MINNESOTA HOME CARE ASSOCIATION
The Voice of Home Care

Mission: *MHCA represents and supports Minnesota home care providers committed to high quality home care service*
Vision: *MHCA will shape the home care landscape to improve and sustain quality care services*

REGION MEETING EDUCATION & REGULATORY UPDATE

Recorded September 13, 2017

Education Topic

TB Prevention and Reporting Requirements: Are You Ready for Survey?

Presented by:

BETH KINGDON, Planner Principal, STD/HIV/TB Section, Infectious Disease Epidemiology, Prevention, and Control Division, Minnesota Department of Health, St. Paul, MN

Followed by

Regulatory Updates

Presented by: Kathy Messerli, Executive Director, Minnesota HomeCare Association

To start the recording, click on the link below:

https://attendee.gotowebinar.com/recording/1353378252876722947

Handouts:

- The power point (PPT) handouts are attached and contain:
  1. TB PPT
  2. MHCA Regulatory Updates PPT
  3. Senior Linkage Line PPT
- **Additional handouts:** You may click here to view/download the TB Regulations Manual

Please Note: Recordings are not eligible for continuing education credits.

DEPARTMENT OF HEALTH

TB requirements in Minnesota home care agencies

Beth Kingdon, MPH | Planner Principal

September 13, 2017

Learning objectives

- Describe three differences between latent TB infection (LTBI) and active TB disease
- List the documentation requirements for TB skin tests and TB blood tests
- Describe the documentation requirements for a HCW with a positive TB skin test or blood test

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Abbreviations

- HC = health care
- HCW = health care worker
- IC = infection control
- IGRA = Interferon Gamma Release Assay ("TB blood test")
- LTBI = latent TB infection
- MDH = Minnesota Department of Health
- TB = tuberculosis
- TST = tuberculin skin test (AKA "Mantoux" or "PPD")

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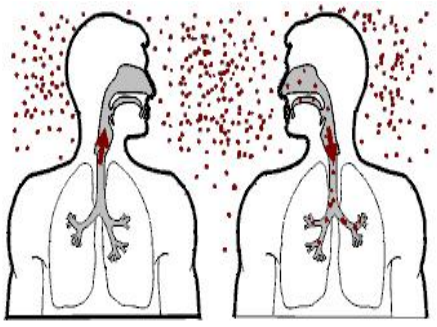
Transmission and pathogenesis

- Serious, sometimes fatal, infectious disease caused by a bacteria (*Mycobacterium tuberculosis*)
- Spread in the air by:
  - Talking
  - Coughing
  - Sneezing
  - Singing
- Two phases:
  - Latent TB infection (LTBI)
  - Active TB disease



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LTBI vs. active TB disease

Approximately 10% of people with LTBI will develop active TB disease

	LTBI	Active TB Disease
TST or TB blood test	Positive	Usually positive
Symptoms	No	Usually
Physical examination	Normal	Usually abnormal
Chest x-ray	Negative	Usually abnormal when pulmonary TB
Infectious?	No	Often when pulmonary TB
Treatment required?	No	Yes
Number of medications	1 or 2	3 or 4
Length of treatment	3 to 9 months	6 to 12 months or more
Report to MDH?	No	Yes

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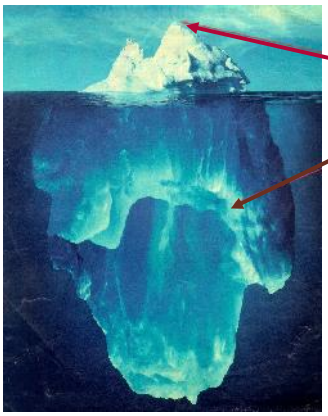
LTBI



- There are approximately 11 million people with LTBI in the US (4 % of population)
- Active TB disease represents the “tip of the iceberg” of people with TB bacteria in their bodies
- Persons with LTBI are the reservoir of future active TB disease

