INPATIENT REHABILITATION FACILITY (IRF) QUALITY REPORTING PROGRAM PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON MAY 9 AND 10, 2018

Current as of July 2018

Acronym List

Acronym	Definition
APRN	Advanced Practice Registered Nurse
APU	Annual Payment Update
BIMS	Brief Interview for Mental Status
BMI	Body Mass Index
CASPER	Certification and Survey Provider Enhanced Reports
CMS	Centers for Medicare & Medicaid Services
DRR	Drug Regimen Review
FY	Fiscal Year
ICD	International Classification of Diseases
IMPACT	Improving Medicare Post-Acute Care Transformation Act
INR	International Normalized Ratio
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRF-PAI	Inpatient Rehabilitation Facility Patient Assessment Instrument
LTCH	Long-Term Care Hospital
LTCH CARE	Long-Term Care Hospital Continuity Assessment Record and Evaluation
NPUAP	National Pressure Ulcer Advisory Panel
NQF	National Quality Forum
PAC	Post-Acute Care
PPS	Prospective Payment System
QRP	Quality Reporting Program
RN	Registered Nurse
SNF	Skilled Nursing Facility
URL	Uniform Resource Locator

#	Question Category	Question	Proposed Response
1	Case Study	How do you code the stairs prior functioning item if the patient does not have stairs in his home?	The intention of GG0100. Prior Functioning, item GG0100C, Stairs, is to describe the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. This information may be used to inform a discussion with the patient about discharge goals. The clinician should ask the patient about his/her ability to go up and down other internal or external stairs (e.g., in the community or at a friend or family member's home). This may provide the necessary information needed to code this item. If the patient reports he/she does not use stairs at all, code 09 – Not Applicable.
2	Case Study	For Section M and N, can you clarify if discharge data are required? If the patient has an unplanned discharge from the inpatient rehabilitation facility (IRF), do these questions need to be answered?	For the IRF Quality Reporting Program (QRP), Section M and Section N data elements are completed for all Medicare (Part A and Part C) patients at discharge, whether the discharge is planned or unplanned. Section M and Section N data may be completed based on medical record review.
3	Focused Review of Sections B, C, H, I, J, K, and O	For the BIMS, I do not see an option to report that the patient is medically inappropriate. Might this be a change in the future?	Attempt to conduct the interview with all patients. If the patient was rarely or never understood during the 3-day assessment period because of a medical condition, code section C as follows: 1. Code C0100 – Should Brief Interview for Mental Status (C0200-C0500) Be Conducted? as 0, No. 2. Skip to C0900 – Staff Assessment for Mental Status – Memory/Recall Abilities. 3. Complete item C0900 by checking all that the patient was normally able to recall.
4	IRF QRP Resources	When are IRF QRP resources, such as the manual, updated?	For QRP resources, we retain recent versions on the QRP web pages and then archive others so they are available for reference. We are working with our counterparts to develop a consistent process for updating the entire manual on a regular basis. We have been updating Section 4 of the IRF-PAI Training Manual each year, due to changes to the Quality Indicator Section of the IRF Patient Assessment Instrument (IRF-PAI). We have incorporated new coding tips and guidance based on help desk questions submitted by providers.

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5	IRF QRP Resources	When do you anticipate the IRF QRP User's Manual Version 2.0 and IRF QRP technical specs will be updated and posted for 10/2018 changes?	The IRF Quality Measure User's Manual Version 2.0 is posted on the IRF QRP website. We are in the process of updating the Quality Measure User's Manual V3.0, and it will be posted soon. We will post an announcement once it becomes available.
6	IRF QRP Resources	Is there a handout for the introduction session of the IRF QRP training program?	Pre-training materials were posted to the IRF QRP Training web pages prior to the training program. Post-training materials (with answers to knowledge checks, scenarios, and the case study) will be posted shortly after the training. The URL for the IRF QRP Training web page is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html. The URL for the LTCH QRP Training web page is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
7	IRF QRP Resources	Could the IRF-PAI Training Manual be posted in a single zip file, with date posted? Very challenging to access all updated portions of the manual as currently posted.	Thank you for your suggestion. We are working to develop a process where the entire manual is updated as a whole.
8	IRF Public Reporting	Why does some data say "not available" for IRF Compare for certain hospitals?	Data may be unavailable on IRF Compare for several different reasons, including: • The provider was open for less than 6 months. • The number of cases/patient stays was too small for public reporting. • No data were submitted for the reporting period. • The data were suppressed by CMS for one or more quarters. For a detailed explanation of the footnotes that accompany a "not available" result see the footnote details at the bottom of the "About the Data" page on IRF Compare (https://www.medicare.gov/inpatientrehabilitationfacilitycompare/#about/theData). If you have a specific facility you would like to inquire about, please contact our help desk and we can provide more detail.

#	Question Category	Question	Proposed Response
9	Readmissions	What is the definition of the potentially preventable within stay readmission measure?	The Potentially Preventable Within Stay Readmission Measure for IRFs was developed for use in the IRF QRP. This measure calculates the facility-level unplanned and potentially preventable risk-standardized readmission rate for readmissions occurring within the IRF stay (i.e., program interruptions where the patient is readmitted to the acute care setting) and readmissions (i.e., acute care transfers) at the end of the IRF stay). The within-stay observation window includes the period from IRF admission to discharge and the day following IRF discharge. For the within-IRF stay window, potentially preventable readmissions should be avoidable with sufficient medical monitoring and appropriate patient treatment. Potentially preventable readmissions are defined based on the reason for hospital readmission and are grouped based on the following clinical rationale, as follows: 1. Inadequate management of chronic conditions – such as congestive heart failure 2. Inadequate management of infections – such as septicemia 3. Inadequate management of other unplanned events – such as arrhythmia 4. Inadequate injury prevention – such as head injury For the full list of conditions for which readmissions are considered potentially preventable, please refer to the detailed specifications at the link below—please see Appendix 2: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf.

