NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
NALTH

NALTH News

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PRESIDENT'S MESSAGE

I am very honored to have been elected to serve as the NALTH President for 2012 through 2014. I was initially elected to the Board of Directors in 2006 and have participated in various committees and task forces – most notably, serving as Chairperson of the Education Committee.

My entire healthcare career has focused on post acute care. I have been employed at Madonna Rehabilitation Hospital in Lincoln, Nebraska for 18 years and have served as Chief Operations Officer since 2006. Madonna is a free-standing rehabilitation hospital that provides a full continuum of post-acute care including a Long Term Care Hospital (LTCH), Acute Rehabilitation Hospital (IRF), Transitional Care Unit (SNF), traditional outpatient services including a rehabilitation day program, Long Term Care (NF) and a medical fitness center. My wife and I continue to be busy with two college-age children – one attending Kansas State University and the other Creighton University in Omaha.

I begin my role as NALTH president at a time of uncertainty. Many aspects of healthcare reform under the Accountable Care Act are still unclear and confusing. The Proposed 2013 LTCH Update Rule reports that the Centers for Medicare and Medicaid Services (CMS) are actively engaged in research on changes to the LTCH payment system. They also note that they may be in a position to advance these changes in the near future. Finally, the Centers for Medicare and Medicaid Innovation are moving forward with the Bundled Payments for Care Improvement Initiative, where payments for services are aligned with an entire episode of care rather than for each service independently. One clear theme rises above these provider reforms – the need to coordinate care and address the fragmentation between the various acute and post acute care provider types. Continuing the silo-based post acute care structure will not serve patient needs, and we must begin to think in different ways. For NALTH to continue its success in the future, we must work in cooperation with other post acute care trade associations and stakeholders to demonstrate our value to CMS.

With that said, I will turn my focus to the present. It has been a busy year for the NALTH Board and its members. I want to thank all who have worked so hard to achieve NALTH's primary goal of eliminating the 25% Rule, the one-time adjustment and the very short stay outlier payment penalty. We have been successful in our efforts. The one-year extension of 25% Rule relief was welcome news to many. I believe that two NALTH sponsored actions were instrumental in achieving this relief. In the preamble to the proposed 2013 update rule, CMS stated that it has become aware of concerns raised by members of Congress to postpone full implementation of the 25% Rule. I think this is a direct reference to the letters to the Secretary from various members of Congress coordinated by NALTH. The second action was the research commissioned by NALTH and completed by KNG that demonstrated the 25% Rule would not result in the savings CMS projected due to LTCH relocations. Even with this success, our work is not over. In the short term, we must focus our efforts to assure relief from full implementation of the 25% Rule for LTCHs with cost reporting periods beginning between July 1 and September 30 of 2012. In addition, NALTH must work to better understand CMS' proposed LTCH payment changes and identify a strategy for the development of a bridge to this alternative payment methodology.

During this time of uncertainty, the NALTH Board will make a concerted effort to maximize communication with our membership and other stakeholders, including CMS, American Hospital Association (AHA) and post acute care trade associations. The leadership forum held on June 7 was in direct response to member input voiced during the Annual Meeting. A follow-up leadership forum will be held in combination with the October education conference in San Antonio. I hope to see and talk with many of our members during these events.

In closing, please contact me or any of your Board representatives with questions or concerns.

Thank you for your ongoing support and commitment to NALTH.

Paul A. Dongilli, Jr., Ph.D.
NALTH President

THIS ISSUE...

NALTH encourages the submission of articles for publication. For more information, please contact

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NALTH CALENDAR

NALTH 2012 EDUCATION CONFERENCE

Transitions: The LTCH Case Manager's Role with LTCH Coding Update & CEO/Leadership Roundtable
October 4-5, 2012
Omni La Mansion del Rio Hotel
San Antonio, TX

NALTH ANNUAL MEETING

April 25-26, 2013
The Dupont Circle Hotel
Washington, D.C.
(NOTE: New Hotel)

NALTH COMMITTEES & TASKFORCES

Executive Committee
Paul A. Dongilli, Jr., Ph.D. – Chair

Communications & Innovations Committee
Arthur Maples – Chair

Education Committee
Paul A. Dongilli, Jr., Ph.D. – Chair

Financial Oversight Committee
James Blanton – Chair

NALTH Criteria Review Taskforce
John Votto – Chair

Membership Committee
Lou Little - Chair

NHIS Database Committee
Margaret Crane – Chair

Nominating And Bylaws Committee
Mike Batchelor – Chair

NALTH 2012 EDUCATION CONFERENCE

Transitions: The LTCH Case Manager's Role with LTCH Coding Update & CEO/Leadership Roundtable
October 4-5, 2012
Omni La Mansion del Rio Hotel
San Antonio, TX

