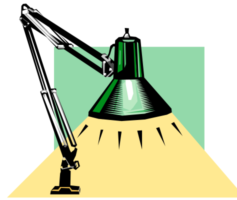
RAI Spotlight



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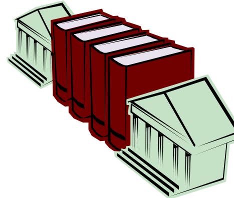
Act 52 — Reporting Health Care-associated Infections



On September 20, 2008, the Patient Safety Authority (PSA) and the Department of Health (DOH) issued a Pennsylvania Bulletin on Reporting Requirements for Nursing Homes under Chapter 4 of the MCARE Act. The purpose of this notice was to give long-term care nursing facilities final notice of their reporting requirements relating to Health Care-associated Infections (HAI) as mandated by Act 52 of 2007. The bulletin may be reviewed at www.pabulletin.com/secure/data/vol38/38-38/1740.html .

Act 52 requires that nursing homes electronically report patient-specific HAIs to both the PSA and the DOH. This will be done through a single web-based interface: the Pennsylvania Patient Safety Reporting System (PA-PSRS), beginning during the second quarter of 2009.

The following list contains the reportable HAIs:

1. Symptomatic Urinary Tract Infection
   1.1 Indwelling urinary catheter related
   1.2 Non-urinary catheter related
2. Respiratory Tract Infection
   2.1 Lower Respiratory Tract Infection (pneumonia/bronchitis/tracheobronchitis)
   2.2 Influenza-like illness
3. Skin and Soft Tissue Infection
   3.1 Cellulitis
   3.2 Burns
   3.3 Vascular and diabetic ulcer (chronic/non-healing)
   3.4 Device-associated soft tissue/wound infection
      3.4.1 Tracheostomy site
      3.4.2 Peripheral/Central IV catheter site
      3.4.3 G-tube site

(Continued on page 3)

Questions about the RAI?

Please submit them to

qa-mds@state.pa.us

Inside this issue:

Section H Continence Q & A	*2*
The MDS and Act 52	*2*
MDS 3.0	*2*
Significant Change Assessment Required?	*3*
New RUG System?	*4*
CE Hours for Teleconference Participation	*4*

Section K Oral/Nutritional Status Teleconference

Date: July 9, 2009
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: Section K Oral/Nutritional Status
Handouts: Power Point slides will be available about July 1 on the DOH Message Board at
http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp
Call in number: 1-888-694-4728 or 1-973-582-2745
Conference ID Number: 99252394

Company Name: Myers and Stauffer
Moderator: Cathy Petko
A recording of this conference will be available; directions for accessing this will be posted on the DOH Message Board.

Additional questions: qa-mds@state.pa.us

Section H Continence Q & A

On April 9, 2009, a training teleconference was provided on Section H Continence. The following questions were received:

Q. How often should a Foley catheter be changed?

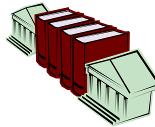
A. *There does not seem to be any definitive standard for this procedure. The State Operations Manual (SOM) Guidance to Surveyors for F315 Urinary Incontinence states "In the absence of evidence indicating blockage, catheters need not be changed routinely as long as monitoring is adequate. Based on the resident's individualized assessment, the catheter may need to be changed more or less often than every 30 days." Clinical indicators for change might include blockage, deterioration of the catheter, formation of crystal deposits ("grit") inside the catheter, etc. Obtain guidance from your resident's attending physician or urologist for frequency of change.*

Q. Must there be an annual urology consult for a resident with a Foley catheter?

A. *There is no regulatory requirement for this type of assessment. The resident's attending physician may consider this necessary and order the consultation.*

Q. Would one day of mental status change be sufficient for a UTI symptom?

A. *Many conditions may lead to a mental status change in the frail nursing home population. The SOM Guidance to Surveyors for F315 Urinary Incontinence states "In someone with nonspecific symptoms such as a change in function or mental status, bacteriuria alone does not necessarily warrant antibiotic treatment." There should be other indicators to identify a UTI. See the article below on The MDS and Act 52 for the differences between a research-based definition of "symptomatic UTI" that should be reported, and the requirements for coding a UTI at I2j on the MDS.*

The MDS and Act 52 

The MDS is a **federally mandated** document that is completed in all states according to the instructions found in the RAI Manual. For example, the standards that must be met to code I2j UTI on the MDS are detailed on pages 3-136 and 3-137 of the manual.