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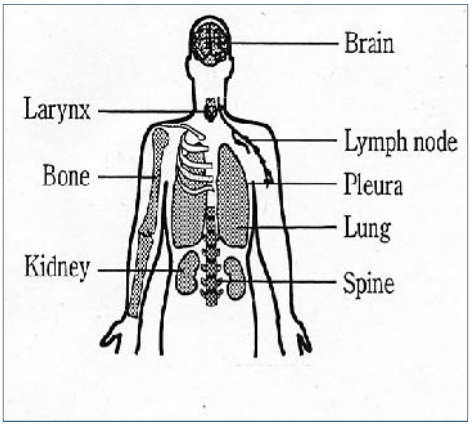
Common sites of active TB disease

- Lungs (~70%)
- Pleural cavity
- Lymph nodes
- Central nervous system
- Genitourinary systems
- Bones and joints
- Disseminated



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Symptoms of active TB disease

- Prolonged cough (>3 weeks)
- Night sweats
- Weight loss/poor appetite
- Chest pain
- Hemoptysis (bloody sputum)
- Fever/chills
- Fatigue

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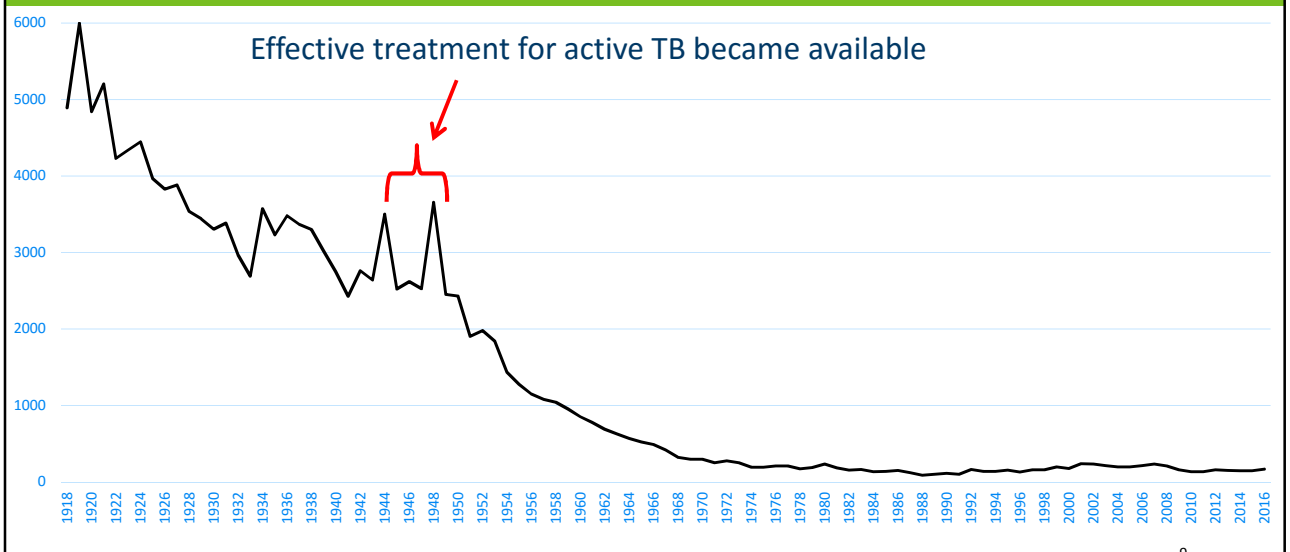
Active TB cases in Minnesota, 1918 - 2016



