LTRAX LTACH OUTCOMES SYSTEM

# *Pressure Ulcers: Clinical Application of Quality Reporting*

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## Objectives

- Review CMS LTCH Quality Reporting Program (QRP) requirements for wound data
- Discuss clinical case scenarios related to reporting requirements
- Review LTRAX pressure ulcer outcomes reports
- Provide performance improvement strategies based on pressure ulcer data

# *CMS LTCH QRP: Background*

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## Required Measures

- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Blood Stream Infections (CLABSI)
- New or Worsened Pressure Ulcers

## Reporting Platform

- CDC's National Healthcare Safety Network (NHSN)
  - CAUTI
  - CLABSI
- LTCH CARE Data Set
  - New or Worsened Pressure Ulcers

# *CMS LTCH QRP: Pressure Ulcer Data*

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## LTCH CARE Data Set

- Medical tab
- Function tab
- Skin CMS tab

## Reporting Timeline

- Admission
  - Admission + 2 days = Assessment Reference Date
  - Three-day assessment period
  - First wound assessment documented
- Discharge
  - Discharge – 2 days = Assessment Reference Period
  - Three-day assessment period

# *Pressure Ulcers: Medical Tab*

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## Pressure Ulcer Covariates (Admission)

- I0900. Active diagnosis: peripheral vascular disease (PVD) or peripheral arterial disease (PAD)
- I2900. Active diagnosis: diabetes mellitus (DM)

## Rationale

- Diseases or conditions that increase the patient's risk for development or worsening of pressure ulcers
- Active diagnoses indicate that the risk is present during the patient's current stay in the LTCH

## Coding

- Diagnoses require a physician-documented diagnosis at the time of assessment
- "Active diagnoses are diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status, medical treatments, nurse monitoring, or risk of death at the time of assessment." (LTCH QRP Manual)

# *Pressure Ulcers: Functional Tab*

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## Pressure Ulcer Covariates (Admission)

- GG0160C. Functional mobility: Lying to sitting on side of bed
- H0400. Bowel incontinence
- K0200A. Height
- K0200B. Weight

## Rationale

- Functional mobility: Decreased and declining mobility increase the risk and complications of pressure ulcers
- Bowel: Incontinence increases the risk of skin breakdown, development and worsening of pressure ulcers
- Height & Weight: Poor nutrition and hydration can contribute to debility that increases the risk for pressure ulcers

## Coding

- Functional mobility: record *usual* (not best or worst) performance during assessment period

## Pressure Ulcer Data (Discharge)

- M0800. Worsening in Pressure Ulcer Status Since Prior Assessment
  - A. Stage 2
  - B. Stage 3
  - C. Stage 4
- Supported by all other Section M questions answered at admission and discharge
- Drawing on documentation from LTRAX Wound tab

# *Wounds: Clinical Scenarios*

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## Identification

- Rule out other types of wounds

## Staging

- Unstageable on admission
- Healed at discharge

## Timing

- Assessment reference periods

## *Identification:*
## *CMS Pressure Ulcer Definition*

A pressure ulcer is a localized injury to the skin and/or underlying tissue *usually* over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

*Adapted from the NPUAP 2007 definition of a pressure ulcer*

# *Clinical Scenarios: Identification*

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## Thorough Skin Assessment

- Head to toe

## Determining Wound Type

- Location
  - Sacrum
  - Heels
  - Buttocks
  - Ankles
- Activity
- Etiology
  - Pressure
  - Pressure w/ friction or shear

# *Clinical Scenarios: Identification*

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## Scenario

Mr. Jones is admitted on 6/5/13 s/p CVA with multiple medical co-morbidities. He is dependent with mobility and transfers and incontinent of bowel and bladder. Upon admission his skin is intact.