The NALTH Coding Education Session, Thursday October 4, 2012 features Lynn Kuehn, President of Kuehn Consulting, LLC, in Waukesha, Wisconsin. She has served on the AHIMA Board of Directors, is facilitator for many Communities of Practice, and authored several of AHIMA's popular books, *Procedural Coding and Reimbursement for Physician Services, CCS-P Exam Preparation* and *A Practical Approach to Analyzing Healthcare Data*. Lynn is a healthcare consultant with over 25 years of experience in professional fee coding and reimbursement systems, data quality, operational assessment, and management of both independent and hospital-based clinic practices.

Lynn will present an all-day education session on:

- Diagnosis Coding the ICD-10-CM Way and A Whole New Way to Code Procedures: ICD-10-PCS.

Please plan to join us for this timely educational session.

Rehabilitation Builds Better Lives

1. 

Madonna Rehabilitation Hospital in Lincoln, Nebraska is one of the nation's largest freestanding rehabilitation hospitals, serving more than 5,000 people annually for inpatient and outpatient treatment programs. Founded in 1958 by the Benedictine Sisters of Yankton, South Dakota, Madonna has focused solely on complex medical and rehabilitative care, and research since the 1970s, helping patients achieve the highest level of independence possible following catastrophic injuries or illness.

Madonna is one of the few rehabilitation hospitals in the United States that provides a full continuum of post-acute care, including a long term care hospital (LTCH), an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), outpatient services (OP) that include a rehabilitation day program (RDP), and a medically based fitness center. This integrated post-acute continuum, known as the Continuing Care Hospital model, has gained national attention and is widely considered a successful structure under healthcare reform.

Madonna is recognized for its expertise in specialized rehabilitation programs for individuals, from infants to elderly, with:

- traumatic brain injury
- spinal cord injury
- stroke
- pulmonary conditions, including those requiring mechanical ventilation
- skin conditions, including severe wounds and burns.

Madonna offers a holistic approach to care, including all aspects of healing the mind, body and spirit. In addition to a peaceful chapel for Catholic Mass and ecumenical services, the facility includes several landscaped outdoor courtyards with flowers and native plants, a full service cafeteria, beauty shop and resource library.

To help individuals regain the skills they'll need when they return to their homes and communities, Madonna has a simulated "town square" environment for therapeutic activities. Patients can practice their physical and cognitive skills in a real working kitchen, shop for groceries in a small grocery store, practice transfers getting into or out of a pickup truck or car, take steps to a porch and open a storm door, or walk on a variety of outdoor surfaces, such as gravel or an uneven lawn. Individuals can relearn or improve their driving skills with a panoramic, computerized driving simulator.

Madonna also offers advanced technology in wheelchair seating and positioning. Individuals may participate in a comprehensive assessment to ensure they are fitted to the appropriate wheelchair for their needs, adjusted to their exact specifications. Madonna uses an electronic pressure mapping system to create the perfect

fit for each individual. When the patient sits on the pressure pad, a computer program graphically outlines the pressure areas, helping the seating therapist identify appropriate equipment and cushions to promote optimal comfort and protect skin integrity.

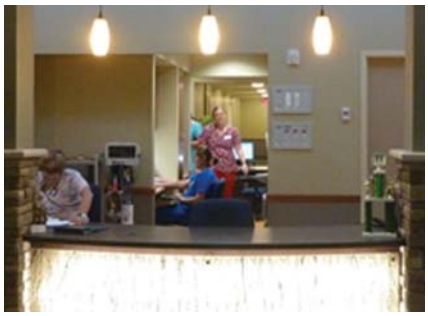
Accreditation

Madonna Rehabilitation Hospital is accredited by the international Commission on Accreditation of Rehabilitation Facilities (CARF) for:

- Comprehensive Inpatient Rehabilitation Program - Inpatient/Outpatient
- Brain Injury Program - Inpatient/Outpatient
- Spinal Cord System of Care - Inpatient/Outpatient
- Stroke Specialty Program - Inpatient/Outpatient
- Pediatric Specialty Program - Inpatient/Outpatient
- Outpatient Medical Rehabilitation Programs - Multiple Service.

