Summary of the IDPH/LTC Association Quarterly Meeting Held on July 13, 2016

The Illinois Health Care Association (IHCA) appreciates the opportunity to sit down face-to-face with the key managers of the Illinois Department of Public Health (IDPH) to discuss items of interest with regard to the long term care program. IHCA and the other Illinois LTC associations are asked to forward agenda items to IDPH, an agenda is established and discussions occur. Many of the IHCA items offered come directly from member questions/concerns, so please don’t hesitate to bring any long term care issues to our attention. The following is a summary of the latest meeting held on July 13, 2016.

1) The first hour of the meeting was a discussion on the Identified Offender Program (IOP), which is in IDPH but not within the Office of Health Care Regulation. The IOP is housed in the IDPH Office of Policy, Planning and Statistics. The two key staff for IOP recently left and the new administrator for the IOP is Audrey Smith and her phone number is 312-793-3914. Daniel Goodman is also with the IOP and he can be contacted at 312-793-3913. Any questions or concerns regarding the IOP can be directed to either of these two individuals.

The IOP is in the process of developing a revised Identified Offenders Program Guideline. This informational document (which includes specific instructions and guidance to help LTC facilities through the process) is in the final review stage and will be made available to LTC facilities in the very near future. As soon as it is released as a final document, we will alert our members and make a copy available. Click here to view a copy of the DRAFT document. If you have any comments/concerns/etc. that will make this document better, please let us here at IHCA know as soon as possible.

There were several related issues raised with regard to the IOP that were discussed at this meeting:

- One of the questions raised was with regard to repeat background checks of residents. Unlike the background checks for employees, which are only done once and the background check follows the employee to different facilities, the background check for residents must be completed each time a resident moves from one facility to another. We asked IDPH to research this issue and see if there could be some exceptions or allowances for not repeating background checks on residents similar to what is done for employees. IDPH stated they understood the concern of the increased cost and the stress this put on residents and their families and agreed to discuss this internally and see if there are options to address the problem.

- Another issue raised had to do with residents guilty of sex offences. There are situations where a person has been found guilty of a sex offense, but they are not listed on any of the Sex Offender Registries. This is a quirk in the system due to older convictions and the reporting systems at that time. They are still considered sex offenders and some facilities have gotten caught admitting such individuals and not finding out about the conviction until after the entire background check is completed. The question is then, how does a facility...
respond to this situation and if they cannot meet the resident’s needs, how is the person properly discharged? The new IOP Guideline will provide guidance on this.

- We believe that the IOP statute only requires sex offences and felonies to be reported. We have heard of instances where the Illinois State Police (ISP) have made visits to LTC facilities and have stated that misdemeanors along with felonies have to be reported. IDPH agreed to discuss this with their legal staff and with ISP and bring this issue back for further discussion at our next quarterly meeting.

- Questions were raised about the required poster. IHCA believes that the poster should only be required when a facility has an identified offender. The current reading of the statute states that every facility must have the poster displayed whether they have an identified offender or not. This is being reviewed and IHCA may seek legislation to require the poster only when an identified offender is in the facility.

- A question was asked about a facility’s obligations/responsibilities when a known sex offender is a visitor. There aren’t any specific rules/guidelines on this; however, a facility needs to take actions necessary to protect the resident being visited and other residents in the facility. The facility should have a policy to address this that would probably include supervision, no closed bedroom doors, visiting only in common areas, etc.

2) Abuse—strict liability? This item was discussed generally and a decision was made to have a more in-depth discussion on this issue at a future meeting. There is currently discussion occurring within IDPH regarding this issue and how to best address it. Should a facility be held totally responsible for an employee action that was no fault of the facility? This issue is having serious managed care ramifications and needs to be thoroughly reviewed and discussed.

3) Elder Justice Act inclusion in facility policy - Each long term care facility shall post (and note in facility policy) conspicuously in an appropriate location a sign specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the secretary against a long term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint. No specific sign has been mandated, however, there has been a sign developed (click here) that meets the requirements of the Elder Justice Act. For further information on this issue, please refer to S&C 11-30.

4) Incident reports – surveyor requests to see all reports – information conflicts with the CMS State Operations Manual – IDPH stated that the facility must have a system for monitoring and responding to incidents. IDPH surveyors should be looking for this system, not asking to see all incident reports. Surveyors can ask to see specific incident reports based on survey issues/findings. IDPH will work with their surveyors regarding this issue.

5) Exit Conference issue with tags not being provided – CMS recently issued S&C 16-11 that clarifies guidance to surveyors regarding the procedures for conducting the exit conference in the review of compliance with Medicare or Medicaid Conditions of Participation, Conditions for Coverage and Requirements for Participation. This S&C states that surveyors are not to give deficiency tags at the exit conference because they are not final at that point. The tags are not final until supervisory review. However, if the facility pushes the issue and seeks further clarification of a deficiency, surveyors can give a tag number they are recommending.

6) Surveyor training on computer skills and electronic records – IDPH agrees that surveyors are having issues with accessing and understanding facility electronic health records (EHR). IDPH is reaching out to various EHR software providers to provide training to surveyors regarding this issue.