Mr. Jones is identified as high risk for developing pressure ulcers due to incontinence of bowel and bladder, malnutrition, decreased sensation, immobility, and decreased cognition. Due to the identified risk, he is placed on several preventive measures, including turning schedule, support surface changes, and frequent skin assessments. His participation increases daily, and he begins to transfer from the bed to chair with a sliding board, max assist of 2.

Mr. Jones had an accident in his brief and when staff went to change it they recognized redness surrounding the sacral, buttock, and perineal regions with some partial thickness skin loss on the left buttock (the side he has been transferring to due his right-sided hemiplegia).

## Identification

- Incontinence-associated dermatitis (IAD) or pressure ulcer?

# *Identification: IAD vs. Pressure Ulcer?*

| | Pressure Ulcers | Incontinence-Associated Dermatitis |
|---|---|---|
| **Location** | Bony prominence | Perineal, inner thighs, buttocks |
| **Etiology** | Pressure or combination of pressure with shear/friction | Bladder and/or bowel incontinence |
| **Shape** | Round or oval shaped if shear is involved | Irregular and widespread |
| **Borders** | Distinct | Indistinct |

# *Clinical Scenarios: Identification*

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## Scenario

Ms. Talbot was admitted s/p severe sepsis and ventilator dependent respiratory failure. She has a history of diabetes with diabetic neuropathy. Upon admission the skin assessment performed by the wound care nurse identified an ulcer on her left heel.

## Identification

- Diabetic foot ulcer or pressure ulcer?

# *Identification: Diabetic vs. Pressure Ulcer?*

| | Diabetic | Pressure Ulcer |
|---|---|---|
| **Location** | Foot: load bearing surfaces | Bony prominence |
| **Etiology** | Neuropathy, vascular compromise | Immobility |
| **Shape** | Round and regular | Round or oval if shear is involved |
| **Borders** | Distinct | Distinct |
| **History & Assessment** | Review past medical history. Assess both feet. Assess foot deformities, pulse presence, and swelling. | Prolonged immobility, location on heel due to pressure |

# *Clinical Scenarios: Identification*

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## Scenario

Ms. Delores was admitted s/p severe sepsis with a co-morbid condition of a prolapsed uterus and resultant mucosal pressure ulcer.

## Identification

- mucosal pressure ulcer or skin?
- CMS quality reporting program is for skin conditions only

# *Clinical Scenarios: Staging*

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## Scenario

Patient is admitted with an unstageable pressure ulcer due to eschar, present on admission. On day 4, the patient underwent an excisional debridement. Following the procedure, the wound care nurse assessed the wound and documented the pressure ulcer as a Stage III.

## Staging

- Admission: unstageable due to slough and/or eschar, present on admission
- Discharge: Stage III, present on admission

# *Clinical Scenarios: Staging*

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## Scenario

A patient has two Stage II pressure ulcers on the left heel, present on admission. During the patient's stay, the two ulcers merge. Do you still record these as two Stage II pressure ulcers or one Stage II pressure ulcer?

## Staging

- Pressure ulcers that merge count as one pressure ulcer

# *Clinical Scenarios: Staging*

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## Scenario

A patient is admitted with a Stage II pressure ulcer identified on the day of admission. On day three, the wound nurse assesses the patient and the pressure ulcer has progressed to a full thickness wound, Stage III.

## Staging

- Admission assessment coded as stage II, present on admission
- Discharge assessment coded as stage III, not present on admission
- Discharge assessment also coded as a stage III worsened

# *Clinical Scenarios: Timing*

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## Scenario

A patient has a Stage II pressure ulcer on the first skin assessment. It heals within the assessment reference period. Do you still report the Stage II pressure ulcer since it was identified in the first assessment?

## Staging

- No. If the pressure ulcer is healed within the first three days, you report no (0) unhealed pressure ulcers on the admission assessment.
- If the pressure ulcer heals after day three, the Stage II is reported on admission and healed at discharge.
  - Stage II is still entered as stage at this assessment on the LTRAX Wound tab, and scored to reflect a healed wound.