CARF specialty accreditation means that Madonna meets the highest standards of care relating to staff competencies, programmatic components, best practices, outcomes measurement, education, and involvement of the family in care planning and school/community transition.

Rehabilitation focused LTCH

2. 

The Long Term Care Hospital (LTCH) at Madonna is a 96-bed facility that offers treatment for acute illnesses, which require a prolonged hospital recovery time.

LTCH offers patients with complex medical conditions access to physical medicine and rehabilitation, and daily visits by internal medicine physicians and other experts, such as physicians and clinicians specializing in pulmonary or wound care. The program is comprehensive, providing a wide array of services, including nursing, physical, occupational, cognitive, speech, respiratory, recreational and nutritional therapies; as well as psychology, case management and social work, spiritual support and orthotics/prosthetics as needed. Combined with an interdisciplinary team approach, this focused care ensures that each patient's plan of care is targeted at achieving functional gains and independence.

Pulmonary Program

3. 

Madonna offers exceptional care for individuals using a ventilator and has an outstanding ventilator weaning rate. Additionally, Madonna is the only hospital in the region approved to rehabilitate individuals who have a Synapse Diaphragm Pacer® implant. This device stimulates the diaphragm, making it possible for its users to breathe independently of a ventilator.

A recent cable TV news program, the World Report, featured Madonna in an educational segment about pulmonary care. The video illustrates Madonna's interdisciplinary team approach to helping patients using a tracheostomy and how they benefit from the Passy-Muir (PM) valve. The PM valve enables these individuals to swallow and talk, greatly improving their independence and quality of life. Passy-Muir, Inc. specifically selected Madonna as the video site because of the hospital's progressive use of the valve and exceptional patient outcomes. You may view the video on the Madonna website at http://www.madonna.org/patient_care/pulmonary_program/resources.html.

Adolescent and Children's Program

Unlike any other rehabilitation setting in the Midwest, Madonna has a dedicated rehabilitation unit for children, from newborn to young adults. The Alexis Verzal Children's Rehabilitation Hospital (AVCRH) is designed for the needs of the whole family with in-room sofa beds for parents, support group meetings and the most technologically advanced rehabilitation services for young patients.

The AVCRH is CARF accredited as a Pediatric Specialty Program and is one of only seven in the country accredited for both brain injury and pediatrics, and one of only four accredited for spinal cord injury and pediatrics.

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NALTH Quality Achievement Award

The Goldberg Award for Innovation is given in recognition of an innovative process or technology that supports long term acute care hospitals, and it is usually presented in conjunction with the NALTH Annual Meeting. All employees and professional staff associated with NALTH member facilities in good standing are eligible to submit entries. The overarching principle in the review process is innovation.

2012 Goldberg Award for Innovation Recipient

North Greenville Hospital (Long Term Acute Care)

Travelers Rest, SC

Improving the Quality of Patient Care: A Three Step Action Plan to Reduce Central Line Associated Bloodstream Infections

Introduction

The patients served in our 45-bed Long Term Acute Care Hospital (LTACH) are medically complex and receive services that include ventilator weaning and management, dialysis, and complex wound care. The presence of central lines (CL) is common in this population, as are the infections associated with their use. We have been active participants in a system level central line associated bloodstream infection (CLABSI) task force since January of 2009. Since that time, we have implemented the Institute for Healthcare Improvement's best practice bundle and all system initiatives aimed at reducing CLABSI's (insertion checklists, standardized CL carts, chlorhexidine site cleanser and dressings, routine dressing changes every 7 days etc.) with only marginal improvements (3.8% reduction) in our CLABSI rates. While we thought our CLABSI rate was high, we believed that we were doing all of the right things and it was the complexity of our patient population that made CLABSI events somewhat expected. The National Healthcare Safety Network (NHSN) published healthcare associated infection (HAI) benchmarks in December of 2009, which included the LTACH specialty care area for the first time. The combined NHSN pooled mean for LTACH's was 1.73 / 1000 CL days. Almost simultaneously, the first state HAI reports of CLABSI rates were posted for public review. In this report, our facility had the highest CLABSI rate (4.31 / 1000 CL days) among six LTACHs in the state. This new information highlighted the need for significant and immediate improvements in the quality of our care. We knew that we would have to start with the CL process basics and think outside the box to find the next right answer. To accomplish this, we formed a physician led patient centered quality care committee (PCQC) composed of leadership, management, interdisciplinary frontline staff and former patients in December of 2009.

