Enhanced Respiratory Care Operations Manual

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Overview

The Enhanced Respiratory Care (ERC) Program for Long-Term Services and Supports (LTSS) is a value-based initiative that provides specialized, high-quality respiratory care for Tennesseans with chronic conditions or complex medical needs in skilled nursing facilities. The program combines advanced therapies, continuous monitoring, and personalized care plans to improve health outcomes, reduce hospital readmissions, and enhance residents' overall quality of life.

This document outlines the key components, guidelines, and procedures of the ERC program for delivering consistent and effective care. It serves as a resource for healthcare plans, providers, and staff, to better understand the program's goals, adhere to established protocols, and adopt best practices in managing residents with acute and complex respiratory care needs. The manual provides guidance on how to review and report on care standards, with a focus on improving clinical outcomes, reducing complications, and promoting high-quality care and patient safety.

This manual will be updated as needed to clearly explain the quality standards, how performance is assessed, and the guidelines for ERC reimbursement. It will also help guide ongoing improvements in care practices and improve resident outcomes.

Online Reporting System - PERLSS

The Pre-Admission Evaluations and Referrals for Long-Term Services and Supports (PERLSS) is TennCare's cloud-hosted solution designed to modernize the LTSS Division's infrastructure and operations. Serving as a centralized platform, PERLSS manages and tracks medical eligibility determinations, enrollments, appeals, and referrals for LTSS programs. This tailored application streamlines eligibility assessments, patient data management, and compliance with state and federal requirements, ensuring efficiency and consistency in care monitoring across LTSS programs.

PERLSS is the system that ERC service providers use to submit detailed reports on resident care, incidents, and performance metrics to ensure that quality outcomes are constantly monitored and aligned with program standards. Providers are required to submit their data to TennCare monthly, with reports due by the 20th day of the month following the assessment period. For example, data for the month of April must be uploaded through PERLSS by May 20th. Failure to meet the deadline may lead to potential delays in reimbursement or other consequences.

To access the system, providers must complete the required registration process and receive their login credentials. The information provided during registration will create a facility profile in the ERC QUILTSS module in PERLSS and assign the appropriate user roles and access permissions for every individual identified at the facility as an end-user. For information and initial access to our online reporting portal, please contact ERC.LTSS@tn.gov.

Data Collection and Clinical Documentation Standards

The ERC data collection process plays a critical role in assessing the quality of ERC services and ensuring they meet established standards. Once access to the ERC QuILTSS module in PERLSS is granted and the required training is completed, providers can begin entering resident-specific data. The process begins with the referral intake, where relevant demographic and medical information is gathered to create a new member profile. This profile is then used to generate the member record, referred to as assessment, which captures detailed information about the member's health status, care needs, and other relevant factors that will inform their care plan.

Following the initial assessment, ongoing monthly assessments are added to the member's record to track any changes in their level of care, services provided, and key data that will inform quality measures and patient outcomes. This process of continuous data collection ensures that care remains aligned with the member's evolving needs and supports the overall goal of improving service quality and health outcomes.

Referral Intake

The referral intake is the first step in data collection, capturing key demographic information, personally identifiable details, payor data, clinical information, and program admission status. A detailed list of the related data elements can be found in the Data Elements section.

Assessment Workflow

The member record, which is created during the referral intake process, is a comprehensive record continuously updated to capture changes in the individual's health status, care plan, service delivery, outcomes, and reportable events. This dynamic assessment is updated monthly reflect any changes in an individual's condition and used for ongoing monitoring of quality outcomes and performance measures overtime. These measures are used to evaluate provider performance, which has directly impact on reimbursement rates and eligibility for incentive payments, ensuring that providers are rewarded for delivering high-quality, outcome-driven care.

Service Details

The service details section documents all critical updates related to the individual. It includes changes in diagnosis, modifications to service delivery (such as care days), and progress in clinical interventions like weaning and decannulation trials and their outcomes. Each reporting period begins with a review of the patient's information and any changes in care status since the previous period. This is followed by a detailed log of the type of services provided and the specific locations where care was delivered, ensuring a clear and thorough account of the individual's ongoing care and treatment progress. Delivery of services is recorded in continuous segments, with each segment representing a specific period of care provided. These segments capture the start and end dates for each type of service delivered, ensuring that all care activities are documented accurately. This method allows for a clear and organized record of service delivery, even when care spans multiple reporting periods or includes admissions or changes in care status during the month.

Technology Utilization

The technology utilization section tracks the technology deployed at the facility and its application based on resident needs. It helps identify areas where technology may be underused or highlight where additional training or resources may be necessary to fully leverage its potential and maximize its impact on care delivery and improving patient outcomes.

Clinical and Reportable Events

This section covers essential clinical incidents and events that require documentation and reporting under regulatory standards. It includes incidents affecting patient safety, significant changes in patient condition, and outcomes impacting clinical care. Accurate documentation and timely reporting of these events help ensure quality assurance, regulatory compliance, and continuous improvement in patient care practices.

Clinical Documentation Standards

It is essential that documentation in the clinical record supports the reported data and aligns with the care plans. Entries must correspond to the correct reporting period and accurately capture the resident's status across all shifts. Documentation should include dated entries, and the author must be identifiable by their signature or initials. All medical records require authenticated signatures, including at least the first initial, last name, and title/credential. If initials are used, they must be accompanied by a full identification of the initials on the same form or in a signature legend. It is important to note that initials cannot replace a signature when one is legally required.

For electronic signatures, a policy must be in place specifying who is authorized to sign electronically and how to protect against unauthorized access. In the event of corrections

or errors, staff must cross out the incorrect information, initial the change, and provide the date of correction along with the accurate information. This process ensures integrity and accuracy in the clinical record, supporting effective care delivery and compliance with regulatory standards.

Performance Measures and Provider Evaluation

This section outlines how providers are assessed on key performance metrics that gauge the quality and impact of care. These evaluations help maintain care standards, improve patient outcomes, and pinpoint areas for enhancement.

Quality Outcome Measures

Measure	Definition (numerator divided by denominator) Numerator	Denominator	Performance Range	Point Value
Ventilator Wean Rate*	Number of vent residents successfully weaned	Number of non-excluded vent residents admitted during the review period	>60% 44-60% 20-44% <20%	40 25 10 0
Average Length of Stay to Wean*	Average days from admission to weaning for vent residents admitted and successfully weaned during the review period.		If wean rate is >44% <45 days ≥45 days If wean rate is 20-44% <45 days ≥45 days If wean rate is <20%	 35 25 25 10 0
Infection Rate This can include <u>any</u> respiratory infection	Number of residents with a Respiratory Infection [>96hrs from admission]	Member months	No points assigned.	