- Includes chronic and acute symptomatic infections in the last 30 days
- Must have significant laboratory findings as determined by the attending physician
- Physician diagnosis
- Current supporting documentation

MDS coding standards are unchanged by Act 52 requirements. Act 52 is a **Pennsylvania specific** regulation requiring reporting of a health care-associated infection (HAI) under certain carefully defined conditions. For example, to report a Symptomatic Urinary Tract Infection in a resident without a catheter, the following standard must be met:

- All signs and symptoms of an infection must be acute, new or rapidly worsening
- The resident must be experiencing THREE or more of the following:
    - Fever and/or chills
    - New burning pain on urinating (dysuria), frequency or urgency
    - Flank or suprapubic pain or tenderness (self described or identified upon examination)
    - Gross hematuria or change in character of urine
    - Change in mental and/or functional (including incontinence) status from daily baseline
- Any laboratory work obtained (not required) must support the presence of infection.

The MDS and Act 52 have very different requirements. Don't get the two confused!

MDS 3.0

CMS has released another draft version of the MDS 3.0 at www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30DraftItemSetv26.pdf

There are several differences from the prior draft, including a return to the MDS 2.0 ADL format at G1 with an addition of code 7: Activity occurred only once or twice. The final version of the form, along with the manual and data specifications, is expected to be released in October, 2009.

Significant Change Assessment Required?

Deciding whether or not a Significant Change in Status assessment (SCSA) should be done is often challenging. According to the federal regulation under F274 (42 CFR §483.20(b)(2)(ii), a "significant change" means "a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both."

Several pages of guidance are provided in the RAI Manual, (2-7 to 2-13) in an attempt to provide assistance in the decision making process. On page 2-8, it states "An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement." However, there is the additional statement that "If there is only one change, however, staff may still decide that the resident would benefit from a SCSA."

If surveyors identify situations where they feel a SCSA should have been done but it was not, a citation may be issued under F274 Significant Change Assessments with possible assessment of civil monetary penalties (CMPs) or other penalties. The facility has the right to appeal such a citation, with the final decision resting with the Appellate Law Judge (ALJ) and the Appellate Review Panel.

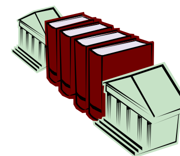
In a case reported in the American Association of Nurse Assessment Coordinators NAC News (www.aanac.org 3/31/09 Miles and Manteuffel), the NF received a citation for not initiating a MDS reassessment after a resident developed pressure ulcers. Though the resident did not have a history of pressure ulcers, she had several risk factors. The facility argued that there was only one area of decline that solely impacted skin integrity and not nutritional status in the absence of any substantial weight loss or gain.

The ALJ and the Appellate Review Panel disagreed for the following reasons, and upheld the citation and penalties:

- They interpreted the first element in the regulation to require only a single change "which can be either a major decline or a major improvement in the resident's status." The development of pressure ulcers where none existed before was a major decline and satisfied that element.
- They found that this major decline did affect two or more areas: the severity of Stage III/IV pressure ulcers can be expected to affect nutritional needs, potential for pain, sleep, emotional well-being and cause likely adjustments to other treatments.
- Development and worsening of a pressure ulcer was "indisputably serious" so as to require the IDT to identify contributing factors and develop interventions.
- Possible significant changes are not limited to the examples provided in various documents. Such examples are "not an exclusive list of the significant changes in a resident's condition to which the facility must respond by conducting a comprehensive assessment with within 14 days."

This decision will be relied on by CMS and state survey agencies in evaluating whether MDS assessments were properly completed. Evaluate very carefully whether your resident's change in condition should trigger a SCSA in the light of this decision.

