be available on your reports. Custom data fields are configured by an LTRAX facility administrator for your facility.

**NOTE:** In order for this filter to be available on the reports, the custom data field must be called "Referring Facility," must be spelled correctly, and must be configured as a drop-down.

**Referring Physician:** This drop-down lets you select from your custom list of referring physicians. If your facility has not configured a custom data field drop-down called **Referring Physician**, this filter will not be available on your reports. Custom data fields are configured by an LTRAX facility administrator for your facility.

**NOTE:** In order for this filter to be available on the reports, the custom data field must be called "Referring Physician," must be spelled correctly, and must be configured as a drop-down.

**Evaluator:** This drop-down lets you select from your custom list of evaluators. If your facility has not configured a custom data field drop-down called **Evaluator**, this filter will not be available on your reports. Custom data fields are configured by an LTRAX facility administrator for your facility.

**NOTE:** In order for this filter to be available on the reports, the custom data field must be called "Evaluator," must be spelled correctly, and must be configured as a drop-down.

**Payer:** This drop-down lets you filter the report based on the primary payer categories of "All," "Medicare," "Medicare Advantage," "Medicare + Medicare Advantage," or "Non-Medicare."



**Denial Reason:** This drop-down lets you filter the report by the denial reason indicated on the pre-admission assessment at the time of denial.

**Admitted Instead:** This drop-down lets you filter the report by the admitted instead location indicated on the pre-admission assessment at the time of denial.

**MDC:** The **MDC** drop-down shows you admissions by selected MDC. Because MDC is not collected on the pre-admission screening, no information on denials is available at the MDC level, so this filter does not appear when you are filtering the report by a selected MDC or when viewing the **Patient Report**.

**DRG:** The **DRG** drop-down shows you admissions by selected DRG. Because DRG is not collected on the pre-admission screening, no information on denials is available at the DRG level, so this filter does not appear when you are filtering the report by a selected DRG or when viewing the **Patient Report**.

**Between:** These boxes let you enter a date range to view your referrals based on denial date and admission date. Click **REFRESH** to rerun the report for your newly selected dates.

## REPORT OUTPUT

**Referrals Outcomes** output appears in tables with accompanying graphs. Click on a column header in any table to sort the list and graph by the selected column in ascending order. Click the column header again to sort the list and graph in descending order. In any table, you can click on a hyperlinked item in the first column to view the report filtered to display only data in the category you chose. For example, if viewing the **Facility Report**, selecting "Dr. Brown" in the **Referring Physicians** table will filter the entire **Facility Report** to display data only for patients referred by Dr. Brown.

## FACILITY REPORT

### Referrals by Referring Physician

If your facility has configured the **Referring Physician** custom field, this table displays a list of referring physicians with counts and percentages of denials, admissions, and referrals for each physician with an accompanying graph showing total referrals by physician. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the total number of referrals from each physician.

### Referrals by Referring Facility

If your facility has configured the **Referring Facility** custom field, this table displays a list of all of referring facilities with counts and percentages of denials, admissions, and referrals for each facility with an accompanying graph showing total referrals by facility. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the total number of referrals from each facility.

### Referrals by Evaluator

If your facility has configured the **Evaluator** custom field, this table displays a list of all of evaluators with counts and percentages of denials, admissions, and referrals for each evaluator with an accompanying graph showing total referrals by evaluator. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the total number of referrals attributed to each evaluator.

### Distribution by Denial Reason

This table displays counts and percentages by denial reason for your facility, your region, and the nation. Percentages are calculated against the total number of denials for each category. The accompanying pie chart shows facility denials.

### Distribution by Admitted Instead Location

This table displays counts and percentages by admitted instead location for your facility, your region, and the nation. Percentages are calculated against the total number of denials for each geographic category. The accompanying pie chart shows facility admitted instead locations.

### Referrals by ZIP Code

This table displays counts and percentages of denials, admissions, and referrals by zip code. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the number of admissions from each zip code. The accompanying pie chart shows referrals by zip code percentages calculated against the total number of referrals.

### Referrals by Payer

This table displays counts and percentages of denials, admissions, and referrals by primary payer. Percentage values for denials and admissions are calculated against the total number of denials and admissions, while the referrals conversion percentages are based on the number of referrals from each payer. The accompanying pie chart shows referrals by payer percentages calculated against the total number of referrals.

### ADMITTED BY MDC

Admitted assessments that began as a pre-admission screening and have been assigned to a major diagnostic category are included in the **MDC Report**. Click on **MDC Report** to view a list of all MDCs. To collapse the list to only display MDCs with admissions at your facility, check the box labeled **Hide codes with zero admission assessments**. Clicking on an individual MDC will give you a report structured like the **Facility Report**, but only for the selected MDC. Filters pertaining only to denied patients are not available on the **MDC Report**.

### ADMITTED BY DRG

Admitted assessments that began as a pre-admission screening and have been assigned to a diagnosis-related group are included in the **DRG Report**. Click on **DRG Report** to view a list of all DRGs. To collapse the list to only display DRGs with admissions at your facility, check the box labeled **Hide codes with zero admission assessments**. Clicking on an individual DRG will give you a report structured like the **Facility Report**, but only for the selected DRG. Filters pertaining only to denied patients are not available on the **DRG Report**.

### PATIENT REPORT

The **Patient Report** displays pre-admission assessments that have been denied or admitted for the selected time period and filters. Click on **Patient Report** to view the report and make your selections. Use the **Patients** filter, available only on this screen, to select whether the screen displays admitted patients, denied patients, or both categories. For each record, the report displays data in the report's columns if the data is relevant and saved to the assessment. For example, **Reason Denied** will be populated for denied patients but not admitted patients. Patients appear in a

time frame according to either the date the pre-admission was marked denied or the patient's admission date.

#### 4. HCAHPS Outcomes

LTRAX HCAHPS Outcomes Reports are available to LTRAX users with the privilege to view outcomes reports or patient satisfaction outcomes reports for their facilities or organizations. To get to the HCAHPS Outcomes Reports menu, click **HCAHPS** on your **LTRAX Launch Screen**.

This user manual contains the following information about the HCAHPS Outcomes Reports:

1. [HCAHPS Outcomes Reports General Information](#)
2. [HCAHPS Outcomes Reports Drill-Down Levels](#)
  - A) [HCAHPS Facility Ranking Report](#)
  - B) [HCAHPS Facility Report](#)
  - C) [HCAHPS Patient Report](#)
3. [HCAHPS Outcomes Reports Regions](#)
4. [HCAHPS Outcomes Reports Measures](#)

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#### HCAHPS OUTCOMES REPORTS GENERAL INFORMATION

The LTRAX **HCAHPS Outcomes Reports** show your facility's aggregated patient responses to the HCAHPS survey (Hospital Consumer Assessment of Healthcare Providers and Systems Survey), an instrument developed by the Agency for Healthcare Research and Quality, a division of the Department of Health and Human Services.

Your facility or the facilities in your organization are included in HCAHPS reporting when one or more HCAHPS surveys are returned in the month, or when you have discharge assessments marked accepted by CMS in any month and had returned one or more HCAHPS surveys in the prior month.

The LTRAX **HCAHPS Outcomes Reports** are delivered in a tiered hierarchy under **Facility Drill-Down**. If your facility belongs to a larger organization, your menu may start with the HCAHPS **Facility Ranking Report**. If not, your menu will start with the HCAHPS **Facility Report**. You can jump to any drill-down level from any other HCAHPS report by using the links under **Facility Drill-Down**. The reports are updated twice daily. A time stamp at the top of the report indicates the last time the reports were generated.

**HCAHPS Outcomes Reports** include all patient satisfaction surveys in which at least one survey question was answered and the associated discharge assessment has been marked accepted by CMS. Because some survey questions may be unanswered, the number of surveys included in any individual measure may not match the total number of surveys returned in the time period.

The HCAHPS reports show aggregated patient satisfaction survey results starting from January 2013, when the survey was incorporated into LTRAX. The Care Transition measure displays data for time periods beginning July 2015, when those questions were added to the survey in LTRAX. Surveys are included in a time period based on the patient's discharge date.

Drop-down menus at the top of the reports allow you to select different time periods and payers. The reports automatically refresh each time you change your selection in one of the drop-down menus. The **Time Period** menu allows you to display the reports by following

time periods: calendar month and quarter; year-to-date; calendar years; and fiscal years. In the **Payer** drop-down menu, the Medicare payer selection includes assessments where one of the selected payers is Medicare (traditional fee-for-service) or Medicare (managed care/Part C/Medicare Advantage). Non-Medicare excludes assessments that have either of the Medicare payers selected.

HCAHPS reports can be printed as PDF documents using the **PRINT PDF** button near the top of the screen. When you click the **PRINT PDF** button, it will open a new window displaying a PDF version of the report.

**NOTE:** This requires Adobe Reader software. If you don't already have Reader installed on your computer, you can get the latest version from the [Adobe website](#).

The reports are also available as an Excel spreadsheet. Click the **OPEN/EXCEL** button near the top of the screen to either open the comma separated (.csv) file as an Excel spreadsheet or save the .csv file to your computer.

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## HCAHPS OUTCOMES REPORTS DRILL-DOWN LEVELS

### **HCAHPS Facility Ranking Report**

For users belonging to organizations with more than one facility, the **HCAHPS Facility Ranking Report** allows you to concurrently display the outcomes for all facilities in your organization for any single HCAHPS measure. A drop-down menu at the top of the table allows you to select the measure to display. To access the **HCAHPS Facility Ranking Report**, your user account must have the privilege to view organization-level **Administrative** and/or **Clinical Outcomes Reports**, or you must be an organization administrator with patient satisfaction outcomes privileges.

In addition to the drop-down menus for all reports as described above in [HCAHPS Outcomes Reports General Information](#), the **HCAHPS Facility Ranking Report** contains drop-down menus that allow you to drill down by diagnosis and, if appropriate, view site-level outcomes.

The **Detail Level** menu allows you to display HCAHPS data for all patients at each facility or to narrow the display to patients within a single Major Diagnostic Category (DRG-MDC) or Diagnosis-Related Group (DRG). To change the detail level, select DRG-MDC or DRG from the **Detail Level** menu. A second drop-down menu will appear, allowing you to choose a specific MDC or DRG.

If any of the facilities within your organization have more than one site associated with a single Medicare Provider ID (CCN), you can use the **HCAHPS Facility Ranking Report** to see the sites compared to each other. Choose the appropriate facility by Medicare Provider ID (CCN) from the facility drop-down menu at the top of the screen. If the facility has multiple sites, you will see an additional checkbox appear on your report labeled: **Your facility also has site-level outcomes**. Check the box to see the HCAHPS outcomes for that facility's sites displayed in facility-ranking style.

For each measure, you will see your facilities' outcomes displayed with variances from the organization and the nation. The variance shows each facility's divergence from the organization and national average for the measure. Variances are calculated by subtracting the organizational or national average outcome from the facility outcome and then dividing by the organizational or national outcome.

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### **HCAHPS Facility Report**

Your **HCAHPS Facility Report** displays all available measures for all included surveys from your facility for your selected time period and payer, with comparisons to national and regional benchmarks.

### **HCAHPS Patient Report**

Your **HCAHPS Patient Report** displays a list of patients whose returned surveys are included in the Facility Report calculations for the selected time period and payer.

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## **HCAHPS OUTCOMES REPORTS REGIONS**

See [Outcomes Reports Regions](#) above.

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## **HCAHPS OUTCOMES REPORTS MEASURES**

### **Summary Table**

#### **Discharges in Sample**

This displays the number of discharges for the time period and payer selected. Medicare patients who experience interruption(s) in stay are included once in the count of discharges. They are counted in the month of the discharge that ended the stay. (For more information about how LTRAX handles interruptions for Medicare patients, please see [Interruptions in Stay/Leave of Absence \(LOA\)](#).)

#### **Surveys Returned**

This displays the number of surveys returned. A survey must have at least one response recorded to be counted as a returned survey.

#### **Survey Return Rate**

This displays the number of surveys returned as a percentage of discharges.

#### **Average Age**

This displays the average age of the patients who returned surveys.

#### **Gender**

This displays the gender (male and female) of the patients who returned surveys.

#### **Case Mix Index**

This displays the average case mix index of the patients who returned surveys, which is calculated by averaging the DRG payment weight for each patient's discharge MS-LTC-DRG. A higher number indicates a higher average acuity.

### **Average Box Percentages Report**

This table displays survey outcomes, with national and regional averages for comparison, using the HCAHPS methodology. The measures in the HCAHPS Average Box Percentages Report are the measures developed by HCAHPS for reporting patient survey results. Some of the measures combine several survey questions into a single measure. For a survey to be included in a composite measure, all questions within the composite must be answered on the survey. For

that reason, the answers from a survey may be included in some composite measures but not others. For each measure, the *Surveys* line shows how many surveys were used to compute the averages for each measure.

### **Composite Survey Questions**

The following measures are composites of the survey questions listed for each measure. Questions not mentioned below are reported individually.

#### **Nurse Communication**

- 1) During this hospital stay, how often did nurses treat you with courtesy and respect?
- 2) During this hospital stay, how often did nurses listen carefully to you?
- 3) During this hospital stay, how often did nurse explain things in a way you could understand?

#### **Doctor Communication**

- 5) During this hospital stay, how often did doctors treat you with courtesy and respect?
- 6) During this hospital stay, how often did doctors listen carefully to you?
- 7) During this hospital stay, how often did doctors explain things in a way you could understand?

#### **Responsiveness of Hospital Staff**

- 4) During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
- 11) How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

#### **Pain Management** (through 12/31/17)

- 13) During this hospital stay, how well was your pain controlled?
- 14) During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

#### **Pain Communication** (1/1/18 and later)

- 13) During this hospital stay, how often did hospital staff talk with you about how much pain you had?
- 14) During this hospital stay, how often did hospital staff talk with you about how to treat your pain?

#### **Communication About Medicines**

- 16) Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- 17) Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

#### **Discharge Information**

- 19) During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

20) During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

**Care Transition**

23) During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

24) When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

25) When I left the hospital, I clearly understood the purpose for taking each of my medications.

**How Answers are Sorted in the HCAHPS “Box” Methodology**

Outcomes results are reported using the HCAHPS “box” methodology, wherein each category displays the average number of survey responses that fall into top box, middle box, or bottom box answers for each question or composite. Survey answers are assigned a box as follows:

	Answer Categories	Box Assignment
<b>Questions 1-17:</b>	Always	Top
	Usually	Middle
	Sometimes	Bottom
	Never	Bottom
<b>Questions 19 &amp; 20:</b>	Yes	Top
	No	Bottom
<b>Question 21:</b>	9-10	Top
	7-8	Middle
	0-6	Bottom
<b>Question 22:</b>	Definitely yes	Top
	Probably yes	Middle
	Probably no	Bottom
	Definitely no	Bottom
<b>Questions 23-25:</b>	Strongly Agree	Top
	Agree	Middle
	Disagree	Bottom
	Strongly Disagree	Bottom

**HCAHPS Box Counts and Average Box Counts**

At the bottom of the HCAHPS Facility Report, you may check a box to display two additional tables related to HCAHPS box-style reporting, both with national and regional comparisons. The **Total Box Counts** table displays the total count of all answers in each box used in computing the **Average Box Percentages** table above. The **Average Box Counts** table displays the average number of answers per survey that fall within each box. You can uncheck the box to hide the tables.

## 5. Dashboards

LTRAX Dashboards are available to LTRAX users with the privilege to edit assessments or view outcomes reports for the facility or organization. These reports aggregate certain indicators for current patients. To get to the Dashboards menu, click [Dashboards](#) on your [LTRAX Launch Screen](#).

The Dashboards menu page offers links to these reports:

1. [Translators](#)
2. [Delirium](#)
3. [Pressure Ulcer Risk](#)
4. [Interruptions](#)

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### TRANSLATORS

The LTRAX [Translators Dashboard](#) is a continually updating list of translator and language needs among current patients. The dashboard can be viewed by users with privileges to edit assessments and/or view reports for their hospital or organization in LTRAX.

The [Translators Dashboard](#) displays translator and language information for all current patients, specifically patients admitted but not discharged at the time you access the report. A patient displays when an admission date has been entered on the [ADMIT](#) tab, and patients no longer display when a discharge date is entered on the [DISCHG](#) tab. Translator and language information appears if it is recorded in the patient's assessment as described below. The report updates in real time, reflecting the information saved to the patient's assessment at the moment the dashboard is displayed.

**NOTE:** Comprehensive translator information for all patients, including discharged patients, can be accessed using LTRAX data downloads.

Users with organization-level privileges in LTRAX have the option to display dashboard information for a single hospital or all hospitals in the organization. Use the Facility drop-down menu to make a selection and click [Refresh](#).

### REPORT OUTPUT

The dashboard displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the dashboard is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

The report returns a line for each admitted patient. If you see multiple records for a single patient, the patient's prior discharge may not yet be recorded in LTRAX.

Each time you access the dashboard, it displays the following information:

**Last Name:** The patient's last name (recorded as LTCH CARE item [A0500C](#) on [ID/PAY](#)).

**First Name:** The patient's first name (recorded as LTCH CARE item [A0500A](#) on [ID/PAY](#)).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item [A0900](#) on [ID/PAY](#)).



**Medical Record #:** The patient's Medical Record Number (recorded on **ID/PAY**).

**Admitted:** The patient's admission date (recorded as LTCH CARE item **A0220** on **ADMIT**).

**Translator?:** The patient's need for a translator (recorded as LTCH CARE item **A1100A**. Need or want an interpreter? on **ID/PAY**). This column will display a blank if the item has not been answered.

Yes - Yes

No - No

UTD - Unable to Determine

**Language:** The patient's preferred language (recorded as LTCH CARE item **A1100B**. **Preferred Language** on **ID/PAY**).