Measure	Definition (numerator divided by denominator) Numerator	Denominator	Performance Range	Point Value
Unplanned Hospitalizations Dialysis and Pediatric residents are excluded from this calculation	Number of unplanned hospitalizations	Member months	<5% 5-10% >10-15% >15-25% >25%	25 20 10 5 0
Decannulation Rate	Number of tracheostomized residents successfully decannulated	Number of non-excluded tracheostomized residents admitted during the review period	>50% >30-50% 10-30% <10%	20 15 10 0
Unexpected Deaths	Total number of unexpected deaths	Member months	<1% 1-3% >3%	20 10 0
Denial Rate	Number not admitted	Number of referrals	No points assigned.	

*** Measure not applied to facilities that do not perform ventilation services.**

Technology Measures

Measure (available and used)	Point Value
Alarm Paging/Beeper System	4
Cough Assist	7
Heated Wire	3
High Flow Molecular Humidification	6
High-Frequency Chest Wall Oscillation or Intrapulmonary Percussive Ventilation	3
Incentive Spirometer or any Positive Expiratory Pressure Device*	1
Mobile Monitoring Device*	3
Non-Invasive Ventilation*	8
Non-Invasive Open Ventilation (Nasal application for mobility) *	3

***Measure not applied to facilities that do not perform ventilation services.**

Tiering and Reimbursement Structures

Nursing facilities (NFs) offering mechanical ventilation services can earn a maximum of 178 points, while those providing only tracheal suctioning can earn up to 88 points. Each facility's score is calculated by dividing the points earned by the total possible points, producing a percentage score. These percentages are then assigned to quality tiers as follows:

NFs contracted to provide all levels of ERC reimbursement.

Tier	Percent of Total Available	Range of Points (out of
High	>66%	>117
Moderate	33-66%	60-117
Low	<33%	<60

NFs contracted to provide Tracheal Suctioning only

Tier	Percent of Total Available	Range of Points (out of 88)
High	>66%	>59
Moderate	33-66%	30-59
Low	<33%	<30

ERC add-on reimbursement rates effective January 1, 2024

Tier	Ventilator Weaning	Ventilator	Sub-Acute Tracheal Suctioning	Secretion Management Tracheal
High	$600	$350	$200	$125
Moderate	$550	$300	$150	$75
Low	$450	$250	$100	$50

ERC add-on reimbursement rates effective January 1, 2024, for Dialysis residents only*

Tier	Ventilator Weaning	Ventilator	Sub-Acute Tracheal Suctioning	Secretion Management Tracheal
High	$750	$500	$350	$275
Moderate	$700	$450	$300	$225
Low	$600	$400	$250	$200

*This add-on payment is for the provision of ERC services to dialysis patients and not the provision of dialysis services. This is an interim approach until quality metrics for ERC dialysis patients have been developed.

Calculation of Quality Outcome Measures

Wean Rate
This metric measures the percentage of residents who successfully transition from mechanical ventilation to independent breathing without assistance during a specified period. It evaluates the effectiveness of ventilator weaning protocols and reflects the overall quality of respiratory care provided by the facility. **Numerator:** Total number of unique ventilator residents successfully weaned from mechanical ventilation during the review period. **Denominator:** The total number of unique ventilator residents who meet the following criteria: • Residents admitted during the review period who do not have a weaning exclusion (Non-Wean Exclusion marked as "No") • Residents with an admission date within the review period, including those with a weaning exclusion (Non-Wean Exclusion marked as "Yes"), who successfully weaned during the review period. • Residents admitted before the review period who successfully weaned within the review period. **Unique**: This refers to the distinct count of ventilator residents within a specified time frame and counted only once regardless of how many months they were present during the period. For example, if Jane Doe were admitted and remained present the entire 6-month review period, she would only be counted once. This count is determined using patient identifying information and their admission date. **Ventilator Resident**: This includes residents with recorded chronic ventilator care days, weaning care days, or both. Residents without these care segments will not be classified as ventilator residents for the wean rate calculation. Additionally, residents requiring less than 12 hours of non-invasive ventilation per day are excluded from this calculation were present during the period. For example, if Jane Doe were admitted and remained present the entire 6-month review period, she would only be counted once. This count is determined using patient identifying information and their admission date. **Successfully Weaned**: Residents who have been off the ventilator for at least 7 consecutive days after the ventilator was removed **AND** have a weaning date within the review period.

Review Period: a specified timeframe during which resident data is assessed.

Wean Excluded: Residents with a Non-Weaning Exclusion marked as "Yes" are excluded from the wean rate until they have successfully weaned.

Average Length of Stay to Wean

This is the average number of days from admission date to wean date for successfully weaned, ventilator residents who were **admitted and weaned during the review period**.

Days from Admission to Wean: Average of days from admission to date of weaning if the resident was weaned successfully and admitted during the review period**.**

Successfully Weaned: Residents who have been off the ventilator for at least 7 consecutive days after the ventilator was removed **AND** have a weaning date within the review period.

Review Period: a specified timeframe during which resident data is assessed.

Note: This calculation includes individuals with a "Wean Excluded" status who were admitted and successfully weaned during the review period.

Decannulation Rate

The decannulation rate refers to the percentage of residents with a tracheostomy who successfully have their tracheostomy tube removed during a specific period and can breath independently without it.

Numerator: Total number of unique residents with a tracheostomy that has successfully decannulated during the review period.

Denominator: The total number of unique tracheostomy residents meet the following criteria:

- Residents admitted during the review period who do not have a weaning exclusion (Non-Wean Exclusion marked as "No")
- Residents with an admission date within the review period, including those with a weaning exclusion (Non-Wean Exclusion marked as "Yes"), who successfully decannulate during the review period.
- Residents admitted before the review period who successfully decannulate within the review period.

Unique: This refers to the distinct count of tracheostomy residents within a specified time frame and counted only once regardless of how many months they were present during the period. For example, if Jane Doe were admitted and remained present the entire 6-month review period, she would only be counted once. This count is determined using patient identifying information and their admission date.

Tracheostomy Resident: This includes residents with sub-acute tracheal suctioning care days, secretion management tracheal suctioning care days, or both. Residents without these care segments will not be classified as ventilator residents for the decannulation rate calculation. Additionally, residents requiring less than 12 hours of non-invasive ventilation per day are excluded from this calculation.

Successfully Decannulated: Residents who have had their artificial airway removed successfully and remained stable for 3 days following the removal without requiring re-insertion.

Review Period: a specified timeframe during which resident data is assessed.

Wean Excluded: Residents with a Non-Weaning Exclusion marked as "Yes" are excluded from the decannulation rate until they have successfully decannulated.

Infection Rate

Numerator: Total count of new respiratory infections recorded during the specified period.