Description of the Process

The infection preventionist (IP) reviewed the 38 CLABSI events that occurred in the previous 12 months to identify and analyze all variances (Figure 1). All negatively contributing factors identified were discussed with the PCQC chair, physician champion and leadership. The first line recommendations from this group were based on the need to achieve immediate yet sustainable improvement, ease of implementation and cost effectiveness.

1. A patient centered quality care committee was formed to address CLABSI opportunities.
2. Responsibility for all routine CL dressing changes and the daily assessment of line need was assigned to the IV coordinator who drafted a tracking tool (Figure 2), and collaborated with physicians and frontline nursing regarding appropriate discontinuation of line.
3. A direct observation witness process was recommended that would require a registered nurse (RN) to witness every CL access to confirm that the CL hub was scrubbed for a minimum of 15 seconds. Leadership held mandatory meetings with all RNs to communicate the background, our mission and the performance expectation. An audit tool was created (Figure 3) and the process was implemented in February of 2010. Audit forms were reviewed daily for completeness and random chart audits were performed monthly to verify that all access opportunities were witnessed. Any process variance identified was entered into our event database which required management follow-up with the care provider.

The PCQC committee meets monthly to review all CLABSI events and discuss all audit variances identified. Our CLABSI rates are reported to all key stakeholders: Board of Directors and system level leadership (quarterly); facility leadership, management, and frontline staff (monthly) through the use of meetings and quality scorecards; and NHSN and the Lewin Group to meet reporting requirements and have access to additional benchmarking data.

Uniqueness of the Process

Our participation in system-level activities provided multidisciplinary input for our main campus but deceived us into believing that we were doing all of the right things. By forming an LTACH-specific multidisciplinary workgroup, we were able to identify our opportunities, collaborate with key stakeholders, and implement an action plan that resulted in immediate and sustainable improvements.

The LTACH environment is demanding and often a difficult place to work with higher than average nursing turnover. We eliminated the CL maintenance defects associated with transition among staff by assigning routine maintenance duties to one highly trained clinician.

According to the Institute of Safe Medical Practice (ISMP) Canada (2003), research demonstrates that 95% of medical errors are identified using a double check process. Unlike the highly successful independent checks used for improving medication errors, our process is a direct observation redundancy check of an RN by an RN for each CL access activity to verify compliance with scrubbing the hub, per policy.

We believe these to be innovative applications of proven patient safety methods in the high risk population served by our LTACH.

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4. 

The facility includes state-of-the-art equipment such as the pediatric Lokomat®, a robotic treadmill that helps children relearn to walk faster and with appropriate gait mechanics, and the Snoezelen® multi-sensory therapy room with a wide variety of equipment and resources for helping children rediscover their sensory abilities.

The AVCRH provides Kit's Academy, a therapeutic learning center where children and teens can regain their study skills and reintegrate to their classes. Additionally, a wide variety of adaptive sports and recreation opportunities help young people heal through play and build their confidence. Adaptive car seats are available to help parents determine which type of seat is most appropriate for their child's needs.

Brain Injury Program

Madonna's brain injury rehabilitation program serves individuals with traumatic or non-traumatic brain injuries of any severity. Madonna is one of just a few facilities to offer intensive medical rehabilitation for individuals with complex medical conditions who require a ventilator and tracheostomy tube for breathing.

The program has more than 50 clinical staff across multiple disciplines and levels of care that have earned specialty certification as Brain Injury Specialists (CBIS) through the Brain Injury Association of America.

5. 

Madonna is one of the only hospitals in the Midwest to earn CARF accreditation as a Brain Injury Program for both inpatients and outpatients, adults and pediatrics.

The program also includes advanced technology to ensure that each person achieves the best possible outcome. The robotic Lokomat® treadmill enhances neural pathway connections, helping the brain and body work together to relearn walking ability through thousands of repetitive steps. Functional electrical stimulation, prism glasses for vision therapy and an entire laboratory devoted to assistive and augmentative communication devices are just a few of the available technology resources for those limited by the devastating effects of a brain injury.

Many individuals with brain injury experience vision problems as a result of their injury. Blurred vision, low vision, double vision and weakness in one or both eyes are common impairments following a brain injury. Madonna offers a comprehensive vision rehabilitation program for both inpatients and outpatients. The experienced clinical team uses advanced vision rehabilitation strategies, techniques and equipment – such as the Dynavision and prism glasses – to help patients improve their vision and regain their ability to drive, read and manage the multitude of tasks requiring accurate sight.