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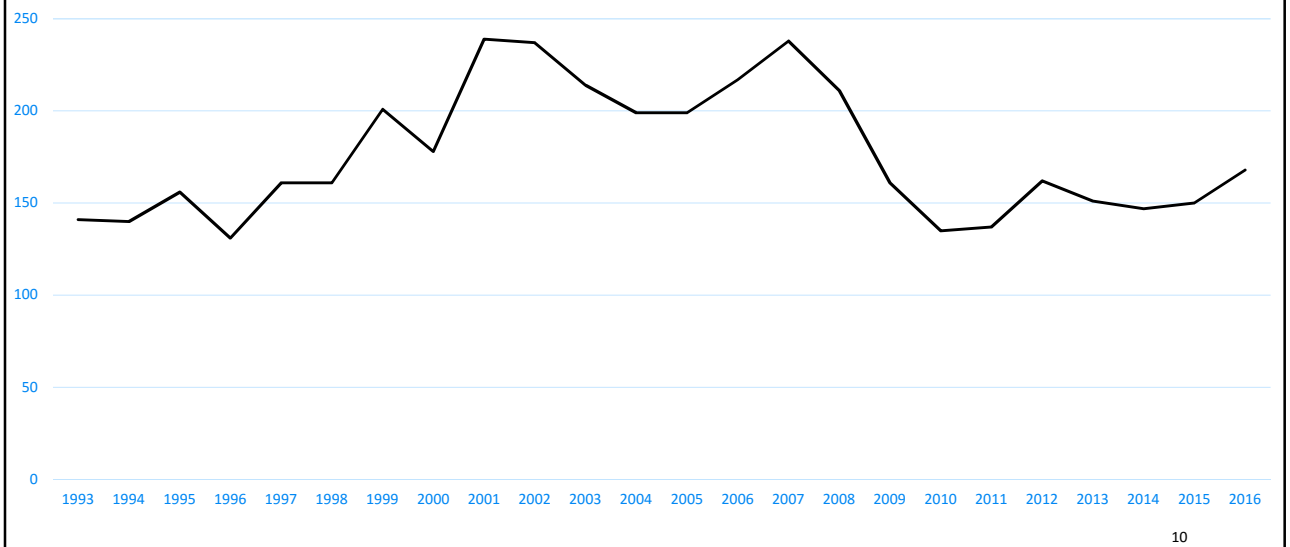
Active TB cases in Minnesota, 1993 - 2016



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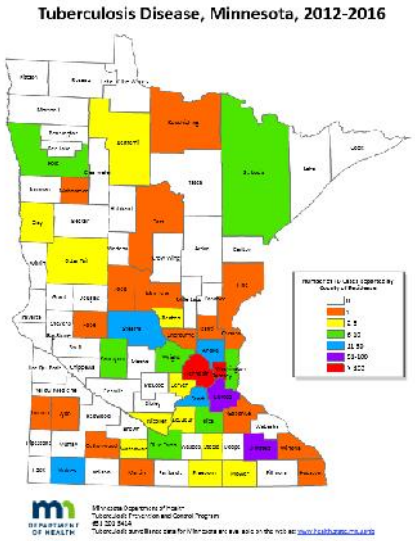
Active TB cases in Minnesota, 2012 - 2016



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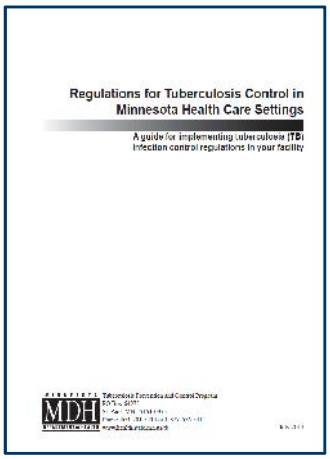
MDH manual: Regulations for Tuberculosis Control in Minnesota Health Care Settings

- Published in 2013
- Based on:
  - CDC guidance (Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005)
  - Public health principles
  - Expert opinion where CDC doesn't provide clear guidance



www.health.state.mn.us/divs/idepc/diseases/tb/rules/index.html

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Three categories of regulations

- Written infection control plan (Chapter 2)
- HCW screening (Chapter 3)
- Patient screening (in certain settings such as nursing homes) (Chapter 4)

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Written TB infection control plan

- An up-to-date TB infection control program includes:
  - A team responsible for TB IC
  - A facility TB risk assessment
  - Written TB IC procedures
  - HCW education

The greatest risk is unrecognized infectious TB

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Facility TB risk assessment (1)

- A home care agency should determine its risk based on the flow chart found in the "Facility Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH)"
- Risk assessment worksheet is found: www.health.state.mn.us/divs/idepc/diseases/tb/rules/index.htm