Denominator: The total count of member months. Each entry indicates one month of care for a resident and contributes to the overall evaluation. Resident duplication is allowed for this measure.

Unplanned Hospitalization Rate

Numerator: Total count of unplanned hospitalizations recorded during the specified period.

Denominator: The total count of member months. Each entry indicates one month of care for a resident and contributes to the overall evaluation. Resident duplication is allowed for this measure. Individuals flagged for Dialysis or Pediatric care will be excluded from this calculation.

Unexpected Death Rate

Numerator: Total count of unexpected deaths recorded during the specified period.

Denominator: The total count of member months. Each entry indicates one month of care for a resident and contributes to the overall evaluation. Resident duplication is allowed for this measure.

Denial Rate

Numerator: Total count of unique denials reported during the specified period.

Denominator: Total count of referral requests submitted during the specified period.

Technology
Points will be awarded for the specified technology if it was used at any point during the review period **AND** is listed as available at the facility

Audit and Compliance

The review protocol ensures the delivery of high-quality care through semi-annual evaluations. These assessments focus on compliance with guidelines, identify areas for improvement and encourage accountability. All providers are subject to review, using a sample size of either 10 residents or 20% of the total population, whichever is greater. The review process consists of three stages: pre-review, review, and post-review activities which include both document reviews and on-site or virtual visits to provide a thorough evaluation of compliance with ERC guidelines.

ERC Compliance Review Protocols

The ERC compliance review protocol consists of three key stages: pre-review, review, and post-review activities. The purpose of the review is to ensure that documentation is accurate, complete, and adheres to established care standards for ventilator services. The review focuses on documents such as written training plans, emergency preparedness plans, ventilator back-up provisions, staff documentation (including contract and licensing agreements), and staffing requirements for licensed care practitioners.

Pre-Review Protocol

Facilities will receive advance notifications regarding the submission of Enhanced Respiratory Care compliance documentation. Email notifications will be sent at least fourteen (14) calendar days before the letter notification, and a follow-up phone call will be made if the email is not verified. The letter notification, also sent at least fourteen (14) days prior to the review, will outline the request for documentation, which must be submitted within the specified timeframe via secure channels such as a secure document delivery system or FTP site.

Email Notification

The facility administrator will receive an email (posted to the FTP site or secure internal document delivery system) letting them know that Enhanced Respiratory Care compliance documents are required. If the email isn't confirmed, a follow-up phone call will be made to ensure they received the notification.

Letter Notification

The facility administrator will be notified by letter (posted to the FTP site) requesting Enhanced Respiratory Care compliance documents. The required documents must be submitted to Myers and Stauffer within 14 days through a secure delivery system or FTP site.

Review Protocol

Facilities will submit the requested documentation to Myers and Stauffer via a secure internal document delivery system or an FTP site provided by Myers and Stauffer. If the facility does not have a secure document delivery system, the provider will be requested to contact Myers and Stauffer at TNCaseMix@mslc.com for a secure FTP site folder for document submission. The following documentation reflecting the time period noted in the letter is required to be submitted within fourteen (14) calendar-days of notification:

- Medical director certification/license number.
- Listing of licensed respiratory care practitioners employed between (first date of review period) and (last date of review period).
- Listing of licensed and non-licensed nursing staff who were employed between (first date of review period) and (last date of review period) and providing direct care to ERC residents.
- Time sheets for licensed respiratory care practitioners between (first date of review period) and (last date of review period).
- Respiratory care practitioners' certification/license number (certification covering the time frame between first date of review period) and (last date of review period).
- Contract agreement for licensed respiratory care practitioners (if applicable).
- Emergency preparedness plan specific to residents receiving ERC services addressing total power failure (including loss of both power and generator) in addition to other emergency circumstances.
- Ventilator back-up provisions.
- Policy for internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power.
- Policy for maintaining sufficient emergency oxygen delivery devices (compressed gas or battery-operated concentrators).
- Policy for at least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilator or with a tracheostomy.
- Policy for a minimum of one (1) patient-ready back-up ventilator which shall be available in the facility at all times.
- Policy for ventilator equipment to be connected to back-up generator power via clearly marked wall outlets (e.g. red outlets).
- Written training program/plan including **annual* demonstration of competencies for alarm response, positioning, transfers, rescue breathing, and care within licensure scope for all staff providing direct care for residents receiving Enhanced Respiratory Care (nursing {licensed and non-licensed} and respiratory therapy staff as provided

on listing requested above). Submitted documentation should clearly identify coverage of the current review period (first date of review period) and (last date of review period
    - ***annual* is defined as yearly (not year to date)**
- Admissions criteria for ERC services including policy for clinical evaluation of residents prior to admission.
- All required documentation will be reviewed off-site.
- Facility will receive letter of review findings (posted to the FTP site) within thirty (30) calendar days of receipt of ALL requested compliance documentation.

Post-Review Protocol

Compliance Review findings will be posted to the FTP site for both the facility and TennCare via the Compliance Review Findings Letter. Additional documentation may be requested or submitted through the FTP site during the review process. All documentation will be retained only until the completion of the compliance review and the end of the appeal period.

ERC On-site or Virtual Review Protocols

The ERC onsite (or virtual) review consists of three key stages: pre-review, review, and post-review activities. The purpose of reviewing clinical notes during an onsite review is to gain a complete and accurate understanding of the resident's care, health status, and key events. This process verifies that documentation is consistent, thorough, and aligned with care standards. By examining notes from various sources—such as MD progress notes, nursing notes, and RT notes—the review provides a holistic view of care continuity, helps identify discrepancies, ensures regulatory compliance, and supports quality assurance by identifying areas for improvement in documentation or care practices.

Onsite Pre-Review Protocol

Facilities will receive notification at least seven days before an on-site review through both telephone and email. For the telephone notification, the administrator is contacted first; if unavailable, the Director of Respiratory Care or Director of Nursing is contacted next, or a message is left with facility staff. The email confirmation, sent after the phone call, includes a document outlining the required documentation for the Enhanced Respiratory Care (ERC) Review.

Telephone Notification

The facility administrator or their designee will be notified as follows:

- **Primary Contact:** The administrator is contacted first regarding the upcoming review.

- **Alternative Contacts**: If the administrator is unavailable, the Director of Respiratory Care will be contacted. If they are also unavailable, the Director of Nursing will be contacted.
- **Backup Notification**: If none of these leadership staff are available, a message will be left with a facility staff member, who will then be responsible for notifying the administrator.

Email Confirmation

The facility will receive an email notification about the on-site Enhanced Respiratory Care (ERC) review, including a list of required documentation. The email address will be confirmed during the phone notification.