7) Deficiency based on interpretive guideline vs. actual rule – IDPH agreed this is being done in error and will be working with their surveyors to make sure any deficiencies are based on the actual rule as opposed to guidance/information in the interpretive guidelines.

8) Discussion regarding reporting of “serious injury” – this is another significant issue that will require additional research and discussion. All involved were asked to research this issue and bring back discussion points for a future
meeting devoted mainly to this issue. The question is what types of incidents need to be reported? What does the term “serious” mean?

9) What nurse aide duties may a nurse aide in training perform during the 120 day training period? – IDPH stated that only the skills they have been taught and have been competency tested on are allowed to be done by a nurse aide in training. In addition, the training program shall include a minimum of 16 hours of training in the following areas, which shall be conducted prior to any direct contact with a resident (42 CFR 483.152(b)(1)):

   A) Communication and interpersonal skills;
   B) Infection control;
   C) Safety/emergency procedures, including airway obstruction clearing procedures;
   D) Promoting residents’ independence; and
   E) Promoting residents’ rights.

10) Will IDPH provide any training with regard to the implementation of the 2102 Life Safety Code (LSC)? – Yes, IDPH is planning on either doing an in-person or a webinar training session on the new requirements of the 2012 LSC in the very near future. The 2012 LSC is in effect, however, the forms and changes necessary to survey are not completed and so the implementation date is November 1, 2016 (click here).

11) Update on Electronic Monitoring device rules – IDPH stated they will develop rules for this activity, but they are taking a wait and see approach to see what type of issues arise before drafting the rules. All of the provider associations feel that rules need to be developed sooner rather than later. IDPH stated that any issues with regard to electronic monitoring devices will be routed through key supervisors to make sure a proper approach is taken. Contact IHCA of any electronic monitoring device issues that arise.

12) Medical Marijuana rules – IDPH is internally discussing and researching rules for many aspects of the medical marijuana program that includes the use within healthcare facilities. We asked that the draft be shared when finalized.

13) Federal Civil Monetary Penalties Inflation Adjustment Act of 2015 – IDPH acknowledged that federal CMS has notified them that federal CMPs will be increasing, but a final decision as to how much and other aspects have not been finalized to date. We were told that the final CMS action will probably be noted in a near future S&C Letter.

14) Federal Informal Dispute Resolutions (IDRs) reasons for denial – IHCA worked to get IDPH to give an explanation of IDR denials for state licensure tags. Now we are asking that IDPH do the same for federal IDRs. There is no federal requirement that IDPH give a reason for denying a federal IDR, but we stated that it is disheartening to feel you have challenged a deficiency with pertinent information, and receive what basically amounts to a form letter, with no explanation. Having some feedback to the points made, even when we’re denied, could potentially help us refine our approaches in meeting the regulations, in turn benefiting those we serve. IDPH stated they will take this under advisement and let us know their decision.

15) Updated status on:

   - [LTC Electronic Incident Report Form](#) – being finalized and will be available on the IDPH website in the very near future
   - [Subpart S rulemaking](#) – IDPH is working with the Governor’s Office to get this set of rules moving forward for proposal in the Illinois Register
   - [Distressed Facility rulemaking](#) – drafted and being reviewed by IDPH Legal
   - [Behavioral Health Unit rulemaking](#) – being drafted
   - [Informed Consent rulemaking](#) – being drafted along with the required form
   - [Electronic POCs](#) - still being discussed within IDPH, not a priority for them at this time


16) **Updates on IDPH staffing changes/hires** –

- George Logan is now the new Division Chief for Administrative Rules and Procedures. He replaced Karen McGrath. This Division also handles the Health Care Worker Background Check Program and the Nurse Aide Registry.
- Jackie Manker left the DD/ID program and the position is being posted to fill. Connie Jensen is acting supervisor for the DD/ID program.
- Jon Absher left and Veronica Marotta assumed that position within the DD/ID program.

17) **Imposed Plans of Correction** – IHCA raised the question of when imposed plans of correction are used. There seems to be disagreement between the Nursing Home Care Act, what is in the LTC rules and what the policy is within IDPH. IDPH stated they will take this issue under advisement and discuss internally with their legal staff to determine proper approach.

18) The next IDPH/LTC Provider Association Meeting is scheduled for October 12, 2016.

**CMS Skilled Nursing Facilities (SNF) Long Term Care (LTC) Open Door Forum Call conducted on July 14, 2016**

The Centers for Medicare & Medicaid Services (CMS) sponsors regularly scheduled “LTC Open Door Forums" providing an opportunity for live dialogue between CMS and the LTC stakeholder community at large. These forums are intended for all LTC stakeholders who interact with CMS or work with consumers who rely on services that CMS provides. They provide an opportunity for CMS to share current information about new initiatives and policies related to Medicare, Medicaid, CHIP and the new Affordable Care Act benefits, and allow participants to ask questions for further clarification. The ultimate goal of these LTC Open Door Forums is to foster strong collaboration and communication between CMS and a diverse spectrum of LTC stakeholders.

To be notified when Open Door Forums are scheduled or when new information is posted to the website, you can subscribe using the link: [All Open Door Forum Mailing List Sign-Up](#).