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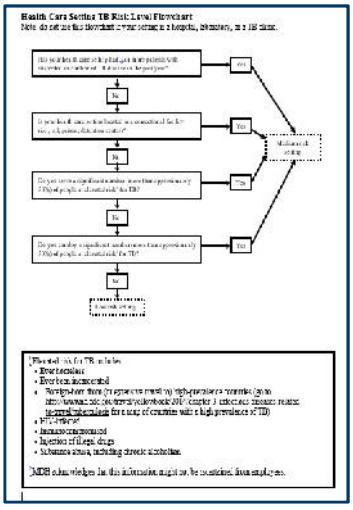
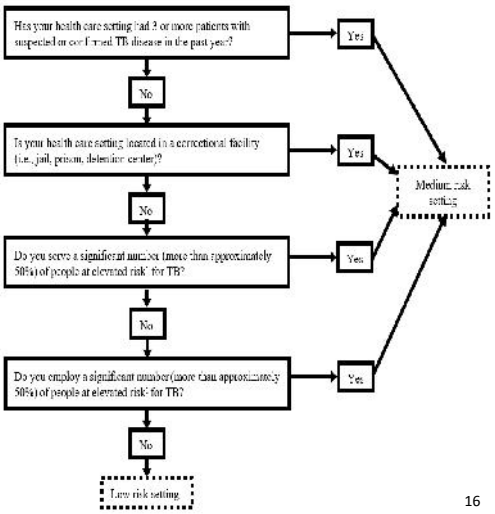
Facility TB risk assessment (2)





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Baseline TB screening of HCWs (1)

- Basic baseline includes:
  - Assessing for current symptoms, and
  - Assessing TB history, and
  - Documentation of either a two-step TST or single IGRA
    - Documentation of previous treatment for latent TB infection or active TB disease may be substituted for documentation of a previous positive TST (or IGRA) test result.

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Baseline TB screening of HCWs (2)

- Health care workers may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) **and** a negative IGRA or TST (i.e., first step) dated within 90 days before hire.
- The second TST may be performed after the health care worker starts working with patients. If a positive TST or IGRA, a chest x-ray and medical examination are required
- If a positive TST or IGRA, a chest x-ray and medical examination are required

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Symptom screen (1)

- Prolonged cough (>3 weeks)
- Night sweats
- Weight loss/poor appetite
- Chest pain
- Hemoptysis (bloody sputum)
- Fever/chills
- Fatigue

Do not wait for TST or IGRA results before referring for work up

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Symptom screen (2)

- Ask "probing questions"
  - When did your cough start?
  - Has there been a change in your cough? (if chronic cough)
  - Do your clothes fit more loosely than usual?
  - Has the amount you are eating changed?
  - Have you lost weight without dieting?
  - Have you woken up during the night full of sweat?

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Risk factors for becoming infected with TB bacteria

- Close contact to a person who has infectious TB
- Born in a part of the world where TB is common
- Work or live in congregate settings like HC settings, jails, and homeless shelters
- Injection drug use
- Other locally defined groups

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Risk factors for becoming sick with active TB disease once infected

- HIV or other immune suppression
- Recent TB infection (< 2 years)
- Age < 5 years
- Certain other medical conditions
- Undernutrition
- Substance abuse
- Scarring/fibrosis on chest x-ray

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BCG (Bacille Calmette-Guerin) vaccine

- Vaccine for TB
  - Used in countries where TB is common
  - May prevent childhood TB
  - Rarely used in the U.S.
- May cause “false positive" reaction to TST
- Disregard BCG history when applying or interpreting TST results
- CDC and MDH prefer IGRAs over TSTs for BCG-vaccinated persons

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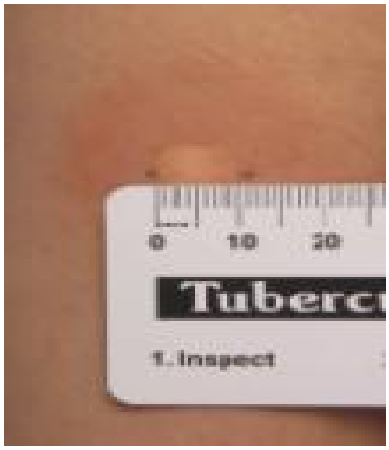
TST documentation