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10	Readmissions	How do you define the preventable transfer from IRFs and what is the source of this information?	The Potentially Preventable Within Stay Readmission measure is the measure that captures preventable transfers. This measure calculates the facility-level potentially preventable risk-standardized readmission rate for readmissions occurring within or during the IRF stay (i.e., program interruptions where the patient is readmitted to the acute care setting and readmissions or acute care transfers at the end of the IRF stay). The within-stay observation window includes the period from IRF admission to discharge and the day following IRF discharge. This measure is based on Medicare fee-for-service claims data. For the within-IRF stay window, potentially preventable readmissions should be avoidable with sufficient medical monitoring and appropriate patient treatment. Potentially preventable readmissions are defined based on the reason for hospital readmission and are grouped based on the following clinical rationale, as follows: 1. Inadequate management of chronic conditions, such as congestive heart failure. 2. Inadequate management of infections, such as septicemia. 3. Inadequate management of other unplanned events, such as arrhythmia. 4. Inadequate injury prevention, such as head injury. Please note this definition differs slightly between the within-stay versus the post-discharge potentially preventable readmission measures. For the full list of conditions for which readmissions are considered potentially preventable, please refer to the detailed specifications at the link below—please see Appendix 2: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf.
11	Section GG: Functional Abilities & Goals	Why does IRF-PAI v2.0 include a skip pattern to GG0170M "1 step (curb)," if Walking 10 feet activity did not occur, and then it skips to GG0170P "Picking Up Object" instead of straight to the wheelchair gateway question?	If a patient does not walk 10 feet but goes up and down a curb in a wheelchair, the activity “1 step (curb)” may be coded. If the patient does not go up or down one step (curb), the patient may still stand and thus it is possible that the activity of pick up object may be coded. Please note that the activity pick up object must be assessed while the patient is standing.

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12	Section GG: Functional Abilities & Goals	In situations where a patient is admitted to an IRF and is discharged emergently, prior to a therapist assessment, we have been told to score 88 for admission and discharge. Is this still necessary?	If the patient's length of stay is less than 3 days, you may code any admission self-care or mobility data element using one of the "activity not attempted" codes, such as 88, Not attempted due to medical condition or safety concern. The situation you describe is also considered an incomplete stay. Patients who meet the criteria for incomplete stays are: • Patients who are discharged to an acute care setting, such as short-stay acute hospital, critical access hospital, inpatient psychiatric facility, or long-term care hospital (LTCH). • Patients who die. • Patients who are discharged against medical advice. • Patients with a length of stay less than 3 days. For IRF-PAI 2.0, effective October 1, 2018: If the patient has an incomplete stay, there is a skip pattern for section GG0130 and GG0170 discharge items. Your software application would not allow any GG0130 or GG0170 discharge data to be entered for a patient with an incomplete stay. The system would insert the caret (^) as part of the skip pattern specifications.
13	Section GG: Functional Abilities & Goals	If a patient walks up and down 12 stairs, can we assume he can manage 4 steps?	Assess the patient managing 4 steps and 12 steps separately. A patient may need more assistance managing 12 steps than 4 steps due to fatigue, and the codes for the 2 data elements may be different. Assessment of 4 steps and 12 steps may occur on the same day or on different days. With IRF-PAI Version 2.0, if the 4 steps data element is coded that the activity was not attempted (i.e., codes 07 – patient refused; 09 – not applicable; 10 – not attempted due to environmental limitations; 88 – activity not attempted due to medical condition or safety concern), the 12 steps data element is skipped.

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14	Section GG: Functional Abilities & Goals	Can the self-care and mobility activities be assessed after therapist intervention on admission, such as with the use of assistive devices?	The admission assessment should reflect the patient's status prior to any benefit from therapy interventions to capture the patient's true admission baseline status. If the patient has been using a device prior to admission to the IRF, the device may be used during the IRF admission assessment. If the patient has not previously used a device, use your clinical judgment to determine if you are providing therapeutic intervention. If the clinician considers the instructions for safe use of the device to be complex and thus represents therapeutic intervention, then use code 88, Not assessed due to medical condition or safety concerns, or code 09, Not applicable, indicating that the activity did not occur at the time of admission and the patient did not perform the activity prior to the current illness, exacerbation, or injury.
15	Section GG: Functional Abilities & Goals	If the intent is to capture the patient's baseline status on admission, why is the assessment period 3 days for the self-care and mobility items, which would include days after therapy has started?	For some activities (e.g., eating, oral hygiene, toileting hygiene), the patient's abilities may be assessed on day 1 or day 2 because these activities occur more than once a day. Certain mobility activities, such as GG0170K, Walk 150 feet, or GG0170O, 12 steps, may only occur once during the 3-day assessment period. If this is the case, code the items based on the single occurrence of an activity, as long as the patient has not benefitted from therapy. If the patient's ability to complete an activity is assessed on day 1 or day 2, and the assessing clinicians determine that the patient has benefited from therapy by day 3, the admission assessment would be based on assessments conducted on day 1 and day 2.
16	Section GG: Functional Abilities & Goals	If the patient is unable to safely complete an activity on days 1 and 2, but is able to complete the task with moderate assistance on day 3, would the correct code be an 88 (because that was the usual performance and closest to admission and baseline) or a 3?	If the patient completes an activity on the third day for the first time, code the patient's ability based upon the amount of assistance needed; for example, code 03 – Partial/moderate assistance for your example, unless the clinician believes that the patient has benefitted from therapy services for that activity.