A summary of the items discussed is as follows:

- **Payroll Based Journal (PBJ) Update** ([click here](#)). This webpage provides information on how data will be collected and who to contact for questions. Future steps will address activities such as how the data will be verified, how compliance will be enforced and how the information will be publically reported (such as quality measures on the Nursing Home Compare website). Information about these future steps will be communicated over the next several months. The PBJ program did go active on July 1, 2016. The first quarter reporting period is 7-1-16 through 9-30-16. The due date for the first quarter is November 14, 2016. CMS is suggesting that facilities submit their staffing data every two weeks. CMS also stated that surveyors will continue to ask facilities to complete the CMS 671 and 672 during surveys.

- **SNF Waiver for Comprehensive Care for Joint Replacement Model (CJR)** ([click here](#)). The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

  The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers. The episode of care begins with an admission to a participant hospital of a beneficiary who is ultimately discharged under MS-DRG 469 (Major joint replacement or reattachment of lower extremity with
major complications or comorbidities) or 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities) and ends 90 days post-discharge in order to cover the complete period of recovery for beneficiaries. The episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with the exception of certain exclusions.

CMS has implemented the CJR model in 67 geographic areas, defined by metropolitan statistical areas (MSAs). MSAs are counties associated with a core urban area that has a population of at least 50,000. Critical Access Hospitals (CAH) and Swing Bed Units are not included in this model.

The three day waiver, which allows participating CJR facilities to waive the three day requirement for post-acute Medicare coverage, will begin on January 1, 2017. This is only for the participating CJR facilities and will be handled on a case-by-case basis.

- **Nursing Home Compare Quality Measure Updates/Five Star** (click here). CMS reported that starting on July 27 at 10 AM ET the Quality Measure (QM) component of the Five-Star Rating System will reflect five of the six new QMs that are currently featured on Nursing Home Compare (NHC). You will recall, the agency announced in March that this change was going to happen in July. For a summary of that presentation and a list of the six new measures, click here.

CMS also announced today that it has posted an updated Technical User's Guide on its website here. On the second page of the guide, there is a short list of the overall changes you can expect. Below are the key changes outlined in the guide:

- The five new QMs will be phased in between July 2016 and January 2017.
- In July 2016, they will have 50 percent of the weight of the current measures.
- In January 2017, they will have the same weight as the current measures.
- The methodological changes that will be introduced in July include:
  - Using four quarters of data rather than three for determining QM ratings.
  - Reducing the minimum denominator for all measures (short-stay, long-stay and claims-based) to 20 summed across four quarters.
  - Revising the imputation methodology for QMs with low denominators meeting specific criteria. A facility's own available data will be used and the state average will be used to reach the minimum denominator.
  - Using national cut points for assigning points for the ADL QM rather than state-specific thresholds.

We recommend members review the guide for more details.

In addition, the agency is making changes to the CASPER provider preview report. The revised report will incorporate the new measures, display updated star ratings and include a new column that shows the points assigned to each QM for a better understanding of the quality rating. All skilled nursing care centers will have access to their preview reports through the QIES System by the end of next week.

At this time, AHCA does not know how the new QMs may impact your star rating; for example, the number of stars that may be lost or gained.

**On Thursday, July 28 at 3 PM ET, AHCA will host an all-member webinar to walk through these changes and answer questions. Please register here.**

In the meantime, members should continue to take steps to prepare for these upcoming changes. Resources, including the updated Technical User's Guide, are available on the members-only Five-Star ahcancalED website here. The AHCA Quality Initiative website here, along with blog posts here and here, provide additional tips and information.
As always, we will continue to share new developments with you as soon as we know more.

- **MDS RAI Manual** – the new MDS RAI manual has been finalized and will be available in the next couple of weeks.

- The next CMS LTC Open Door Forum is scheduled for August 25, 2016.

**AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 6 of 13**

This is part of a series featuring one element of the Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcomes.

Success in achieving positive resident/patient outcomes is even more critical now than ever before. The link between quality and payment in long term and post-acute care is growing stronger, as evidenced by the SNF Value Based Purchasing Program (VBP), Improving Post-Acute Care Transformation (IMPACT) Act, SNF Quality Reporting Program (QRP) and more.

In addition, regulatory activity is intensifying through focused surveys on adverse events, dementia care and MDS. The Five-Star Rating system and Nursing Home Compare have been revised and will add items in the future as it broadens public reporting and transparency. Most importantly, consumers expect and deserve high quality care.

The entire framework outlines key elements from both an organizational and clinical nature that are critical to successful clinical and organizational outcomes. Positively, these elements reflect common denominators that cross multiple care situations. Therefore, instead of being yet another initiative or single focused project to achieve just one outcome, it is a way of acting, thinking and being that will benefit multiple areas across an organization. Each element is addressed in detail throughout the framework.

This week we will feature the element of **Clinical Foundation: Consistent Use of Evidence-Based Practice**

**Key Takeaways: Consistent Use of Evidence-Based Practice**

- Practice is based on evidence as well as shared decision-making between clinical experts, the residents’ experiences and preferences and other robust sources of information.