- An appropriately documented TST **must** include:
  - Date (i.e., month, day, year), *and*
  - Exact number of mm of induration (if no induration document “0” mm), *and*
  - Interpretation (i.e., positive or negative)
- Individuals should not read their own TST
- Do not measure redness (erythema)



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Two-step TSTs (1)

- TST has been used for decades
- Very good test but has some limitations
- One limitation is that if a person was exposed and infected with TB many years ago, the person's immune system might "forget" about the infection
- The work-around for this limitation is to perform a two-step TST

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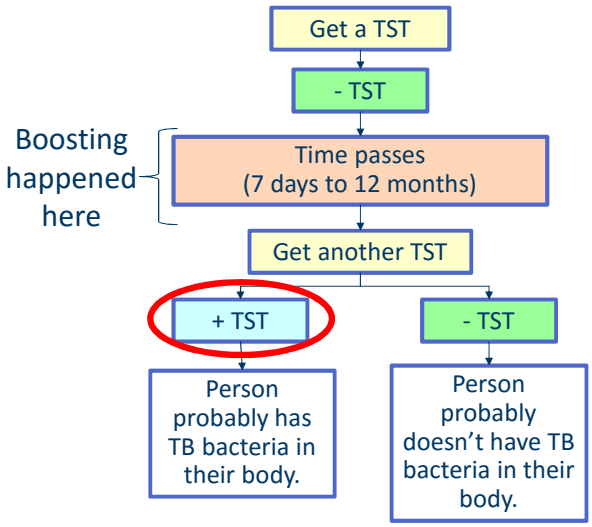
Two-step TSTs (2)

- Note: this flowchart assumes that the person has not been exposed to TB either shortly before the first TST or between the first and second TST
- What happened?
  - The first TST was a "false negative."
  - This person had the TB bacteria in their body when they had their first TST but their immune system "forgot" about it.
  - Having the injection of tuberculin "woke up" (or boosted) the immune system.



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Options for meeting the two-step TST requirement

All options below assume:

- All TSTs are negative
- All TSTs are appropriately documented, and
- There is at least 7 days from the time the first TST is read and the second TB is administered

Option	TST #1 placed		TST #2 placed
A	Within a few days before hire	and	7 – 21 days after the first TST was read
B	Within 12 months before hire	and	Within 90 days before hire
C	Within 90 days before hire	and	Within 90 days before hire
D	Within 90 days before hire	and	Within 21 days after hire

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IGRA documentation

- An appropriately documented IGRA must include:
  - Date of the test (i.e., month, day, year), *and*
  - Qualitative results (i.e., positive, negative, indeterminate or borderline), *and*
  - Quantitative assay (i.e., Nil, TB and Mitogen concentrations or spot counts)

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Documentation requirements for HCWs with a positive TST/IGRA (1)

- If a new positive:
  - Positive TST/IGRA result, *and*
  - Assessment for current TB symptoms, *and*
  - Chest x-ray to rule out infectious TB disease, *and*
  - Medical evaluation to rule out infectious TB disease

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Documentation requirements for HCWs with a positive TST/IGRA (2)

- If a bringing in a positive TST/IGRA:
  - Positive TST/IGRA result, *and*
  - Assessment for current TB symptoms, *and*
  - Chest x-ray to rule out infectious TB disease, *and*
  - Medical evaluation to rule out infectious TB disease. No medical eval is required if the health care worker already has a chest x-ray that is:
    - Dated after or within the three months prior to the positive TST/ IGRA as long as the HCW has not been exposed to infectious TB disease since the chest x-ray was done

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Chest x-rays

- After a baseline chest x-ray is performed and infectious TB disease has been ruled out, the HCW will not need additional chest x-rays unless they develop symptoms or a clinician recommends one

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"Catch up" technique for HCW baseline screening (1)

- "Catch up" is a technique to establish baseline TB screening months or years after hire
- It has limitations but an imperfect baseline is better than having no baseline
- If the agency misses the 7 to 21 day window they could be cited however the remedy is to administer another TST.