Onsite Review Protocol

Facilities will provide a work area free of audio or video recording and surveillance for the onsite review, which will be conducted by a certified RN (The Reviewer). The review will include the following activities:

- An entrance conference will take place before the review begins, where the required documentation will be discussed.
- The RN Reviewer will explain the review process and identify the facility liaison.
- The RN Reviewer will provide a list of residents involved in the review.
- Facility attendee(s) will be asked to initial and sign the entrance conference form.
- The facility liaison will conduct a tour of the facility.
- The facility liaison must provide the original legal medical records.
- The RN Reviewer will request the liaison's assistance in navigating electronic health records or locating documentation in the residents' medical records for the ERC review.
- Once the medical records are brought to the review area, they should remain there until released by the RN Reviewer; however, facility staff should have access to records in emergency situations.
- Medical records may be in electronic form, hard copy, or a combination of both.

Onsite Post-Review Protocol

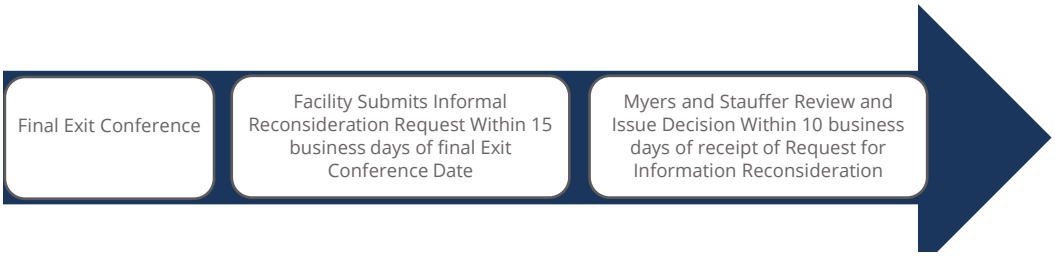
A final exit conference is conducted with the facility administrator or designee upon completion of the review. If the review spans multiple days, an additional exit conference will be held each day, during which the Reviewer will present preliminary findings. An exit conference form will be signed by all participating parties at the conclusion of the review.

Informal Reconsideration Request Process

Myers and Stauffer LC share preliminary findings from the ERC clinical review using an Exit Conference Form, which they provide to the ERC provider during the final exit conference. The provider then has the chance to review these written findings. If the provider disagrees with the findings, they can submit a written informal reconsideration request to TennCare within 15 business days of the final exit conference. This request must specify the review issues that the provider believes were misunderstood or incorrectly applied. Supporting documentation must be provided with the written informal reconsideration request supporting the provider's specific concerns. TennCare will then review the informal reconsideration request utilizing a clinician who was not directly involved with the original ERC review. Within 30-business days of receiving the request, TennCare will communicate the final ERC review findings to the provider.

Informal Reconsideration Process Summary

The facility has 15 business days from the exit conference date to request an informal reconsideration. Myers & Stauffer will respond within 10 business days of receiving the request.



Following the informal reconsideration, the provider must follow the appeal rights instructions per **CHAPTER 1200-13-18 TENNCARE ADMINISTRATIVE ACTIONS AND PROVIDER APPEALS**

Request for Information Consideration

<table>
<tr><td>Introduction</td><td colspan="2">Information for informal reconsideration including:
Definition of a request for informal reconsideration
Initial steps for handling a request for informal reconsideration.
Appeal rights in the decision notice</td></tr>
<tr><td>Definition</td><td colspan="2">A request for an informal reconsideration is a request from a provider for TennCare to reconsider one of its review decisions that was made during the ERC Review.</td></tr>
<tr><td rowspan="4">Initial Steps</td><td colspan="2">The table below describes the initial steps for handling a request for an informal reconsideration:</td></tr>
<tr><td>If the provider submits….</td><td>Then….</td></tr>
<tr><td>Documentation, within 15 business days of the date of the final exit conference, that outlines the area in question with the ERC Review findings and contains specific documentation to support their concerns</td><td>The documentation will be reviewed, and a decision rendered within 30 business days of the date of receipt of the informal reconsideration request.

NOTE: Documentation for the informal reconsideration will be reviewed by a clinician who was not directly involved with the original ERC on-site review</td></tr>
<tr><td>Adequate documentation to support their specific concerns</td><td>A decision to overturn the original findings will be issued</td></tr>
<tr><td>Inadequate documentation to support their specific concerns</td><td>A decision to uphold the original findings will be issued</td></tr>
<tr><td>Appeals Rights</td><td colspan="2">Appeal rights per CHAPTER 1200-13-18 TENNCARE ADMINISTRATIVE ACTIONS AND PROVIDER APPEALS will be referenced in a decision notice issued in response to a request for an informal reconsideration.</td></tr>
</table>

Standards of Care

The table provides key requirements from the standards of care for ventilator services, covering protocols, staff qualifications, equipment readiness, and emergency preparedness to ensure safe and high-quality care for ventilator-dependent residents.

Standards of Care for Ventilator Services

The table provides key requirements from the standards of care for ventilator services, covering protocols, staff qualifications, equipment readiness, and emergency preparedness to ensure safe and high-quality care for ventilator-dependent residents.

Medical Director
Definition: 1. Physician licensed to practice in Tennessee. 2. Board certified in pulmonary disease or critical care medicine as recognized by either the American Board of Medical Specialties or American Osteopathic Association, as applicable.
Required Supporting Documentation: 1. Tennessee medical license. 2. Contract agreement (if applicable) 3. Board certification in: a. Pulmonary Disease OR b. Critical Care Medicine
Licensed Respiratory Care Practitioners
Definition: 1. Defined by Tennessee Code Annotated Section 63-27-102(7) "Respiratory care practitioner means a registered respiratory therapist, a certified respiratory therapist, or a respiratory assistant licensed under this chapter."
Required Supporting Documentation: 1. Listing of all respiratory care practitioners employed during the reporting month(s). 2. License/certification. 3. Contract agreement (if applicable). 4. Time sheets for reporting periods. **5.** Annual competencies for reporting periods.
Ventilator back-up provisions
Definition: 1. Internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power; 2. Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery-operated concentrators; 3. At least one (1) battery-operated suction device available per every eight (8) residents on a mechanical ventilator or with a tracheostomy; AND **4.** A minimum of one (1) resident-ready backup ventilator which shall be available in the facility at all times.
Required Supporting Documentation: 1. Back-up provisions visualized during facility tour. 2.