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17	Section GG: Functional Abilities & Goals	Please define incomplete stay.	Patients with incomplete stays include: • Patients who are unexpectedly discharged to an acute care setting (short-stay acute care hospital, critical access hospital, inpatient psychiatric facility, or LTCH, because of a medical emergency). • Patients who die or leave the IRF against medical advice. • Patients with a length of stay of less than 3 days. For IRF-PAI 2.0, effective for patients discharged October 1, 2018: If the patient has an incomplete stay, there is a skip pattern for section GG0130 and GG0170 discharge items.
18	Section GG: Functional Abilities & Goals	The incomplete stay skip pattern in the IRF-PAI data submission specifications differs from the incomplete stay definition in the functional quality measure specifications as it does not include discharges to hospice (44D = 50/51). Will this be corrected to be consistent with the quality measure exclusion?	Discharge to hospice is an exclusion criteria for the functional outcome measures. Discharge to hospice is not included in the definition of an incomplete patient stay. For additional information, please see the measure calculation details in the IRF Quality Measure User's Manual, which is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html. If a patient is discharged to hospice, code the patient's discharge self-care and mobility items based on the amount of assistance needed to complete the activities. If the patient is too ill or has too much pain, and an activity did not occur, you may code 88, Not attempted due to medical condition or safety concern.
19	Section GG: Functional Abilities & Goals	How does the Centers for Medicare & Medicaid Services (CMS) recommend IRFs reflect significant functional improvements for code 4? Patients may require Contact Guard Assist on admission with a discharge goal of supervision. Current coding definitions would represent "maintaining function." However this would require very different care from family upon discharge.	If a patient requires supervision while completing an activity, the helper is often present for most or all of the time that the patient performs an activity, and the code 04 reflects this amount of time. Code 04 includes supervision, cueing, and touching assistance. If the helper provides more than touching assistance, such as lifting assistance or trunk support, a lower code, 03, reflects this type of assistance. With regard to functional improvement, a patient who does not show improvement in one activity may demonstrate improvement in another activity.

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20	Section GG: Functional Abilities & Goals	For GG0130 and GG0170, if you are gathering information from family or other sources, is that documented in the medical record?	Data reported on the IRF-PAI should be supported by documentation in the medical record.
21	Section GG: Functional Abilities & Goals	For coding discharge goals, is a dash the same as leaving the item blank? Or is a dash required?	At least one self-care or mobility goal must be coded for the IRF QRP. Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect annual payment update (APU) determination. The data submission specifications require a response to be entered.
22	Section GG: Functional Abilities & Goals	What kind of supporting documentation is CMS expecting that would support the code chosen for each function activity?	Documentation in the medical record, which may include clinical notes, is used to support assessment coding of self-care and mobility data elements. Data entered in Section GG should be consistent with the clinical assessment documentation in the patient's medical record.
23	Section GG: Functional Abilities & Goals	Please clarify the GG130G practice scenario regarding lower body dressing. The shrinker and stump are medical devices, not clothing. Would it not be more appropriate to count application of lower limb orthotics as setup for ambulation/transfers than mod-assist for lower extremity dressing when he donned clothing independently?	This information is provided in the IRF-PAI Training Manual on page GG-17, which can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-QRP-Manual.html. If donning and doffing an elastic bandage, compression stockings, or an orthosis or prosthesis occurs while the patient is dressing/undressing, then consider the elastic bandage or compression stocking or orthosis or prosthesis as a piece of clothing when determining the amount of assistance the patient needs when coding the dressing item. The following items are considered a piece of clothing when coding the dressing items: • **Upper body dressing:** Thoracic-lumbar-sacrum-orthosis, abdominal binder, back brace, sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic. • **Lower body dressing:** Knee brace, elastic bandage, sock/shrinker, lower-limb prosthesis. • **Footwear:** Ankle foot orthosis, elastic bandages, foot orthotic, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).

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24	Section GG: Functional Abilities & Goals	Where is the function decision tree found?	The Section GG self-care and mobility coding decision tree is currently available on the training slides under IRF QRP Training Materials on the CMS IRF QRP website.
25	Section GG: Functional Abilities & Goals	Would one step be considered part of the four steps with handrails? Many patients are able to complete four steps with handrails, but it is not safe to complete a curb (one step) without handrails on admission.	Code one step (curb) and four steps separately. The one step may include a handrail or device.
26	Section GG: Functional Abilities & Goals	If the patient has a catheter, how is toileting hygiene coded?	If the patient has an indwelling urinary catheter, the toileting hygiene tasks are not completed for bladder management. Code the toileting hygiene item based on the amount of assistance needed by the patient when moving his or her bowels.
27	Section GG: Functional Abilities & Goals	Are elastic compression stockings included with putting on and off footwear?	Yes, compression stockings are considered a piece of clothing when coding GG0130H, Putting on and taking off footwear.
28	Section GG: Functional Abilities & Goals	Does item GG0130F Upper body dressing include gathering clothes?	If a patient requires the assistance of a helper only to retrieve clothing, then code GG0130F - Upper body dressing as 05, Set-up or clean-up assistance. The rationale is that the helper provides setup assistance, and the patient completes the activity. For additional examples, please see the IRF-PAI Training Manual Section GG, which can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-PAI-and-IRF-QRP-Manual.html.