# *Clinical Scenarios: Timing*

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## Scenario

Patient is admitted with a Stage III pressure ulcer, transfers to acute care for surgical debridement and returns within three days with a Stage IV that does not heal or improve at time of discharge. Is this considered worsened?

## Staging

- Admission: Stage III, present on admission
- Discharge: Stage IV, not present on admission and worsened since last assessment at time of discharge

# *Clinical Scenarios: Timing*

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## Scenario

Patient unexpectedly transfers to acute care emergently and does not return with three days. There was no skin assessment conducted by the wound coordinator within the three-day discharge assessment reference period. Patient had a Stage III at admission and a Stage III on the weekly wound care nurse assessment.

## Staging

- Utilize RN daily assessment of skin
- Leave blank and record notes on why the assessment was not conducted

# *LTRAX Outcomes Reports*

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## Purpose

- Compliance
- Validation
- Performance improvement
  - Historical
  - Benchmarking

## Interpretation

- Critical to understand reporting requirements
- Differentiate between volume of wounds and volume of assessments

## Application

- Identify opportunities for improvement
  - Prevention
  - Identification/Assessment
  - Healing

# *LTRAX Outcomes Reports: Orientation*

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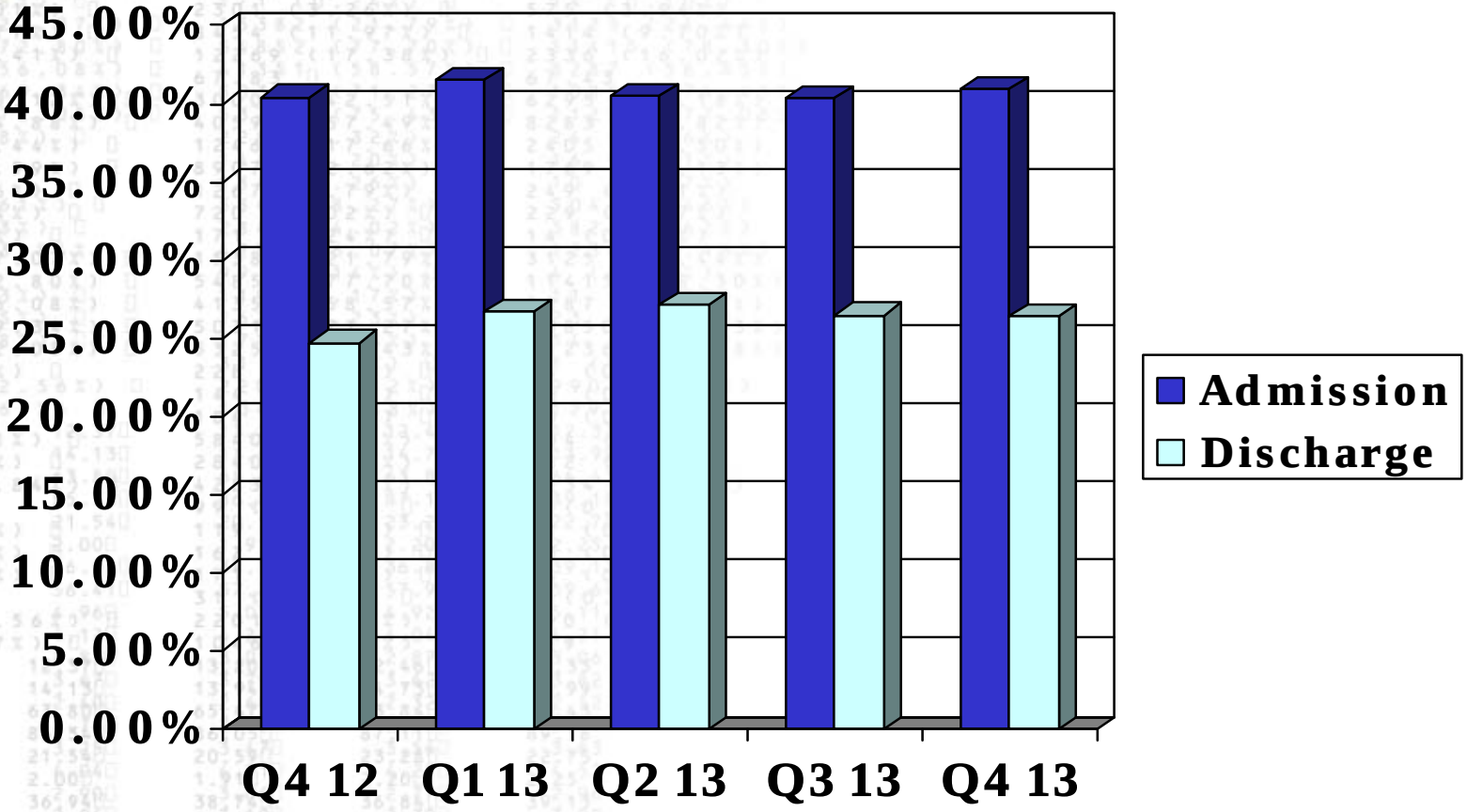
## Review of Pressure Ulcer Outcomes Reports