Emergency Preparedness Plan
Definition: 1. A plan specific to residents receiving ERC which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.
Required Supporting Documentation: 1. Emergency preparedness plan containing all specified requirements.
Written training program/plan
Definition: 1. A written training program, including an annual demonstration of competencies, for nursing staff (including nurse aides, registered nurses, and licensed practical nurses) and respiratory therapy staff providing direct care services for residents receiving Enhanced Respiratory Care**.**
Required Supporting Documentation: 1. Written training program/plan. 2. Documentation of annual demonstration of staff competencies for all staff caring for ERC residents.
Electronic Signature Policy (if applicable)
Definition: 1. Must have written policy in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
Required Supporting Documentation: 1. Electronic signature policy

Secretion Management Guidelines

This section outlines protocols and best practices for regular assessment, techniques for secretion clearance, and recommended equipment use to prevent complications and maintain airway patency. These guidelines are designed to enhance patient comfort, reduce infection risk, and ensure consistent, high-quality care.

An applicant must have a functioning tracheostomy and a <u>copious volume of secretions</u>
Definition: 1. A copious volume of secretions shall be defined as 25-30 ml per day- about 1 fluid ounce or “a shot glass full” occurring over the course of the day, and not necessarily at every suctioning. Please note, however, that for residents whose secretions are managed using a high flow device, the device is expected to provide ongoing relief of the copious volume of secretions, which shall not negate the need for intervention (and eligibility for Secretion Management Tracheal Suctioning Reimbursement), if

absent the high flow device, the copious volume of secretions would require more invasive management.

Required Supporting Documentation:

1. The resident's original permanent medical record contains documentation of secretion measurements or
2. The resident's original permanent medical record documents the use of a high flow device and effectiveness in providing relief of copious volume of secretions during the reporting month.

Invasive tracheal suctioning, at a minimum, once every three (3) hours with documented assessment pre-and post-suctioning

Definition:

1. The requirement for invasive tracheal suctioning, at a minimum, once every three (3) hours shall be applied as a marker of the severity of the Applicant's respiratory care needs. Secretion Management Tracheal Suctioning is not a scheduled intervention and shall not be performed as a medication would be delivered, i.e., at scheduled intervals (except as prescribed by an appropriately licensed health care professional practicing with the scope of his or her license). Rather, tracheal suctioning should be provided as clinically indicated, based on the needs of each person requiring such care; evidence of the need should be clearly and "accurately" documented. This could mean a shorter or longer interval at any point, but with a clinical need for invasive tracheal suctioning an average of every three (3) hours or more often in order to qualify for Secretion Management Tracheal Suctioning Reimbursement.
2. Note also that invasive tracheal suction is one of two options.

Required Supporting Documentation:

1. The resident's original permanent medical record must contain documentation of invasive tracheal suctioning, at a minimum, once every 3 hours during the reporting month.
2. The resident's original permanent medical record must contain documentation of an assessment both pre- and post- suctioning during the reporting month.

The use of mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy, at a minimum, three (3) times per day with documented assessment pre-and post.

Definition:

1. This provision is an effort to guide NFs away from the practice of suctioning the trachea which is an invasive maneuver that irritates the trachea and causes trauma as well as increased risk for infection. In these cases, there must be documented evidence of the Applicant's copious secretions, but they are managed non-invasively using a cough assist device periodically or high flow molecular humidity continuously or at least three (3) times per day as ongoing treatment. The high flow device will provide ongoing relief of the copious volume of secretions, which shall not negate the need for intervention (and eligibility for Secretion Management Tracheal Suctioning Reimbursement), if absent the high flow device, the copious volume of secretions would require more invasive management.

Required Supporting Documentation:

1. The resident's original permanent medical record must document the use of a mechanical airway clearance device at a minimum of 3 times per day; and/or
2. The resident's original permanent medical record must document the use of a heated high flow molecular humidification via the trach at a minimum of 3 times per day.
3. The resident's original permanent medical record must document pre- and post- assessments.
4. Requires daily use notes and/or flow sheet/log.

The suctioning (or airway clearance, as applicable) must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the Applicant's spontaneous effort.

Definition:

Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement.

1. An MCO may authorize, based on medical necessity, short-term payment at the Sub-Acute Tracheal Suctioning ERC rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention during the post-weaning period which shall include documented progress in weaning from the tracheostomy.

Required Supporting Documentation:

1. The resident's original permanent medical record documents that suctioning (or airway clearance, as applicable) must be required to remove excess secretions and or aspirate from the trachea.
2. The resident's original permanent medical record documents that Applicant (resident) cannot remove excess secretions by spontaneous effort.
3. Requires daily note and/or flow sheet/log.

A PAE for Secretion Management Tracheal Suctioning Reimbursement shall be approved for no more than a period of thirty (30) days.
Definition: 1. Clinical review and approval of a new PAE shall be required for ongoing coverage, which shall include evaluation of clinical progress and the NF's efforts to improve secretion management through alternative methods. 2. TennCare may, on a case-by-case basis, approve a PAE for Secretion Management Tracheal Suctioning Management Reimbursement for a period of more than thirty (30) days, e.g., if a person has ALS or another progressive neuromuscular disorder, spinal cord injury, or chronic respiratory failure, or is in a persistent vegetative state, where ongoing secretion management tracheal suctioning is expected to continue.
Required Supporting Documentation: 1. Requires approved PAE for the reporting month.

Standards of Care for Dialysis

Facilities may qualify for additional payments for delivering ERC services to residents requiring dialysis, contingent on TennCare approval and payor authorization. To be eligible, an ERC provider must maintain a high-tier (Tier 1) status for two consecutive reporting periods and meet all regulatory, reporting, and audit requirements. Additionally, the facility must meet the following minimum standards within the most recent six-month reporting period:

- Facility must not be on probationary status.
- Maintain a high ERC tier level.
- Keep the unplanned hospitalization rate below 30%.
- Ensure the unexpected death rate is under 1%.

In addition to the eligibility requirements, the following criteria must be met and verified through an initial and ongoing onsite assessment:

- **Care Plan by Nephrologist**: Each ERC resident receiving dialysis must have a care plan established by a board-certified nephrologist, including physical assessment and a detailed treatment plan. This plan should address anemia management (including transfusion needs if applicable), monitoring and treatment for electrolyte imbalances, use of phosphate binders, and evaluation/treatment for secondary hyperparathyroidism. All treatments outlined in the plan should be feasible within the SNF facility.
- **Non-Weaning Exclusion Order:** Upon admission, an order must be entered in the resident's chart stating "Non-Weaning Exclusion due to ESRD and receiving dialysis." Additionally, a pulmonologist must provide a ventilator and/or tracheostomy weaning plan specific to each ERC dialysis resident, where applicable.

- **Respiratory Therapist Support During Dialysis**: For ERC residents receiving dialysis outside the ERC unit, a Respiratory Therapist (RT) must be present during transport and remain with the resident throughout the dialysis session.
- **Emergency Equipment:** While off the ERC unit, the resident must have access to an ambu bag, back-up tracheostomy tubes, and a compressed oxygen source at all times.
- **Supply Validation by Respiratory Therapist**: The RT must ensure adequate oxygen, suction, and suction supplies are available and readily accessible for the resident during transport and treatment outside the ERC unit.