**Facility:** The name of the facility where the patient was admitted.

**Provider ID:** The provider ID of the facility where the patient was admitted.

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## DELIRIUM

The LTRAX **Delirium Dashboard** is a continually updating list of delirium indicators for current patients. The dashboard can be viewed by users with the privilege to edit assessments and/or view reports for their hospital or organization in LTRAX.

The **Delirium Dashboard** displays Short Confusion Assessment Method (Short CAM) indicators for current patients, specifically patients admitted but not discharged at the time you access the report. A patient displays when an admission date has been entered on the **ADMIT** tab, and patients no longer display when a discharge date is entered on the **DISCHG** tab. Delirium information appears if it is recorded in the patient's admission assessment as described below. The report updates in real time, reflecting the information saved to the patient's assessment at the moment the dashboard is displayed.

**NOTE:** Comprehensive cognition information for all patients, including delirium assessments done at discharge and all data for discharged patients, can be accessed using LTRAX data downloads.

Users with organization-level privileges in LTRAX have the option to display dashboard information for a single hospital or all hospitals in the organization. Use the **Facility** drop-down menu to make a selection and click **Refresh**.

## REPORT OUTPUT

The dashboard displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the dashboard is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

The report returns a line for each admitted patient. If you see multiple records for a single patient, the patient's prior discharge may not yet be recorded in LTRAX.

Each time you access the dashboard, it displays the following information:

**Last Name:** The patient's last name (recorded as LTCH CARE item **A0500C** on **ID/PAY**).

**First Name:** The patient's first name (recorded as LTCH CARE item **A0500A** on **ID/PAY**).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item **A0900** on **ID/PAY**).

**Medical Record #:** The patient's Medical Record Number (recorded on **ID/PAY**).

**Short CAM Score:** The result of the *Signs and Symptoms of Delirium* as entered on the patient's admission assessment (recorded as LTCH CARE items **C1610A-E** on **COGNITION**). This column will show a blank if the admission assessment has incomplete information in the *Signs and Symptoms of Delirium* section.

*Probable or Definite Delirium* - **A. Acute Change**, **B. Fluctuate**, and **C. Inattention** must all be answered "Yes," *and* either **D. Disorganized Thinking** or **E2. Vigilant, Lethargic, Stupor, or Coma** must be answered "Yes."

*Possible or Probable Delirium* - **A. Acute Change** or **B. Fluctuate** must be answered "Yes," *and* **C. Inattention** must be answered "Yes," *and* either **D. Disorganized Thinking** or **E2. Vigilant, Lethargic, Stupor, or Coma** must be answered "Yes."

*Delirium Not Indicated* - All **C1610** items have been answered and do not indicate delirium.

**Facility:** The name of the facility where the patient was admitted.

**Provider ID:** The provider ID of the facility where the patient was admitted.

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## PRESSURE ULCER RISK

The LTRAX **Pressure Ulcer Risk Dashboard** is a continually updating list displaying the risk of current patients developing pressure ulcers. The dashboard can be viewed by users with the privilege to edit assessments and/or view reports for their hospital or organization in LTRAX.

The **Pressure Ulcer Risk Dashboard** displays pressure ulcer risk information for all current patients, specifically patients admitted but not discharged at the time you access the report. A patient displays when an admission date has been entered on the **ADMIT** tab, and patients no longer display when a discharge date is entered on the **DISCHG** tab. Pressure ulcer risk information appears if it is recorded in the patient's assessment as described below. The report updates in real time, reflecting the information saved to the patient's assessment at the moment the dashboard is displayed.

**NOTE:** Comprehensive pressure ulcer information for all patients, including discharged patients, can be accessed using LTRAX data downloads.

Users with organization-level privileges in LTRAX have the option to display dashboard information for a single hospital or all hospitals in the organization. Use the **Facility** drop-down menu to make a selection and click **Refresh**.

## REPORT OUTPUT

The dashboard displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the dashboard is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

The report returns a line for each admitted patient. If you see multiple records for a single patient, the patient's prior discharge may not yet be recorded in LTRAX.

Each time you access the dashboard, it displays the following information:

**Last Name:** The patient's last name (recorded as LTCH CARE item **A0500C** on **ID/PAY**).

**First Name:** The patient's first name (recorded as LTCH CARE item **A0500A** on **ID/PAY**).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item **A0900** on **ID/PAY**).

**Medical Record #:** The patient's Medical Record Number (recorded on **ID/PAY**).

**Admitted:** The patient's admission date (recorded as LTCH CARE item **A0220** on **ADMIT**).

**PU at Admit?:** Whether the patient had pressure ulcers when admitted to the LTCH (recorded as "Yes" or "No" for LTCH CARE item **M0210** on **SKIN**). This column will display a blank if the item has not been answered.

**Braden Date:** The assessment date recorded on the most recent Braden Scale for Predicting Pressure Sore Risk© (recorded on **BRADEN**).

**NOTE:** The dashboard displays Braden information from the most recent assessment. If the patient does not have a Braden assessment, or has incomplete information, some or all of the Braden columns will display a blank. If the patient has multiple Braden assessments, data from the assessment with the most recent assessment date will display.

**Braden Score:** The numeric value of the calculated **Braden Score** on the most recent Braden Scale for Predicting Pressure Sore Risk© (recorded on **BRADEN**).

**Braden Risk:** The risk category that corresponds to the patient's most recent score on the Braden Scale for Predicting Pressure Sore Risk© (recorded on **BRADEN**).

**Severe** - 1-9

**High** - 10-12

**Moderate** - 13-14

**Mild** - 15-18

**None** - 19-23

**Facility:** The name of the facility where the patient was admitted.

**Provider ID:** The provider ID of the facility where the patient was admitted.

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## INTERRUPTIONS

The LTRAX **Interruptions Dashboard** is a continually updating list of discharged Medicare patients still within the readmission window for a qualified interruption in stay. The dashboard can be viewed by users with the privilege to edit assessments and/or view reports for their hospital or organization in LTRAX.

Unlike other LTRAX Dashboard Reports, which track indicators for patients still admitted to the hospital, the **Interruptions Dashboard** maintains a list of recently discharged patients who would qualify for a Medicare interrupted stay if readmitted on the day you access the

dashboard. Patients drop off the list when a readmission would no longer continue an interruption but would instead constitute a new stay.

Patients appear on the **Interruptions Dashboard** when they meet all of the the following qualifications:

- The patient has a discharge date (recorded as LTCH CARE item **A0270** on **DISCHG**).
- **Medicare (traditional fee-for-service)** has been selected as a payer at discharge (recorded in the Disch. column of LTCH CARE item **A1400** on **ID/PAY**).
- The patient has been discharged to one of the following locations (recorded as LTCH CARE item **A2110** on **DISCHG**):
  - Community residential setting
  - Hospital emergency department
  - Short stay acute hospital (IPPS)
  - Inpatient rehabilitation facility or unit (IRF)
  - Skilled nursing facility (SNF)

Patients continue to display on the **Interruptions Dashboard** during the time frame in which a readmission would constitute the continuation of an interrupted stay. Patients disappear from the dashboard when readmitted to continue an interrupted stay, or when the interruption span for the selected discharge location has elapsed.

If readmitted to continue an interrupted stay, LTRAX will detect the new assessment as a readmission and display an interruption message. Otherwise, patients will disappear after the following number of days, where the discharge date is counted as day 1:

- Community residential setting - 3 days
- Hospital emergency department - 9 days
- Short stay acute hospital (IPPS) - 9 days
- Inpatient rehabilitation facility or unit (IRF) - 27 days
- Skilled nursing facility (SNF) - 45 days

Users with organization-level privileges in LTRAX have the option to display dashboard information for a single hospital or all hospitals in the organization. Use the **Facility** drop-down menu to make a selection and click **Refresh**.

## REPORT OUTPUT

The dashboard displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the dashboard is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

The report returns a line for each discharged patient that meets the qualifications described above. Each time you access the dashboard, it displays the following information:

**Last Name:** The patient's last name (recorded as LTCH CARE item **A0500C** on **ID/PAY**).

**First Name:** The patient's first name (recorded as LTCH CARE item **A0500A** on **ID/PAY**).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item **A0900** on **ID/PAY**).

**Medical Record #:** The patient's Medical Record Number (recorded on **ID/PAY**).

**Admitted:** The patient's admission date (recorded as LTCH CARE item **A0220** on **ADMIT**).

**Discharged:** The patient's discharge date (recorded as LTCH CARE item **A0270** on **DISCHG**).

**Discharge Location:** The patient's discharge location (recorded as LTCH CARE item **A2110** on **DISCHG**).

**Facility:** The name of the facility where the patient was admitted.

**Provider ID:** The provider ID of the facility where the patient was admitted.

## 6. Transmissions

LTRAX Transmissions Reports are available to LTRAX users with the privilege to view outcomes reports or manage CMS transmission files for the facility or organization. To get to the Transmissions Reports menu, click **Transmissions** on your **LTRAX Launch Screen**.

The Transmissions menu page offers links to these reports:

1. [Continued Stay Warnings](#)
2. [Late Transmittal Summary](#)
3. [Transmittal Report](#)
4. [ORP Override Summary](#)
5. [ORP Override Report](#)

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### CONTINUED STAY WARNINGS

The Continued Stay Warnings Report is a live list of patients who have separate assessments reflecting a discharge and readmission within three calendar days. This report is designed to help facilities identify assessments that may have been created and/or transmitted to CMS in error. Under the rules of the LTCH CARE Data Set, a patient who leaves an LTCH and returns within three calendar days (including the date of transfer) may not need assessments transmitted for the discharge and readmission. Please see the [Interruptions in Stay/Leave of Absence \(LOA\)](#) section of this manual for more information.

The report returns two rows for each patient identified as having been readmitted within three calendar days of discharge. The first row shows data for the record containing the discharge date, and the second row shows data for the record containing a readmission within three days of the discharge date in the row above. The report is updated in real time, instantly reflecting the addition of new admissions and discharges. Users with privileges to see reports and/or download data can see the Continued Stay Warnings Report.

## REPORT FILTERS

Use the report filters to determine the parameters of your desired report. Click **Refresh** to display the report with the updated selections.

**Facility:** Use this drop-down menu to generate a Continued Stay Warnings Report for all facilities in the organization or a single selected facility.

**NOTE:** This drop-down menu shows only for users at multi-facility organizations with organization-level access to LTRAX reports.

**Time Period:** The time period fields allow you to choose the assessments included in the report based on the patient's readmission date. Enter start and end dates for the desired date range. The date range defaults to the past 30 days.

**NOTE:** In-progress assessments must have the relevant discharge or readmission date in order to be included in the report.

## REPORT OUTPUT

The report returns two lines for each patient identified as having assessments that may indicate a continued stay. The report displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the report is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

For your selected facility and date range, the report displays the following information:

**Last Name:** The patient's last name (recorded as LTCH CARE item **A0500A** on **ID/PAY**).

**First Name:** The patient's first name (recorded as LTCH CARE item **A0500C** on **ID/PAY**).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item **A0900** on **ID/PAY**).

**Medical Record #:** The patient's Medical Record Number (recorded on **ID/PAY**).

**Admitted:** The patient's admission date (recorded as LTCH CARE item **A0220** on **ADMIT**).

**Admit Status:** The status of the assessment:

- **Incomplete** for an assessment that is still in progress and has not passed the LTRAX completion check;
- **Complete** for an assessment that has passed the LTRAX completion check but has not yet been accepted by CMS;
- **Complete, xmit: Ready** for an assessment that has passed the LTRAX completion check and been marked XMIT READY but has not yet been placed into a CMS transmission file;
- **Complete, xmit: Prepared** for an assessment that has passed the LTRAX completion check and been placed into a CMS transmission file but has not yet been marked accepted by CMS;
- **Complete, Accepted by CMS** for an assessment that has been marked as accepted by CMS.

**Discharged:** The patient's discharge date (recorded as LTCH CARE item **A0270** on **DISCHG**). An admission assessment with no associated discharge assessment may show a blank in this column.

**Discharge Location:** The patient's discharge location (recorded as LTCH CARE item **A2100** on **DISCHG**). An admission assessment with no associated discharge assessment may show a blank in this column.

**Discharge Type:** The LTCH CARE discharge assessment type. An admission assessment with no associated discharge assessment may show a blank in this column.

- D - planned discharge
- DU - unplanned discharge
- DE - expired

**Discharge Status:** The status of the assessment. An admission assessment with no associated discharge assessment may show a blank in this column.

- **Incomplete** for an assessment that is still in progress and has not passed the LTRAX completion check;
- **Complete** for an assessment that has passed the LTRAX completion check but has not yet been accepted by CMS;
- **Complete, xmit: Ready** for an assessment that has passed the LTRAX completion check and been marked XMIT READY but has not yet been placed into a CMS transmission file;
- **Complete, xmit: Prepared** for an assessment that has passed the LTRAX completion check and been placed into a CMS transmission file but has not yet been marked accepted by CMS;
- **Complete, Accepted by CMS** for an assessment that has been marked as accepted by CMS.

**Facility:** The name of the facility where the patient was admitted.

**Provider ID:** The Medicare Provider ID (CCN) of the facility where the patient was admitted.

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## LATE TRANSMITTAL SUMMARY

Users with privileges to see reports and/or download data for the entire organization can see a snapshot of their organization's transmittal status on the **Late Transmittal Summary**. The **Late Transmittal Summary** lists all facilities in the user's organization with a tally of late assessments in progress and late assessments accepted by CMS. Click on any facility in the list to go to the detailed Transmittal Report for that facility.

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## TRANSMITTAL REPORT

The LTRAX Transmittal Report is a live report of LTCH CARE assessment transmissions. The report is updated in real time, instantly reflecting the addition of new admissions and discharges and the updated status of assessments marked accepted by CMS.

In order to appear in the Transmittal Report, an admission assessment must have a recorded admission date, and all types of discharge assessments must have recorded discharge dates.

The report's color coding indicates which assessments will soon reach the deadline for submission and which assessments have already passed the deadline for submission. Past due assessments also show the number of days late in the **Days Late** column.

## TRANSMITTAL REPORT FILTERS

Use the report filters to determine the parameters of your desired report. Click **Refresh** to display the report with the updated selections.

**Facility:** Use this drop-down menu to generate a transmission report for all facilities in the organization or a single selected facility.

**NOTE:** This drop-down menu displays only for users at multi-facility organizations with organization-level access to LTRAX reports.

**Time Period:** The time period fields allow you to choose the assessments included in the report based on admission and/or discharge dates. Enter start and end dates for the desired date range. The date range defaults to the past 30 days.

**Assessments:** This drop-down menu allows you to choose the types of assessments included in the report: **Admission only**, **Discharge only**, or both **Admission and Discharge**.

**Assessment Status:** Make a selection to view assessments **Accepted by CMS only**, **In-Progress Assessments only**, **Late In-Progress Assessments only**, or **All** assessments.

## TRANSMITTAL REPORT OUTPUT

The report displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the report is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

The report returns a line for each admission, discharge, and corrected assessment, so you may see multiple records for a single patient.

For your selected facility, date range, assessment type, and assessment status, the report displays the following information:

**Last Name:** The patient's last name (recorded as LTCH CARE item **A0500A** on **ID/PAY**).

**First Name:** The patient's first name (recorded as LTCH CARE item **A0500C** on **ID/PAY**).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item **A0900** on **ID/PAY**).

**Medical Record #:** The patient's Medical Record Number (recorded on **ID/PAY**).

**Assess Type:** A one- or two-letter code indicating the assessment type: A for admission, D for planned discharge, DU for unplanned discharge, or DE for expired.

**Admitted:** The patient's admission date (recorded as LTCH CARE item **A0220** on **ADMIT**).

**Discharged:** The patient's discharge date (recorded as LTCH CARE item **A0270** on **DISCHG**). An admission assessment with no associated discharge assessment may show a blank in this column.

**File Created:** The date a CMS transmit file was created containing that record. A blank value in this column may indicate that the assessment has not yet been included in a CMS transmit file or that the assessment was prepared for transmission outside of LTRAX.

**Transmission Date:** The date entered into LTRAX as the date the assessment was accepted by CMS. This value is set when an assessment is marked **Accepted** on the **CMS**



**Transmit File** screen, and it can be viewed and edited on individual assessments on the **CMS INFO** tab.

**NOTE:** It is up to each facility to accurately record the transmission date based on information returned from CMS after each file submission.

**Days Late:** This column shows the best possible estimation of whether an assessment has passed the CMS deadline for submission based on key dates entered into the assessment. LTRAX will check the following dates in reverse order when determining whether the assessment is late: admission or discharge date (**A0220** or **A0270**), assessment reference date (**A0210**), and completion date (**Z0500**).

The combination of color coding and numbers in the **Days Late** column shows whether an assessment is coming due or past due.

- If an assessment is not late, a zero will appear in the **Days Late** column.
- If an assessment is one or two days from the submission deadline, the column will show a zero with a yellow background.
- If an assessment is due for submission that day, the column will show a zero with a red background.
- If an assessment is late, the **Days Late** column will display the number of days past due with a red background.

**Correction:** If a correction was made to an assessment, you may see more than one record for the same assessment type. This column displays the correction number for corrected assessments. If an inactivation record was transmitted, **Inactivation** is displayed. Inactivation records may be sent to correct key LTCH CARE fields or to retract an assessment transmitted to CMS.

**SUBMISSION SCHEDULING**

CMS has issued the following guidelines for completing and submitting LTCH CARE assessments (see also Table 2-1 & 2-2 in Chapter 2 of the [CMS LTCH Quality Reporting Program Manual](#)):

<b>Admission Assessment Timing</b>		
Assessment Reference Date	<i>no later than</i>	Admission Date + 2
		<i>OR equal to Discharge date (whichever is sooner)</i>
Completion Date	<i>no later than</i>	Assessment Reference Date + 5
Transmission Date	<i>no later than</i>	Completion Date + 7
<b>Discharge Assessment Timing</b>		
Assessment Reference Date	<i>is equal to</i>	Discharge Date
		<i>OR equal to date of death (if patient dies within 3 days of discharge)</i>
Completion Date	<i>no later than</i>	Assessment Reference Date + 5
Transmission Date	<i>no later than</i>	Completion Date + 7

In addition, CMS issues quarterly deadlines for the submission of all missing and corrected LTCH CARE assessments. Assessments submitted past the final deadlines will not count toward your facility's participation in the LTCH Quality Reporting Program. For more information on assessment scheduling and submission deadlines, please see the [CMS LTCH QRP Manual](#) and CMS's [LTCH PPS rules and regulations](#).