- Use the Facility Ranking Report to identify outlier facilities within your organization and opportunities for improvement.
- Use the Facility Report to see your facility's outcomes for new and worsened pressure ulcers, and track changes over time.
- Use MDC & DRG Drill-Down Reports to identify patient categories with poorer record and increased risk for pressure ulcers.

## Benchmarking

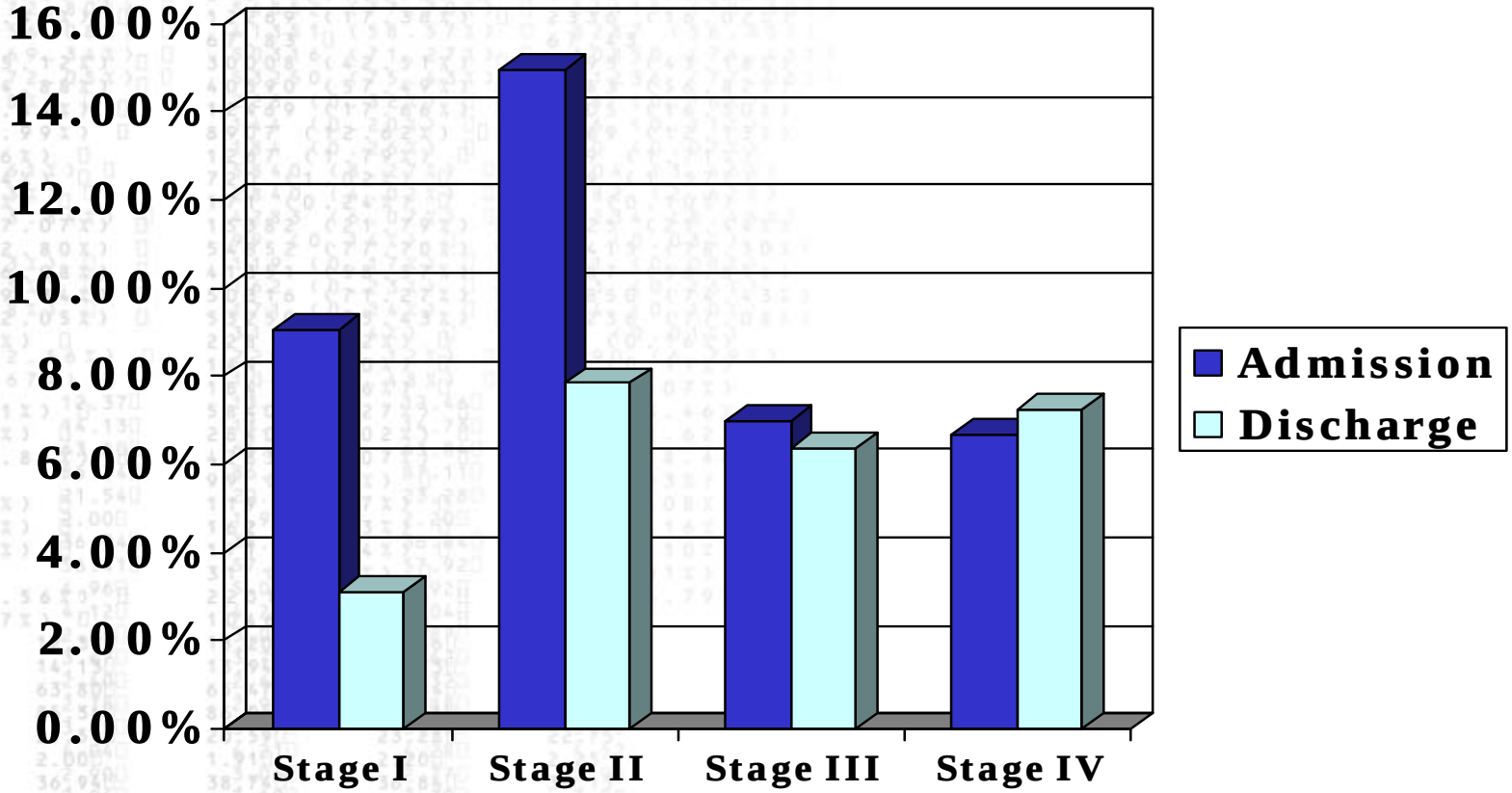
- Facility Ranking Report allows benchmarking against the organization as a whole and the nation
- Facility & Drill-Down Reports allow for benchmarking against the organization, nation and region
- Use weighted measures to get apples-to-apples benchmarking, as though the nation, organization, or region had a case mix identical to your facility.