#	Question Category	Question	Proposed Response
29	Section GG: Functional Abilities & Goals	How does CMS recommend IRFs reflect significant functional improvements for code 2? If a patient is admitted requiring assistance with more than 75 percent of a task with a discharge goal requiring help with more than half the task, both the admission and discharge codes would be 2. However, this would require significantly different care upon discharge.	A code of 02, Substantial/maximal assistance, would be coded if the helper performs more than half of the effort, and the patient participates in completing the activity. With regard to functional improvement, a patient who does not show improvement in one activity may demonstrate improvement in another activity.
30	Section GG: Functional Abilities & Goals	Steadying assistance seems to be more than contact guard assistance. Can you clarify?	If the helper provides touching assistance or steadying assistance, code 04. Supervision/touching assistance.
31	Section GG: Functional Abilities & Goals	Is there risk adjustment based on diagnoses such as spinal cord injury or stroke for the functional outcome measures?	Primary diagnosis is a risk adjustor for the functional outcome measures. The impairment group codes coded in item 21 are used for risk adjustment. For technical specifications for the quality measures included in the IRF QRP, please refer to the IRF QRP Measure Calculations and Reporting User's Manual Version: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html.
32	Section GG: Functional Abilities & Goals	Regarding exclusion criteria for the change in mobility score, is there a list of specific ICD-10 codes?	Yes, the exclusion criteria and other technical specifications for the IRF QRP quality measures are included in the IRF QRP Measure Calculations and Reporting User's Manual Version: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html.

#	Question Category	Question	Proposed Response
33	Readmission Measures	What is the difference between the All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge measure and the Potentially Preventable 30-Days Post-Discharge Readmission measure?	The All-Cause Readmission measure captures all unplanned readmissions to hospitals following discharge from a PAC setting. The Potentially Preventable Readmission measure subsets the patients included in the All-Cause Readmission measure by capturing patients readmitted to a hospital with a diagnosis deemed potentially preventable, such as infections or complications of chronic conditions. For more information about the determination of what constitutes a potentially preventable readmission, please see the measure specifications from the FY 2017 IPPS/LTCH PPS final rule, page 17: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-LTCH-QRP-Final-Rule.pdf. This is also available at FY 2017 IRF PPS final rule, page 17: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Measure-Specifications-for-FY17-IRF-QRP-Final-Rule.pdf. The development of the Potentially Preventable 30-Days Post-Discharge Readmission Measure was mandated by the IMPACT Act of 2014.
34	Public Reporting and Overview of QRP Reports	With the transition to the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure for IRF, for patients discharged on or after October 2018, when will the existing pressure ulcer measure (NQF #0678) be removed from IRF Compare and be replaced with the Post-Acute Care: Pressure Ulcer/Injury measure? What is the initial date range for new measure?	The quality measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, is anticipated to be posted on IRF Compare in Fall 2020. The data collection period for the initial Compare Website display for the new pressure ulcer measure will be January 1, 2019, through December 31, 2019. The last reporting period for the existing pressure ulcer measure, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678), will be 10/1/2017-9/30/2018, which is anticipated to be posted on Compare in Fall 2019 until replaced with the new Pressure Ulcer measure.

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35	Public Reporting and Overview of QRP Reports	From the IRF Compare website, how does the consumer know the time the data was collected? Why is the data collection for the readmission measure based on a different timeframe than other measures, such as the pressure ulcer measure or the *Clostridium difficile* infection measure?	Information about the data collection periods being reported can be found on the IRF Compare website by clicking on the "Read More" hyperlink above each measure. The information is listed for each measure on the "About the Data" page: https://www.medicare.gov/inpatientrehabilitationfacilitycompare/#about/theData. The data collection periods differ by the type of measure. Claims-based measures, such as the readmission measure, are only updated annually. The assessment-based measures and the Centers for Disease Control and Prevention's National Healthcare Safety Network measures tend to be updated quarterly (except the influenza measure).
36	Public Reporting and Overview of QRP Reports	Are readmission rates included in the CASPER reports?	Yes, information on claims-based measures, such as the readmission measures, are available in the Facility-Level Quality Measure reports and the Provider Preview reports.
37	Section M: Skin Conditions	Are admission items M0300A-G used for data completeness and APU updates, or just the discharge Section M items?	Admission items M0300A-G are not used in determining the APU minimum submission threshold. The discharge items, M0300B1-G2, are used in determining the APU minimum submission threshold.

#	Question Category	Question	Proposed Response
38	Section M: Skin Conditions	Previous versions of the IRF-PAI and LTCH CARE Data Set include instructions for coding items in M0800, worsening in pressure ulcer status since admission, that indicate if a previous Stage 3 or Stage 4 pressure ulcer is unstageable due to slough or eschar at discharge, it would not be coded as worsened. The instructions for "the present on admission" items M0300x2, do not include the same guidance.	Effective with the implementation of the IRF-PAI V 2.0 and the LTCH CARE Data Set V 4.00, coding instructions for Stage 3 and Stage 4 pressure ulcers that become unstageable due to slough/eschar by discharge have been updated. Beginning July 1, 2018, for LTCHs and October 1, 2018, for IRFs, if a Stage 3 or Stage 4 pressure ulcer observed on admission is unstageable due to slough or eschar on discharge, the unstageable pressure ulcer would be coded on the discharge assessment (M0300F1 = 1) and it would not be considered as present on admission on the discharge assessment (M0300F2 = 0). Also, please note for the new skin integrity pressure ulcer quality measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, and with the implementation of the IRF-PAI V 2.0 and the LTCH CARE Data Set V 4.00, the M0800 data elements have been removed from the item sets. The discharge M0300 data elements, which capture the number of identified pressure ulcers/injuries at each stage on discharge (M0300X1) and whether that pressure ulcer/injury was present upon admission (M0300X2), are used to calculate the quality measure. For example, a pressure ulcer/injury reported at discharge and coded as not present upon admission on the discharge assessment would be considered a new or worsened pressure ulcer/injury. A pressure ulcer/injury reported at discharge and coded as present upon admission on the discharge assessment would not be considered new or worsened.
39	Section M: Skin Conditions	Please provide recommendations regarding the coding of wounds identified as mixed etiology; for example, moisture-associated skin damage and pressure.	If an ulcer/injury arises from a combination of factors, and pressure is considered the primary cause, then the ulcer/injury would be coded in Section M as a pressure ulcer/injury. Per the requirements of Section M of the LTCH CARE Data Set and the IRF-PAI, pressure should be the primary cause of the wound. Other types of skin injuries or alterations are not coded on Section M of the LTCH CARE Data Set or IRF-PAI.