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## QRP OVERRIDE SUMMARY

Users with privileges to see reports and/or download data for their entire organization can see a snapshot of their organization's compliance on the **QRP Override Summary**. The **QRP Override Summary** lists all facilities in the user's organization with a tally of assessments in progress and accepted by CMS that have the override checkbox checked. Click on any facility in the list to go to the detailed QRP Override Report for that facility.

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## QRP OVERRIDE REPORT

The LTRAX QRP Override Report is a live report of LTCH CARE assessments that have the LTCH Quality Reporting Program completion requirements override checkbox checked, enabling transmission of assessments to CMS with incomplete QRP data. The QRP Override Report can be viewed by users with privileges to download assessments and/or view outcomes reports on LTRAX.

The report is updated in real time, instantly incorporating new assessments that qualify for inclusion. To be included in the report, an admission assessment must have a recorded admission date. A planned or unplanned discharge assessment must have a recorded discharge date. Additionally, the assessments shown on the report have had the override box checked on the **MGMT** tab, acknowledging incomplete CMS LTCH QRP data. More information about the field requirements for each type of LTCH CARE assessment can be found in the CMS LTCH QRP Manual.

## REPORT FILTERS

Use the report filters to determine the parameters of your desired report. Click **Refresh** to display the report with the updated selections.

**Facility:** Use this drop-down menu to generate a QRP Override Report for all facilities in the organization or a single selected facility.

**NOTE:** This drop-down menu displays only for users at multi-facility organizations with organization-level access to LTRAX reports.

**Time Period:** The time period fields allow you to choose the assessments included in the report based on admission and/or discharge dates. Enter start and end dates for the desired date range. The date range defaults to the past 30 days.

**Assessments:** This drop-down menu allows you to choose the types of assessments included in the report: **Admission only**, **Discharge only**, or both **Admission and Discharge**.

**Assessment Status:** Make a selection to view assessments **Accepted by CMS only**, **In-Progress Assessments only**, or **Both**.

## REPORT OUTPUT

The report displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column determining the sort order. For example, if the report is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

The report returns a line for each admission or discharge assessment with the QRP override acknowledgment checked, so you may see multiple records for a single patient.

For your selected facility, date range, assessment type, and assessment status, the report displays the following information:

**Last Name:** The patient's last name (recorded as LTCH CARE item **A0500A** on **ID/PAY**).

**First Name:** The patient's first name (recorded as LTCH CARE item **A0500C** on **ID/PAY**).

**Birth Date:** The patient's birth date (recorded as LTCH CARE item **A0900** on **ID/PAY**).

**Medical Record #:** The patient's medical record number (recorded on **ID/PAY**).

**Assess Type:** A one- or two-letter code indicating the assessment type: A for admission, D for planned discharge, or DU for unplanned discharge.

**Admitted:** The patient's admission date (recorded as LTCH CARE item **A0220** on **ADMIT**).

**Discharged:** The patient's discharge date (recorded as LTCH CARE item **A0270** on **DISCHG**). An admission assessment with no associated discharge assessment may show a blank in this column.

**Status:** The status of the assessment:

- **Incomplete** for an assessment that is still in progress and has not passed the LTRAX completion check;
- **Complete** for an assessment that has passed the LTRAX completion check but has not yet been accepted by CMS;
- **Complete, xmit: Ready** for an assessment that has passed the LTRAX completion check and been marked XMIT READY but has not yet been placed into a CMS transmission file;
- **Complete, xmit: Prepared** for an assessment that has passed the LTRAX completion check and been placed into a CMS transmission file but has not yet been marked accepted by CMS;
- **Complete, Accepted by CMS** for an assessment that has been marked as accepted by CMS.

**Missing Fields:** The incomplete fields that CMS has identified for quality measure calculations that were not completed on the assessment. The column displays the item number and the tab where the field is located. Click the hyperlinked **Missing Fields** column header for more detail about each of the fields that may be itemized in that column.

**Missing Risk Adjusters:** The incomplete fields that CMS has identified for quality measure risk adjustment that were not completed on the assessment. The column displays the item number and the tab where the field is located. Click the hyperlinked **Missing Risk Adjusters** column header for more detail about each of the fields that may be itemized in that column.

**Notes:** Any notes entered in the Notes section of the QRP override acknowledgment checkbox on an assessment's **MGMT** tab appear in this column.

## 7. HL7 Messages

The LTRAX HL7 Message Report is a live report of LTRAX message processing, instantly reflecting whether LTRAX accepted or rejected incoming HL7 messages. The HL7 Message Report can be viewed by users with the privilege to view HL7 reports on LTRAX.

## REPORT FILTERS

Use the report filters to determine the parameters of your desired report. Click **Refresh** to display the report with the updated selections.

**Facility:** Use this drop-down menu to generate an HL7 message report for all facilities in the organization or a single selected facility.

**NOTE:** This drop-down menu shows only for users at multi-facility organizations with organization-level access to LTRAX HL7 reports.

**Time Period:** The time period fields allow you to select the messages displayed in the report based on processing dates. Enter start and end dates for the desired date range. The date range defaults to the past seven days.

**Message Type:** This drop-down menu allows you to choose the types of messages included in the report. You can select a single message type or select **All**.

**NOTE:** The message types received and processed for your organization or facility depend on many factors, including the messaging capabilities of any systems sending information to LTRAX. Not all message types may be processed for your organization or facility.

**Message Status:** Make a selection to view messages that were **Accepted, Rejected,** or **All**.

## REPORT OUTPUT

The report displays with columns that can be clicked to sort the output by a selected column. Click a column header once to order the report by that column in ascending alphabetical, chronological, or numeric order. Click the same column header again to reorder the report in descending order. Brackets surround the header of the column that controls the sort order. For example, if the report is ordered by discharge date, the discharge date column header will be displayed like this: [ Discharged ].

The report returns a line for each message, so you may see multiple messages for a single patient.

For your selected facility, date range, message type, and message status, the report may display the following information:

**Last Name:** The patient's last name.

**First Name:** The patient's first name.

**Account #:** The patient's account number.

**Admitted:** The patient's admission date.

**Discharged:** The patient's discharge date.

**Message Type:** An alphabetic code indicating the message type: **P** for pre-admission, **A** for admission, **XA** for cancel admission, **D** for discharge, **XD** for cancel discharge, **LOA** for leave of absence, **RLOA** for return from leave of absence, or **U** for update.

**Process Date:** The date and time LTRAX processed the message.

**Result:** The outcome of message processing: **A** for accepted or **R** for rejected.

**Notes:** This column displays any detail or explanatory notes returned after LTRAX processed the message. For rejected messages, the column may include information explaining why LTRAX could not accept the message.

**Facility:** The name of the facility that generated the message.

**Provider ID:** The Medicare Provider ID (CCN) of the facility that generated the message.

**NOTE:** Information displayed in the report is taken primarily from incoming messages. A blank space in any column may indicate that the information was not contained in the message sent to LTRAX.

## II.F. Enhancement Requests

LTRAX is continually enhanced and refined in response to user input to better serve the needs of all users. If you have a suggestion or recommendation for how you think the system might be improved, or if you find a problem (a “bug”) in the system, you can log your suggestions or problems in **Enhancement Requests**. The **Enhancement Requests** screen is available to all users through the **Enhancement Requests** link on the **LTRAX Launch Screen**.

### VIEW ENHANCEMENT REQUESTS

To access the **Enhancement Requests** screen, log in to LTRAX and click **Enhancement Requests** on your **LTRAX Launch Screen**. You'll see a list of all reports on file, including when each request was posted, the severity of any bugs, the name of the screen in question, the subject (which is a brief description of the request or bug) and its current status (fixed, in progress, etc.). You can read a detailed description of each report by clicking on the subject line. We recommend perusing the existing list before logging a report so the list doesn't grow unnecessarily long with duplicates.

You can sort the list by **Date Created**, **Date Modified**, **Severity**, **Status**, or **Screen Name** using the **Sort By** drop-down at the top of the screen. You can also filter the list to view only new reports, only reports that you have posted, or all reports not marked as **Fixed**, **Closed**, or **Not a Bug**.

### POST NEW REQUEST

If the request or suggestion you want to log isn't already in the enhancement requests, click **Post New Request**. You'll see a drop-down list at the top of the screen with five options for severity:

**Enhancement Request**

**Low:** Doesn't interfere with work

**Medium:** Mildly interferes

**High:** Bad/incorrect functioning

**Critical:** Major problem of system/prevents work/data loss

Choose the severity option that best describes your report. If you are making a suggestion or request, use **Enhancement Request**. Type in a short description of the request and select the relevant screen. In the full description box, enter a detailed description. Be as specific as possible; the more information you give, the better the chance we can find a solution or incorporate your suggestion.

When you have entered in all of the information, click **Post Report**. Your bug will appear in the list of bugs as **New**.

**NOTE:** If you encounter a problem that requires immediate attention, please send a message to the Support account through the **Send Message** link on your **LTRAX**

**Launch Screen** or call LTRAX support staff at 301-357-8110 rather than posting a request.

## II.G. LTRAX User Forums

We created the LTRAX Forums Bulletin Board (the Internet version of a message corkboard) to allow users to communicate with other users at other facilities and to provide an easy way to gather feedback on planned LTRAX improvements and reports. It works much the same as a community message board. Any LTRAX user can browse through all the messages in the forums, post a new message, or reply to another user's message so that LTRAX users can share thoughts, tips, questions, and experiences with other LTRAX users. Since the LTRAX forums are only available from within the LTRAX application, only active users can access the forums.

To access the forums, log in to LTRAX and click **User Forums**. The forums home page displays links to each forum, representing main topics: **General** or **LTRAX Software**. Under each forum or main topic are individual threads or sub-topics that may correspond to a particular aspect of the main topic. Users can create their own new threads under a forum, read and/or reply to other users' messages, and edit or delete messages they have posted previously.

To browse the forums, click one of the forum names. You'll then see a list of all threads posted under that forum organized in chronological order, with the thread containing the latest posted message appearing at the top. You can choose to start a new thread by clicking **Start New Thread** on the left side of the screen or at the bottom of the threads index page.

To browse the messages posted under a thread, click on the name of the thread. You can reply to a message in a thread by clicking **Reply** on the left side of the screen or **Reply to this thread** at the bottom of the messages page.

You can send a private message to a user who has posted a message on the forums by clicking on that user's username. You can also edit or delete messages you have posted by selecting the thread in which the message is posted and clicking the **Edit** or **Delete** link in your message.

Above the threads list you'll see what are called "breadcrumbs." These links represent your location in the forums. For instance, if from the forums index you clicked on the "**General**" forum, the breadcrumbs at the top of the screen would look like this: **LTRAX Forums > General**. Each time you click to a deeper level in the forums, the breadcrumbs will expand to illustrate where you are and offer you links to climb back up the hierarchy, so you're never more than a click or two away from any of the other forums or threads.

You can also use the links on the left side of the screen to jump to the forums index, the threads index (if you have selected a thread), or your **LTRAX Launch Screen**.

## III. FACILITY ADMINISTRATOR FEATURES

### III.A. Facility Administrator General Information

Users with LTRAX facility administrator privileges are responsible for managing the facility's information, settings, and user accounts on LTRAX. This includes creating and updating user account profiles and privileges; setting password expiration requirements for all LTRAX user accounts at the facility; creating and updating optional custom data fields; and configuring facility bed count data for outcomes reporting purposes.

Once a facility has at least one facility administrator account configured on LTRAX, that user is encouraged to set up any other required user accounts and manage them directly. This includes resetting user passwords when lost or forgotten. In case an LTRAX facility administrator is unavailable to adjust user accounts or other information, we recommend that each facility have at least two users with LTRAX facility administrator privileges.

There is no limit to the number of facility administrator accounts a facility can have.

### III.B. Manage Facility Screen

The **Manage Facility** screen is the starting point for all administrator functions, including managing user accounts, facility custom data, and other facility settings.

To access the administration screen, log in to LTRAX and click **My Facility** under the **Manage** header on the left side of your **LTRAX Launch Screen**. You will see a table displaying the names of all LTRAX users for your facility, including your own. If your facility has more than one site, you can toggle between the sites to display the users for each site by selecting the site name from the **Sites** box at the bottom of the screen and clicking **Switch Site**.

#### EDITING USER ACCOUNTS

You can edit an existing user account from **Manage Facility** by clicking on a username. The screen will refresh with the selected user's account information displayed at the top. Click **Edit User** to make any changes to the user's account. If you update a user's password, the user will be prompted to reset it immediately after logging in.

As a security precaution, LTRAX will automatically disable a user's account after six unsuccessful login attempts. An administrator can reactivate the account by resetting the password. See the [Add User](#) instructions below for an explanation of user account requirements and privileges.

You will also see the option **Delete User**. If the user has ever logged on to LTRAX, even once, you will not be able to delete the user from the system. This option is included only to allow you to correct mistakes in account assignment. If you need to deactivate a user's account, you can remove all of the privileges and then select **No** under **Active?** on the edit screen. See the [Add User](#) instructions below for more information.

## MANAGE FACILITY SCREEN OPTIONS

On the left side of your Manage Facility screen you will see the following links grouped under the headers **Facility Admin**, **Recent Activity**, and **Systems**:

- 1) [Add User](#)
- 2) [Bed Count](#)
- 3) [Custom Data Fields](#)
- 4) [Facility Settings](#)
- 5) [Recently Modified Assessments](#)

An explanation of the functions of each link follows. If you have a [My Facility](#) link on your [LTRAX Launch Screen](#) and you do not see all of these links on your [Manage Facility](#) screen, you are either a Site Administrator or an Organization Administrator, not a Facility Administrator.

### 1. Add User

Facility administrators are responsible for managing all user accounts for the facility. This includes multiple sites if your facility has more than one location operating under a single Medicare Provider ID (CCN). Each user should be given his or her own user account with a unique username and password, but all users will use their facility's Medicare Provider ID (CCN) as part of the login authentication.

Each user should also be given a set of user privileges that corresponds to his or her duties on the LTRAX system. Privileges can be combined to ensure that each user has the unique combination of user privileges required in order to perform his or her job. There is no limit to the number of user accounts a facility can have.

To add a new user, from [Manage Facility](#) click [Add User](#). You will see the following fields:

**Site:** If your facility has more than one site, select the site this user will be associated with from the drop-down list.

**User Name:** This is the name the user will log in with. A standard format for a username is first initial of the first name followed by last name with no spaces (for example, jdoe for John Doe), but you may choose whatever format you wish. The username is not case-sensitive. *\*required*

**Password:** An LTRAX password must be at least eight characters long. It must include uppercase and lowercase letters, at least two numbers, and at least one special character (~ ! @ % ^ & \* \_ - + = ` | ( ) { } [ ] ; : " ' < > , . ?). It cannot include any part of the user's name, the facility's name, or the word "password." LTRAX will immediately prompt the user to change his or her password when logging in for the first time. Passwords cannot be reused. *\*required*

**Confirm Password:** Type in the password again, exactly as you entered it the first time. *\*required*

**First Name:** The user's first name. *\*required*

**Last Name:** The user's last name. *\*required*

**MI:** The user's middle initial.

**Suffix:** The user's suffix (Ph.D., Esq., II, etc.).



**Email Address:** The user's email address. This is not required, but it is highly recommended, especially if the user should receive emails from the LTRAX email listserv. Listserv recipients receive emails at the address listed in LTRAX. Users can edit their own email addresses.

**Phone Number:** The user's phone number. This is not required, but it is recommended in case LTRAX support staff needs to contact a user. Users can edit their own phone numbers.

**Extension:** Any applicable extension to the user's phone number.

**Active?:** This is the on/off switch for a user account. The default setting is **Yes**. A user with an **Active** setting of **Yes** will be able to log on to LTRAX. To de-activate a user account and prevent that user from logging on, select **No**.

**Roles:** When creating a user account, consider the user's requirements. Will the user need to be able to create other user accounts? Will the user be creating patient assessments? Will the user be uploading data to LTRAX? The answers to these questions will determine the combination of privileges the user needs. You can refer to the [Privileges Reference Guide](#) below for help in determining which privileges to assign each user account.

We offer roles you can select in order to assign a user a pre-determined group of privileges, or you can customize a user's privileges using the list of available privileges. Roles provide a shortcut for assigning groups of privileges based upon a user's role in the facility. Selecting one of these roles will automatically assign a set of privileges from the list of available privileges. These privileges may be individually added, removed, or combined as desired. Each role described below includes a description of its purpose and the included privileges. When editing an existing user account, click the **RESET** button to restore the privilege selections to the user's previously saved privileges. Click **CLEAR** to clear all privilege selections.

### **Facility Administrator Role**

This role allows the user to create and manage user accounts; create custom data fields; configure facility settings; view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys; lock and unlock patient records; manage CMS transmission files; download assessment data; and view outcomes reports for the facility.

The "facility administrator" *privilege* by itself does not offer the same level of access to LTRAX as the "facility administrator" *role*.

### **Power User Role**

This role is intended for LTRAX users who need full clinical access with some limited administrative abilities, without the need to create or manage user accounts. This role allows the user to view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys; lock and unlock patient records; perform advanced maintenance functions on assessments; manage CMS transmission files; download assessment data from LTRAX; and view outcomes reports for the facility.

### **Clinical User**

This role allows the user to fulfill all requirements for completing and submitting assessments by granting the privileges to view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys; lock and unlock assessments; perform advanced maintenance functions on assessments; and manage CMS transmission files for the facility.