- Evidence-based practice can help decrease uncertainty and lead to important improvements in resident quality and safety, while also contributing to cost savings.

- The identification and use of reliable evidence-based approaches contributes substantially to safe, effective, patient-centered, efficient, timely and equitable care.

**Probing Questions for Team Reflection and Discussion:**

1. What evidence-based practices do we use?
2. What areas of our practice do we have uncertainty? Are there evidence-based practices that will help us improve?
3. Do we use evidence-based care paths to systematically address care?

Visit the AHCA Clinical Practice [website](#) to learn more about the element of “Clinical Foundation: Consistent Use of Evidence-Based Practice” and answers to these key questions:
What does this mean? Why is this important? What are some examples? What is my part (as an individual employee, manager or practitioner)? What can my organization do?

Start somewhere, pick one element and work through it with your team.

Enjoy the journey through the framework!

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*

**Top Ten Tags**
The Illinois Department of Public Health (IDPH) recently released the latest Top Ten Tags Cited—information based on 1st quarter information 2016.

The tags/deficiencies in order of number of times cited were:

- F323—Environment free from accident hazards/supervision/assistive devices
- F441—Infection Control
- F314—Treatment /Service to Prevent Pressure Ulcers
- F309—Provide Care/Services for Highest Well Being
- F312—ADL Care Provided for Dependent Residents
- F371—Food Procurement/Store/Prepare/Serve in Sanitary Manner
- F315—No Catheter/Prevent UTI/Restore Bladder Function
- F157—Notification of Changes
- F226—Develop/Implement Policies to Prevent Abuse and Neglect
- F225—Investigate/Report Allegations of Abuse

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**Important Regulations, Notices & News Items of Interest**

1) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 16-30 – OPO/Transplant** - Notice of Proposed Rulemaking (NPRM) for Organ Procurement Organizations (OPOs) and Transplant Centers. On July 6, 2016, the CMS released the Calendar Year (CY) 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System policy changes, quality provisions and payment rates proposed rule (CMS-1656-P). The NPRM includes sections related to changes for OPOs and Transplant Centers.

2) Federal HHS/CMS released the following notices/announcements since the last issue of Regulatory Beat:

- **New Hospice Report Available July 17.** The Hospice Timeliness Compliance Threshold Report will be available beginning July 17, 2016. This report will display provider level data on Hospice Item Set (HIS) records submitted successfully to CMS. For more information, visit the [Hospice Quality Reporting Spotlight & Announcements](#) webpage.
• **HIPAA Administrative Simplification Enforcement and Testing Tool.** CMS launched an enhanced HIPAA Administrative Simplification Enforcement and Testing Tool (ASETT) with easier navigation, new features and greater security that allows you to:
  - Test transactions
  - File complaints
  - Track your complaint status

• **Complying With Medicare Signature Requirements Fact Sheet – Revised.** A revised Complying With Medicare Signature Requirements Fact Sheet is available. Learn about:
  - Comprehensive Error Rate Testing (CERT) Program errors related to signature requirements
  - Documentation needed to support a Medicare claim

• **Improved Medicare Learning Network Website.** The Medicare Learning Network (MLN) website has a fresh new look and improved navigation. Now it’s easier to access MLN knowledge, resources and training. Visit the new MLN homepage. What’s new:
  - Enhanced navigation – access the information you want faster
  - Improved organization – choose your preferred product type
  - Streamlined content – save time

• **SNF Readmission Measure: Top 10 Things You Should Know.** A new fact sheet is available for the Skilled Nursing Facilities (SNFs) Readmission Measure (SNFRM). The SNF Value-Based Purchasing (VBP) program ties portions of SNF payments to performance on this measure, which is calculated by assessing the risk-standardized rate of all-cause, unplanned hospital readmissions for Medicare Fee-For-Service SNF patients within 30 days of discharge from a prior proximal hospitalization. Visit the SNF VBP webpage for more information on the program.

• **Quality Measures and the IMPACT Act Call** - During this recent National Provider Call, CMS experts discussed key quality measures related to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and how they will affect you. The IMPACT Act requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. Call materials included:
  - Slide Presentation [PDF, 1MB]
  - Audio Recording [ZIP, 18MB]
  - Written Transcript [PDF, 361KB]

• **CMS Proposes Payment Changes For Alzheimer’s Care.** CMS has proposed changes to the way it pays for primary care with a focus on care management and behavioral and cognitive health. Learn more.

• **CMS Predicts Health Spending Increase Through 2025.** Total health spending growth is expected to average 5.8 percent annually from 2015 to 2025, but is at a lower growth rate that the previous two decades, according to the Centers for Medicare & Medicaid Services. Learn more.

3) The United States Government Accountability Office (GAO) recently issued the following report entitled, “Drug Shortages – Certain Factors Are Strongly Associated With This Persistent Public Health Challenge.” When available supplies of prescription drugs are insufficient, patient care may be adversely affected. The number of new shortages has generally decreased since 2011, while the number of ongoing shortages remained high.