## Admission to Discharge: Any Stage




Source: LTRAX

## Admission to Discharge (CY 2013)




Source: LTRAX

# *Pressure Ulcers: Admission to Discharge*

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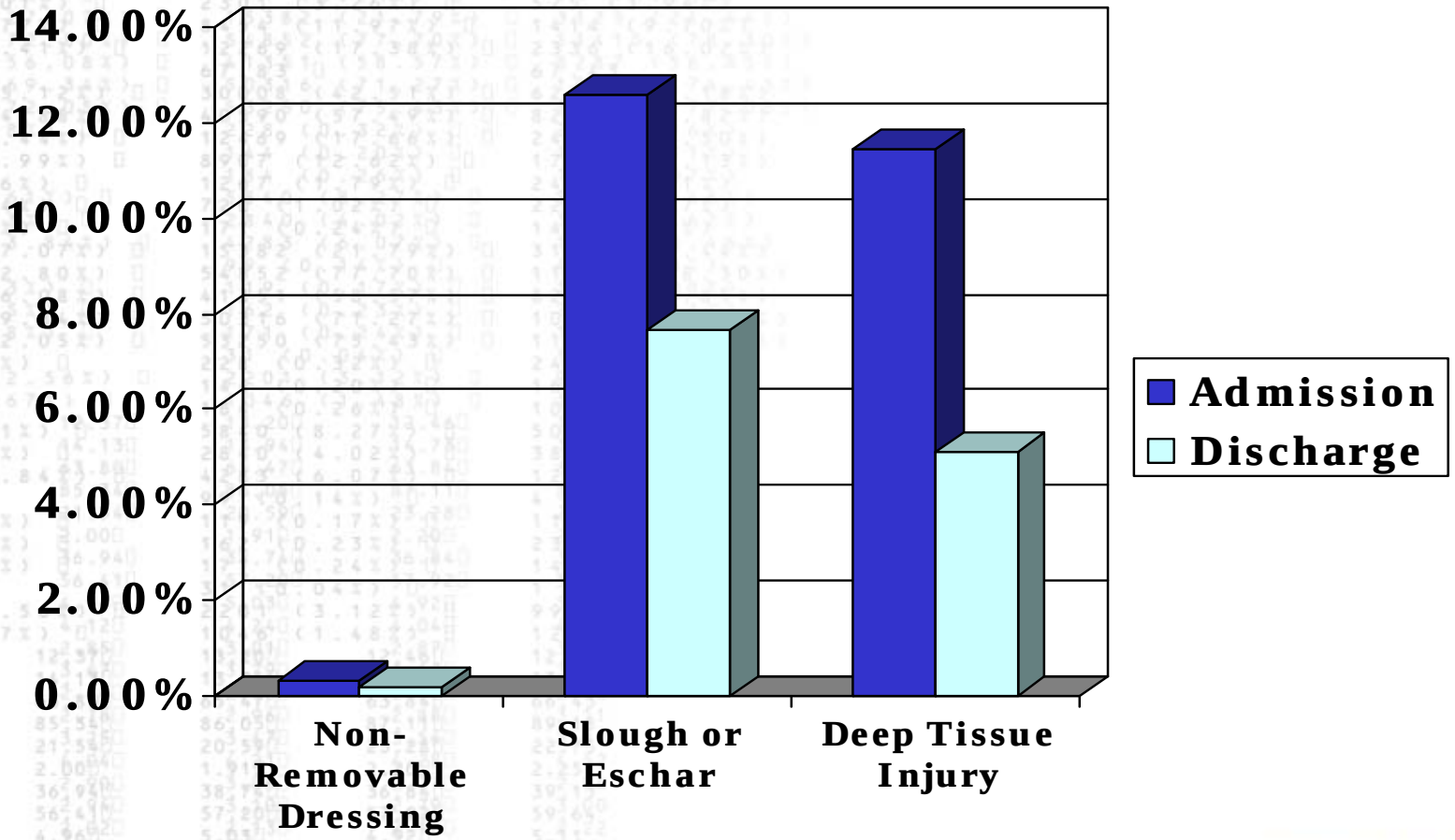
## Identification (present on admission)