Act 52—Reporting Health Care-associated Infections



(Continued from page 1)

3.4.4 Supra pubic catheter site
3.4.5 In-dwelling drain
3.4.6 In-dwelling vascular catheters (dialysis)
3.5 Decubitus Ulcer (pressure related)
4. Gastrointestinal Tract Infection
5. Other infections
5.1 Intra-abdominal infection (peritonitis/deep abscess)
5.2 Meningitis
5.3 Viral Hepatitis
5.4 Osteomyelitis
5.5 Primary Bloodstream Infection

The PA Bulletin also contains specific information in *Exhibit B. Criteria for Defining HAIs in Long-term Care* as to what symptoms must be present to make the infection reportable. Read it carefully to understand the standards of this reporting program. If you need assistance, call the DOH HAI Prevention staff at 717-425-5422.

New SNF PPS RUG System?

As CMS moves to implement a new MDS assessment on October 1, 2010, many correlating pieces must be put into place. For the Medicare Prospective Payment System (MC PPS), the link between the assessment document and payment that measures the resident's acuity must be developed. The Staff Time and Resource Intensity Verification (STRIVE) project began in 2005 to study the time required and the staff skill levels needed to care for residents with varying conditions. This represented the first nationwide time study for nursing facilities in the U.S. since 1997.

The final results have not been published, but the latest information was presented to the Technical Expert Panel (TEP) on March 11, 2009 (https://www.qtso.com/download/strive/STRIVE_TEP_2009_Mar_11_Final_For_Posting.pdf) . Some of the early study results are leading to several possible changes in the RUG system used for classification:

- Reconsideration of the way concurrent therapy is recorded
- Evaluation of the use of pre-admission treatments in the classification system
- New ways to calculate the RUG ADL Score
- Changes in the hierarchical groups, e.g., Cognitive Impairment and Behavioral Problems are now one group
- Shifting of items between classification groups
- Splitting the Special Care group into SC High and SC Low

These changes are so significant that a new version of the classification system, RUG-IV, is being proposed. This would be implemented with MDS 3.0 on October 1, 2010 for MC PPS. You can review a comparison of RUG-III 53 group and RUG-IV 66 group at www.cms.hhs.gov/SNFPPS/02_Spotlight.asp#TopOfPage. Scroll down to RUGs III version 4 Comparison. Alternately, you may find it at the end (beginning on page 22302) of the Medicare PPS Proposed Rule posted in the Federal Register at http://edocket.access.gpo.gov/2009/pdf/E9-10461.pdf

There is both excitement and concern about how these changes will affect nursing facilities and the residents for whom they care. There may be adjustments to both the MDS 3.0 and the classification system before the final regulations are passed; what is published now may not be what is finally required. Implementation will not take place until October 1, 2010.

Continuing Education Hours for Teleconference Participation

Questions have been asked regarding whether the Department of Health will be providing Continuing Education hours for teleconference presentations. The Department of Health is unable to verify facility staff attendance for these presentations and cannot issue certificates of attendance.

Facilities may accept responsibility for Continuing Education hours for the Division of Nursing Care Facilities, Department of Health-sponsored teleconference presentations. The facility acts as the provider and is responsible for issuing the certificate of attendance and verifying staff attendance.

Per Commonwealth of Pennsylvania, Title 49. Professional and Vocational Standards, §21.134 Continuing education sources, a Certificate of Attendance must contain the following items:

- Name of the individual to whom the certificate is awarded
- Full name and address of the Provider
- Title of the activity
- Date and Location of activity
- Hours of Continuing Education

It should also include the name of the state agency as the sponsor of the program. The following is an example of the certificate that might be created:

Certificate of Attendance
Jane Doe
XYZ Nursing Home
123 Maple Ave
Anytown, PA 12345
MDS Section H Continence
April 9, 2009 Teleconference Presentation
XYZ Nursing Home
1 Continuing Education Hour
1:30 to 2:30 pm EDT
Sponsored by the Division of Nursing Care Facilities,
Pennsylvania Department of Health

Any questions regarding the facility accepting this responsibility can be directed to the Department of State, Bureau of Professional & Occupational Affairs, State Board of Nursing.