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"Catch up" technique for HCW baseline screening (2)

- Create/update policies and procedures and train staff as needed
- Correctly screen all newly-hired HCWs
- Confirm that current HCWs have the following on file; if not on file complete now:
  - TB screening worksheet
  - Two negative TSTs or single IGRA ***or*** one positive TST or IGRA with chest x-ray and medical exam as noted in the MDH manual
  - Use the two oldest TSTs even if they are both dated after time of hire

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Take home messages

- If the HCW is symptomatic, do not wait for TST/IGRA results to begin medical exam
- The greatest risk is unrecognized infectious TB
- Always check the regs manual before calling MDH. Almost all questions are answered in the manual. You'll be able to get a more timely answer to your question.

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"Tuberculosis … is like a fire – unless it is aggressively controlled, the disease will spread."

- Dr. William Clapp

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Persons now working in tuberculosis control in Minnesota have the advantage of building on the firm foundation constructed by those who preceded them. There is a tendency for many current workers to accept the present favorable situation as a matter of course. Much that is being done today is possible only because of the decades of hard work by our predecessors.

-Dr. J. Arthur Myers
(Invited and Conquered: Historical Sketch of Tuberculosis in Minnesota, 1949)

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On behalf of the

MDH TB Prevention and Control Program…

Thank you for the vital work you do every day

to help prevent and control TB in Minnesota!

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DEPARTMENT OF HEALTH

Thank you again!

Beth Kingdon

Elisabeth.Kingdon@state.mn.us

651-201-5414

www.health.state.mn.us/tb

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MHCA Region Meeting

Kathy Messerli, Executive Director

Welcome

Welcome prospective members!

Opportunity for you to experience an MHCA member activity.

We hope you'll consider joining!

Sponsor

Senior Linkage Line – THANK YOU!

- Region Representatives
- Ask how you can collaborate with the Return to Community Program

Agenda

- Team Updates
- State Update
- Federal Update
- MHCA Resources

Team Updates

- **Clinical Quality Team:** Best Practices series for Informer
- **Legislative:** Day at Capitol: March 6, 2018
- **MA:** EVV working group
- **Medicare:** Proposed Rule, CMS comments
- **Membership**: Membership Survey
- **Rehab:** Informer article series
- **SRA:** Re-launch Survey Watch Tool

State Advocacy

- Home Care Statute Revisions
- EPI-PEN
- VAA
- EVV
- Other

www.mnhomecare.org
MINNESOTA HOME CARE ASSOCIATION The Voice of Home Care

Capitol Hill Visits 2017

- Senator Amy Klobuchar
- Senator Al Franken

- Rep Jason Lewis
- Rep Collin Peterson
- Rep Erik Paulson
- Rep Tom Emmer (agency visit)

- Staff Members for Representatives Keith Ellison, Richard Nolan, Tim Walz, and Betty McCollum

Capitol Hill Visits 2017

Capitol Hill Visits 2017

Federal Issues

- CMS
  - Proposed Rule – HHGM
- Bills
  - Rural Add-on Extension (S. 353)
  - Non-Physician Orders (S. 445, H.R. 1825)
  - F2F Reform (H.R. 2663)

MHCA Resources

- **Website Refresh**
  - **Easy access to member resources and information!**
- Employment Law Hotline
- Nurse Consultants
- Medicare Benchmarking Reports
- Survey Savvy
- Region Meetings
- Informer and News Alerts