#	Question Category	Question	Proposed Response
40	Section M: Skin Conditions	Please describe how to code a pressure ulcer when a patient admitted to an LTCH with a fragilely healed pressure ulcer that reopens during the LTCH stay. Would this be considered a progression or worsening of a pressure ulcer or a new facility-acquired pressure ulcer?	If a patient is admitted to an IRF/LTCH with a healed pressure/injury ulcer, and a pressure ulcer/injury occurs in the same anatomical area, and remains at discharge, it would be coded as observed at discharge and would not be coded as present on admission on the discharge assessment. Therefore, this pressure ulcer/injury would be considered new or facility-acquired.
41	Section M: Skin Conditions	Please confirm that a patient admitted with a healing Stage 4 pressure ulcer that is observed to be a Stage 2 on admission, should be coded as a Stage 4 on the admission assessment. Also, please confirm if the same pressure ulcer becomes a Stage 3 while in our facility, the wound has worsened, but is not coded as such since the wound started out as a Stage 4 pressure ulcer.	Correct, the pressure ulcer is a Stage 4 until it is healed. A healing Stage 4 pressure ulcer is coded as Stage 4 on the admission and discharge assessments until it has healed. Do not reverse or backstage. Pressure ulcers do not heal in a reverse sequence. That is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize.
42	Section M: Skin Conditions	If pressure ulcer/injury staging documentation from a previous stay is only found in a nursing note, but not a physician's note, is that considered sufficient?	Yes, the nursing notes are part of the medical record and, therefore, are considered sufficient for coding Section M. Documentation in the medical record from the previous facility, as well as a clinical assessment upon admission, is necessary to identify the history and stage of the pressure ulcer/injury.
43	Section M: Skin Conditions	Please clarify CMS' policy on coding stageable pressure ulcers/injuries that become unstageable pressure ulcers due to slough or eschar. It appears now that pressure ulcers/injuries that were assessed on admission are now considered to be unit-acquired.	If a numerically staged pressure ulcer/injury observed on admission worsens to an unstageable pressure ulcer due to slough or eschar, it is considered not present on admission. For example, if a numerically staged pressure ulcer observed on admission is unstageable due to slough or eschar on discharge, the unstageable pressure ulcer would be coded on the Discharge assessment (M0300F1=1) and would not be coded as present on admission (M0300F2=0). This guidance is effective as of the following item set implementation dates: July 1, 2018, for the LTCH CARE Data Set Version 4.00 and October 1, 2018, for the IRF-PAI Version 2.0.

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44	Section M: Skin Conditions	If a patient develops a Stage 2 pressure ulcer during an IRF stay, but it heals prior to discharge, how would that be coded in Section M of the IRF-PAI?	The pressure ulcer items in Section M of the IRF-PAI and LTCH CARE Data Set collect data at two points in time: admission and discharge. This pressure ulcer would not be coded on either the admission or discharge assessments, because it was not observed upon admission and it was not observed at discharge (it healed prior to discharge). Only pressure ulcers/injuries observed at admission and discharge are coded on the IRF-PAI or LTCH CARE Data Set.
45	Section M: Skin Conditions	Would a wound vacuum-assisted closure device be considered an example of a nonremovable dressing if it is ordered to only be changed every 3 days and is changed prior to admission?	Yes, a wound vacuum-assisted closure device used for negative-pressure wound therapy would be considered a nonremovable dressing when there is a physician order that the dressing is not to be removed during the 3-day assessment period.
46	Section M: Skin Conditions	If a pressure ulcer is unstageable on admission for one reason (e.g., nonremovable device) and unstageable on discharge for another reason (e.g., slough/ eschar), would this be considered a new or worsened pressure ulcer?	For the new skin integrity pressure ulcer quality measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury and with the implementation of the IRF-PAI V 2.0 and the LTCH CARE Data Set V 4.00, the M0800 data elements have been removed from the item sets. The discharge M0300 data elements, which capture the number of identified pressure ulcers/injuries at each stage on discharge (M0300X1) and whether that pressure ulcer/injury was present upon admission (M0300X2), are used to calculate the quality measure. For example, a pressure ulcer/injury reported at discharge and coded as not present upon admission on the discharge assessment would be considered a new or worsened pressure ulcer/injury. A pressure ulcer/injury reported at discharge and coded as present upon admission on the discharge assessment would not be considered new or worsened. If a patient is admitted with an unstageable pressure ulcer due to a nonremovable device and that pressure ulcer is observed as an unstageable pressure ulcer due to slough/eschar when the device is removed, and it remains unstageable due to slough/eschar when the patient is discharged (M0300F1=1), it is considered present on admission on the discharge assessment (M0300F1=1).