Spinal Cord Injury (SCI) Program

Madonna's Spinal Cord Injury (SCI) Program's interdisciplinary team includes experts with advanced training and certification in providing exceptional rehabilitation for individuals with spinal cord injury.

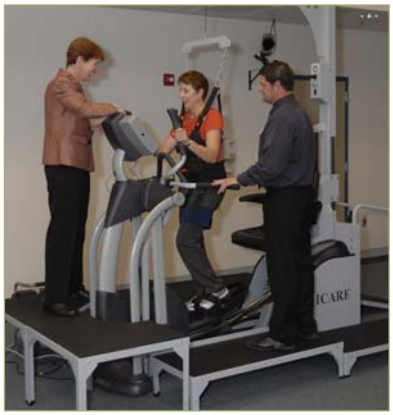
Madonna is the only independent rehabilitation hospital in the Midwest with a dedicated SCI unit with an assistive technology lab and a wide variety of advanced equipment, such as the Lokomat® robotic gait trainier, the ERICA II® eye gaze communication system, the AccuPoint Head Tracker® environmental access/communication access device and the SmartWheel® computerized wheelchair propulsion evaluation system.

6. 

The SCI Rehabilitation Program is the only program in the region that has earned CARF accreditation as a Spinal Cord System of Care for inpatients, outpatients and pediatrics. It is also one of the only programs to serve individuals with SCI who are ventilator dependent.

Madonna offers a wide variety of adaptive sports and recreational opportunities for persons with SCI. From wheelchair basketball and adaptive golf, to sled hockey and power soccer, Madonna helps individuals discover talents they may not have known they had through the thrill of new activities.

Research

7. 

Madonna's Institute of Rehabilitation Science and Engineering is one of the leading rehabilitation laboratories in the nation. The institute faculty conduct applied research to identify best practices and develop the rehabilitation technology of the future, creating affordable solutions that improve the independence and quality of life of individuals with physical disabilities and chronic conditions.

The Institute is comprised of three Centers of Excellence:

- The Movement and Neurosciences Center of Excellence conducts biomechanical and physiological research to enhance the independence and quality of life of individuals with and without disabilities, in order to maximize full participation in life activities, such as walking and exercising.
- The Communication Center of Excellence focuses on research of new assistive technologies to support communication and independence for patients with the most severe disabilities.
- The Clinical Informatics Center of Excellence seeks to advance rehabilitation science and practice through the identification and refinement of innovative applications of information technology to enhance rehabilitation processes and outcomes.

Emphasizing partnerships of clinicians, researchers, students and individuals served, the Institute embodies a culture of hope and a passionate commitment to life-long learning. Funding from the National Institute on Disability and Research (NIDRR) and the

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Measurement Indicators

The maintenance variances identified in the 15 month pre-implementation period were compared to the 15 months post-implementation period and were used to evaluate the effectiveness of the 3 step action plan (Figure 4). Significant reductions were realized in every outcome measure reviewed with a range of 29.8% and 92.9%.

- As illustrated (Figures 5), a dramatic and consistent downward trend was noted within a few months of initiating our 3 step action plan.
- Our monthly CLABSI rate has been zero for 10 of the last 15 months and the CY 11 CLABSI Rate was 0.85/1000 CL days, which demonstrates the sustainability of our actions (Figure 6).

Financial Impact

Over one million dollars in cost avoidance has been achieved by reducing CLABSI events through the innovative application of proven tools in a new manner. Estimates are calculated using low and high ranges of the average attributable per-patient costs for CLABSI events (Figure 7).

There were no education or training costs associated with the implementation of these action steps. Training of all staff RN's was conducted during their normal work hours and no staffing pattern adjustments were necessary to offset the additional time requirement created by the witness activity, because staff no longer had to do routine dressing changes. The IV coordinator spends approx one hour/day monitoring line need and approximately eight hours per week changing dressings, which equates to approximately $20,000 in salary costs but these responsibilities were merely shifted from staff RNs to the IV coordinator so no additional costs were incurred.

The material costs associated with this project were miniscule and included:

- 8,908 pieces of paper @.006 cents totaling $53
- 64% of a high volume (13,000 copies) printer cartridge @ $208 = $133 Total: $186

Lessons Learned

Small facilities are often overshadowed in the grand scheme of big system-level activities. Because healthcare is complex and technical, we often overlook the importance of the basic foundations on which our 'high tech' care is built. By focusing on facility specific defects among our unique patient population and applying a three step action plan, we learned some very valuable lessons.