Data Elements

Data Elements: *Referral Intake*

Data Elements	Required Data Point	Supporting Documentation (if required)
Person Name	Y	
Date of Birth (DoB)	Y	
Gender	Y	
Social Security Number	Y	
Individual Mailing Address This is the address where documents, correspondence, and bills are sent	Y	
Physical Address This is the resident's location, which may differ from the mailing address if they use a P.O. Box or alternate mailing location, including the facility's site address.	N	
Contact Information This includes the individual's email address, cell phone number, home phone number, or work phone number as applicable.	N	
Preferred Communication Method Data fields to capture an individual's preferred communication methods, including spoken or written language preferences, any sign language needs, and specific communication requirements.	Y	
Referral Source The entity that referred the resident. Choose from the drop-down list containing the following: • Acute Care Hospital • Long-Term Acute Care Hospital (LTACH) • Skilled Nursing Facility (SNF) • Home	Y	

Data Elements	Required Data Point	Supporting Documentation (if required)
• Other - Specify		
Date NF Received Referral The date referral was received, not the date resident was admitted to the facility(mm/dd/yyyy)	Y	
Name of Referral Source	Y	
Primary Payor Refers to the insurance company that pays first on claims submitted by suppliers and providers. One of the following must be chosen from the drop-down list: • TennCare (MCO) - Medicaid ID mandatory when selected as a payor source. • Medicare • Other State Medicaid • Commercial • Other – Specify	Y	
Secondary Payor Secondary Payor - Refers to the insurance company that may pay an amount not covered by the primary insurance payer. The referral source will have this information on file. For example, an individual may have Medicare as a Primary payer and Medicaid, BCBS, etc. as an additional or "secondary" payer. Choose from the following options in the drop-down list: • TennCare (MCO). Medicaid ID is mandatory when selected as a payor source. • Medicare • Other State Medicaid • Commercial • Other - Specify • None	Y	
Hospitalization in Last 12 Months Number of times the resident has been in the hospital in the past 12 months, regardless of diagnosis.	Y	
Number of Wounds (not stages) The referral source will provide this information, or the facility will conduct an onsite evaluation to document wounds accordingly.	Y	
Primary Diagnosis Primary diagnosis for ERC services should be the condition identified as the main reason for requiring ERC specific services or care. Example: A resident receiving ERC will have	Y	

Data Elements	Required Data Point	Supporting Documentation (if required)
a respiratory-related illness or an illness that compromises respiratory function. One of the following options will be chosen from the drop-down list: • Chronic Obstructive Pulmonary Disease (COPD) – J44.9 • Chronic Respiratory Failure (CRF) – J96.10 • Acute Chronic Respiratory Failure (ACRF) – J96.20 • Hypoxemia – J96.00 • Pneumonia – J18.9 • Other - Specify		
Secondary Diagnosis (Diagnosis in addition to Primary) Secondary Diagnosis reflects an additional illness that contributes to but does not necessarily cause the need for ERC services. One of the following options will be chosen from the drop-down list: • Chronic Obstructive Pulmonary Disease (COPD) – J44.9 • Chronic Respiratory Failure (CRF) – J96.10 • Acute Chronic Respiratory Failure (ACRF) – J96.20 • Cerebrovascular Accident (CVA) – I67.9 • Trauma • Other - Specify	Y	
Admitted to the ERC Program (Y/N) **Reason Not Admitted** If "N" is selected, one of the following reasons must be chosen: • Dialysis • No available beds • PASRR • Can't meet medical needs • Resident deceased prior to admission • Resident chose another NF • Insurance	Y	
ERC Admission Date (if admitted) This is the date the resident was admitted to ERC services at the facility, not the referral date. **Hospitalization and Discharge**: If a resident is discharged to the hospital for 30 days or less, they should be reinstated with the original admission date. For stays over 30 days, a new admission date and referral are required.	Y	The resident's original permanent medical record must have documentation of admission date to ERC services.
State of Residence at the Time of Admission	Y	

Data Elements	Required Data Point	Supporting Documentation (if required)
Pursuant to TennCare Rule 1200-13-01-.03(5)(i): Eligibility for access to ERC services by individuals from out of state is governed by 42 CFR 453.403. A NF shall not recruit individuals from other states to receive ERC in Tennessee. A NF shall not be eligible to receive TennCare reimbursement for ERC services for a resident placed by another state or any agency acting on behalf of another state in making the placement because such services are not available in the individual's current state of residence, including residences admitted to NF/SNF under the Medicare Skilled Nursing Facility care benefit when such benefit has been exhausted. The NF shall be responsible for arranging, before the resident's admission to the facility, Medicaid reimbursement for ERC services from the Medicaid Agency of the state which placed the resident and which will commence when other payment sources (e.g., Medicare, private pay, but not TennCare) has been exhausted.		
Acute Care Days Prior to NF Admission (if admitted) Number of days the resident was in acute care before the referral was received.	Y	

Non-Weaning Exclusion (Y/N)
 	
This includes:
• Residents who have a diagnosis of a progressive neuromuscular disease which makes weaning from mechanical ventilation detrimental to the residents' survival. This will include:
  ○ Amyotrophic lateral sclerosis (ALS)
  ○ Duchenne muscular dystrophy (DMD)
  ○ Other progressive neuromuscular disease (must be specified in medical record)
• Residents who have an irreversible neurological injury, disease, or dysfunction, which impacts diaphragmatic function, such as high spinal cord injuries and brain stem infarctions.
• Residents who have end stage renal disease and are undergoing dialysis.
• Residents who are undergoing hospice care or end of life care as a result of resident or family choice.
	Y	The resident's original permanent medical record must have documentation as per definitions of:
		• ALS
		• DMD
		• Other progressive neuromuscular disease
		• Irreversible neurological injury, disease or dysfunction, which impacts diaphragmatic function, such as high spinal cord injuries and brain stem infarctions.
		• ESRD/dialysis