#	Question Category	Question	Proposed Response
47	Section M: Skin Conditions	Please provide guidance for the following scenario. A patient is admitted to the PAC setting with documentation in the medical record of a sacral pressure ulcer/injury. This ulcer/injury is covered with a nonremovable dressing; therefore, this pressure ulcer/injury is unstageable. On Day 5 of the stay, the dressing is removed by the physician and the wound is assessed as a Stage 3 pressure ulcer/injury and remains at Stage 3 until discharge. Would M0300C2 be coded as "1" on the discharge assessment?	In the scenario described, if the pressure ulcer remained at a Stage 3 through the patient's stay, then that Stage 3 pressure ulcer/injury would be coded as present on admission on the discharge assessment (M0300C2 =1). If a patient is admitted with an unstageable pressure ulcer/injury that is subsequently numerically staged, then the first numerical stage is the stage at which the pressure ulcer/injury is considered to have been present on admission when coding the discharge present on admission data elements.
48	Section M: Skin Conditions	If a previous stay's documentation does not indicate a pressure ulcer/injury, but a head-to-toe skin assessment identifies a pressure ulcer/injury within 24 hours of admission, is that pressure ulcer/injury considered present on admission?	Yes, if a patient is assessed upon admission, which is defined as close to admission as possible, and a pressure ulcer/injury is observed, that pressure ulcer/injury would be coded on the admission assessment. If the pressure ulcer/injury does not worsen or heal by discharge, the pressure ulcer/injury would be considered present upon admission on the discharge assessment.
49	Section M: Skin Conditions	If a large pressure ulcer/injury that is assessed at admission begins to heal and appears as two separate wounds on discharge, how is this recorded on the discharge assessment?	If a large pressure ulcer/injury assessed at admission begins to heal and appears as two separate wounds at the time of discharge, the pressure ulcer would be considered a single, healing pressure ulcer at the time of discharge. If the pressure ulcer did not increase in numerical stage, then the pressure ulcer would be coded as present on admission (M0300X2=1) on the discharge assessment. If the pressure ulcer increased in numerical stage or became unstageable due to slough or eschar, then the pressure ulcer would not be coded as present on admission on the discharge assessment (M0300X2=0).

#	Question Category	Question	Proposed Response
50	Section M: Skin Conditions	What is the impact of the accuracy of coding risk assessment items for pressure ulcer coding?	The purpose of risk adjustment is to account for differences in patient complexities so quality measure scores can be fairly compared. For the purposes of quality measure calculation, not coding the risk adjustment items may negatively impact the facility's quality measure score that is publicly reported. The Quality Measure Reports also report risk-adjusted quality measure scores and are intended to help guide the facility's quality improvement initiatives. Data entered on the item set and submitted to CMS should be comprehensive and accurately represent the patient's status at the time of the assessment, as required as a part of the attestation in Section Z: Assessment Administration.

#	Question Category	Question	Proposed Response
51	Section M: Skin Conditions	Please provide guidance for coding the pressure ulcer/injury items for the following scenarios. Scenario 1: A patient is admitted to a PAC facility with a pressure ulcer that is unstageable due to slough/eschar. The pressure ulcer is assessed at Stage 3 on day 5 and remains a Stage 3 until discharge. Would this pressure ulcer be assessed as a Stage 3 pressure ulcer at discharge that was present on admission, or would this pressure ulcer be considered a new or worsened pressure ulcer? Scenario 2: A patient is admitted to a PAC facility with a pressure ulcer that is unstageable due to slough/eschar. The pressure ulcer is assessed at Stage 3 on day 5 and increases in numerical stage to a Stage 4 pressure ulcer at discharge. Would this Stage 4 pressure ulcer at discharge be considered present on admission or a worsened pressure ulcer at discharge?	If on admission, a pressure ulcer/injury was unstageable, but becomes numerically stageable later in the patient's stay, and remains at that stage until discharge, it would be considered and coded as present on admission on the discharge assessment at the stage at which it first becomes numerically stageable. However, if that same pressure ulcer/injury that becomes numerically stageable subsequently increases in numerical stage by discharge, it would be coded at that higher stage on the discharge assessment (M0300x1 = 1) and would not be considered nor coded as present on admission on the Discharge assessment (M0300x2 = 0).

#	Question Category	Question	Proposed Response
52	Section M: Skin Conditions	If a pressure ulcer/injury appears during a program interruption, how is the pressure ulcer/injury attributed?	For a pressure ulcer/injury that occurred during a program interruption (i.e., in the case where the patient did not have the pressure ulcer/injury prior to the program interruption but returned to the facility with a new pressure ulcer/injury) and remained present at discharge, code the pressure ulcer/injury on the discharge assessment (M0300x1 = 1) and do not code as present on admission (M0300x2 = 0). For example, as depicted in training slides, if the patient returns to the LTCH or IRF from the acute care hospital within 3 calendar days with a Stage 2 pressure injury that was not observed when the patient was transferred from the LTCH or IRF, you would code M0300B1 = 1 and M0300B2 = 0 on the discharge assessment if the Stage 2 pressure injury is present when the patient is discharged from the LTCH or IRF.
53	Section M: Skin Conditions	How is low body mass index (BMI) defined for Section M coding?	Section M does not require coding BMI. For purposes of risk adjustment for the pressure ulcer quality measure, BMI is calculated using the items height and weight in the formula: BMI = (weight * 703 / height^2). Low BMI is defined as a BMI between 12 and 19. A value lower than 12 would reflect invalid height or weight data.
54	Section M: Skin Conditions	Wound, ostomy, and continence nurse pressure ulcer staging guidelines sometimes do not correspond to CMS guidelines. How should such discrepancies be handled?	IRFs and LTCHs must code the IRF-PAI or LTCH CARE Data Set Section M items according to the instructions and definitions in Section M of the IRF-PAI Training Manual or the LTCH QRP Manual. The pressure ulcer definitions used in the CMS IRF-PAI Training Manual and LTCH QRP Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Stages and in consultation with nationally recognized pressure ulcer experts.
55	Section M: Skin Conditions	Our wound nurses do not stage but primarily use descriptors, which seems to be a trend in wound care. Please provide suggestions on how to reconcile CMS coding requirements with how pressure wounds are documented.	Section M of the IRF-PAI Training Manual and the LTCH QRP Manual provide descriptions of each stage of pressure ulcer/injury. Please refer to Section M of the manual to reconcile coding.
56	Section N: Medications	Does the two-way communication between the clinician(s) and the physician or physician-designee need to be documented in the EMR?	Data in the LTCH CARE Data Set/IRF Patient Assessment Instrument (IRF-PAI) should be consistent with information reported in the patient's medical record.