### **Data Entry**

This role is intended for users who need only to view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys. It grants only the privileges to view, create, and edit assessments for the facility.

### **Research**

This role is intended for users who need access to facility data for research purposes but do not need to enter data, create assessments, or perform any clinical functions. It grants only the privileges to view outcomes reports and download assessment data for the facility.

**Privileges:** Individual privileges are grouped by general tasks as described below. If you began the privileges selection by choosing a role for the new user account, you can then add or subtract individual privileges by checking or unchecking items in the Privileges area if necessary. If you did not choose a role, you can select each individual privilege you want to grant to a new user and thereby customize the user's access to LTRAX.

### **Administrator Privileges**

**Facility administrator (user can create/manage all user accounts for their facility and configure facility information - includes all sites):** This privilege allows the user to create and manage all user accounts for the facility, including multiple sites associated with that facility (*site administrator privileges inclusive*). The facility administrator can also create facility custom data fields, edit facility settings such as password expiration, access assessment tracking information and perform advanced functions on individual assessments. Facilities can have more than one facility administrator. In fact, it is recommended that each facility have more than one administrator as it distributes responsibility in case an administrator is ill, on vacation, or otherwise unavailable.

**Site administrator (user can create/manage user accounts only for their site):** This privilege restricts a user's administrative capacity to the site only. *This is only applicable if a facility has more than one site, and the site administrator should not have access to user accounts at other sites.* A site administrator creates and manages user accounts for the site only and does not have the ability to grant user privileges associated with a facility. (For instance, a site administrator cannot authorize a user to view reports.) Site administrators also cannot create custom data fields or manage any other facility-level settings.

**NOTE:** If you are designating the user as a facility administrator, this privilege is unnecessary and redundant.

### **Sub-Administrator Privileges**

**Non-admin user can perform Clinical Assessment advanced maintenance functions:** This privilege allows a user who is not an LTRAX facility administrator to act outside the usual LTRAX workflow to correct mistakes or undo actions, such as to revert assessments back to their previous state (from admitted assessments back to pre-admission or discharged assessments back to admission) or to change the CMS transmission status of an assessment.

**NOTE:** This privilege is not necessary if the user has facility administrator privileges.

**Non-admin user can move assessments from their facility to other facilities in their organization:** This privilege allows a user who is not an LTRAX organization administrator to move PAS Tool assessments from one facility to another in the organization. This is intended for use by facilities sharing liaisons who may not know the admitting facility at the time of the pre-admission screening.

**NOTE:** This privilege is not necessary if the user has facility administrator privileges.

### **Clinical Privileges**

**User can view all assessments for their facility (includes all sites):** This privilege gives the user the ability to see all patient assessments at the facility, including assessments from multiple sites if the facility has more than one site. This does not include the ability to create or edit assessments.

**User can view only assessments for their site:** This limits the user to seeing only assessments at one site. This does not include the ability to create or edit assessments.

**NOTE:** This privilege is not necessary if the user has the privilege "User can view all assessments for their facility (includes all sites)." It is also unnecessary if the facility has only one site.

**User can create/edit Clinical assessments:** This gives a user the ability to create pre-admission and admission assessments and edit existing assessments, including patient satisfaction surveys.

**User can lock assessments:** This gives the user the ability to lock assessments against any edits to prevent any changes.

**User can unlock assessments:** This gives the user the ability to reopen locked assessments for further edits.

### **CMS Transmission Files Privileges**

**User can manage CMS transmission files for assessments in their facility:** This privilege gives the user the ability to create, download, and reconcile CMS transmission files for the facility.

### **Data Download/Upload Privileges**

**User can download assessments from their facility:** This gives the user the ability to download any or all of the facility's patient assessment data to their local computer or network, such as to make a local backup or to import into another software application for data analysis.

**User can upload files to LTRAX:** This gives the user the ability to upload files, such as patient satisfaction surveys, to the LTRAX system.

### **Outcomes Reports Privileges**

**User can view all Administrative-level reports for their facility:** This privilege allows a user to view LTRAX Administrative Outcomes Reports for the facility, including patient satisfaction outcomes reports.

**User can view all Clinical reports for their facility:** This privilege allows a user to view LTRAX Clinical Outcomes Reports for their facility, including patient satisfaction outcomes reports.

**User can ONLY view Patient Satisfaction outcomes reports for their facility:** This privilege allows users without clinical or administrative outcomes reports privileges to view the facility's patient satisfaction survey outcomes.

**NOTE:** This privilege is not necessary if the user has any of the outcomes reports privileges above.

**User can view HL7 reports for their facility:** This privilege allows a user to see the live report of message processing results for any interface(s) between LTRAX and the facility's other information systems.

### **Notification Privileges**

**User can receive admissions office notification emails:** This privilege allows a user to be selected for email notification of Pre-Admission Screening (PAS) Tool assessments ready for admissions office review. To be assigned this privilege, a user must have all of the following:

- a valid email address;
- a privilege to view assessments ("User can view assessments for their site" or "User can view all assessments for their facility (includes all sites)"); and
- a privilege to edit assessments ("User can create/edit pre-admission assessments only" or "User can create/edit Clinical assessments").

### **Special Limited Privileges**

**User can create/edit pre-admission assessments only:** This allows users who do not have the privilege "User can create/edit Clinical assessments" to create pre-admission assessments.

**NOTE:** This privilege is not necessary if the user has the privilege "User can create/edit Clinical assessments," and it cannot be combined with other special limited privileges such as "User can create/edit patient satisfaction surveys only."

**User can create/edit patient satisfaction surveys only:** This allows users who do not have the privilege "User can create/edit Clinical assessments" to enter patient satisfaction survey results. Such users will be able to view assessment data for the surveys they are entering, but they will not be able to change any assessment data other than the patient satisfaction survey responses. If the user needs to print surveys for distribution to patients, the user will also need the privilege "User can view all assessments for their facility (includes all sites)."

**NOTE:** This privilege is not necessary if the user has the privilege "User can create/edit Clinical assessments," and it cannot be combined with other special limited privileges such as "User can create/edit pre-admission assessments only."

Once you have entered all of the user account information and made your privilege selections, click **Save** to create the account and return to **Manage Facility**.

## **PRIVILEGES REFERENCE GUIDE**

Almost everything a user can do in LTRAX is controlled by a separate user privilege. This guide will help you determine the privileges appropriate to each user account based on the tasks each user has to perform. These privileges can be combined as necessary to allow each user only the access required.

### **Administrative Tasks**

***Does the user need to...***

- Create other user accounts and manage user privileges?
- Reset passwords for users who have forgotten them?
- Create custom data fields for clinical assessments?
- View activity tracking in assessments?

*For any combination of the above tasks, assign the privilege:*

- ***Facility administrator (user can create/manage all user accounts for their facility and configure facility information - includes all sites)*** if the user needs to perform these tasks at a single facility
- ***Organization administrator (user can create/manage all user accounts for their organization)*** if the user needs to perform these tasks for all facilities in the organization

***Does the user need to...***

- Revert an assessment back to a prior state, such as a pre-admission assessment that was accidentally admitted?
- Correct CMS transmit file problems, such as assessments mistakenly marked accepted by CMS?

*An administrator can already perform these tasks. If the user needs to do these tasks WITHOUT the additional administrator tasks listed above, the user will need the privilege:*

- ***Non-admin user can perform Clinical Assessment advanced maintenance functions***

***Does the user need to...***

- Move a pre-admission assessment from one facility to another in the organization?

*If the user is not an organization administrator, the user will need the sub-administrator privilege:*

- ***Non-admin user can move assessments from their facility to other facilities in their organization***

***Does the user need to...***

- Troubleshoot problems with interfaces between hospital information systems and LTRAX?

*The user will need the Outcomes Reports privilege:*

- ***User can view HL7 reports for their facility, or***
- ***User can view HL7 reports for all facilities in their organization (includes all facilities)***

### **Assessment Tasks**

***Does the user need to...***

- Enter patient assessments (including pre-admission, admission, and patient satisfaction surveys)?

*If yes, the user will need the privileges:*

- **User can view all assessments for their facility (includes all sites)** and **User can create/edit Clinical assessments**, if the user needs to create and enter patient assessment data at a single facility
- **User can view assessments belonging to any facility in their organization** and **User can edit Clinical assessments belonging to any facility in their organization**, if the user needs to edit or manage assessments across multiple facilities in an organization

**Does the user need to...**

- Enter pre-admission assessments only?

*If the user only enters pre-admission assessments without entering any clinical assessments, the user will only need the Special Limited Privilege:*

- **User can create/edit pre-admission assessments only**

**Patient Satisfaction Surveys**

**Does the user need to...**

- Print and/or enter patient satisfaction surveys only?

*If the user only enters patient satisfaction survey data without entering any clinical assessments, the user will only need the Special Limited Privilege:*

- **User can create/edit patient satisfaction surveys only**

**Assessment Submission Tasks**

**Does the user need to...**

- Prepare files for transmission to CMS?
- Reconcile the CMS transmission results in LTRAX?

*If yes, the user will need the privilege:*

- **User can manage CMS transmission files for assessments in their facility**, if the user manages CMS transmission files for a single facility
- **User can manage CMS transmission files for assessments belonging to any facility in their organization**, if the user needs to manage the CMS transmission process across multiple facilities in an organization

**Data Download Tasks**

**Does the user need to...**

- Download patient data for analysis or custom reporting?
- Create custom templates to share with others for analysis or custom reporting?

*If yes, the user will need the privilege:*

- **User can download data from their facility**, or
- **User can download data from all facilities in their organization**

## Outcomes Reports

### *Does the user need to...*

- View administrative and/or clinical outcomes reports?
- View patient satisfaction results in HCAHPS reports?
- View transmissions reports without being responsible for managing CMS transmission files?

*If yes, the user will need the privilege:*

- **User can view all Administrative-level reports for their facility** and **User can view all Clinical reports for their facility**, or
- **User can view all Administrative-level reports for all facilities in their organization (includes all facilities)** and **User can view all Clinical reports for all facilities in their organization (includes all facilities)**

### *Does the user need to...*

- View only patient satisfaction outcomes reports without seeing any other outcomes reports?

*If yes, the user will need the privilege:*

- **User can ONLY view Patient Satisfaction outcomes reports for their facility**

## 2. Bed Count

Your facility bed count is used to calculate occupancy data in LTRAX. If your facility maintains the same number of patient beds over time, you only need to configure one bed count value. If your facility gains or loses patient beds, you will need to configure multiple bed counts to reflect those changes and ensure accurate occupancy rate calculations over time.

### CONFIGURING YOUR BED COUNT

To set your bed count value, click on **My Facility > Bed Count**, then click **Add New**. You will see the following input boxes:

**Description of effective date range (e.g., "FY2011"):** Enter a description of the time period covered (for instance, "Current" or "2008 - 2011").

**Effective Date Start:** Enter the date when your facility acquired this number of beds (MM/DD/YYYY). If your bed count has remained the same since you started using LTRAX, you can use 01/01/2011 as your start date.

**Effective Date End:** Enter the last date your facility had or will have this number of beds (MM/DD/YYYY). If this bed count is current and is not expected to change, use a date far in the future.

**Facility Beds:** Enter the number of patient beds available during this date range.

When you have entered in all of your bed count data, click **Save**. You will see your new bed count value appear on the Bed Count screen.

**NOTE:** Completion of all fields is required for configuration of your bed count.

## EDITING A BED COUNT

To edit a bed count, click on **My Facility > Bed Count**. From your list of bed counts, select the radio button to the left of the bed count you wish to edit and then click **Edit**. Make your changes on the edit screen and click **Save Changes**.

**NOTE:** If your facility's bed count changes, do not edit the existing bed count value or you will affect the accuracy of your occupancy calculations for assessments within its effective date range. Instead, edit the current bed count's end date and create a new bed count to appropriately reflect the date that the change takes effect.

To delete a bed count, click on **My Facility > Bed Count**. From your list of bed counts, select the radio button to the left of the bed count you wish to delete and click **Delete**, then click **OK** to confirm deletion.

## 3. Custom Data Fields

Custom data fields provide a way for facilities to expand the information collected with patient assessments. These fields can be used to store patient or associated information that is not a standard part of the LTRAX patient assessment, such as patient contact information or attending physician. All custom data elements appear in assessments on a tab labeled **CUSTOM**. **Referring Physician** and **Referring Facility**, when configured properly as drop-downs, also appear on the **REFERRAL/PAYER** tab in the pre-admission screening as well as on the **CUSTOM** tab. Evaluator can be similarly configured for custom display on the **JUSTIFICATION** tab. If you have no custom data elements, the **CUSTOM** tab does not appear.

Any user with organization or facility administrator privileges can create and manage custom data fields. Creation of these items is optional, and the data stored in them are available to your facility or organization in patient assessments and in downloads.

### ADDING CUSTOM FIELDS

To add a custom data field, click on **My Facility > Custom Data Fields**, then click **Add Element**. Then, complete the following input fields:

**Element Name:** Type in a simple name that will be used to identify the field.

**Description of element:** Type in a longer, more user-friendly description which will be displayed on the **CUSTOM** tab on assessments. This can include instructions to the user, examples of acceptable values, etc.

**Data Type of element:** This is used to error-check data entry. **TEXT** allows any characters to be entered, while **DATE**, **INTEGER**, and **DECIMAL NUMBER** all require that values conform to a specific definition. **INTEGER** refers to whole numbers with no decimal points, and **DECIMAL NUMBER** means "real" or "floating point" values (for example, 98.6). If you specify a datatype other than **TEXT**, LTRAX will apply the appropriate validation check to that element. For example, if you specify a **DATE** data type and a user tries to enter anything other than a proper date value, a warning will be displayed, and the invalid value will not be saved.

**Entry method:** This refers to the means by which the user will enter the data into this field on the **CUSTOM** tab. Two methods are available: **Text Box** and **Drop-Down**. **Text Box** allows the user to type in values. **Drop-Down** allows the element to be configured with a list of values from which the user can choose. The latter method is useful for preventing data-entry errors due to typos and for enforcing the standardization of data. Drop-down configuration is required for your Referring Physician and Referring Facility fields in order for them to appear on the **REFERRAL/PAYER** tab of pre-admission screenings. See [Configuring Custom Drop-Downs](#) below for more information on drop-down fields.



The next set of options refers to the list of checkboxes that control when the element can or must be filled out during the assessment process. You can select more than one of the following options:

**Required?:** Check this box to require that the field be filled out before an assessment can be marked *Complete*. As with the other tabs, the **CUSTOM** tab uses the green / yellow / red color coding to indicate completion state.

**Pre-Admit / Assessments:** Use these checkboxes to specify the stage(s) of the assessment process in which the field can be edited. Items not allowed before a given stage will not appear on the **CUSTOM** tab until that stage is reached. For example, a field configured for entry only at discharge will not appear during pre-admission or admission, but will appear on discharge assessments.

Once you have completed the form, click **Save** to create your new custom data field.

### EDITING CUSTOM FIELDS

To edit a custom data field, click on **My Facility > Custom Data Fields**. From your list of existing facility custom data elements, select the radio button to the left of the element you wish to edit, and then click **Edit Element**. Make your changes on the edit screen, and click **Save Changes**.

### REORDERING CUSTOM FIELDS

By default, your facility custom fields appear on the **CUSTOM** tab in the order in which they are created. You can reorder the fields using the *Order* input boxes on your **Custom Data Fields** administration screen. To change the order of your facility custom elements, click on **My Facility > Custom Data Fields**. Use the input boxes in the *Order* column next to your existing elements to type in numbers representing the order for those fields. Then click **Reorder Elements** and review the new order.

### CONFIGURING CUSTOM DROP-DOWNS

Drop-downs are intended as a means to avoid data-entry errors, make facility custom data entry faster and easier, and standardize data values for accuracy. Custom data fields configured as drop-downs will also appear on your **LTRAX Launch Screen** as drop-downs that you can use to filter your assessments lists by in addition to the other filters available.

To configure a drop-down field, first set the *Entry Method* to **Drop-down (select list)** as specified above. An input box labeled *Allowable Values* will appear. You will use this box to specify both the descriptions that will appear in the drop-down itself and the corresponding values that are saved to the database when a selection is made using the drop-down.

Enter the valid values in the edit box by typing only one item per line in the form **value : description**. Value is what is stored in the database, and description is what is displayed in the drop-down on the **CUSTOM** tab during assessment data-entry, with the two separated by a colon. If a line only contains only a value, then that will also be used in the description.

Values and descriptions may not contain the characters " (double quotes), < or >. If there are multiple colons on one line, the first colon is treated as the value / description separator and the rest are kept as part of the description. The values are also type-checked against the *Data Type* specified. For example, if an element is configured as a *Date*, then each choice configured must be a valid date.

**For example:** An element called “Attending Physician” is configured as a text drop-down with the following allowable values:

X : Dr. Xavier  
N : Dr. Nelson  
Other

Line 1: “Dr. Xavier” is what the user selects in the drop-down on the **CUSTOM** tab, and “X” is what is actually stored to the database and downloaded in your facility custom data files.

Line 2: “Dr. Nelson” appears in the drop-down, “N” is stored in the database.

Line 3: “Other” is displayed in the drop-down *and* stored in the database.

Values automatically appear in the drop-downs in the order in which you enter them in the Allowable Values box.

### EDITING CUSTOM DROP-DOWNS

Editing the list of options available for a drop-down will not automatically alter any data in existing assessments. For instance, in the above example, if “Dr. Xavier” is removed from the list, any assessments that already have that value will retain that value. However, if an assessment containing “Dr. Xavier” is selected from the **LTRAX Launch Screen** and the user goes to the **CUSTOM** tab on that assessment, “Dr. Xavier” will appear as a temporary value in the drop-down and a message displayed on screen will alert the user to the fact that the value no longer exists as a valid option. If the user doesn’t then select a different option from the drop-down, the data will not be updated to reflect one of the available values.