- Having a facility-level physician led, frontline staff driven, quality team is a must have for improving quality and patient safety.
- Whether based on the 71.8% reduction in CLABSI rates or the 83.7% reduction in CLABSI events, the return on investment for the three step action plan was immediate due to negligible material costs.
- Creating a culture of patient safety is more easily accomplished when shortcuts, and work arounds are identified and eliminated. Knowledge of policy is not an adequate indicator of actual bedside practice. The access witness process was not a popular initiative among staff initially. Many said that it couldn't be done. However, transparent communication of the 'Why' we had to try this and ongoing communication of our dramatic improvements facilitated nursing 'buy-in' within a few months.
- The efficiency of limited resources has been maximized by identifying unit specific defects, eliminating defects and restructuring responsibilities.
- Results of this work have been shared with our state hospital association and we presented our activities during a National CUSP-stop BSI content call set-up by the facilitators of that program. As a result, we have been contacted by several other LTACHs and have mentored them through the implementation of similar initiatives.
- Finally, the number of lives saved (4-9) is priceless and is the reason that we will continue to strive for constantly improved care as evidenced in every outcome measure. We have recently expanded this improvement model to include eight additional indicators that have opportunities for improvement. To date, many are realizing similar success.

Member Spotlight ...continued from page 5

National Institutes of Health has enabled the Institute team to transform research to reality with products such as the ICARE (an Intelligently Controlled Assistive Rehabilitation Elliptical, pictured), which allows individuals with mobility limitations to participate in the therapeutic exercise needed to improve walking ability and enhance cardiovascular fitness. The ICARE is a valuable and affordable rehabilitation technology for hospitals and health care centers, medical fitness centers and, eventually, even home use. See the ICARE in action at http://bit.ly/NewICARE.

8.

Madonna Employees Make a Difference

The power of rehabilitation to restore lives is driven by more than 1,500 talented employees. Madonna Rehabilitation Hospital's team of highly specialized physicians, neuropsychologists, therapists, rehabilitation nurses and clinicians work with the most advanced technology and best practices to help each person achieve the highest level of independence.

Madonna is proud to have 50 nurses certified as Rehabilitation Registered Nurses (CRRN). CRNNs are dedicated to the rehabilitation profession, and help improve patient outcomes and patient satisfaction. In addition, 114 clinical staff have advanced certification in their areas of expertise.

Madonna clinicians contribute to rehabilitation education and research on a local to global scale. More than 30 clinicians have conducted and participated in advanced rehabilitation research projects.

9.

Rebuilding Lives

When a person has a serious injury or illness, it takes a coordinated effort to save a life, then rebuild it. From 911 call operators and first responders, to ER teams and intensive acute care, and to specialized rehabilitation programs, Nebraska offers the very finest health care to individuals from throughout the nation. Madonna is the rehabilitation hospital of choice for hundreds of physicians and hospitals throughout the region and nation. Referring physicians know their patients will achieve the highest level of independence and get back to their lives. Each year, thousands of people turn to Madonna for the most progressive rehabilitation treatment delivered by compassionate care teams.

Photo cutlines:

1. Madonna Rehabilitation Hospital main entrance
2. LTCH nursing station.
3. Respiratory therapist working with a patient who is ventilator dependent.
4. Pediatric patient getting occupational therapy in the Snoezelen® multisensory room.
5. Young man rehabilitating from a traumatic brain injury sustained during a high school football game.
6. Madonna patients enjoying the camaraderie and competition of a Nebraska-Kansas basketball game.
7. The ICARE helps individuals regain and improve their walking ability and increase their physical fitness.
8. It takes a family – not only the patient's, but the broader family of Madonna staff, friends, volunteers and other patients.
9. Young boy illustrating the joy of walking again by using the pediatric Lokomat®, a robotic gait training device.

Edward D. Kalman, Esq. – NALTH General Counsel
Rochelle Zapol, Esq.

NALTH is pleased with the progress which has been made in the areas of continuing regulatory relief and reform. NALTH has been successful in asking the Secretary of Health and Human Services ("the Secretary") to extend the current stay on full implementation of the 25% rules beyond the time which Congressional protections are set to expire to hospital cost reporting periods beginning on and after July 1, 2012. NALTH has also been closely involved with the Secretary's efforts to adopt quality measures for LTCHs. NALTH has been asked by CMS to authorize use by CMS of quality measure definitions which have been developed as part of the NALTH LTCH National Health Data Information System (NHIS). NALTH has provided CMS with explicit authority to incorporate definitions of quality measures used in the NHIS in CMS' ongoing rulemaking process regarding LTCH quality measures. We are pleased to update the NALTH membership on NALTH's ongoing public policy advocacy and development.