4) The Agency for Healthcare Research and Quality (AHRQ) reported on a couple of items of interest:

• **Hospitals Are Getting Better at Sharing Medication Histories and Reducing Unnecessary Stays, New AHRQ Chartbook Shows.** Nearly half of all hospitals electronically exchanged patients’ medication histories with
other hospitals by 2013, and unnecessary hospitalizations were reduced by more than 20 percent, according to AHRQ’s new *Chartbook on Care Coordination*.

- **AHRQ Research Summaries Support Decision Making About Treatments for Fecal Incontinence in Adults.** New evidence-based research summaries are available from AHRQ to help clinicians, adults and their caregivers make informed treatment decisions about fecal incontinence – the recurrent and involuntary loss of feces, defined by the frequency of episodes and consistency of the feces. The summaries present the benefits and harms of both nonsurgical and surgical treatments for fecal incontinence. Because the evidence on treatments is limited, it is important that clinicians and patients work together to decide which treatment approaches might be best. A [research summary for clinicians](#) and a companion [brochure for patients and their caregivers](#) provide important discussion points that can most affect outcome priorities and quality of life of the patient. Access the full [research review](#), or obtain more evidence-based clinician and consumer publications about treatment options for a variety of health conditions at the [Effective Health Care Program](#) website.

- **AHRQ Study: Hospital Readmissions Less Likely With High-Quality Discharge Planning.** Hospital patients who receive high-quality discharge planning are less likely to be readmitted within 30 days, according to an AHRQ study that examined 2.1 million hospital patients in 16 states who were treated for heart attack, heart failure, pneumonia and total hip or joint replacement. According to the study, ideal discharge planning begins several days in advance, with the goal of ensuring that patients understand basic questions such as where they will go after discharge, what special care and medications they may need, whether they must restrict certain foods or activities and what symptoms to monitor. The study found an increased likelihood that if readmissions did occur, most patients would return to the same hospital for continued treatment. Researchers used AHRQ’s [Hospital Consumer Assessment of Healthcare Providers and Systems](#) survey data to measure the quality of hospitals’ discharge planning and AHRQ’s [Healthcare Cost and Utilization Project](#) data to study hospital readmissions. The study cited the cost of readmissions, indicating that Medicare spent $17.5 billion in 2012 on hospital readmissions that occurred within 30 days of discharge. “Discharge Planning and Hospital Readmissions” and [abstract](#) were published in *Medical Care Research and Review*. In addition, AHRQ has tools for [hospitals](#) and [patients and families](#) to help prevent avoidable readmissions.

5) The U.S. Food and Drug Administration (FDA) posted an alert “Oral Liquid Docusate Sodium by PharmaTech: Recall - Contaminated with B. Cepacia.” The FDA is alerting health care professionals that PharmaTech LLC, Davie, Florida, is voluntarily recalling all non-expired lots of Diocto Liquid, a docusate sodium solution distributed by Rugby Laboratories, Livonia, Michigan. The agency confirmed the product has been contaminated with Burkholderia cepacia, a bacteria linked to an outbreak in five states. FDA joins CDC in recommending that clinicians not use any liquid docusate sodium product as a stool softener or for any other medical purpose. FDA and CDC will provide additional information when it is available.

6) The U.S. Office of the Inspector General (OIG) recently released a report entitled, “Adverse Events In Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries.” Almost 30 percent of patients who receive care at inpatient rehabilitation hospitals experience some sort of harm relating to their care, according to a [new government report](#). The Department of Health and Human Services' Office of Inspector General found that nearly 29 percent of Medicare beneficiaries admitted to inpatient rehab facilities experience an adverse event during their stay including health care-acquired infections, medication errors and pressure ulcers. That rate places rehab hospitals — which require patients to have at least three hours of therapy per day, five days a week — just above the care-related harm rate for skilled nursing facilities. A [2014 OIG report](#) found one in five skilled nursing patients suffered some type of adverse event during their stay.

7) The Illinois Department of Healthcare and Family Services (HFS) posted the following notices:

- HFS has posted a new provider notice regarding Chapter J-200, Handbook for Providers of Therapy Services – Reissue. You may view the notice [here](#).
HFS has posted a new Dental Fee Schedule to the Dental page. You may view the new Dental Fee Schedule [here](#).

8) The Illinois Department of Public Health (IDPH) Town Hall regional meetings dates are below. They are very informal and an excellent opportunity to ask questions. Please have staff from each facility attend one of these Town Hall Meetings. Contact the IDPH Regional Office to RSVP due to limited space in some locations.

- 8/11 – Hamilton Memorial Rehab – McLeansboro – 1-3 p.m.
- 8/31 – Memorial Education Building – O’Fallon – 1-3 p.m.
- 9/14 – Alden Estates of Shorewood – Shorewood – 1-3 p.m.
- 10/19 – Brookens Building – Champaign – 1-3 p.m.
- 11/15 - Friendship Village – Schaumburg – 10 a.m.-12 noon

9) The Illinois Department on Aging posted the following report, “Long Term Care Ombudsman Program (LTCOP) Benchmark Review Report for FY 2016” ([click here](#)).