Data Elements	Required Data Point	Supporting Documentation (if required)
• Residents who are receiving respite care (short-term to provide respite for the caregivers, where short-term is up to 3 months). • TennCare Approved In addition to meeting the qualifying criteria, a resident's non-weaning exclusion status must be discussed with the resident or their family, and both the attending physician and pulmonologist must document their agreement in the medical record within 3 days of admission. A corresponding physician's order confirming the resident's non-weaning exclusion status must also be entered into the medical record on the same day. A non-wean status may be assigned later if the resident receives a new diagnosis for one of the qualifying conditions. Note that advanced directive "Code status" is not a factor in determining the non-weaning care plan. If an ERC facility accepts transfers from another ERC facility due to licensure, certification, or quality concerns, chronic, non-weanable cases will not be counted against the receiving when determining quality scores. These would be reported as **non-wean exclusion admissions with special circumstances**. The details of the circumstance should be documented in the comment section of the PERLSS system. However, each admission must still be evaluated for weaning potential, with the goal of achieving improved outcomes.		• End of life hospice care • Respite care The resident's original permanent medical record must have documentation of resident status discussion with resident or family: • Documentation of resident status discussion at admission • Agreed to by attending physician and consulting pulmonologist. • Corresponding order for non-weaning care

Data Elements: *Assessments*

Data Elements	Required Data Point	Supporting Documentation (if required)
Resident Status Resident status as of the last day of the reporting period, or if admitted mid-month, on their ERC admission date. "Invasive" ventilation indicates use of a tracheostomy, while "non-invasive" refers to ventilation by mouthpiece or mask. Refer to TennCare Rule §1200-13-01-.10(5)(c) for reimbursement specifics on non-invasive ventilation.	Y	The resident's original permanent medical record must have documentation of resident status as of • Beginning of the reporting month; or

Data Elements	Required Data Point	Supporting Documentation (if required)
One of the following options must be chosen from the drop-down list: • Invasive Ventilator – Chronic Vent • Invasive Ventilator – Weaning Vent • Non-Invasive Ventilator (less than 12 hours per day) • Chronic Non-Invasive Ventilator (12 or more hours per day due to progressive neuromuscular disorder, spinal cord injury, or chronic respiratory failure) • Sub-Acute Tracheal Suctioning • Secretion Management Tracheal Suctioning **Note:** Non-Invasive ventilation which does not meet the requirements of the Rules of TennCare 1200-13-01-.10(5)(c), **Non-Invasive less than 12 hrs**, is not eligible for enhanced ERC reimbursement.		• If admitted after the beginning of the month, status as of admission to ERC services; and • Ventilator dependence for at least 12 hours each day verified by daily notes and/or flow sheet/log; and • TennCare authorization for chronic ventilator reimbursement if applicable
Chronic Ventilator Care Days The number of days in the reporting month that the resident received chronic ventilator care (Code 94004 for CHOICES residents). If this segment is left blank, it will be interpreted as zero chronic ventilator care days during the reporting month. If the resident had chronic ventilator care days during the reporting month, please ensure to record the start and end date of the care segment(s). **Validation:** The combined total of Ventilator, Weaning, Sub-Acute, Secretion Management, Hospital Care Days, and Non-Invasive Vent (Less than 12 Hours) Care Days should equal the total number of days in the reporting month. **For new admissions**, this total must reflect the number of days from the admission date to the end of that month.	N	The resident's original permanent medical record must have documentation of daily ventilator use notes and/or flow sheet/log as well as the TennCare or MCO authorization for chronic ventilator reimbursement, if applicable.
Ventilator Weaning Care Days The total number of days in the reporting month that the resident received ventilator weaning care (Code 94004 SC for CHOICES residents). This count may include days during the weaning process when the resident was periodically off the ventilator for spontaneous breathing trials but had not yet successfully weaned. If this segment is left blank, it will be interpreted as zero ventilator weaning care days during the	N	Medical record must have documentation of daily weaning notes and/or flow sheet/log as well as the TennCare or MCO authorization for ventilator weaning reimbursement, if applicable

Data Elements	Required Data Point	Supporting Documentation (if required)
reporting month. If the resident had ventilator weaning care days during the reporting month, please ensure to record the start and end date of the care segment(s). **Note:** If a resident successfully weans, the seven consecutive days after the last day on mechanical ventilation should be reported as vent weaning care days. **Validation:** The combined total of Ventilator, Weaning, Sub-Acute, Secretion Management, Hospital Care Days, and Non-Invasive Vent (Less than 12 Hours) Care Days should equal the total number of days in the reporting month. **For new admissions**, this total must reflect the number of days from the admission date to the end of that month.		
Ventilator Weaning Outcome Indicate whether the resident was off the ventilator for at least seven consecutive days during the reporting month, and if the wean was successful. If the resident was never on the ventilator, select "No." Choose either "Yes" or "No" from the drop-down menu. If a resident successfully weans, the seven (7) consecutive days after the last day on the mechanical ventilation should be reported as *Ventilator Weaning care days.* **Note:** A terminal wean occurs when an individual is taken off the ventilator with the expected outcome being death (either immediately or soon after) without life support. This should not be counted as a successful wean. Please ensure terminal weans are marked as "yes" for non-weaning exclusion. **Validation:** Successful weans must occur within the current reporting period.	Y (if weaning care days recorded)	The resident's original permanent medical record must have documentation of actual wean end date. Daily weaning notes and/or flow sheet/log for 7 consecutive days after the last date on mechanical ventilation.
Sub-Acute Tracheal Suctioning Care Days The total number of days in the reporting month that the resident received sub-acute tracheal suctioning care (Code 31899 for CHOICES residents). If this segment is left blank, it will be interpreted as zero sub-acute tracheal suctioning care days during the reporting month. If the resident had sub-acute tracheal suctioning care days during the reporting	N	The resident's original permanent medical record must have documentation of daily tracheal suctioning notes and/or flow sheet/log as well as the TennCare or MCO authorization for sub-

Data Elements	Required Data Point	Supporting Documentation (if required)
month, please ensure to record the start and end date of the care segment(s). **Note:** If a resident successfully decannulates, the three consecutive days after the removal of the artificial airway should be reported as Sub-Acute Tracheal Suctioning care days. **Validation:** The combined total of Ventilator, Weaning, Sub-Acute, Secretion Management, Hospital Care Days, and Non-Invasive Vent (Less than 12 Hours) Care Days should equal the total number of days in the reporting month. **For new admissions**, this total must reflect the number of days from the admission date to the end of that month.		acute tracheal suctioning reimbursement, if applicable.
Tracheostomy Weaning Outcome Indicate whether the resident's artificial airway successfully removed in the reporting month and if the resident remained stable for three (3) consecutive days without the need for re-insertion. If a resident successfully decannulates, the three consecutive days after the removal of the artificial airway should be reported as *Sub-Acute Tracheal Suctioning care days.* **Note:** If the decannulation date is before or on the weaning date, then the information should be verified with facility. Incidents validated by facility should be compiled and submitted to ERC.LTSS@tn.gov for review. Incidents may be forwarded to MCO ERC contractors if necessary. **Validation**: Successful decannulations must occur within the current reporting period.	Y (if sub-acute tracheal suctioning care days recorded)	The resident's original permanent medical record must have documentation that the resident remained stable for 3 consecutive days following date of decannulation. Daily weaning notes and/or flow sheet/log for the three consecutive days after the removal of the artificial airway.
Secretion Management Tracheal Suctioning Care Days The total number of days in the reporting month that the resident received secretion management care (Code 31899 SC for CHOICES residents). If this segment is left blank, it will be interpreted as zero secretion management tracheal suctioning care days. If the resident had secretion management tracheal suctioning care days during the reporting month, please ensure to record the start and end date of the care segment(s).	N	The resident's original permanent medical record must have documentation of daily tracheal suctioning notes and/or flow sheet/log as well as the TennCare or MCO authorization for secretion management