#	Question Category	Question	Proposed Response
57	Section N: Medications	Is CMS suggesting that a facility's patient documentation practices be changed to meet the drug regimen review (DRR) measurement requirements?	Each facility delivers patient care according to their unique characteristics and standards (e.g., patient population). Thus, each facility self-determines their policies and procedures for patient documentation practices and completing the assessments in compliance with State and Federal requirements. Data in the LTCH CARE Data Set/IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records.
58	Section N: Medications	Does CMS expect the pharmacist to document the medication review in the patient's medical record?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which LTCH or IRF staff members may complete a DRR. Data in the LTCH CARE Data Set/IRF-PAI should be consistent with information reported in the patient's medical record. The necessary information needed and used to code the items should be recorded in the patient's medical records. Each facility determines their policies and procedures for completing the assessments. Each facility provides patient care according to their unique characteristics and standards (e.g., patient population).
59	Section N: Medications	If a physician orders medications on admission, and the pharmacist contacts the physician prior to developing the medication profile and resolves the questions/potential issues, is this still considered an issue?	If the issue was determined to be clinically significant, then the issue identified by the pharmacist and communicated to the physician and resolved by midnight of the next calendar day meets the requirements for coding N2001. Yes, issues found during review and N2003. Yes, medication follow-up on the admission assessment.

#	Question Category	Question	Proposed Response
60	Section N: Medications	If the physician-designee (such as an Advanced Practice Registered Nurse (APRN)) identified a potential or actual clinically significant medication issue and resolved it without registered nurse (RN) or licensed practical nurse input, would this still need to be coded in items N2001 and N2003?	We interpret this question to mean that a facility-based physician-designee performed the DRR, identified a medication issue, and addressed it without needing to communicate with another physician/physician-designee. In this scenario, the APRN identified and resolved a medication issue and therefore it did not require two-way communication with facility staff. The definition of a clinically significant medication issue requires the identification of a medication issue that warrants contacting a physician or physician-designee, two-way communication, in a timely manner and addressing all physician (or physician-designee) prescribed /recommended actions by midnight of the next calendar day at the latest. If no clinically significant medication issues were identified, then N2001 would be coded 0 and N2003 would be skipped.
61	Section N: Medications	Please clarify the term physician-designee. Can this include RNs or pharmacy technicians, or nurse practitioners and pharmacists only?	The role of a physician-designee is defined by Federal and State licensure regulations. CMS does not provide guidance on who can or cannot code the DRR items. Each facility determines its policies and procedures for completing the assessments. Please refer to facility, Federal, and State policies and procedures to determine which LTCH or IRF staff members may complete a DRR.
62	Section N: Medications	If a medication-related order (e.g., Vancomycin peak/trough) is not appropriate to be completed by midnight of the next calendar day, does the order serve as a response to a potential or actual clinically significant medication issue?	If the provider followed the physician's order that included an action after midnight of the next calendar day, this would meet the requirement of coding N2003, Yes, as the potential or clinically significant medication issue was addressed in accordance with the ordered timeframe.
63	Section N: Medications	What do you mean by timely?	Timely for the DRR refers to by midnight of the next calendar day at the latest.
64	Section N: Medications	There are codes for LTCH planned, unplanned, and expired assessments. What assessment should an IRF use to code an unplanned discharge or if the patient expires?	Data element, N2005. Medication Intervention is coded for patients with planned and unplanned discharges and for patients who expire in the IRF/LTCH. This data element is included on the IRF-PAI in the Discharge Section. These data elements are included on the LTCH Planned and Unplanned Discharge, and Expired Assessments.

#	Question Category	Question	Proposed Response
65	Section N: Medications	When does data collection begin for the DRR quality measure?	Data collection begins July 1, 2018, for LTCHs and October 1, 2018, for IRFs and SNFs.
66	Section N: Medications	What is the rationale for coding 0, No for N2003 in scenario number 3 if the physician ordered the international normalized ratio (INR) laboratory test within the first calendar day? Why would the nurse need to request the laboratory test? Does CMS expect the results of the INR by midnight of the next calendar day or that the laboratory order is requested prior to midnight of the next calendar day?	The intent of coding N2003 is to determine if the facility contacted a physician or physician-designee by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified/potential clinically significant medication issues. In this scenario, the expectation is that the physician ordered an INR and the nurse would implement the physician's order (submitted the request for the laboratory test) by midnight of the next calendar day at the latest. For this scenario, and for coding N2003, it is not the intent that the laboratory result be available by midnight of the next calendar day.

#	Question Category	Question	Proposed Response
67	Section N: Medications	How does CMS define clinically significant medication issues?	A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest. Potential or actual clinically significant medication issues may include, but are not limited to: • Medication prescribed despite medication allergy documented in the patient's medical record. • Adverse reactions to medications. • Ineffective drug therapy. • Drug interactions (serious drug–drug, drug–food, and drug–disease interactions). • Duplicate therapy (e.g., generic name and brand name equivalent drugs are co-prescribed). • Wrong patient, drug, dose, route, and time errors. • Omissions (drugs missing from a prescribed regimen). • Nonadherence (purposeful or accidental). Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the DRR items. The necessary information needed and used to code the items should be recorded in the patient's medical record. This information may be found on page N-2 of the LTCH QRP Manual Version 4.0 and the IRF-PAI Training Manual Section 4 Quality Indicators Version 2.0.