The 2013 Medicare Update Rule

A. Payment Provisions

At the close of the 2011 legislative session, Congress did not extend statutory relief from the 25% rule, just a one time adjustment and very short stay policy beyond sunset dates for these rules which occur at various time starting on July 1, 2012. In the spring of 2012, NALTH engaged in a variety of activities which were directed at encouraging the Secretary to exercise her discretionary authority to extend relief from these rules in the context of the 2013 Medicare update regulation. These efforts included sponsoring letters of support from members of Congress and encouraging NALTH members to meet with their congressional delegations to discuss the need for continued relief from these rules. NALTH also sponsored two studies which called into question whether the 25% rule, if fully implemented, would achieve its purposes. One study showed that a significant number of LTCHs had relocated since adoption of the 25% rule. A second study showed that many of the LTCHs that had relocated prior to the moratorium on LTCH expansions had expanded their bed complement. Together, these studies showed that there has been a substantial decline in the number of Medicare patients who would be subject to the 25% rule. NALTH believes these studies demonstrate that the 25% rule may not achieve the original purpose for the rule. The Secretary responded in the proposed rate year 2013 Medicare update rule by including a one-year extension of 25% rule regulatory relief. The Secretary is offering to extend 25% rule relief which was originally provided by Congress and is scheduled to expire starting this year. The Secretary has also stated that, in the "near future," she will propose new payment policies which will make the 25% rule "unnecessary." The Secretary has asked for an extension of the current moratorium on LTCH expansions. The Secretary also is proposing a three-year phase-in of the one time budget neutrality adjustment, which would reduce the LTC-MS-DRG amount by -3.75%, and the implementation of the very short stay payment adjustment.

NALTH is participating in the rule-making process by asking the Secretary to consider the following:

1. Extend relief from the 25% rule at least through 2014 cost reporting periods.
2. Provide that LTCHs with cost reporting periods beginning before the October 1, 2012 effective date for the rule also be extended relief from the 25% rule on the same basis as all other LTCHs.
3. Defer implementation of the very short stay policy.
   a. NALTH performed an analysis that showed that the negative margins that result from the current short stay policy are 300% higher than the national average for LTCHs located in rural areas, and that the margins associated with patients who become deceased while a patient in an LTCH are 80% higher than the national average. This data points to inequitable consequences of current short stay payment policies which likely will be exacerbated by the proposed very short stay policy.
4. Reduce or eliminate the one time adjustment. NALTH has pointed out that a portion of "savings" which resulted when Congress provided for permanent LTCH payment reductions in 2007 by eliminating the LTCH update in 2008, were earmarked as a "pay for" the one-time adjustment. Since this payment reduction effectively reduced the LTCH base amount, the reduction perpetuates in all future years. NALTH has requested a credit from the proposed -3.75% one-time adjustment to properly reflect the offsetting related payment which is already in place.
5. Provide an additional payment to LTCHs that serve patients who use dialysis services. NATLH is requesting CMS to provide this payment on the same basis it currently pays short-term acute hospitals for whom dialysis patients constitute 10% or more of patient discharges.

B. Quality Measure Comments

The Secretary has adopted three quality measures for long-term care hospitals (LTCHs):

(1) Catheter Associated Urinary Tract Infection (CAUTI);

(2) Central Line Associated Bloodstream Infection (CLABSI); and

(3) Pressure ulcers that are new or have worsened (measured by the CARE Tool).

CAUTI and CLABSI have been endorsed for use in LTCHs by the National Quality Forum (NQF), while the use of the CARE Tool to measure pressure ulcers is undergoing review by the NQF.

LTCHs are required to report on these measures for admissions occurring on or after October 1, 2012. If a LTCH fails to comply with the quality reporting requirements, it will experience a 2% reduction in its FY 2014 standard federal rate. The data collection timeframe for the determination of the FY 2014 annual payment update is October 1, 2012 through December 31, 2013. The final deadline for making corrections to the data is May 15, 2013. The LTCH quality reporting program is currently a "pay for" reporting program. Eventually, the program will change to a pay for performance program, and data on a LTCH's performance will be available to the public.