MHCA Events

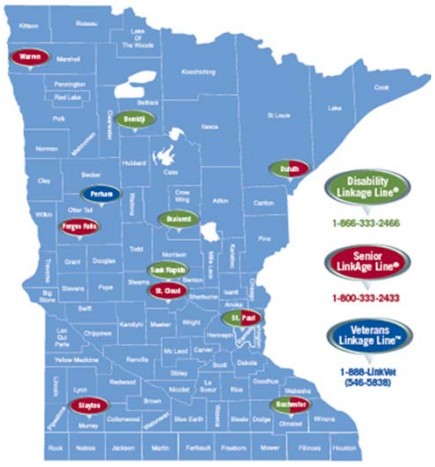
- OASIS
  - Oct 11-13th
- Policy Conference
  - November 16th
- December Region Meeting
  - December 6th – Millennials in Home Care
- Annual Meeting
  - May 16-17, 2018
  - ***Explore the Future of Home Care: What's Your Next Adventure?***

Questions?

The Senior LinkAge Line®: Who we are and what we do

Senior LinkAge Line®
1-800-333-2433
LINK TO A LOCAL AGING EXPERT

MinnesotaHelp Network™



- **Telephone Assistance**
  - Senior LinkAge Line® (1-800-333-2433)
  - Disability Linkage Line® (1-866-333-2466)
  - Veterans Linkage Line™ (1-888-Linkvet)
- **Face-to-Face Assistance**
  - Through county Long Term Care Consultation (MnChoices)
  - Outreach Sites
  - Access Points
- **Online Assistance**
  - www.MinnesotaHelp.info®
    - Live Chat and Resource database
- **Print**
  - *Before a Move: Consider Your Options*
  - *Health Care Choices*
  - *Planning Ahead*
  - *Returning Home booklet*

MinnesotaHelpNetwork™

- Four Channels!
  - Phone
  - Internet/Chat
  - In person/face-to-face assistance
  - Print

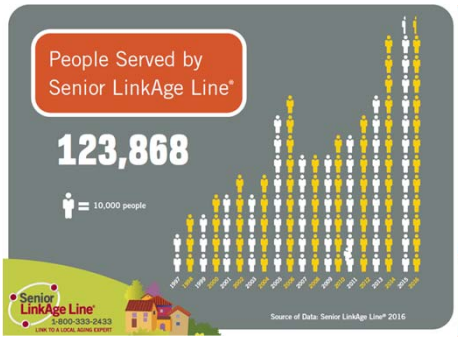
Phone Assistance: The Linkage Lines

Senior LinkAge Line® 1-800-333-2433
A One Stop Shop for Minnesota Seniors

Disability HUB

Veterans Linkage Line
your link to experts
minnesotaveteran.org | 1-888-LinkVet (546-5838)

Total Senior LinkAge Line® Contacts



Senior LinkAge Line® Areas of Expertise

- Long term care options counseling
  - Care Transitions
  - Planning for the future or to remain in the community
- Health insurance counseling
  - Medicare (Part A, B, C and D)
  - Fraud, appeals and advocacy
- Prescription drug expense assistance
- Long term care partnership insurance
- Caregiver planning, support and training
- Forms assistance

6

What Return to Community Does.

- http://www.mnaging.net/en/News/Allen.aspx

Return to Community Initiative

- In-person assistance for nursing home residents
  - Service officially began in April 2010
  - Expanded in 2014 (will expand again beginning January 2018 in partnership with MHCA)
- In-depth interview and comprehensive support planning occurs in conjunction with nursing home staff, consumer and caregivers
- Intense follow-up protocol once consumer transitions from facility
  - Follow-up at 72 hours,14, 30, 60 days and then every 90 days for 5 years
  - At least one in-person visit is conducted within 10 days

Expansion of the service starts 1/1/18

- Five populations targeted but largest group is people for whom Medicare Home Care is ending and,
  - Who the home care staff feel could benefit from a community living specialist or caregiver support
  - Are referred into the Senior LinkAge Line® for the CLS to come out to their home to meet and discuss all options/services