It is important to recognize that a selection made in the drop-down is identified in the database by the value, not the description. Here is another example: Patient Smith’s assessment had its “Attending Physician” value set to “Other.” The next day, the administrator edited the facility custom element and changed that option from “Other” to “Other : Other Attending.” If Smith’s assessment is loaded, and the user clicks on the **CUSTOM** tab, it will appear as if the choice was changed from “Other” to “Other Attending.” In this case, because only the *Description* changed, the database entry stays the same (“Other”).

However, if instead the line were changed to “Other Attending” (no colon) then both the *value* and *description* would change. If the assessment were then loaded and the **CUSTOM** tab clicked, the drop-down would display a *temporary* value of “Other” because the value of “Other” is no longer a valid drop-down option, and the assessment is in edit mode. This same scenario would be true if the choice were completely removed. It is therefore recommended that great care be taken when editing facility custom items once assessments have been saved using those options.

Values are not case-sensitive, meaning that if you change “x : Dr. Xavier” to “X : Dr. Xavier” and then load an assessment where “x : Dr. Xavier” had been selected, the drop-down will identify that as “X : Dr. Xavier” and will save the uppercase “X” to the database if the Attending Physician field is in edit mode.

### CONVERTING FREE-TEXT ENTRY FIELDS TO DROP-DOWN FIELDS

An existing free-text entry field can be switched to a drop-down simply by making the choice on the administration screen. For more information, see the [Configuring Custom Drop-Downs](#) section of this user manual.

**NOTE:** When converting a text entry field to a drop-down, if your goal is to match values in the new drop-down to values that had been typed into the text field, you will need to do an inventory of all of your existing values in order to identify all the previously entered options. This will offer an opportunity to identify and correct any

typos or other data variances in the assessments before finalizing the list of allowable values for your drop-down.

## 4. Facility Settings

The **Facility Settings** screen stores information about your facility, including identification numbers, address, and billing information. It also allows you to configure a password expiration interval that will require all users at your facility to update their passwords at your specified interval.

To verify or update your facility settings, click **My Facility > Facility Settings**.

### FACILITY INFORMATION

Your Medicare Provider # (Medicare Provider ID or CCN) is a six-digit number assigned to your facility by CMS. It is unique to your facility. All users at your facility will use this number as part of their login when logging in to LTRAX.

Your Assigned Facility/Provider Submission ID (also called the QIES Facility ID or Fac\_ID) is assigned to your facility by QIES for purposes of submitting assessments to the ASAP system. It is not the same as the Medicare Provider ID (CCN). Please contact the QIES Technical Support Office (QTSO) at 1-800-339-9313 or help@qtso.com if you need assistance with your QIES Facility ID.

The National Provider ID (NPI) assigned to your facility and/or site can only be configured in LTRAX by LTRAX support. Please contact LTRAX for assistance entering or updating your hospital's NPI(s).

After you have entered your values, click **Save** at the bottom of the screen.

### BILLING CONTACT INFORMATION

The billing contact information section of **Facility Settings** is used to indicate where any communication regarding LTRAX invoices should be directed.

### PASSWORD EXPIRATION SETTINGS

Facility administrators can specify how often all users at the facility will need to change their LTRAX user passwords. Enter a value between 0 and 365 to set how long the facility's passwords remain valid. If you enter 0, your facility's passwords will never expire; however, this is not recommended for reasons of security and HIPAA compliance. You should check with the person in charge of HIPAA compliance at your facility before setting your password expiration to 0.

## 5. Recently Modified Assessments

The **Recently Modified Assessments** screen allows LTRAX facility administrators to track assessment activity for their facilities. From **Manage Facility**, click **Recently Modified Assessments** to view a list of assessments that have been modified within the last specified number of days. Click on a patient name to list all the users who have accessed that patient's assessment and the date and time the record was accessed. Click on a Session ID : Username link to list all of the screens that user visited during that particular session, including the time and duration visited.

## IV. ORGANIZATION ADMINISTRATOR FEATURES

### IV.A. Organization Administrator General Information

Users with LTRAX organization administrator privileges are responsible for managing user accounts for all subscribed facilities belonging to the organization. This type of account is only necessary if an organization has more than one facility, a facility being defined by a unique Medicare Provider ID (CCN).

This level of access has been included for convenience, to allow one user to manage user accounts for all of the organization's facilities without needing to log out and log back in under each provider number. An organization administrator has access to assign organization-level privileges for data downloading, outcomes, and/or assessment editing to any user under the organization.

There is no limit to the number of organization and facility administrator accounts an organization can have.

### IV.B. Manage Facility Screen

The **Manage Facility** screen is the starting point for all administrator functions, including managing user accounts.

To access this administration screen, log in to LTRAX and click **My Facility** under the **Manage** header on the left side of your **LTRAX Launch Screen**. You will see a table displaying the names of all LTRAX users for your facility. You can toggle between the facilities under your organization and display the users for any one facility by selecting the facility name from the facilities box at the bottom of the screen and clicking **Switch Fac**. If you do not see the facilities box, you do not have organization administrator privileges.

Likewise, if a facility has more than one site, you can toggle between sites by selecting the site name and clicking **Switch Site**.

#### EDITING USER ACCOUNTS

You can edit an existing user account from **Manage Facility** by clicking on a username. The screen will refresh with the selected user's account information displayed at the top. Click **Edit User** to make any changes to the user's account. If you update a user's password, the user will be prompted to reset it immediately after logging in.

As a security precaution, LTRAX will automatically disable a user's account after six unsuccessful login attempts. An administrator can reactivate the account by resetting the password. See the [Add User](#) instructions below for an explanation of user account requirements and privileges.

You will also see the option **Delete User**. If the user has ever logged on to LTRAX, even once, you will not be able to delete the user from the system. This option is included only to allow you to correct mistakes in account assignment. If you need to deactivate a user's account, you can remove all of the privileges and then select **No** under **Active?** on the edit screen. See the [Add User](#) instructions below for more information.

## MANAGE FACILITY SCREEN OPTIONS

On the left side of your **Manage Facility** screen you will see the following links:

- 1) [Add User](#)
- 2) [Custom Data Fields](#)

If you see links for [Bed Count](#), [Facility Settings](#), and [Recently Modified Assessments](#), you are either solely a facility administrator or a facility administrator and an organization administrator. Please refer to the [Facility Administrator Features](#) section for information about how to manage facility-level information.

If you are an organization administrator with facility administrator privileges, you will be able to manage facility information for only *one* facility at a time, corresponding to the Medicare Provider ID (CCN) you log on with. To edit facility information for other facilities in your organization, you will need to create a facility administrator user account for yourself under each of those facilities.

### 1. Add User

Organization administrators are responsible for managing all user accounts for all facilities under the organization. Each user should be given his or her own user account with a unique username and password, and each user will use their facility's Medicare Provider ID (CCN) as part of the login authentication.

Each user should also be given a set of user privileges that corresponds to his or her duties on the LTRAX system. Privileges can be combined to ensure that each user has the unique combination of user privileges required in order to perform his or her job. There is no limit to the number of user accounts a facility or organization can have.

To add a new user, from your **Manage Facility** screen click [Add User](#). You will see the following fields:

**Org / Facility / Site:** Select the org/facility/site this user will be associated with from the drop-down list.

**User Name:** This is the name the user will log in with. A standard format for a username is first initial of the first name followed by last name with no spaces (for example, jdoe for John Doe), but you may choose whatever format you wish. The username is not case-sensitive. *\*required*

**Password:** An LTRAX password must be at least eight characters long. It must include uppercase and lowercase letters, at least two numbers, and at least one special character (~ ! @ % ^ & \* \_ - + = ` | ( ) { } [ ] : ; " ' < > , . ?). It cannot include any part of the user's username, the facility's name, or the word "password." LTRAX will immediately prompt the user to change his or her password when logging in for the first time. Passwords cannot be reused. *\*required*

**Confirm Password:** Type in the password again, exactly as you entered it the first time. *\*required*

**First Name:** The user's first name. *\*required*

**Last Name:** The user's last name. *\*required*

**MI:** The user's middle initial.

**Suffix:** The user's suffix (Ph.D., Esq., II, etc.).

**Email Address:** The user's email address. This is not required but it is recommended, especially if the user should receive emails from the LTRAX email listserv. Listserv recipients receive emails at the address listed in LTRAX. Users can edit their own email addresses.

**Phone Number:** The user's phone number. This is not required, but it is recommended in case LTRAX support staff needs to contact a user. Users can edit their own phone numbers.

**Extension:** Any applicable extension to the user's phone number.

**Active?:** This is the on/off switch for a user account. The default setting is **Yes**. A user with an active setting of **Yes** will be able to log on to LTRAX. To de-activate a user account and prevent that user from logging on, select **No**.

**Roles:** When creating a user account, consider the user's requirements. Will the user need to be able to create other user accounts? Will the user be creating patient assessments? Will the user be uploading data to LTRAX? The answers to these questions will determine the combination of privileges the user needs. You can refer to the [Privileges Reference Guide](#) in the facility administrator features section for help in determining what privileges to assign each user account.

We offer roles you can select in order to assign a user a pre-determined group of privileges, or you can customize a user's privileges using the list of available privileges. Roles provide a shortcut for assigning groups of privileges based upon a user's role in the facility. Selecting one of these roles will automatically assign a set of privileges from the list of available privileges. These privileges may be individually added, removed, or combined as desired. Each role described below includes a description of its purpose and the included privileges. When editing an existing user account, click the **RESET** button to restore the privilege selections to the user's previously saved privileges. Click **CLEAR** to clear all privilege selections.

### **Organization Administrator Role**

Intended for LTRAX users at an organization with more than one LTRAX subscriber facility, this role includes a privilege combination that offers the highest level of access available to an LTRAX user. The organization administrator role bestows privileges to create and manage user accounts across the organization, view all reports for the organization, and download assessment data from all facilities in the organization. This role also allows the user to create custom data fields for all facilities in the organization; view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys at all facilities in the organization; and lock and unlock patient records at any facility in the organization. Additionally, a user in the organization administrator role can act as the facility administrator for the facility associated with the Medicare Provider ID (CCN) used to log in to LTRAX.

The "organization administrator" *privilege* by itself does not offer the same level of access to LTRAX as the "organization administrator" *role*. Additionally, this role can only be granted by an LTRAX user with the organization administrator privilege.

**NOTE:** This role does not confer the privilege to manage CMS transmission files across the organization. To add organization-level access to CMS transmission files to a user's account, opt in by checking the **User can manage CMS transmission files for assessments belonging to any facility in their organization** privilege for that user.

### **Facility Administrator Role**

This role allows the user to create and manage user accounts; create custom data fields; configure facility settings; view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys; lock and unlock patient records; manage CMS transmission files; download assessment data; and view outcomes reports for the facility.

The "facility administrator" *privilege* by itself does not offer the same level of access to LTRAX as the "facility administrator" *role*.

### **Power User Role**

This role is intended for LTRAX users who need full clinical access with some limited administrative abilities, without the need to create or manage user accounts. This role allows the user to view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys; lock and unlock patient records; perform advanced maintenance functions on assessments; manage CMS transmission files; download assessment data from LTRAX; and view outcomes reports for the facility.

### **Clinical User**

This role allows the user to fulfill all requirements for completing and submitting assessments by granting the privileges to view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys; lock and unlock assessments; perform advanced maintenance functions on assessments; and manage CMS transmission files for the facility.

### **Data Entry**

This role is intended for users who need only to view, create, and edit pre-admission assessments, clinical assessments, and patient satisfaction surveys. It grants only the privileges to view, create, and edit assessments for the facility.

### **Research**

This role is intended for users who need access to facility data for research purposes but do not need to enter data, create assessments, or perform any clinical functions. It grants only the privileges to view outcomes reports and download assessment data for the facility.

**Privileges:** Individual privileges are grouped by general tasks as described below. If you began the privileges selection by choosing a role for the new user account, you can then add or subtract individual privileges by checking or unchecking items in the Privileges area if necessary. If you did not choose a role, you can select each individual privilege you want to grant to a new user and thereby customize the user's access to LTRAX.

### **Administrator Privileges**

**Organization administrator (user can create/manage all user accounts for their organization):** This privilege allows the user to create and manage user accounts for all facilities and sites in the organization and enables the user to grant organization-level access to data downloads and reports to any user. This level of privileges is only applicable to users belonging to an organization that has more than one subscriber facility on LTRAX.

**NOTE:** Organization administrator privileges do not give a user full control over each facility in the organization. To access facility-level settings and functionality such as facility settings, facility password expiration, etc., an organization administrator also requires facility administrator accounts at each facility.

**Facility administrator (user can create/manage all user accounts for their facility and configure facility information - includes all sites):** This privilege allows the user to create and manage all user accounts for the facility, including multiple sites associated with that facility (*site administrator privileges inclusive*). The facility administrator can also create facility custom data fields, edit facility settings such as password expiration, access assessment tracking information, and perform advanced functions on individual assessments. Facilities can have more than one facility administrator. In fact, this is recommended as it distributes responsibility in case an administrator is ill, on vacation, or otherwise unavailable.

**Site administrator (user can create/manage user accounts only for their site):** This privilege restricts a user's administrative capacity to the site only. *This is only applicable if a facility has more than one site, and the site administrator should not have access to user accounts at other sites.* A site administrator creates and manages user accounts for the site only and does not have the ability to grant user privileges associated with a facility. For instance, a site administrator cannot authorize a user to view reports. Site administrators also cannot create custom data fields or manage any other facility-level settings.

**NOTE:** If you are designating the user as a facility administrator, this privilege is unnecessary and redundant.

### **Sub-Administrator Privileges**

**Non-admin user can perform Clinical Assessment advanced maintenance functions:** This privilege allows a user who is not an LTRAX facility administrator to act outside the usual LTRAX workflow to correct mistakes or undo actions, such as to revert assessments back to their previous state (from admitted assessments back to pre-admission or discharged assessments back to admission) or to change the CMS transmission status of an assessment.

**NOTE:** This privilege is not necessary if the user has facility administrator privileges.

**Non-admin user can move assessments from their facility to other facilities in their organization:** This privilege allows a user who is not an LTRAX organization administrator to move PAS Tool assessments from one facility to another in the organization. This is intended for use by facilities sharing liaisons who may not know the admitting facility at the time of the pre-admission screening.

**NOTE:** This privilege can only be assigned by an LTRAX organization administrator. It is not necessary if the user already has organization administrator privileges.

### **Clinical Privileges**

**User can view assessments belonging to ANY facility in their organization:** This privilege gives the user the ability to see patient assessments at any facility in the organization. This does not include the ability to create or edit assessments. Users with this privilege will be able to select from a drop-down list of the organization's facilities at the bottom of the **LTRAX Launch Screen** in order to display each facility's assessments.

**User can view all assessments for their facility (includes all sites):** This privilege gives the user the ability to see all patient assessments at the facility, including assessments from multiple sites if your facility has more than one site. This does not include the ability to create or edit assessments.



**User can view only assessments for their site:** This limits the user to seeing only assessments at one site. This does not include the ability to create or edit assessments.

**NOTE:** This privilege is not necessary if the user has the privilege "User can view all assessments for their facility (includes all sites)." It is also unnecessary if your facility has only one site.

**User can edit Clinical assessments belonging to ANY facility in their organization:** This gives a user the ability to create pre-admission and admission assessments and edit existing assessments, including patient satisfaction surveys, at any of the organization's facilities. This includes the ability to move PAS Tool assessments from any facility in the organization to any other facility in the organization.

**User can create/edit Clinical assessments:** This gives a user the ability to create pre-admission and admission assessments and edit existing assessments, including patient satisfaction surveys.

**User can lock assessments:** This gives the user the ability to lock assessments against any edits to prevent any changes.

**User can unlock assessments:** This gives the user the ability to reopen locked assessments for further edits.

#### **CMS Transmission Files Privileges**

**User can manage CMS transmission files for assessments belonging to ANY facility in their organization:** This privilege gives the user the ability to create, download, and reconcile CMS transmission files for any or all facilities in the organization. This privilege is only applicable to users belonging to an organization that has more than one subscriber facility in LTRAX, and it can only be assigned by an LTRAX organization administrator.

**NOTE:** This privilege is not part of any "role" template; organizations will need to choose to add this privilege for users to have this access.

**User can manage CMS transmission files for assessments in their facility:** This privilege gives the user the ability to create, download, and reconcile CMS transmission files for the facility.

#### **Data Download/Upload Privileges**

**User can download assessments from all facilities in their organization:** This gives the user the ability to download patient assessment data from any or all of the facilities in the organization to their local computer or network. This privilege is only applicable to users belonging to an organization that has more than one subscriber facility on LTRAX, and it can only be assigned by an LTRAX organization administrator.

**User can download assessments from their facility:** This gives the user the ability to download any or all of the facility's patient assessment data to their local computer or network, such as to make a local backup or to import into another software application for data analysis.

**User can upload files to LTRAX:** This gives the user the ability to upload files, such as patient satisfaction surveys, to the LTRAX system.

### **Outcomes Reports Privileges**

**User can view all Administrative-level reports for all facilities in their organization (includes all facilities):** This privilege allows a user to view LTRAX Administrative Outcomes Reports for all facilities in the organization, including patient satisfaction outcomes reports. This privilege is only applicable to users belonging to an organization that has more than one subscriber facility on LTRAX, and it can only be assigned by an LTRAX organization administrator.

**User can view all Administrative-level reports for their facility:** This privilege allows a user to view LTRAX Administrative Outcomes Reports for the facility, including patient satisfaction outcomes reports.

**User can view all Clinical reports for all facilities in their organization (includes all facilities):** This privilege allows a user to view LTRAX Clinical Outcomes Reports for all facilities in the organization, including patient satisfaction outcomes reports. This privilege is only applicable to users belonging to an organization that has more than one subscriber facility on LTRAX, and it can only be assigned by an LTRAX organization administrator.

**User can view all Clinical reports for their facility:** This privilege allows a user to view LTRAX Clinical Outcomes Reports for the facility, including patient satisfaction outcomes reports.