Data Elements	Required Data Point	Supporting Documentation (if required)
Validation: The combined total of Ventilator, Weaning, Sub-Acute, Secretion Management, Hospital Care Days, and Non-Invasive Vent (Less than 12 Hours) Care Days should equal the total number of days in the reporting month. **For new admissions**, this total must reflect the number of days from the admission date to the end of that month.		tracheal suctioning reimbursement, if applicable.
Hospital Care Days The total number of days in the reporting month the resident received care in a hospital, planned or unplanned. If the resident had any hospital care days during the reporting month, please ensure to record the start and end date of the care segment(s). **Unplanned Hospitalizations:** includes any unexpected trips to the emergency room (ER) or admission to the hospital that were not scheduled in advance. This definition excludes any non-emergency appointments or scheduled procedures. If a resident is admitted to the hospital after a planned appointment or procedure—without arranging for it ahead of time – that counts as an unplanned hospitalization too. **Validation:** The combined total of Ventilator, Weaning, Sub-Acute, Secretion Management, Hospital Care Days, and Non-Invasive Vent (Less than 12 Hours) Care Days should equal the total number of days in the reporting month. **For new admissions**, this total must reflect the number of days from the admission date to the end of that month.	N	The resident's original permanent medical record must have documentation of the number of days in the hospital within the reporting month including emergency department and observation stays.
Non-Invasive Ventilator (Less than 12 Hours) Care Days The total number of days in the reporting month the resident received non-invasive ventilator care for less than 12 hours a day. If the resident had non-invasive ventilator (less than 12 hrs) care days during the reporting month, please ensure to record the start and end date of the care segment(s). **Validation:** The combined total of Ventilator, Weaning, Sub-Acute, Secretion Management, Hospital Care Days, and Non-Invasive Vent (Less than 12 Hours) Care Days should equal the total number of days in the reporting month. **For new**	N	The resident's original permanent medical record must have documentation of the number of days in the hospital within the reporting month.

Data Elements	Required Data Point	Supporting Documentation (if required)
admissions, this total must reflect the number of days from the admission date to the end of that month.		
Alarm Paging/Beeper System Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.	N	The facility must demonstrate, upon request, working alarm paging/beeper systems
Cough Assist Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.	N	The resident's original permanent medical record must have documentation of actual use of a cough assist device within the reporting month.
Heated Wire Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.	N	The resident's original permanent medical record must have documentation of actual use of a heated wire device within the reporting month.
High Flow Molecular Humidification Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.	N	The resident's original permanent medical record must have documentation of actual use of a high flow molecular humidification device within the reporting month.
High Frequency Chest Wall Oscillation (HFCWO) or Intrapulmonary Ventilation (IPV) Indicate whether the specific technology was utilized for the resident during the reporting period.	N	The resident's original permanent medical record must have documentation of actual use of a high

Data Elements	Required Data Point	Supporting Documentation (if required)
Validation: This technology must be identified as available for use at the facility during the registration process.		frequency chest wall oscillation or IPV device within the reporting month.
Incentive Spirometer or any PEP Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.	N	The resident's original permanent medical record must have documentation of actual use of an incentive spirometer or any PEP device within the reporting month.
Mobile Monitoring Device Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.	N	The resident's original permanent medical record must have documentation of actual use of a mobile monitoring device within the reporting month
Non-Invasive Ventilation Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.	N	The resident's original permanent medical record must have documentation of actual use of non-invasive ventilation within the reporting month
Non-Invasive Open Ventilation Indicate whether the specific technology was utilized for the resident during the reporting period. **Validation:** This technology must be identified as available for use at the facility during the registration process.		
Number of New Respiratory Infections	Y	The resident's original permanent medical

Data Elements	Required Data Point	Supporting Documentation (if required)
Number of new respiratory infections or incidents of pneumonia. This metric specifically tracks respiratory infections that are acquired or exacerbated more than 4 calendar days after entering the facility, not those acquired during hospitalization or prior to admission. Respiratory Infections are to be reported for each new organism and without regard to treatment.		record must have documentation of each respiratory infection and include lab results, chest x-ray results, and MD orders within the reporting month. The resident's original permanent medical record must have documentation of actual treatment provided (if applicable) for each respiratory infection and/or incident of pneumonia within the reporting month.
Sentinel Event These are significant and often reportable events, including unexpected deaths, serious injuries, situations where the resident required emergency respiratory interventions by staff or EMS to sustain life, as well as deaths within 72 hours of hospitalization. Either "yes" or "no" will be chosen from a drop-down list to respond to this item. If "yes," is chosen, the date and type of sentinel event are required. **Type of Sentinel Event:** • Death (Required Emergency Intervention) • Death within 72 hours of hospitalization • Other – Specify **Validation:** The date must fall within the reporting month. If a sentinel event occurred before or on the wean or decannulation date, verify with the facility. Validated incidents should be submitted to TennCare (ERC.LTSS@tn.gov) for review and may be forwarded to the MCO ERC contractor(s) as needed. Please be sure to transmit PHI/PII data via a secure, encrypted channel.	Y	The resident's original permanent medical record must have documentation of the date and type of sentinel event within the reporting month
ERC Discharge Date		The resident's original permanent medical

Data Elements	Required Data Point	Supporting Documentation (if required)
Indicate the date the resident stopped receiving ERC services during the reporting month (i.e., the date the resident is no longer billed at the ERC rate, regardless of the reason). If a discharge date is provided, include the discharge disposition as well. **Discharge Dispositions:** • 01 – Discharged to Home • 02 – Discharged to Hospital – not planning to return • 03 - Discharged/Transferred to SNF • 04 – Discharged/Transferred to ICF • 07 – Left against medical advice or discontinued care • 20 - Expired • 30 – Still Patient • 63 – Discharged/Transferred to LTACH • 70 – Discharged/Transferred to another setting not defined above **Hospitalization and Discharge**: If a resident is discharged to the hospital for thirty (30) days or less they should not be issued a new admission date. The previous admission date should continue to be used unless a resident is discharged to the hospital for more than thirty days.		record must have documentation of the actual date of discharge from ERC services within the reporting month