10) The American Health Care Association (AHCA) announced that the Five-Star Preview Reports are now available ([click here](#)). Your new Five-Star data, which reflects changes that include the addition of five new quality measures (QMs), is now available for review through the CMS QIES System. Instructions on how to access your preview report are available on the members-only ahcancalED site [here](#). On Thursday, July 28 at 3 PM ET, AHCA will host an all-member webinar to walk through the new changes and answer any questions. Please be sure to register [here](#)!

11) The latest Telligen events/announcements can be found at [https://www.telligenqinqio.com/](https://www.telligenqinqio.com/).

12) Kaiser Health News reports:

- **Research Letter Indicates Medicare Beneficiaries Have Highest Rate Of Opioid Use Disorder.** *Kaiser Health News* reports “a research letter published Wednesday in *JAMA Psychiatry* found Medicare beneficiaries had the highest and most rapidly growing rate of ‘opioid use disorder.’” Data show six out of every 1,000 Medicare beneficiaries “struggle with the condition, compared with one out of every 1,000 patients covered through commercial insurance plans.” In addition, the letter suggested “Medicare beneficiaries may face a treatment gap,” because figures indicate that in 2013, physicians “prescribed a high number of opioid prescription painkillers for this population – which put patients at risk for addiction – but far fewer prescriptions for buprenorphine-naloxone, the only effective drug therapy for opioid use disorder covered by Medicare Part D.”

- **Feds Keep Watch For Fraud, Overbilling On Compounded Medicines.** *Kaiser Health News* reports that as government spending on “compounded” drugs that are custom made by retail pharmacists, Federal investigators are paying closer attention, looking for “potential fraud and overbilling.” Medicare Part D spending on such medications “rose 56 percent last year,” and “over just four years, the federal workers’ compensation program saw its spending on compounded medications spike from $2.35 million to $214 million.” According to Miriam Anderson, who helped oversee a June report on Medicare spending by IG at HHS, those increases, “along with a sharp jump in the number of patients getting compounded drugs, ‘may indicate an emerging fraud trend.’”

- **Seniors Often Leaving Hospital With Opioid Prescriptions, Study Finds.** *Kaiser Health News* reported a study analyzing “pharmacy claims of a random sample of more than 623,000 Medicare beneficiaries who were hospitalized in 2011,” first published online in *JAMA Internal Medicine* last month, found “that 14.9 percent of the hospitalized beneficiaries filled a prescription for an opioid within a week after being discharged,” and of those who filled a prescription, “42.5 percent had another pharmacy claim for an opioid painkiller at least 90 days later.” The study only analyzed people who did not previously have an opioid prescription claim “for at least 60 days before being hospitalized.”
Medicare Spending Per Person Peaks At Age 73, Study Finds. Kaiser Health News reports Medicare spending per person peaks at age 73 and then falls significantly, according to a report from the Kaiser Family Foundation. Researchers were surprised that the average Medicare spending per person was $43,353 for people age 73, but then lower at $33,381 for people age 85 and $27,779 for people age 90. The Kaiser Family Foundation’s associate director of the program on Medicare policy Juliette Cubanski says the research goes against the conventional wisdom that physicians “are throwing everything including the kitchen sink at people at the end of life regardless of how old they are.”

13) New Virtual Reality Program Aimed At Elderly. On its website, the NPR “Shots” blog reports that new virtual reality programs that target seniors are being developed. The article highlights Dr. Sonya Kim who helped develop Aloha VR, which allows participants to visit a virtual world that features pictures of beaches. According to Dr. Kim, research has shown that virtual reality can help patients manage anxiety, chronic pain, and depression, so it could improve seniors’ health.

14) More Seniors With Disabilities Opting To Live At Home, Study Suggests. HealthDay reports more seniors with disabilities are deciding to live at home, according to a new study published in the Journal of the American Medical Association. Researchers from the University of Michigan found that the proportion of seniors with a disability receiving some type of home health care increased from 42 percent in 1998 to nearly half in 2012.

15) Modern Healthcare reports:

- CMS Releases Guidance On Value-Based Drug Purchasing. Modern Healthcare reports that CMS released a guidance document encouraging state Medicaid agencies and manufacturers that drug purchasing contracts’ payments be “based on outcomes to offset high drug costs.” In response to manufacturer concerns “that lower price offers and additional service offerings contained in” value-based purchasing “agreements would lower the manufacturers’ calculated best price and add to their rebate obligations, making the agreements less attractive to drugmakers,” CMS says “that the impact on manufacturers’ best prices will differ based on the structure of individual VBP arrangements, so the agency recommends that manufacturers consult federal law and regulations surrounding best price and ask the CMS if they need any further assistance.”

- HHS Transgender Anti-Discrimination Rule To Take Effect. Modern Healthcare reports that next week HHS’ policy against discriminating against patients based on their gender or gender identity goes into effect. While insurers are not explicitly required to cover gender-transition treatments, they “could face questions if they deny medically necessary services related to gender transition.” Meanwhile, “in the days leading up to implementation of the rule, there were few signs that providers were ready.”