**User can ONLY view Patient Satisfaction outcomes reports for their facility:** This privilege allows users without clinical or administrative outcomes reports privileges to view the facility's patient satisfaction survey outcomes.

**NOTE:** This privilege is not necessary if the user has any of the outcomes reports privileges above.

**User can view HL7 reports for all facilities in their organization (includes all facilities):** This privilege allows a user to see the live report of message processing results for any interface(s) between LTRAX and other information systems in the organization.

**User can view HL7 reports for their facility:** This privilege allows a user to see the live report of message processing results for any interface(s) between LTRAX and the facility's other information systems.

### **Notification Privileges**

**User can receive admissions office notification emails:** This privilege allows a user to be selected for email notification of Pre-Admission Screening (PAS) Tool assessments ready for admissions office review. To be assigned this privilege, a user must have all of the following:

- a valid email address;
- a privilege to view assessments ("User can view assessments for their site," or "User can view all assessments for their facility (includes all sites)," or "User can view assessments belonging to ANY facility in their organization"); and
- a privilege to edit assessments ("User can create/edit pre-admission assessments only," or "User can create/edit Clinical assessments," or "User can edit Clinical assessments belonging to ANY facility in their organization").

### **Special Limited Privileges**

**User can create/edit pre-admission assessments only:** This allows users who do not have the privilege "User can create/edit Clinical assessments" to create pre-admission assessments.

**NOTE:** This privilege is not necessary if the user has the privilege "User can create/edit Clinical assessments," and it cannot be combined with other special limited privileges such as "User can create/edit patient satisfaction surveys only."

**User can create/edit patient satisfaction surveys only:** This allows users who do not have the privilege "User can create/edit Clinical assessments" to enter patient satisfaction survey results. Such users will be able to view assessment data for the surveys they are entering, but they will not be able to change any assessment data other than the patient satisfaction survey responses. If the user needs to print surveys for distribution to patients, the user will also need the privilege "User can view all assessments for their facility (includes all sites)."

**NOTE:** This privilege is not necessary if the user has the privilege "User can create/edit Clinical assessments," and it cannot be combined with other special limited privileges such as "User can create/edit pre-admission assessments only."

Once you have entered all of the user account information and made your privilege selections, click **Save** to create the account and return to the **Manage Facility** screen.

## **2. Custom Data Fields**

Organization administrators can create and manage custom data fields for all of the facilities in their organizations. These fields can be used to store patient or other information that is not part of the patient assessment itself, such as patient contact information or physician name. For instructions on creating and managing custom data fields, please refer to the [Custom Data Fields](#) section of this manual under [Facility Administrator Features](#).

## V. ASSESSMENT FEATURES

### V.A. LTRAX Clinical Assessment: General Information

If you will be working on patient assessments in LTRAX, it is recommended that you review this section as well as the sections on displaying assessments on the **LTRAX Launch Screen** and using individual assessment types that follow.

1. [LTCH CARE Data Set](#)
2. [Accessing Patient Assessments](#)
3. [Creating New Assessments](#)
4. [Editing Existing Assessments](#)
5. [Working in Multiple Browser Windows or Tabs](#)
6. [An Important Note about Saving Assessment Data](#)
7. [Clinical Assessment Section Color Coding](#)
8. [Assessment Tabs \(Navigation\)](#)
  - A) [Mgmt \(Management\) Tab](#)
  - B) [Pre Adm Tab](#)
  - C) [Custom Tab](#)
  - D) [CMS Info Tab](#)
  - E) [Files Tab](#)
  - F) [Metrics Tab](#)
  - G) [P.S.I. Tab](#)
9. [Assessment Warnings, Errors, and Completion Checking](#)
10. [Data Entry Tips](#)
11. [Assessment Tools](#)

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#### LTCH CARE DATA SET

The data collection fields required for the LTCH CARE Data Set are incorporated into the LTRAX clinical assessment screens on pre-admission, admission, and discharge records. These fields are identified by the LTCH CARE number preceding the field name or section. For example, on the **ID/PAY** tab the patient name section is labeled **A0500. Legal Name of Patient**.

The admission and discharge assessment screens offer links to the respective sections of the LTCH CARE Quality Reporting Manual for on-screen reference when completing those fields. You can find more information about the LTCH CARE Data Set on the [LTCH Quality Reporting website](#).

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## ACCESSING PATIENT ASSESSMENTS

Access to the assessment screens on LTRAX is controlled by a combination of user privileges. All information about the assessment screens in this section assumes the highest level of privileges. If you don't see all of the buttons, screens, or functions described below, you most likely do not have the privileges necessary to view or do what is described. If you believe you do not have the privileges you require in order to perform your assessment duties, contact one of your LTRAX facility administrators and ask him or her to adjust your user permissions.

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## CREATING NEW ASSESSMENTS

### Pre-Admission Screening

You can create a new pre-admission assessment by clicking **Pre-Admission** on your **LTRAX Launch Screen** or by uploading an Offline PAS Tool record. For more information on pre-admissions, please see the [Pre-Admission Screening \(PAS\) Tool Assessments](#) section of this user manual.

### Admission Assessments

You can create an admission assessment in one of two ways: by clicking the **Admit** button on the **MGMT** screen of a pre-admission assessment, or by clicking **New Admission** on your **LTRAX Launch Screen**.

### Discharge Assessments

You can create a discharge assessment by clicking the **Discharge** button on the **MGMT** screen of an admission assessment, then selecting the type of discharge assessment (planned, unplanned, or expired) and clicking **CONFIRM**.

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## EDITING EXISTING ASSESSMENTS

To view or edit an existing assessment, click on the patient name from your assessments lists on your **LTRAX Launch Screen**. For more information on searching for and displaying assessments on your **LTRAX Launch Screen**, please see the [Displaying Patient Assessments on the LTRAX Launch Screen](#) section of this manual.

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## WORKING IN MULTIPLE BROWSER WINDOWS OR TABS

Your web browser can only track one patient record at a time. If you attempt to open multiple patient records in separate browser windows or tabs, you will see a **Multiple Windows Warning** message that will prevent you from opening more than one record simultaneously or visiting the **CMS Transmit File** screen while you have a record open in another tab or window. If you get a multiple windows warning message, you should locate all windows or tabs open to LTRAX, click the **HOME** button on each of those, and then close all but one. If that does not clear the multiple windows warning message, you will need to click the **LOG OUT** button in the top navigation bar and then log in again. To avoid this problem, **only work in one browser window or tab at a time**.

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## AN IMPORTANT NOTE ABOUT SAVING ASSESSMENT DATA

The data you enter into your assessment screens saves only when you go to another screen or refresh the current screen by clicking the corresponding tab. For example, if you are on the Medical screen entering Medical codes, you can save your entries and remain on the **MEDICAL** screen by clicking the **MEDICAL** tab, or you can save your data by navigating to another screen by clicking any other tab, the **NEXT** button at the bottom of the screen, **HOME**, or **LOG OUT**.

**NOTE:** It is important to remember that information isn't saved as you type into each field, but only after you click a tab or button on LTRAX. To illustrate, let's say you are entering medical information onto the **Medical** screen and you are called away from your desk. You leave without logging out of LTRAX. You are gone long enough (about two hours) that the system assumes you are no longer active and automatically logs you out, ending your user session.

In this case, if you had clicked the **MEDICAL** tab to save your data to **Medical** before you left your desk, your data will be saved. If you didn't click the **MEDICAL** tab (or another tab or button) to save your data, you will still see the information you entered displayed on **Medical** when you return, but because your session timed out, you will be redirected to the login screen and the information you entered will be lost.

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## CLINICAL ASSESSMENT SECTION COLOR CODING

The colored flags next to the tabs for each section indicate the completion status of each section, with green indicating that nothing more is required for that section and yellow indicating that some required information is missing. Red flags are displayed after you click the **Complete** button on the **MGMT** screen to highlight sections that still need attention. Completion requirements for each record are based on the LTCH CARE data specifications published by CMS. Records that do not pass all completion checks cannot be transmitted to CMS until the required fields have been completed to CMS's specifications.

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## ASSESSMENT TABS (NAVIGATION)

The patient assessment screens on LTRAX have a unique navigation scheme as compared to the rest of the LTRAX site. While in a patient record, you'll see a list of tabs on the left side of the screen displayed next to colored flags. Most tabs are specific to different sections of the patient assessment, with the exception of the **MGMT**, **PRE ADM**, **CUSTOM**, **FILES**, **NOTES**, and **P.S.I.** tabs.

The tabs that are not specific to the patient assessment are as follows:

### **Mgmt (Management) Tab**

The **Assessment Management** screen is the starting point for all functions you can perform on an assessment. Clicking on an existing assessment from your **LTRAX Launch Screen** brings up the management screen for that assessment, or you can use the **MGMT** tab from within an assessment to get to the **Management** screen.

The top of the management screen displays some general information about the record you are viewing, including Medicare number and birth date. Below that is a list of buttons you can use to do things such as print the assessment. The list of function buttons changes depending on the kind of assessment, the assessment status, and your user permissions. The complete list of all possible buttons on the management screen and their functions is as follows:

**Print/Admission Form/Discharge Form:** *On the PAS Tool*, click **Print** to pop up a window from which you can print a PDF version of all of the PAS Tool data entered. To print a PAS Tool from an admission assessment, click on the **PRE ADM** tab and then click **PRINT PDF**.

*On an admission or discharge record*, click **Admission Form** or **Discharge Form** to pop up a window from which you can print the respective LTCH CARE Data Set record. When printing a discharge form, the form that prints will be

the form for the type of discharge created for the patient (planned, unplanned, or expired). The **Discharge Form** button does not appear on the **MGMT** tab until after the discharge record has been created.

There is currently no print option for the complete LTRAX patient record, which includes wound and vent assessments.

**Admit:** *On a PAS Tool assessment*, click **Admit** to create an admission assessment from the pre-admission record. *On a discharge assessment*, click **Edit Admit** to unlock the admission assessment fields in order to make any necessary changes.

**Edit Admit:** *On a discharge assessment*, click **Edit Admit** to unlock the admission assessment fields in order to make any necessary changes.

**Discharge:** *On an admission assessment*, click **Discharge** to create a discharge assessment from the admission assessment. Clicking **Discharge** will open a list from which you can select the type of discharge record you need to complete (planned, unplanned, or expired).

**Edit Discharge:** *On a discharge assessment*, click **Edit Discharge** to lock the admission fields unlocked by clicking **Edit Admit** (see above) and return to editing discharge assessment fields.

**Change Form:** *On a discharge assessment*, click **Change Form** to switch to a different discharge assessment type.

**NOTE:** Changing to a different discharge assessment type will delete any previously saved information not applicable to new discharge assessment type.

**Complete Admit/Complete Discharge:** Click the respective **Complete** button to run a completion check on the admission or discharge assessment. If the assessment is complete (i.e., for the type of assessment, all required fields have been filled out), the **Complete** button will disappear and the assessment status will change to complete. If the assessment is NOT complete, flags next to the tabs that represent the sections with missing or incomplete data will turn red, and a list of all missing information will be displayed.

**Xmit: Ready:** *On a complete admission or discharge assessment*, click **Xmit: Ready** to place it in the queue for transmission to CMS. Assessments marked Xmit: Ready will appear in **Step 1** on the **CMS Transmit File** screen.

**Xmit: Remove:** *On an assessment marked Xmit: Ready*, click **Xmit: Remove** to remove it from the CMS transmission queue.

**Correct Admit/Correct Discharge:** On an assessment that has been marked as accepted by CMS, click the respective **Correct** button to make changes to LTCH CARE information that has already been transmitted to CMS. When making corrections to an admission record that has an associated discharge record, you'll first need to click **Edit Admit**, then click **Correct Admit**.

**NOTE:** The **Correct** button is not necessary when making changes to the LTRAX data items that don't affect the LTCH CARE Data Set, such as: any field not identified by an LTCH CARE item number, and LTRAX-only data entry on the Braden, vent, or wound screens.

*On records in which both the admission and discharge assessments have been marked as accepted by CMS:* If a correction is made on

an admission assessment to patient demographic information that is shared with the discharge record (e.g., patient name, birth date, gender, admission date, SSN), **CMS Transmit File** will auto-correct the discharge record and prompt you to submit the corrected discharge. For example:

- An admission record is completed, transmitted to, and accepted by CMS.
- A discharge record is completed, transmitted to, and accepted by CMS.
- A correction is made on the admission record to a field that is shared by the discharge record (e.g., patient name, admission date, SSN, gender, birth date).

In these cases, **CMS Transmit File** will auto-correct the discharge record, adjust the correction number as appropriate, and mark the record as XMIT: READY so that it can be included in your next CMS transmission file.

**Lock:** Click **Lock** to prevent users from making any changes to the record.

**Unlock:** *On a locked assessment*, click **Unlock** to open the record for edits.

**Re-Screen:** *On PAS Tool assessments*, click **ReScreen** to create another assessment attached to the originating PAS Tool, to be used to capture updates or changes in the patient's condition in subsequent screenings prior to admission.

**Alter PAS Tool Record:** *On assessments that began as PAS Tool assessments*, click **Alter PAS** to unlock the pre-admission screening for the selected admission in order to make any necessary changes.

**Move PAS Tool:** *On PAS Tool assessments*, click **Move PAS** and select the destination hospital to move a PAS Tool assessment from one hospital to another. Once moved, the PAS Tool will no longer be visible in its original location.

**Duplicate PAS Tool Record:** *On PAS Tool assessments or assessments that began as PAS Tool assessments*, click **Duplicate PAS** to create a completely separate PAS Tool assessment for a new admission. This is especially useful in cases where a patient is initially denied but then rescreened later for admission, or when a patient leaves the facility and returns as a new admission. When you click **Duplicate PAS**, a list of checkboxes appears that allows you to control the sections from the previous screening that will copy forward to the new one.

**Forward:** The **Forward** button allows you to forward the assessment in a message to another LTRAX user at your facility through the secure LTRAX internal messaging system. This is a HIPAA-compliant means by which you can communicate with other users about a record, as opposed to regular email, which is not secure and could potentially be intercepted in transit. For more information on the LTRAX messaging system please see the [LTRAX Messaging System \(Send Message\)](#) section of this manual.

**Attach Files:** Click **Attach Files** to access a screen that will allow you to upload files to LTRAX for storage with an assessment record. The LTRAX document repository allows you to store files such as documents, PDFs, scanned images of other documents, or any other file or document in electronic



format that you want to store with the assessment record on LTRAX. Attached files are not subject to any processing.

**Deny:** On pre-admission assessments, click **Deny** to access the **Denial Reason** screen. This screen checks the pre-admission assessment for values present in the fields included in the LTRAX Referrals Outcomes Reports. Any missing or incorrectly configured fields will be listed. You can complete those fields before selecting a reason for denial and click **Deny**; select a reason for denial and click **Deny** without filling out the missing information.

**Edit Denial:** *On denied pre-admission assessments*, click **Edit Denial** to modify the denial date and/or reason for denial, then click **Update** to save your changes.

**Undeny:** To revert a denied pre-admission assessment back into an active pre-admission assessment, first click **Edit Denial**, then click **Undeny**.

**Delete:** Click **Delete** to delete the assessment. **Delete** deletes all records associated with an assessment, including pre-admission screenings, and should not be used to try to delete part of a record, such as in cases where a pre-admission was admitted prematurely or a discharge record was created in error. See **Revert** under **Advanced** below for more information.

**Tracking:** Click **Tracking** to display a list of all of the LTRAX users who have accessed the assessment, along with the screens they visited, when the screens were visited, and whether any data were saved to a screen. **Tracking** is only available to users with facility administrator privileges.

**Advanced:** The **Advanced** button gives you access to two specific functions and is generally only used when a mistake was made in processing an assessment using normal workflow channels. **Advanced** is only available to users with either facility administrator privileges or are not facility administrators but users who have been specifically granted permission to perform advanced maintenance functions. On discharge assessments, the **Incomplete/Accept** and **Decrement/Increment** buttons will appear twice on the **Advanced** screen: once under the Admission Advanced Maintenance section, and again under the Discharge Advanced Maintenance section. Make sure you click the button under the section you intend to edit. The advanced functions are as follows:

**Incomplete/Accept:** On assessments that have the status **Accepted by CMS**, click **Incomplete** to manually change the status back to Incomplete. On assessments that have at some point been placed into a CMS transmit file and have the status **Incomplete**, click **Accept** to manually change the status to **Accepted by CMS**.

**NOTE:** The **Incomplete** button should only be used if an assessment was marked as accepted by CMS in error. To make corrections to an assessment that has been accepted by CMS and marked as such in LTRAX, use the appropriate **Correct** button on the **MGMT** tab instead. The **Accept** button should only be used if an assessment was marked as rejected by CMS in error. If you use the **Accept** button, make sure to visit the **CMS INFO** tab and enter the date that the admission or discharge assessment was accepted by CMS as noted on your CMS Final Validation Report.

**Decrement/Increment:** Use the **Decrement/Increment** buttons to decrease or increase an assessment's correction number as necessary. Use of

these buttons is generally only necessary if an assessment had previously been incorrectly marked accepted or rejected.

**Include/Exclude:** On assessments that did not begin as pre-admission assessments in LTRAX, click **Include** to include them in the Referrals Outcomes Reports. To exclude individual assessments from the Referrals Outcomes, click **Exclude**.

**Undo Rescreen:** On a pre-admission record that was rescreened by mistake, click **Undo Rescreen** to delete the rescreening.

**Revert:** On an admission assessment, click **Revert** to delete the admission assessment and move the assessment back into the pre-admission assessments table. On a discharge assessment, click **Revert** to delete the discharge assessment and move the assessment back into the admission assessments table.

**NOTE:** When you revert an assessment back into a pre-admission assessment, all admission assessment information will be deleted. When you revert a discharge assessment back into an admission assessment, all discharge assessment information will be deleted.