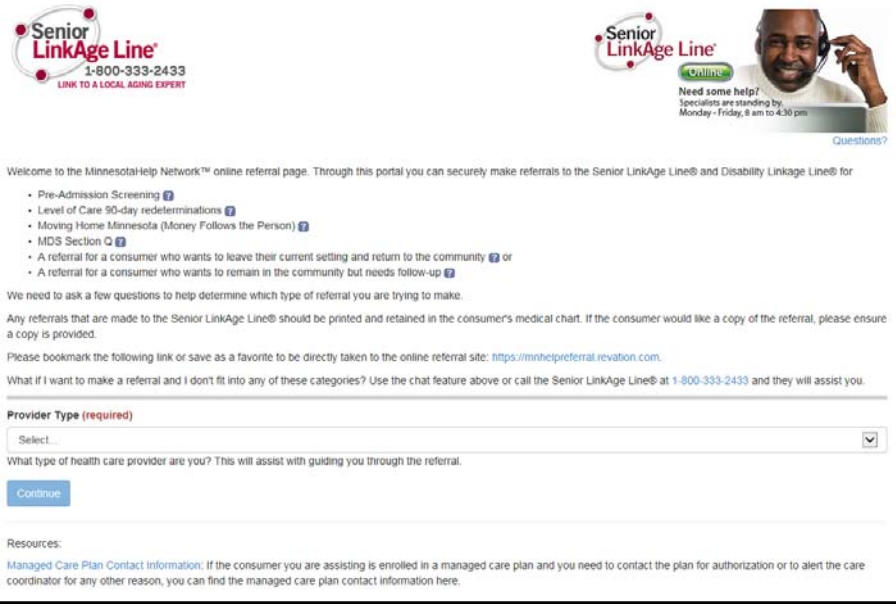
Services/Options

- Using Minnesotahelp.info staff will discuss available services that may assist someone in avoiding readmission
- May include ways to continue some level of home care at a private pay rate
- Finding options to support the caregiver including caregiver supports, adult day, chore, homemaker etc.

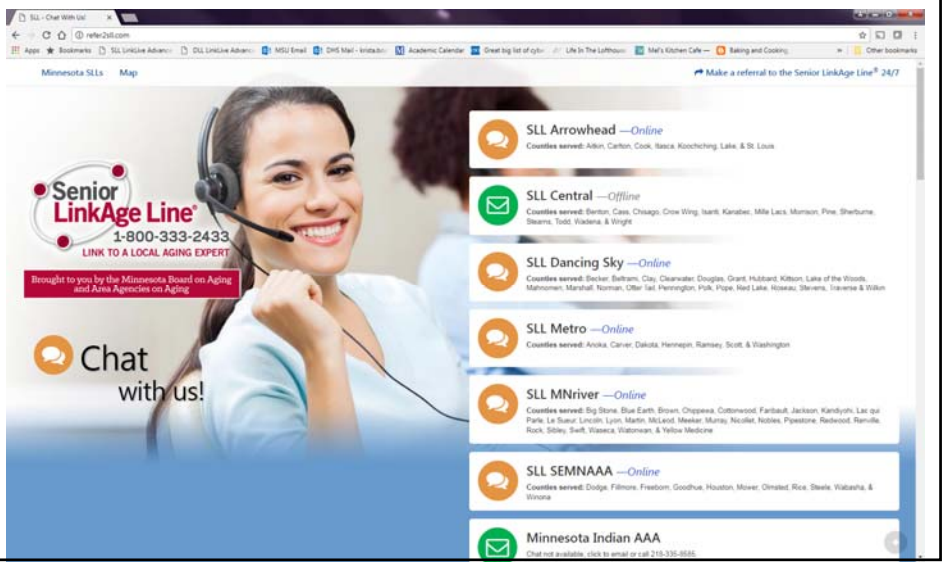
Referral Options

- Online
- Chat
- Phone
- Fax

Online Referral Site



Chat Referral - http://refer2sll.com/



Phone Referral

- LinkAge Line call center staff will take referrals and fill out the form on your behalf to start the referral process.

Senior LinkAge Line®
1-800-333-2433
LINK TO A LOCAL AGING EXPERT

Fax

- A fax option that routes referrals to the correct regional area agency on aging is in development.

Questions and Contact Information

- An Area Agency staff who works with the Senior LinkAge Line is at your site and would like to say a few works and answer questions.