In the proposed 2013 update rule, the Secretary proposes five new quality measures for FY 2016:

1. NQF # 0680 – Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay)
2. NQF # 0682 – Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Short Stay)
3. NQF # 0431 – Influenza Vaccination Coverage Among Healthcare Personnel
4. NQF # 0302 – Ventilator Bundle
5. Not NQF Endorsed – Restraint Rate per 1,000 Patient Days

The proposed quality measure on restraint rate per 1,000 patient days was developed by the NALTH National Health Information System (NHIS). It is used as a non-core measure for the Joint Commission's ORYX initiative. CMS asked NALTH for permission to use the measure and place it in the public domain for rulemaking purposes, and NALTH intends to grant CMS a license to use the measure.

In its comments on the proposed LTCH quality measures, NALTH recommended that CMS:

1. Clarify the standards to be applied in determining whether the influenza or pneumococcal vaccine was "appropriately given" to a patient.
2. Defer to the medical judgment of the patient's treating physician if there is a disagreement between CMS and a LTCH on this point.
3. Require acute care hospitals, skilled nursing facilities, home health agencies and physicians treating patients eligible for Medicare and/or Medicaid benefits to document in the patients' records whether an influenza vaccine has been administered and the date of the vaccine.
4. Track information on when a pneumococcal vaccine was given to a patient, as it is in the best position to do so (at least with regard to patients who are receiving Medicare and/or Medicaid benefits).
5. Not penalize a LTCH if it is not able to obtain information on when/if vaccinations were given, as long as it has made reasonable efforts to do so.
6. Not penalize a LTCH if a patient refuses the influenza vaccine or the pneumococcal vaccine, or if a healthcare worker is offered but declines to receive the influenza vaccine.

NALTH also noted that there is no research on the use of the ventilator bundle in LTCHs, that it is not NQF endorsed for use in LTCHs and that it needs to be modified to apply to LTCH patients.

NALTH member hospitals may find the following resources on LTCH quality measures helpful:

CMS' website with information on the LTCH Quality Reporting Program: http/www.gov/LTCH-Quality-Reporting

CMS' email box for questions on the LTCH Quality Reporting Program: LTCHQualityQuestions@cms.hhs.gov

National Train-the-Trainer Conference

CMS held a National Train-the-Trainer Conference in Baltimore on May 4 - May 5, 2012. Some statements made by a CMS representative during the Conference raised concerns by providers. For example, a CMS representative stated that a pressure ulcer acquired during an acute hospital transfer of three days or less would be considered to be acquired during the LTCH stay. In response to the proposed 2013 update rule, NALTH commented that penalizing a LTCH for a pressure ulcer acquired in an acute care hospital would exceed the scope of CMS' rulemaking and would violate a LTCH's substantive due process rights. A CMS representative also stated that if a patient admitted to a LTCH develops a pressure ulcer on his/her foot during the LTCH stay, and the foot is amputated as a result, the pressure ulcer is not counted on discharge.

According to CMS' technical consultant, the Long Term Care Hospital Assessment Submission Entry & Reporting (LASER) application system to report to CMS on pressure ulcers will not be in operation until August or September of 2012, leaving little time for providers to practice on the system before October 1, 2012. Other computer applications may be used to report to CMS on pressure ulcers but it is unclear which applications are compatible. Provider passwords will expire every 60 days. In its comments on the proposed 2013 update rule, NALTH requested that CMS urge its technical consultant to make a concerted effort to have the LASER application system up and running as soon as possible.

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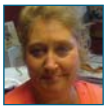

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Transitions: The LTCH Case Manager's Role
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THURSDAY, OCTOBER 4, 2012

CONCURRENT SESSIONS:

Transitions: The LTCH Case Manager's Role
Thursday, October 4, 2012 | 8am–4pm CT
Kathleen A. Bower, DNSc, RN, FAAN
Principal and Co-owner, The Center for Case Management

- The New World of Health Care Finance (or, Why We're Here)
- The Challenges of Case Management in LTACs
- Clinical Documentation Improvement Programs: Their Crucial Role in Today's LTAC
- Expanding Horizons: The Clinical Resource Manager Role
- The LTAC Nurse Liaison Role and Patient Care Management
- Effective Communication with Physicians

- OR -

LTCH Coding Update
Thursday, October 4, 2012 | 8am–4pm CT
Lynn Kuehn, MS, RHIA, CCS-P, FAHIMA
Principal, Kuehn Consulting, LLC

- Diagnosis Coding the ICD-10-CM Way
- A Whole New Way to Code Procedures: ICD-10-PCS

Motivational, Humorous and Stress Reducing Session: Excellent Customer Service
Thursday, October 4, 2012 | 4pm–5pm CT
Greg Thompson, Vice President of Operations, Premier Senior Living