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Electronic Staffing Data Submission Payroll-Based Journal

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Over time, CMS has utilized staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes. Section 6106 of the Affordable Care Act requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information, can then be used to not only report on the level of staff in each nursing home, but also to report on employee turnover and tenure, which can impact the quality of care delivered.

Therefore, CMS has developed a system for facilities to submit staffing and census information - Payroll-Based Journal (PBJ). This system will allow staffing information to be collected on a regular and more frequent basis than currently collected. It will also be auditable to ensure accuracy. This article provides an overview of how and when CMS will implement the PBJ.

CMS intends to collect staffing and census data through the PBJ system on a voluntary basis, which began on October 1, 2015, and on a mandatory basis beginning on July 1, 2016. Registration for voluntary submission began in August 2015. Training will also be provided on registration for both

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voluntary and mandatory submissions. For more information on how to register as well as the draft policy on PBJ one may access **URL:** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

Submission Timeliness and Accuracy -

Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. The deadline for submissions must be received by the end of the 45th calendar day after the last day in each fiscal quarter in order to be considered timely.

Registration -

Submission of staffing information through PBJ will be accessed through the Quality Improvement & Evaluation System (QIES). To connect to PBJ through QIES one must have a CMSnet user ID. Most long term care facilities will already have connectivity to QIES and CMSNet because they submit minimum data set (MDS) or other CMS data. For more information on registration one may visit the following website URLs:

* https://www.qtso.com/cmsnet.html

* https://www.qtso.com/accessmds.html

* https://www.qtso.com/webex/qiesclasses.php

Methods of Submission -

The PBJ system has been designed to provide two primary submission methods - 1) manual data entry, and 2) uploaded data from an automated payroll or time and attendance system (XML format only). In addition, users can use either methods or combinations of these methods for submitting data as needed or desired.

"Have you registered for manual submission even if your submitting electronically?"

1) Entering information manually will require an individual(s) at a facility to key in information about employees, hours worked, and census information directly into the PBJ User Interface. The system has been designed to be user-friendly and intuitively guide users to successfully complete the process.

2) Uploading data directly from an automated payroll or time and attendance system will function very similarly to how MDS data are submitted currently. The data will be required

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to meet very specific technical specifications in order to be successfully submitted. These requirements can be found at URL: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html
Additionally, technical questions from vendors or software developers related to the PBJ Data Submission Specifications should be sent to: URL: NursingHomePBJTechIssues@cms.hhs.gov

3) The updated Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual (version 2.1 April 2016) may be viewed at
URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/PBJ-Policy-Manual-Final-V21.pdf

4) On June 7, 2016 CMS posted templates in Excel format for data entry and may be viewed at
URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

5) This website also posted PPJ 2.0 Submission Specs 2.00 for the June 26, 2016 release.

On June 10, 2016 CMS posted a presentation in PDF format, which summarizes the PBJ processes and may be viewed at
URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/PBJ-Summary-Presentation.pdf

If you have any questions please feel free to contact Nathan Shaw at nathan@rbhealthpartners.com or Robin Bleier at robin@rbhealthpartners.com or call 727.786.3032.

MDS & Staffing Compliance Survey

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How prepared is your center?

In 2104, the CMS piloted a short-term focused survey to assess the coding practices of the Minimum Data Set (MDS) and the usage of the information from the Resident Assessment Instrument (RAI) which includes the MDS, the Care Area Process (Care Area Triggers [CATs], Care Area Assessments [CAAs], and the CAA Summary Sheet), as well as the Utilization Guidelines and their relationship to person centered care. In review I found it interesting that in the 2014 Pilot results from the volunteer facilities an indication for improvement in MDS accuracy coding and in the medical record management noting opportunities related to the severity of injury associated with falls, pressure ulcer status, restraint use, and late loss activities of daily living status.

In 2015, the expansion of the CMS MDS & Staffing Compliance Surveyors was announced by CMS as a nationwide initiative and by the close of September 30, 2015, Florida had completed 16 of these surveys. If you have not read the article that Lee Ann Griffin, FHCA Staff, wrote you may very well want to. In her article she references certain unique aspects of this survey process noting that there is no opportunity to correct, that there are per instance fines, and for those SNFs cited for F 356 (staffing) CMS is imposing directed plans of correction. In the February 13, 2015 S & C: 15-25-NH Memorandum based on the results of the pilot study, CMS revised the processes and structure. The goal of this change was to enhance the overall effectiveness of the process.