16) Provider Magazine reports:

- FDA Approves Device That Can More Quickly Identify Certain Forms Of Antibiotic-Resistant Bacteria. Provider Magazine reports the US Food and Drug Administration “recently cleared for marketing the Xpert Carba-R Assay, an infection control aid that tests for specific genetic markers associated with bacteria that are resistant to carbapenem antibiotics.” Alberto Gutierrez, Ph.D., the director of the FDA’s Office of In Vitro Diagnostics and Radiological Health, says, “By using a specimen taken directly from a patient to test for the presence of genetic markers, hospitals can more quickly identify these dangerous bacteria resistant to certain antibiotics.”

- What Caregivers Need to Know About Aging Eyes. With the aging of the baby boomer generation, the growing prevalence of eye diseases and vision loss has become a major public health concern. As such, directors of skilled nursing care, assisted living, and rehabilitation centers need to be equipped with science-based information to educate and train staff on key eye health issues affecting their residents and patients.

17) Caregivers Sharing Inappropriate Photos And Videos Of Nursing Home Residents on Social Media. On its website, WITI-TV Milwaukee reports on the “growing problem across the country of caregivers abusing, degrading and
humiliating the elderly on social media.” The article highlights several examples of caregivers in nursing homes taking inappropriate photos and videos of residents, sometimes while abusing them, and then sharing them through social media. American Health Care Association spokesman Greg Crist says his organization takes the problem seriously. Crist said, “The good news is it’s uncommon. It’s rare — one case is one too many.”

Op-Ed Discusses Examples Of Social Media Used To Degrade Nursing Home Residents. In a piece for McKnight’s Long Term Care News, Editorial Director John O’Connor writes on social media posts that are degrading to nursing home residents, briefly highlighting a few incidents. O’Connor adds that the American Health Care Association “has been far more vigilant” in addressing the issue. The association “recently posted suggestions intended to help its more than 11,000 members better deal with this ugly side of social media.” Its 13-page document “urges providers to review social media policies, conduct related training and investigate possible abuses. It also offers specific ways operators can respond to possible scenarios.”

18) LDL-C Variability In Seniors May Be Associated With Impaired Cognitive Function. MedPage Today reports that in seniors, “higher 'visit-to-visit' variability in” low-density lipoprotein cholesterol (LDL-C) “levels had negative implications for the brain – independent of mean LDL-C levels and statin treatment.” The findings of the 4,428-participant study were published online in Circulation.

19) White Paper Says Value-Based Reimbursement In Healthcare Will Surpass Fee-For Service By 2020. The American Journal of Managed Care reports that in a new white paper that McKesson Corporation says the move “toward value-based reimbursement in health care picked up steam over the past two years, and if trends continue, new payment models will bypass fee-for-service by the year 2020.” The article adds that HHS Secretary Sylvia Mathews Burwell said that Medicare has already reached this year’s goal of basing 30 percent of payments on alternate models, and the goal for 2018 is 50 percent.” Meanwhile, last week, Acting CMS Administrator Andy Slavitt told lawmakers that the Medicare Access and CHIPs Reauthorization Act (MACRA) “might need to be delayed, because many small practices and rural providers are not ready to comply.”

20) Loss Of Independence After Surgery For Older Patients Associated With Increased Risk Of Hospital Readmission. In a study published online by JAMA Surgery, Julia R. Berian, M.D., of the American College of Surgeons, Chicago, and colleagues examined loss of independence (LOI; defined as a decline in function or mobility, increased care needs at home, or discharge to a non-home destination) among older patients after surgical procedures and the association of LOI with readmission and death after discharge. Currently, quality metrics prioritized by hospitals and medical professionals focus on discrete outcomes, such as readmission or mortality.

21) Antibiotics: New CDC Stewardship Program Will Affect Most US Prescribers. Antibiotic resistance has been declared a crisis by the Centers for Disease Control and Prevention (CDC), the World Health Organization and President Obama. The concern is that we will soon face a "post-antibiotic era." The genesis of this crisis was the failure of new antibiotics to keep pace with resistance and the massive overuse of these drugs. A shocking observation is that on any given day, about 50 percent of all hospitalized patients in the United States receive antibiotics. The consensus is that antibiotics are given too often, for too long, and are too broad in spectrum. The CDC has responded with a comprehensive program designed to facilitate the smart use of antibiotics, slow resistance and improve patient care. All health care facilities that receive funding from the CMS will be required to participate in the program, so all health care providers who prescribe antibiotics within these facilities will likely be affected.

22) MedlinePlus reports:

- **ER Death Rate In U.S. Drops By Nearly Half.** Hospital emergency room deaths in the United States plummeted by nearly half over a 15-year period, with several factors likely accounting for the drop, a new study indicates. The upshot: It’s unlikely you’ll die in the ER, say researchers who analyzed almost 368,000 emergency department visits by adults between 1997 and 2011. They found a 48 percent reduction in deaths over that period.

- **Why Kicking The Opioid Habit Can Be So Tough.** He was 26, a specialist fifth class with the U.S. Army, and stationed abroad, when an accident on the German autobahn sent him careening through the windshield of
his car. The now 60-year-old veteran prefers to withhold his name, but not his story, of a decades-long struggle against chronic back pain and an addiction to the opioid painkillers he'd hoped would help him.

23) Medical News Today reports:

- **Cheap Blood Test Can Discriminate Between Bacterial, Viral Infections, Study Finds.** Researchers at the Stanford University School of Medicine have made an important breakthrough in their ongoing efforts to develop a diagnostic test that can tell health-care providers whether a patient has a bacterial infection and will benefit from antibiotics.