- Skin assessments
- Timing

## Prevention

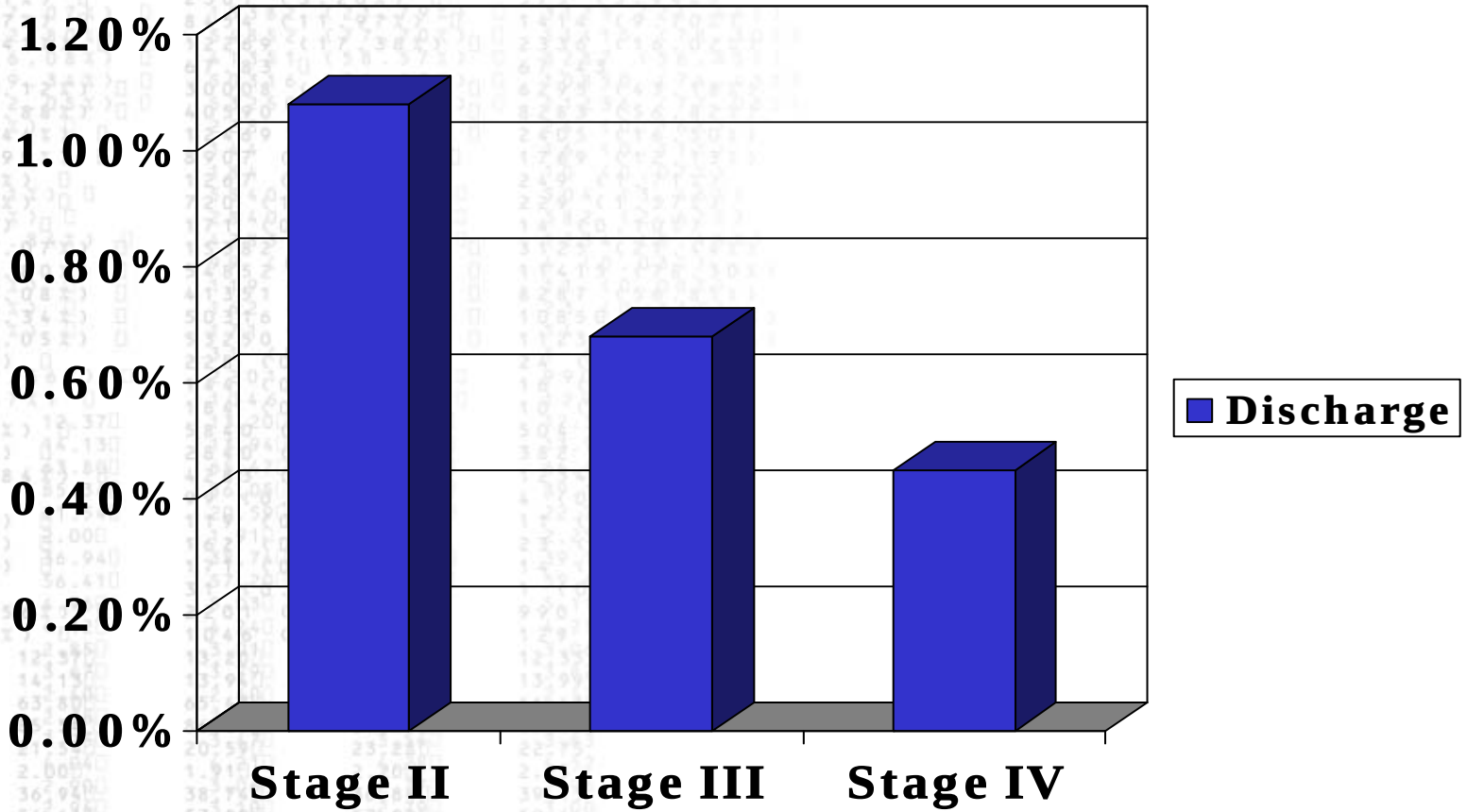
- Risk assessment (Braden; predictive modeling)
- Interventions
  - Surfaces
  - Nutrition
  - Turning teams
  - Mobility
  - Patient/Family education

## Admission to Discharge: Unstageable Pressure Ulcers (CY 2013)




Source: LTRAX

## New or Worsened at Discharge by Stage (CY 2013)




Source: LTRAX

# *Pressure Ulcer: New or Worsened*

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## Prevention/Intervention

- Wound Care Coordinator
- Bates Jenson Wound Assessment Tool (BWAT)
- Integrating assessment to CPOE and wound order sets
- Treatment protocols
  - Surfaces
  - Nutrition
  - Turning schedules
  - Wound treatment team
  - Interventions
    - Excisional debridements
    - Therapeutic

## Timing

- Post debridement and unexpected discharge

# *Hospital-Acquired Pressure Ulcer: Incidence*

## Methods for Internal Reporting

- Limitations using CMS LTCH QRP data for HAPU incidence rates
- Incident reporting system
- Internal quality scorecards

## Validate with CMS LTCH QRP Data

- Present on admission or discharge
- New or worsened

## Benchmarking

# *Future of Pressure Ulcer Data*

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## What We Know

- Data is tracked across post-acute care settings
- Will be reported in some manner (risk-adjusted)
- Upcoming changes to LTCH CARE Data Set (July, 2014)
- Non-reporting results in 2% payment reduction, effective October 2014 (for calendar year 2013 data)

## What We Don't Know

- Value-based purchasing
  - When
  - What

## What We Should Do

- Ensure compliance
- Improve performance

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*Questions?*
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**Next Call**: March 6, 2014
Patient Perception Survey Process and Use of Data

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