#	Question Category	Question	Proposed Response
68	Section N: Medications	For the DRR items, when you refer to clinician's professional judgment, what level of clinician are you referring to?	CMS does not provide guidance on who can or cannot code the DRR items. Please refer to facility, Federal, and State policies and procedures to determine which LTCH or IRF staff members may complete a DRR. Each facility determines its policies and procedures for completing the assessments.
69	Section N: Medications	If a dash is used to code N2003, does this count against the 95-percent IRF-PAI completion requirement and the 2-percent APU penalty, or is it similar to the current use of dashes for the Section GG discharge codes?	Yes, coding the three DRR items with a dash would count against the APU requirement.
70	Section N: Medications	Does Section N need to be completed within the 3-day admission assessment timeframe?	A DRR should be completed upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. Patient assessments are to be completed in compliance with facility, State, and Federal requirements. Each facility delivers care according to its unique characteristics and standards. Thus, each facility establishes its policies and procedures for completing assessments and data collection.
71	Section N: Medications	The clinical scenarios presented during the LTCH and IRF training refer only to acute care hospital discharge documents as the source of information to compare to PAC orders. Is CMS suggesting that this represents a complete medication reconciliation process in the absence of other information sources?	No, the DRR clinical scenarios presented during the LTCH and IRF training were examples of patients who are admitted from an acute care hospital. These scenarios depicted a source of information to review when a patient is admitted to an LTCH or IRF to reconcile the patient's medications. CMS recognizes that patients may be admitted from another type of facility to an LTCH or IRF, and the information that is transferred from that facility is a source of information for completing the DRR upon admission. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the DRR, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

#	Question Category	Question	Proposed Response
72	Section N: Medications	How do I code the DRR items if there are no potential or clinically significant medication issues?	A DRR is completed upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. For N2001, Drug Regimen Review, if no actual or potential clinically significant medication issues were identified upon admission, then N2001 is coded 0, No issues found during review or 9, NA, the patient was not taking any medications upon admission. If N2001 is coded as 0, No, or 9, NA, at admission then you would skip N2003 and go to O0100, Special Treatments, Procedures, and Programs. If there were no potential or actual clinically significant medication issues identified throughout the stay (admission through discharge) and/or the patient was not taking any medication at any time during the stay then N2005, Medication Intervention, would be coded 9, NA - Not applicable.
73	Section N: Medications	How do I code N2003, Medication Follow-up, if N2001, Drug Regimen Review, was coded 0, No issues found during review?	If N2001 is coded as 0, No, or 9, NA, at admission then you would follow the skip pattern according to your PAC setting admission assessment, LTCH CARE Data Set, or IRF-PAI. For the LTCH CARE Data Set and IRF-PAI, you would skip to O0100, Special Treatments, Procedures, and Programs. In this scenario, you would not need to code N2003, Medication Follow-up, due to the skip pattern.
74	Section N: Medications	Are patient stays the number of patient days?	A patient stay is the period of time between a patient's admission date into an LTCH or IRF and date of discharge. Interrupted stay(s) of 3 calendar days or less are included as part of the patient stay.
75	Section N: Medications	How would you code N2003 and N2005 if a clinician identifies a potential clinically significant medication issue and notified the physician within the appropriate timeframe. However, the physician's response, within the appropriate timeframe, was that no action was necessary. Would you code both items as "yes" a potential clinically significant medication issue occurred?	N2003, Medication Follow-up, and N2005, Medication Intervention, would both be coded as 1, Yes, in this scenario if the following occurred: 1. At admission and at any time throughout the patient stay, the clinician(s) contacted the physician/physician-designee regarding all identified potential or actual clinically significant medication issues. 2. The physician/physician-designee communicated to the clinician(s) that no actions were necessary regarding the reported issues. 3. All communications took place by midnight of the next calendar day.

#	Question Category	Question	Proposed Response
76	Section N: Medications	How would you code the DRR items if the patient does not adhere to their prescribed medications and is not taking any medications prior to admission? Is this considered not applicable?	We interpret this question to mean that the patient refused to take medications that were prescribed prior to the admission. The clinician should use clinical judgement to determine if the patient's refusal to take the prescribed medications would be considered a clinically significant medication issue that would require following the requirements of the measure. N2001. Drug Regimen Review, may be coded using the following responses: • Yes, if the patient's refusal to take the medications, based on clinical judgement, identified a potential or actual clinically significant medication issue. • No, if the patient's refusal to take the medications, based on clinical judgement, identified no potential or actual clinically significant medication issue. • 9. NA, if the patient was not taking any medications which includes prescribed and over the counter, total parenteral nutrition, and oxygen.
77	Section N: Medications	During the admission process, defining "current medication therapy" is not always clear cut. We are using multiple sources of information to best determine this. Would we report a potential or actual clinically significant medication issue even if we have not confirmed that it is included in the patient's current medication therapy? For example, a patient may be a poor historian.	We interpret this question to mean how would you code N2001, Drug Regimen Review, on the admission assessment if the information you have is not confirmed in the patient's current medication therapy? You would code N2001, Drug Regimen Review, based on all available information, in this scenario patient reported information, and use clinical judgement to determine if there is a potential or actual clinically significant medication issue.

#	Question Category	Question	Proposed Response
78	Section N: Medications	A DRR includes all medications. When you state nutritional supplements, are you referring to nutrition products that are provided to the patient on meal trays, such as Ensure nutritional supplement? Or are you only referring to vitamins, minerals, and or protein powder ordered?	Nutritional supplements, such as Ensure, are considered medications for the purposes of coding the DRR items. The DRR includes all medications, prescribed and over-the-counter (including nutritional supplements, vitamins and homeopathic and herbal products), administered by any route (e.g., oral, topical, inhalant, injection, sublingual, parenteral, and by infusion).
79	Training Resources	Could you provide the URL for these slides?	IRF materials for today's event can be found at the bottom of this page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html. LTCH materials for today's event can be found at the bottom of this page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.
80	Training Resources	When will we receive copies of the rationale slides for all scenarios?	Presentations with answers to scenarios will be posted to the IRF and LTCH QRP Training websites shortly following the training. The URL for the IRF QRP Training web page is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html. The URL for the LTCH QRP Training web page is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html.