### Pre Adm Tab

On a pre-admission assessment, the **PRE ADM** tab allows you to access the pre-admission data entry screens. When present on a patient assessment, the **PRE ADM** tab allows you to view the information that was entered on the pre-admission screening.

### Custom Tab

If your LTRAX facility administrator has created any custom data fields to track information not otherwise entered as part of the regular LTRAX assessment, your assessments will include a **CUSTOM** tab that you can click on to complete your custom data fields.

### CMS Info Tab

The **CMS INFO** tab appears on a record once the record has been placed into a file for transmission to CMS. This tab lists each CMS file that a patient record has been placed into; the type of record (admission or specific discharge type); the date the file was created; the person who created the file; the correction number (if greater than 0); and the result of the transmission (Accepted/Rejected) as recorded in Step 3 on the **CMS Transmit File** screen. This tab also includes a section labeled **CMS Transmission Dates**, which displays the dates that admission and discharge records were marked as accepted by CMS and allows you to edit those dates to accurately reflect when records were transmitted to and accepted by CMS.

### Files Tab

If you have uploaded any files to an assessment using the **Attach Files** button on the **MGMT** tab, click the **FILES** tab to review your uploaded files or upload new files.

### Metrics Tab

The **METRICS** tab displays the ongoing results of LTRAX patient criteria analysis, which categorizes each patient for purposes of Medicare reimbursement. A patient may be categorized as an LTCH criteria patient or a site neutral patient, depending on the outcome of the three-part criteria test. The tab displays the results of each

step in the analysis, as well as the final outcome. A patient will have "unknown" status until all necessary data have been entered into the assessment.

### **P.S.I. Tab**

Click the **P.S.I.** (Patient Satisfaction Instrument) tab to access the patient satisfaction survey. For more information on the patient satisfaction system and instructions on entering patient satisfaction survey data, please see the [LTRAX Patient Satisfaction System](#) section of this manual.

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## **ASSESSMENT WARNINGS, ERRORS, AND COMPLETION CHECKING**

The data entry screens on LTRAX include a variety of built-in checks that look for data entry problems ranging from simple typos, such as invalid dates or Social Security numbers; to logic routines, such as verifying that a patient's admission date is later than the birth date but earlier than the discharge date; to alerts that data doesn't meet the specifications in the LTCH QRP Manual such as wound reverse staging. Some problems trigger a warning message alerting you to review the suspect data. Other problems trigger errors that will not allow data to be saved at all. In both cases, a message is displayed at the top of the screen detailing the problem encountered.

Error messages are displayed at the top of the assessment screens with a red header when either an invalid value has been entered or the **Complete Admit/Complete Discharge** button has been clicked on the **MGMT** tab and errors were found during the completion check. Errors will prevent an assessment from being marked as complete.

Warning messages are displayed at the top of the assessment screens with a gray header when any information triggering a warning has been entered. Warning messages do not prevent the completion of an assessment, and the display of these messages can be hidden by clicking the **Hide** link at the top of the assessment screens. Hiding the warning messages on one assessment will hide them for all assessments until you click the **here** link at the top of the assessment screens to display the warnings again.

The requirements for completion of LTCH CARE records are determined by the type of assessment (admission, planned discharge, unplanned discharge, or expired). LTRAX follows the submission specifications for LTCH CARE data for each kind of assessment. Where the submission specifications differ from the instructions in the LTCH QRP Manual for assessment completion, LTRAX follows the more conservative guidelines.

CMS has two sets of requirements for data: the minimum data set that must be present in order for a record to be accepted into the QIES ASAP database; and the data set required under the LTCH Quality Reporting Program. If any items belonging to the CMS minimum data set are missing from a record in LTRAX, you will not be able to complete and send the record to CMS until the missing information has been entered.

Items belonging to the QRP dataset can be omitted. However, failure to submit QRP items may result in a 2 percentage point across-the-board reimbursement penalty for your facility for the applicable fiscal year. For records that must be transmitted with incomplete QRP items, LTRAX offers an override checkbox that appears on the **MGMT** tab when you click **Complete Admit/Complete Discharge**. If any QRP items have not been completed, you will see a warning message like this:

**CMS Quality Reporting Program data are missing.** The following fields are required for quality measure calculation. Failure to submit this data may result in Medicare payment reductions for your facility:

- (missing QRP items listed here)

Check this box to override LTRAX completion checking for incomplete fields that CMS has identified as required to preserve full Medicare reimbursement in the CMS LTCH Quality Reporting Program. This may result in Medicare payment reductions for your facility.

Notes:

To complete an assessment with missing QRP data, check the override box in the warning message and use the **Notes** field to record the reason the QRP data are missing. The notes entered here are available for review on the QRP Override Report.

LTRAX completion checking will also highlight any missing QRP items used solely for risk adjustment of quality measure calculations. Medicare will not consider an assessment missing only risk adjustment data as incomplete. However, omitting risk adjustment data means that the patient's medical complexity will not be reflected in your hospital's publicly reported quality measure calculations. Like missing QRP data, you must check the override box to complete an assessment that lacks risk adjustment data.

In addition to the CMS minimum data set requirements, LTRAX requires some fields that are used for outcomes reports and interruptions tracking. These additional fields that LTRAX requires for assessment completion are:

- Complete Birth Date (CMS only requires birth year)
- Program Interruption Transfer Destination
- Discharge DRG
- Optional facility custom data fields (custom data field requirements are configured by your LTRAX facility administrator)

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## DATA ENTRY TIPS


Here are some tips for entering data into the assessment screens on LTRAX:

- While entering data on assessment screens, you can use the Tab key on your keyboard to navigate through input fields.
- In numeric drop-down lists, you can use the number keypad on your keyboard to select a number or use the up and down arrows to scroll up and down through the drop-down list. When you arrive at your desired selection, hit Tab to move on to the next field.
- Similarly, in alphabetical drop-down lists, you can use your keyboard to type the first characters of the selection you wish to make. When you arrive at your desired selection, hit Tab to move on to the next field.
- If you tab to radio buttons or check boxes, you can use the space bar on your keyboard to check the checkbox and the arrow keys on your keyboard to move to different radio button choices.
- When you tab to a submit button, for example the **Next** button at the bottom of an assessment screen, you can hit Enter on your keyboard to effectively click the button.

## ASSESSMENT TOOLS

The assessment screens on LTRAX have a variety of built-in tools to assist you with data entry. These tools include:

**ICD Lookup:** LTRAX allows you to search libraries of ICD-10 diagnosis and ICD-10 procedure codes for entry into LTRAX screens. Look for the **ICD-10-CM Lookup** and **ICD-10-PCS Lookup** links on the **ADMIT**, **MEDICAL**, and **DISCHG** tabs, as well as on the **STATUS** tab of the pre-admission screening. Click the relevant lookup link to open a box and search by ICD code or partial ICD code, or by keywords in the description.

If your search returns a code or codes you want to enter into LTRAX, click the red double arrow to the right of the ICD code description and the code will automatically populate the ICD field. Click the  **HELP** icon inside the ICD Lookup search window for additional tips for searching and entering ICD codes.


**DRG-MDC Crosswalk:** Below Major Diagnostic Category on the **MEDICAL** and **DISCHG** tabs is a link to the DRG-MDC Crosswalk, a PDF displaying DRG codes and descriptions and the MDCs to which they belong. This file is also accessible from the **Valid Codes** links on the same tabs.

**Copy Wounds:** If you record wound assessments using the LTRAX **WOUNDS** tab, you can click the **COPY** button on the **SKIN** tab to automatically fill out the LTCH CARE Skin Conditions questions. This is useful for ensuring accurate and consistent data entry in the Section M questions. In order for wound assessment information to copy to the **SKIN** tab, the wound assessments must meet the following qualifications:

- 1) The recorded **Wound Type or Origin** must be **Pressure**. Wounds of other types or no recorded type will not copy.
- 2) The **Wound Assessment Date(s)** must fall within the appropriate assessment reference period. For admission assessments, the assessment reference period is the admission date plus two calendar days. For discharge assessments (planned and unplanned), the assessment reference period is the date of discharge and the two calendar days prior to discharge.
- 3) In addition to **Wound Type** and **Wound Assessment Date**, each wound assessment must have the following required fields completed:
  - **Present on Admission?**
  - **Stage at This Assessment**
  - Complete **BWAT** or **PUSH score**

In addition to the above requirements for wound assessments, the patient's record must also have the following dates completed:

- **Admission Date** and **Admission Assessment Reference Date** for an admission assessment
- **Discharge Date** and **Discharge Assessment Reference Date** for a discharge assessment

See the documentation available under the  **HELP** icon on the **WOUNDS** tab for more information on assessing and copying wounds.

**LTCH QRP Manual:** LTRAX assessment screens that include LTCH CARE data items offer links to the respective sections of the LTCH QRP Manual for those items. These links are found at the bottom of the data entry portion of the sections or screens.

## V.B. Displaying Patient Assessments on the LTRAX Launch Screen

The first screen that you come to when you log in to LTRAX is the **LTRAX Launch Screen**. Users with the privilege to view patient assessments will see assessments lists displayed on this screen. You may see rows of patient names displayed in different tables labeled **Pre-Admission Assessments**, **Admission Assessments**, and **Discharge Assessments**. The display of each table is controlled by a checkbox. If you see one of the table labels displayed with no assessments appearing below it, make sure the box is checked. The screen will automatically refresh if you check or uncheck a checkbox to show or hide a table.

**NOTE:** You will not see a table if you do not have at least one patient record to match the table type (e.g., if you have no pre-admission assessments, that table will not appear).

In addition to the checkboxes, a number of other user-selectable options control the assessments displayed, the number of assessments displayed per list, and the information displayed for each assessment. These options appear in the box at the bottom of the screen as drop-downs, input boxes, and a **List Options** link. The options you select are applied to all available assessments tables and can be used in any combination. The options are also “sticky,” meaning that the LTRAX system will remember the options you selected the last time you logged out and apply those same selections the next time you log in.

**NOTE:** The options you select will not be saved for future LTRAX sessions until you log out, so if your session expires before you click **LOG OUT**, you will need to repeat your selections the next time you log in.

If you have trouble finding the assessments you expect to see on the **LTRAX Launch Screen**, review your display options to make sure the selections are correct for what you intend to display. The options are as follows:

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### DISPLAY OPTIONS

**Show:** The **Show** option includes two drop-downs that are used together.

The first **Show** drop-down controls the assessments that are displayed based on the current state of the assessments. The options you have depend on your user privileges. Assessment status options include:

- In-Progress
- Admit Incomplete (*The admission assessment has not been completed.*)
- Admit Complete (*The admission assessment has been completed.*)
- Admit Accepted (*The admission assessment has been sent to and accepted by CMS.*)
- Discharge Incomplete (*The discharge assessment has not been completed.*)
- Discharge Complete (*The discharge assessment has been completed.*)
- Discharge Accepted (*The discharge assessment has been sent to and accepted by CMS.*)
- Accepted (Admit and Discharge) (*Both admission and discharge assessments have been sent to and accepted by CMS.*)
- In-Progress and Accepted
- Filed (*Prior to October 1, 2012, it was possible to file completed records.*)
- In-Progress or Filed

- Denied Pre-Admission

The second **Show** drop-down controls the assessments displayed by owner. These options include:

- **Only assessments I have created:** Select this to display only the assessments that you created.
- **All assessments for my site:** Select this to display assessments created by any LTRAX user at your site. This is only applicable if your facility has more than one site sharing the same Medicare Provider ID (CCN). Site assignment at this level is controlled by the user account's association with a site, not any custom data fields.
- **All assessments for my facility:** Select this to display assessments created by any LTRAX user at your facility. This option is only available to users who have the privilege "User can view all assessments for their facility (includes all sites)" and is the recommended default setting.

**Sort by:** This option also includes two drop-downs that are used together.

The first **Sort** drop-down controls the value by which the assessments lists are ordered. Sort options include:

- Date Admitted
- Date Created (*sorts the assessments by the date the record was first created in LTRAX*)
- Date Denied (*sorts the assessments by the date a pre-admission was marked denied*)
- Date Discharged
- Medicare Number
- Medical Record #
- Patient Name
- Payer
- SSN
- Admit Type
- DRG

The second **Sort** drop-down controls whether your sort value is listed in ascending or descending order.

- **Ascending:** Select this to sort your assessments in ascending order. For example, sorting assessments by **Patient Name** in ascending order will display them alphabetically, with assessments with no last name at the end.
- **Descending:** Select this to sort your assessments in descending order. For example, to view your assessments with the most recent admissions at the top of the lists, sort your assessments by **Admit Date** descending.

**NOTE:** It is also possible to sort an assessments list individually by clicking on a column header to sort the list by that column. Clicking once on a column header sorts the list by that column in ascending order. Clicking a second time on the column header sorts the list by that column in descending order.

**Restrict to:** Depending upon your selections in this section, this option includes three drop-downs and up to three input boxes.

The first **Restrict to** drop-down allows you to filter assessments based on a selected assessment date. Assessment date options include:

- **Admitted:** Select this to apply your date range to assessments admitted during the date range.
- **Discharged:** Select this to apply your date range to assessments discharged during the date range.
- **Created:** Select this to apply your date range to assessments created during the date range.
- **Denied:** Select this to apply your date range to pre-admission assessments marked as denied during the date range.

The second **Restrict to** drop-down controls the date range applied to your selected assessment date. Date ranges include:

- **None (blank):** Select this if you do not want to restrict your assessments lists to any date type (e.g., admission date) or range.
- **Custom:** Select this to enter your own date range. If you select this option, two additional input boxes will appear for you to enter your start and end dates. Enter your start and end dates and then click **Enter**.

The remaining options allow you to list assessments that have either been admitted, discharged, created, or denied within a specified time period. Those periods include:

- **Last 90 days**
- **Last 365 days**
- **Cal Yr**

The third **Restrict to** drop-down lets you search for assessments by hand-entered values applied to one of four assessment fields, and it is used in conjunction with the **starting with** input box to its right. Searchable fields include:

- **Last Name:** Select this to search for records by patient last name.
- **Med. Rec. #:** Select this to search for records by medical record number.
- **Medicare #:** Select this to search for records by patient Medicare number.
- **SSN:** Select this to search for records by Social Security number.

Once you have selected the field you wish to search by, type your search string into the **starting with** input box and click **Enter**.

**Facility-Specific:** If your facility has any facility-specific (custom) fields that have been configured as drop-downs, you can filter assessments based on the facility custom values. Using the **Facility-Specific** drop-down, select your facility custom field. Another drop-down containing all of the possible values for that field will appear, and you can use that to filter by your custom data field.

**Display:** Use this option to control the maximum number of assessments displayed in each assessment list at any one time. Enter a large number to display a lot of information or a smaller number to shrink the vertical size of your **LTRAX Launch Screen**. This doesn't limit the number of assessments returned by your search filters, and if the total number of records returned exceeds the number you enter in this box, your assessments lists will display links that



you can use to page through the records. The default value is 50. To change it, type in your desired maximum number and click **Enter**.

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## CONFIGURING LIST OPTIONS

The List Options feature allows you to specify the information or values to be displayed in the assessments tables on your **LTRAX Launch Screen** and to customize three additional home page display settings. To access the list options settings, click **List Options** on the bottom of your **LTRAX Launch Screen**.

On the left side of the **Launch Screen Options** page is a table listing all available display columns. The right side of **Launch Screen Options** offers several options that control how your assessments tables appear and how the **LTRAX Launch Screen** refreshes when a change is made to any of the display options.

## DISPLAY COLUMNS CONFIGURATION

The display columns section includes two controls for each column you can display in your assessments lists. The first is a simple checkbox that determines whether or not the column will appear on your **LTRAX Launch Screen**. If the box next to a column is not checked, that column will not appear on your home page. The second is a text box to the right of the column name, which allows you to specify the order of display.

- If a column is added but no order number is entered, it will be appended to the list when you click **Save**.
- If a column is changed to the same order number as another column, the changed column will be inserted before the unchanged column of the same number.
- If more than one column is added without specifying an order, the new columns will be added at the end of the list in alphabetical order.

**NOTE:** Depending on the type of assessment, some selected display columns will not appear in some assessment tables. For example, **Admit Date**, **Discharge Date**, and **LOS** will not appear in the **Pre-Admission Assessments** table.

### Individual column information:

**Line Number:** If you choose to display line number, each row in your assessments lists will begin with a number representing the row number.

**Name:** This is the default for the link you use to select and load an assessment. If you choose not to display the patient name, the selection link will default to whatever data is in the first column. If there is no value in that column for an assessment, you will not be able to click on that assessment. Make sure that the first column is one that will always have a value, such as **Creation Date**, if you are not displaying the patient name.

**Admission Decision:** In the pre-admission assessments list, this column displays the recommendation recorded in **Admission Disposition** on the **JUSTIFICATION** tab of the PAS Tool. Pre-admission assessments without a recorded admission decision will show a blank in this column.

**Admission Type:** This column displays the **Primary Admission Type** if recorded on the **ADMIT** tab of the patient's assessment.

**Assessment Reference Date:** This column displays the relevant **Assessment Reference Date** as recorded for LTCH CARE Item **A0210** on either the **ADMIT** tab (admission assessments) or the **DISCHG** tab (discharge assessments).

**Assessment Status:** Separate columns display the assessment status for the admission and discharge assessments contained in a record. Possible assessment status values are:

**Complete:** The **COMPLETE** button was clicked, and the assessment satisfied all completion requirements.

**xmit: Ready:** The **XMIT: READY** button was clicked, and the assessment is in the queue for inclusion into a CMS submission file. The assessment is in read-only mode unless it is unmarked **xmit:Ready** using the **XMIT: REMOVE** button.

**xmit: Prepared:** The assessment has been included in a file for submission to CMS in **Step 2** on the **CMS Transmit File** page. It is in read-only mode, and no changes can be made until it is marked **Accepted** or **Rejected** on the **CMS Transmit File** page.