In Florida we have completed a reported 16 CMS MDS & Staffing Compliance Surveys ending fiscal year September 30, 2015. Citations occurred in all but one of the 16 facilities surveyed. They included:

- Thirteen instances Accuracy of Assessment F-278
- Twelve instances of Nurse Staffing Information (includes CNAs, LPNs, & RNs) F 356 *
- One instance of Accident Hazards F - 323
- Two instances of Access to telephone with privacy F - 174
- Two instances of Development of Comprehensive Care Plan F - 279

Isolation beyond standard precautions.

- Three instances of Care Plan Development F - 280
- One instance of Qualifications of Facility Staff F - 282
- One instance of Pressure Ulcers F-314
- Two instances of Urinary Incontinence F-315
- Four instances of Unnecessary Drugs F - 329
- One instance of Infection Control Program F - 441
- Two instances of *Maintaining/Content of clinical Records F-514*

To Isolate or Not Isolate. That is the Question

Prepared by:
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The CDC recommends using standard precautions for the care of all patients regardless of the presence of illness or infection status. Standard precautions go beyond protecting health care workers from exposure to blood borne pathogens and includes attention to body substances that may contain potentially infectious microorganisms and applies to: blood; all body fluids, secretions and excretions except sweat regardless of whether or not they contain visible blood; non-intact skin; and mucous membranes.

In addition to standard precautions, it is prudent for life care centers and other health care facilities to implement transmission-based precautions. Transmission-based precautions are additional prevention measures that need to be implemented when a resident is suspected of or has colonization/infection due to a highly infectious or epidemiologically significant organism in order to interrupt transmission to others. The three types of transmission-based precautions are contact, droplet, and airborne isolation. Contact isolation includes the use of gowns and gloves when in the immediate patient care environment. Droplet precautions requires the use of a mask when within three-six feet of the patient. Airborne isolation requires the use of an N95 mask in addition to the patient being placed in a negative pressure room. At times, more than one type of isolation may be necessary in order to interrupt transmission of infection. For example, some respiratory illnesses, such as those due to multi-drug resistant organism or adenovirus, require both contact and droplet precautions. Disseminated shingles or someone who is immunocompromised with shingles is another example that requires two types of isolation, airborne and contact.

Isolation precautions can be challenging in the long-term care environment, especially when it comes to determining when isolation precautions can be discontinued.

The Healthcare Infection Control Practices Advisory Committee (HICPAC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings is the "go-to" resource for recommendations on the type and duration of isolation required for infections, however there are times when the guidelines do call for evaluation of the patient and environment in order to make a decision on discontinuing isolation. This scenario is often encountered when a resident has an infection due to a multi-drug resistant organism (MDRO) such as MRSA, ESBL, or MDR-Pseudomonas. To determine when to discontinue isolation precautions consider the following:

- Is the resident symptomatic? Has the resident been treated for their infection?
    - Does the resident have any draining wounds or uncontained body fluids?
- Are there currently other residents with this type of infection making it more challenging to prevent transmission to others?
- Does the resident have the ability to maintain good hand hygiene or can staff ensure that the resident performs hand hygiene prior to leaving their room?

Residents who are colonized or have an infection due to an MDRO, must be asymptomatic, have all body fluids contained, and be able to demonstrate hand hygiene performed in order to discontinue isolation. Always remember to ensure facility policy reflects your practice!

ICD-10-CM Coding Corner - Focus on Sequencing

Prepared by:
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Sequencing of diagnoses has always been an important part of the coding and billing process. With the end of the one-year grace period on ICD-10 coding accuracy fast approaching, it is imperative that centers have appropriately identified and sequenced residents' active diagnoses. Per the CMS Billing Manual, the Medicare billing

system does not currently review any additional diagnoses after the first eight. Thus, it is imperative to sequence the most pertinent additional diagnoses that impact care in the top eight.

Selection of a primary, or principle, diagnosis is key to overall accuracy of code sequencing. The principle diagnosis is the main reason why a resident is being admitted to a center for care. When selecting the principle diagnosis assess which condition the has required the majority of care. If resident is admitting after a hospitalization for skilled service, this diagnosis should be a condition treated during hospitalization.

Additional diagnoses are added to support the principle diagnosis and care needs. These are conditions present on admission or during stay that may impact the residents care or length of stay. Supporting diagnoses should always include those being treated by therapy.

OUR MISSION

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RB Health Partners' mission is to remain a nationally recognized consultancy firm dedicated to the creation of committed partnerships using a client-focused approach. We achieve this by recognizing client-driven goals and the provision of identification, analysis, planning, and a validation service model which emphasizes that client success is our success!

Learn more on our website

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