- **Promising New Methods For Early Detection Of Alzheimer’s Disease.** New methods to examine the brain and spinal fluid heighten the chance of early diagnosis of Alzheimer’s disease. Results from a large European study, led by researchers at the Karolinska Institutet, are now published in the medical journal Brain. These findings may have important implications for early detection of the disease, the choice of drug treatment and the inclusion of patients in clinical trials. Despite many years of intensive research, no effective treatment currently exists for Alzheimer's disease, which is the most common form of dementia. It has become increasingly clear that, if the disease is to be treated successfully, it must be detected early, perhaps even before symptoms are evident. Thus, there is a great need for reliable diagnostic methods so that treatment to slow or prevent the disease can begin as early as possible.

24) McKnight’s reports:

- **Diversity In Age, Ethnicity Of Post-Acute Residents Increasing, Research Finds.** The long term care population has grown more diverse in age and ethnicity over recent decades, according to new research published in JAMDA: The Journal of Post-Acute and Long-Term Care Medicine. The results, last month, found the proportions of nursing home residents younger than 65 and those older than 85 increased 7 percent and 4.5 percent, respectively, from 1995 to 2012. The majority of residents were still between 65- and 85-years-old, researchers noted.

- **Answers To Lingering Questions About PBJ.** As you hopefully know by now, CMS’ required Payroll-Based Journal reporting is upon us. Even though the kick-off date was earlier this month, it’s understandable that questions still cloud this new process. It behooves providers to get up to speed and become better informed as soon as possible. An initiative from the Affordable Care Act requires that nursing facility staffing data be reported electronically to CMS starting July 1, 2016. One mechanism for reporting staffing data is via the Payroll-Based Journal (PBJ) upload process.

- **Navigating the Five-Star Conflict For The Mentally Ill.** Skilled nursing facilities across the country are seeing an increasing number of patients who suffer from mental health conditions. According to a study in published in the journal Health Affairs in 2009, more than 500,000 persons with mental illness (excluding dementia) reside in U.S. nursing homes on a given day, far more than the number in all other institutions combined. Unfortunately for the skilled nursing facilities and healthcare providers treating these patients, the Five-Star Quality Rating System for nursing homes can be directly at odds with the Centers for Medicare & Medicaid Services’ guidelines for nursing homes when it comes to diagnosing and treating patients with mental health conditions.

- **National Nursing Home Hiring Upswing Continues.** The nursing home industry added 3,100 jobs in June, according to new data from the Bureau of Labor Statistics. Click here to read the BLS’ full Employment Situation report for June 2016.

- **End-Of-Life Orders Widely Embraced By SNF Residents, Study Finds.** Nearly half of all nursing home residents in California completed a form expressing their end-of-life wishes in 2011, showing the state's widespread acceptance of the orders. The first-of-its-kind study included data from 296,276 people residing in one of
California's 1,220 nursing homes in 2011. Researchers found completion of the POLST forms grew from 33 percent at the start of 2011 to 49 percent by the end of the year.

- **Electronic Hand Hygiene Monitoring Cuts MRSA Rates By 42 Percent.** Use of an electronic hand hygiene monitoring system decreased the rate of healthcare-acquired MRSA infections in one health system by 42 percent, research shows. Investigators with the Greenville Health System in Greenville, SC, used data collected by an electronic compliance system to track how health care workers adhered to the World Health Organization's Five Moments hand hygiene guidelines. Results showed that compliance rates increased 25.5 percent when the electronic system was used, and the organization's rate of health care-associated MRSA infections dropped 42 percent. That infection decrease saved the provider nearly $434,000 in total care costs between July 2012 and March 2015.

- **CMS: Fraud Prevention Efforts Saved Medicare, Medicaid $42 Billion.** CMS' fraud prevention efforts saved the agency $42 billion dollars in fiscal years 2013 and 2014. That amounts to $12.40 for every dollar invested in the agency's Medicare fraud, waste and abuse programs, Shantanu Agrawal, M.D. deputy administrator and director for the CMS Center for Program Integrity said in a blog post published Wednesday. Those savings were largely made through efforts to prevent improper payments, as opposed to the traditional “pay-and-chase” method of recovering payments after they had already been made, Agrawal said. Prevention activities accounted for 68 percent of the agency's total savings in 2013, rising to nearly 74 percent in 2014. That percent is estimated to grow again in 2015 according to preliminary data.

- **Feds Acknowledge “Large Gaps” in HIPAA Regulation Of Health Apps, Wearable Tech.** The rise of health-focused mobile applications, websites and wearable technologies has left gaps in regulations meant to protect consumers' data, according to a long-awaited federal report. The report, released in June by the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology, identifies gaps that exist between data covered by HIPAA and the information collected by non-traditional healthcare organizations that aren't included in HIPAA's coverage. The report was originally supposed to be completed in 2010.

25) **Interesting Fact:** (AP) The typical American adult is using media for a full hour a day more than just last year, with smartphones accounting for most of the increase.

If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don’t hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!