**Accepted by CMS:** The assessment has been marked **Accepted by CMS** in **Step 3** on the **CMS Transmit File** page.

**Locked:** The record has been locked. It is in read-only mode, and no changes can be made unless it is first unlocked using the **Unlock** button.

**Filed:** The record has been locked and filed. It is in read-only mode, and no changes can be made unless it is first unfiled and then unlocked using the **Unfile** and **Unlock** buttons.

**Denied:** The pre-admission screening has been denied. It is in read-only mode, and no changes can be made unless the **Edit Denial** button is clicked.

**Completion Date:** This column displays the date entered in LTCH CARE Item **Z0500** on the **SIGN** tab for the relevant assessment type.

**Discharge Type:** In the discharge assessments list, this displays the type of LTCH CARE discharge record following this abbreviation key:

- D - Planned Discharge
- DU - Unplanned Discharge
- DE - Expired

**Evaluator:** If your facility has configured a custom data field called **EVALUATOR**, this column displays the value in that custom field for each pre-admission assessment.

**Length of Stay:** If **Length of Stay** is specified as a display column, but there is no discharge date for an assessment, the running LOS will be displayed *in italics* in the LOS column. This means that the value displayed shows how many days have passed since the patient was admitted, not the final LOS.

**MS-LTC-DRG:** This column displays the **Diagnosis-Related Group** as recorded on the **MEDICAL** tab. The **Discharge MS-LTC-DRG** is displayed unless it has not been entered, in which case the **Admission MS-LTC-DRG** is displayed.

**Patient Type:** For pre-admission assessments, this column displays the **Anticipated Reimbursement Type** as selected on the **JUSTIFICATION** tab of the screening. For admitted patients, this column displays the patient's criteria status, if known, based on LTRAX patient criteria analysis. Assessments for patients who pass the LTCH patient criteria test will display **LTCH Criteria** in this column. Assessments for patients who fail the test will display **Site Neutral**. Records that lack enough information to determine criteria status will show a blank in this column.

**Payer:** This column displays abbreviations for all payers selected on the record. The abbreviations key is as follows:

- M - Medicare (traditional fee-for-service)
- MC - Medicare (managed care/Part C/Medicare Advantage)
- D - Medicaid (traditional fee-for-service)
- DC - Medicaid (managed care)
- W - Workers' compensation
- TP - Title programs (e.g., Title III, V, or XX)
- OG - Other government (e.g., TRICARE, VA, etc.)
- P - Private insurance/Medigap
- PC - Private managed care
- SP - Self-pay
- NO - No payor source
- UN - Unknown
- O - Other

**Referring Facility:** If your facility has configured a custom data field called **REFERRING FACILITY**, this column displays the value in that custom field for each pre-admission assessment.

**Referring Facility Type:** This column displays the **Referring Facility Type** selected on the **REFERRAL/PAYER** tab for pre-admission assessments.

**Site:** If your facility has configured a custom data field called **SITE**, this column displays the value in that custom field for each assessment.

## ASSESSMENT LISTS SETTINGS

**Screen Refresh:** Select the first button to require the click of a **Refresh** button to refresh the **LTRAX Launch Screen** after you've made changes to the display options. To have the screen automatically refresh each time you change a drop-down selection, select the second radio button.

**Codes:** To display the numeric code with a text description of the code for **Admission Type** and **Discharge Setting** in your assessments lists, select the first radio button. To display just the numeric or letter code, select the second radio button. This is useful for minimizing the width of your **LTRAX Launch Screen**, especially if you are displaying a large number of columns.

**Line Separator:** To display a distinct line between each column to visually separate one column from the next in each row, select the first radio button. To display the rows with no lines demarcating the columns, select the second radio button.

When you have made all of your selections on the **List Options** screen, click **Save** to save your settings. The screen will refresh with a “Changes saved” message at the top. Then click **HOME** to return to your **LTRAX Launch Screen** and review your settings.

**NOTE:** The options you select will not be permanently saved for future LTRAX sessions until you log out. If you allow your session to expire without logging out by clicking the **LOG OUT** button, your changes will be lost.

**ASSESSMENT COLOR CODING**

Patient admission and discharge dates shown in the in-progress assessments lists on the **LTRAX Launch Screen** are displayed against color-coded backgrounds to guide you through the timeline for completing and transmitting LTCH CARE records. The background color identifies a record’s place in the workflow from entry of the admission or discharge date through the assessment reference date, completion date, and transmission date.

Two days before an imminent deadline for either assessment completion or transmission the background color changes to a shade of yellow, orange, light blue, or medium blue, depending on the current state of the assessment and the action required. On the actual deadline day, the background turns red and stays red until the required action is taken.


The **LTRAX Launch Screen** cues you to the next action needed for each assessment as follows:

	<b>Status: Incomplete</b>	<b>Status: Complete</b> (or Xmit: Ready/Prepared)
<b>Admission Date present</b>	Assess Patient and Enter Data	
<b>Assessment Reference Date present</b>	Enter Assessment Data	
<i>Completion Date Pending</i>	Complete Assessment	
<b>Completion Date present</b>	<b>Completion Due</b>	Ready for Transmission
<i>Transmission Date Pending</i>	<b>Completion Past Due</b>	Transmit Assessment
<b>Transmission Date present</b>	<b>Completion Past Due</b>	<b>Transmission Due</b>
<i>(after Transmission Date due)</i>	<b>Completion Past Due</b>	<b>Transmission Past Due</b>

The color coding is based on the assessment completion and transmission guidelines summarized below, which can be found in Tables 2-1 and 2-2 in Chapter 2 of the LTCH QRP Manual.

Admission Assessment Timing		
Assessment Reference Date	<i>no later than</i>	Admission Date + 2
		<i>OR equal to Discharge Date (whichever is sooner)</i>
Completion Date	<i>no later than</i>	Assessment Reference Date + 5
Transmission Date	<i>no later than</i>	Completion Date + 7
Discharge Assessment Timing		
Assessment Reference Date	<i>is equal to</i>	Discharge Date
		<i>OR equal to date of death (if patient dies within 3 days of discharge)</i>
Completion Date	<i>no later than</i>	Assessment Reference Date + 5
Transmission Date	<i>no later than</i>	Completion Date + 7

### V.C. Pre-Admission Screening (PAS) Tool Assessments

The LTRAX Pre-Admission Screening (PAS) Tool provides long-term acute care hospitals a means to gather a comprehensive, uniform set of data on potential patients. The tool's multipurpose mission is to streamline data collection; introduce uniformity in admission justifications; and feed information on referrals, admissions, and denials to the Referrals Outcomes Reports. For more information about the PAS Tool, please see the documentation located under the  icon on the PAS Tool screens.

An offline version of the PAS Tool is available for users with chronic Internet connectivity problems. For more information about the offline PAS Tool, please see [Functional Settings](#) under the [User Features](#) section of this user manual.

**NOTE:** Use of the LTRAX PAS Tool Offline Form requires the Chrome web browser.

To create a pre-admission assessment, on the left side of your **LTRAX Launch Screen** click **Pre-Admission** or upload an Offline PAS Tool record. You can use the tabs at the top of the screen or the **Next** buttons at the bottom of each screen to navigate to the different sections of the assessment.

#### Saving PAS Tool Data/Data Entry Tips

Saving data to the PAS Tool screens works the same way it does for the admission and discharge records. For more information on how to save data, and for some data entry tips, please see [Working in Multiple Browser Windows or Tabs](#) and [Assessment Warnings, Errors, and Completion Checking](#) in the [LTRAX Clinical Assessment: General Information](#) section above.

#### PAS Tool Notifications

The LTRAX PAS Tool includes a notification feature that enables you to alert others when a pre-admission screening requires attention.

Users with the privilege to create and edit assessments for the hospital or the entire organization can send notifications to other LTRAX users. To receive notifications, a user must have the "User can receive admissions office notification emails" privilege.

Users sent notifications of pending PAS Tools get notified by email, and they can access the pending pre-admission screening in two different ways. The emailed notification includes a special link that takes the recipient directly to the specific PAS Tool requiring attention. No

patient data is sent in the email. Instead, the user can click the emailed link, log into LTRAX if necessary, and view the PAS Tool. Also, the recipient will see a list of notified PAS Tools on his or her LTRAX Launch Screen and can click the patient name to access the assessment.

To notify someone of a PAS Tool in progress, go to the **MGMT** tab of the screening and click **Notify** to get started.

### Patient Referrals & Denials Tracking

The pre-admission assessments also include a patient referrals/denials tracking feature, which is intended for use generating Referrals Outcomes. This feature is voluntary but will allow you to run reports on admission referrals and denials at your facility.

This feature incorporates three facility custom fields you can configure: **Referring Facility**, **Referring Physician**, and **Evaluator**. In order for these custom fields to be incorporated into the referrals outcomes, they must be configured for drop-down data entry and must be named exactly as stated. For more information on configuring facility custom fields, please see the [Custom Data Fields](#) section of this user manual under [Facility Administrator Features](#).

For more information about the screens and functions on pre-admission assessments, please see the [Assessment Tabs \(Navigation\)](#) section of this user manual.


To create an admission assessment from a pre-admission assessment, from the **MGMT** tab on the pre-admission assessment click the **Admit** button.

## V.D. Admission and Discharge Assessments

To create an admission assessment, click the **Admit** button on the **MGMT** tab of a pre-admission assessment, or click **New Admission** on your **LTRAX Launch Screen**. To create a discharge assessment, click the **Discharge** button (not the **DISCHG** tab) on the **MGMT** tab of an admission assessment, then select the type of discharge (planned, unplanned, or expired), and click **CONFIRM**.

LTRAX patient assessments incorporate the LTCH CARE Data Set into the LTRAX patient record, which captures patient demographic and clinical information and enables you to record skin and wound assessments and ventilator weaning information. The LTCH CARE Data Set fields are identified by the LTCH CARE number preceding the field name or section. For example, on the **ID/PAY** tab the patient name section is labeled **A0500. Legal Name of Patient**. Using the tabs on the left side of the assessment screen or the **Next** buttons at the bottom of each screen, you can navigate to the different sections of the assessment.

The patient assessments feed into the nightly outcomes reports, which offer clinical and administrative outcomes measures with national and regional comparisons.

For more information about the skin, wounds, and vent portions of the LTRAX patient assessment, please see the documentation located under the  **HELP** icon on the **SKIN**, **WOUNDS**, and **VENT** tabs within a patient record.

For more information about the screens and functions on admission and discharge assessments, please see the [Assessment Tabs \(Navigation\)](#) section of this user manual.

## V.E. Interruptions in Stay/Leave of Absence (LOA)

Under CMS policies, there are two different definitions of an interruption in a patient's stay. One is specific to the guidelines for completing LTCH CARE records, and the other is specific to Medicare reimbursement for Medicare patients. LTRAX accommodates both of these definitions in the following ways:

### Interruptions Lasting Three Days or Fewer (LTCH CARE Data Set):

If a patient leaves your hospital and returns within three days, no new admission record is required upon the patient's return. An interruption of three days or fewer is considered a continuation of the patient's initial admission, so a discharge record and a new admission record should not be created in LTRAX. The three-day period counts the day the patient leaves as day 1, so that if a patient leaves August 1 and returns August 3, he has returned on day 3 and the original admission is continued. If he returns on August 4, that is day 4, in which case a discharge record and a new admission record are required. This rule applies for all patients, regardless of payer, who experience a qualified interruption in stay.

If a new admission record is created for an interruption lasting fewer than three days, the following warning message will be displayed at the top of the second admission record:

An assessment exists that matches this patient's Last Name and Birth Date and has a Discharge Date within three days of this patient's Admission Date. Patients who return within three calendar days of discharge should be treated as a continued stay and do not need a new admission assessment.

The warning will include a link to the previous record for your reference. If the patient noted in the link is not the same person as the previously discharged patient with the same last name and birth date, you may disregard the message and continue to complete the assessment.

### Interruptions Lasting More than Three Days (Medicare Long Term Care Hospital Prospective Payment System [LTCH PPS]):

Under the payment policy for long-term acute care hospitals, Medicare considers patients to have had a single stay in an LTACH if they experienced an interruption in stay of the following lengths, according to discharge destination:

*Any discharge destination:* three days or fewer

*Inpatient Acute Care Hospital (IPPS):* nine days or fewer, including the date of discharge

*Inpatient Rehabilitation Facility (IRF):* 27 days or fewer, including the date of discharge

*Skilled Nursing Facility or Swing Bed (SNF):* 45 days or fewer, including the date of discharge

If a patient goes to any other location, the return to the LTACH is considered a new admission. If a patient goes to more than one discharge destination before readmission to the LTACH, the readmission is considered the beginning of a separate stay.

LTRAX detects interruptions in stay for Medicare patients by comparing **A1802. Admitted From** and **A2110. Discharge Location** on the most recent discharge with the location on the patient's new admission. If LTRAX finds that a patient has been admitted from the same location as the most recent discharge, and if the readmission occurs within the number of days that define an interruption, LTRAX will automatically link the assessments together as a single Medicare stay. LTRAX considers a discharge to the emergency department and a readmission from an inpatient acute care hospital to be the same as an IPPS interrupted stay. If LTRAX finds duplicate or overlapping assessments, it will not link assessments to represent a single stay until the duplicate or overlapping assessments have been resolved.

When an interruption is detected, LTRAX will display a message similar to the following, with the appropriate discharge location and days of interruption:

This patient was discharged to a Short stay acute hospital (IPPS) within 9 days of this Admission Date, which indicates that this assessment continues an interrupted stay. LTRAX has linked the assessments. See the Interruptions section of the **MGMT** tab to manage this link.

The link joins the two sets of assessments together under a single stay. You can confirm or break the link between assessments on the **MGMT** tab of the second admission record. The **MGMT** tab will include a section called *Manage Interrupted Stay Link*, in which you are asked whether the patient went to more than one setting since the previous discharge. If the you answer **No**, LTRAX will confirm the link between assessments as a single stay for Medicare payment purposes. If the you answer **Yes**, then LTRAX will break the link and consider the readmission the beginning of a new stay.


Linking assessments that belong to the same stay for Medicare payment purposes ensures that your facility's length of stay and related calculations remain accurate in LTRAX Outcomes Reports.

For more information about the LTCH PPS and interrupted stays, please see the [CMS Medicare Learning Network long-term care hospital PPS fact sheet](#).

### Wounds & Interrupted Stays

The LTRAX wound assessment has several features designed to ensure accurate wound tracking and outcomes when patients experience interruptions in stay.

If a Medicare patient experiences an interruption of more than three days, the record will display prior wound assessments, making preexisting wounds available for reassessment after readmission. Prior wounds display when LTRAX links two sets of LTCH CARE records as described above in [Interruptions Lasting More than Three Days](#). Also, you can manually connect two or more separate wounds that should be treated as a single wound.

Please see the documentation located under the  icon on the **WOUNDS** tab within a patient record for more detailed instructions for managing wounds across interruptions in stay.

## V.F. LTRAX Patient Satisfaction System

The LTRAX Patient Satisfaction System integrates the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey into LTRAX's patient assessments and outcomes reports. Surveys are available on all assessments under the **P.S.I.** tab.

### PATIENT SATISFACTION SYSTEM SURVEY

#### HCAHPS Discharge Survey

The purpose of the discharge survey is to gather information about a patient's total experience in the hospital.

The survey should be distributed to the patient the day before or the day of discharge. The patient and/or family should be given a printed copy of the survey to complete. Once completed, the survey should be returned in a sealed envelope or by other such discreet means to the person or department responsible for data entry or for mailing the completed survey to LTRAX. Physicians, staff, and other administrative employees should not be allowed to see the completed survey.



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## PRINTING SURVEYS

In order to print patient satisfaction surveys you will need the privilege "User can view all assessments for their facility (includes all sites)." If you do not have this privilege, contact your LTRAX facility administrator and ask him or her to adjust your user privileges.

The survey forms print out as PDF documents and requires Adobe Reader software. If you don't already have Reader installed on your computer, you can get the latest version from the [Adobe website](#).

To print out a patient satisfaction survey, from your **LTRAX Launch Screen** select the patient's assessment from the list of patient assessments and then click the **P.S.I.** tab on the left side of your screen.

Click the **PRINT** button below the survey header to pop open a window with the PDF survey document. In the pop-up window menubar, click **File**, then **Print** to print out your survey.

**NOTE:** Each printed survey form displays a unique ID number in the upper right corner that identifies the assessment record to which the survey belongs. If you are printing multiple surveys and the number doesn't change from survey to survey, stop printing and go to the [Adobe website](#) to download and install the latest version of Adobe Reader. Then reprint the surveys and check the numbers again.

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## SCANNABLE SURVEYS

All HCAHPS surveys are scannable. Your facility's subscription to the HCAHPS patient satisfaction system includes a scanning service. Please return completed surveys to LTRAX for scanning and processing into HCAHPS Outcomes Reports.

**NOTE:** Prior to January 1, 2013, LTRAX offered a proprietary Patient Satisfaction System. Facilities that subscribed to the LTRAX PSS can contact LTRAX for access to their historic survey data.

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## ENTERING COMPLETED SURVEYS

In order to enter completed patient satisfaction surveys by hand, you will need either the privilege "User can create/edit Clinical assessments" or "User can create/edit patient satisfaction surveys only." If you do not have one of these privileges, contact your LTRAX facility administrator and ask him or her to adjust your user privileges.

To manually enter a patient's survey responses into LTRAX, scroll to the bottom of your **LTRAX Launch Screen**. Below your assessments display options is a box labeled **Patient Satisfaction Survey ID**. Enter the number from the upper right corner of the survey form into the box and click **Load**.

Referring to the patient's answers on the completed survey printout, fill out the patient's survey on LTRAX. If the patient skipped any questions on the survey, select **Not Answered**.

When you are finished entering all of the patient's answers, click the button at the bottom of the screen labeled **Next: Assessment Management**, or any one of the tabs on the left side of your screen, or the **HOME** button under the LTRAX logo at the top of your screen to save the information.