September 6, 2016 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat will feature focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

IDPH Bureau of Long Term Care

The IDPH Bureau of Long-Term Care is made up of three Divisions, the Division of LTC Field Operations (LTCFO), the Division of Long-Term Care Quality Assurance (LTCQA) and the Division of Assisted Living. This article will focus just on LTC. Quite simply, the Division of LTC Field Operations performs the surveys and LTC Quality Assurance processes the surveys for both state licensure and federal Medicare/Medicaid certification.

Approximately 1141 facilities are regulated under the Illinois Nursing Home Care Act (210 ILCS 45), the ID/DD Community Care Act (210 ILCS 47) and the MC/DD Act (210 ILCS 46) and/or federal requirements for Medicare and/or Medicaid. Of the 1141 facilities, 1050 are licensed under the three Acts noted above and 91 are associated with a licensed hospital operated as a nursing home under the Hospital Licensing Act (210 ILCS 85). A total of 1050 (92 percent) of the 1141 facilities participate in the federal certification program for Medicare and/or Medicaid. Approximately 214 surveyors (nurses, sanitarians, dietitians and architects) and 32 field supervisory staff conduct the filed survey activities that include annual, complaint, follow-up, initial, incident report and special LTC surveys. The current surveyor to bed ratio is approximately 1:400. The Nursing Home Care Act requires a 1:300 ratio, but due to the budget problems and lengthy personnel processes, hiring is delayed.

LTC Field Operations conducts approximately 925 surveys per month including all the types noted above. If a facility is federally certified, that survey usually takes the lead. The structure, format and time frame of federal certification activities are mandated and regulated by the U.S. Department of Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (CMS). While state licensure is mandatory under the Nursing Home Care Act, federal certification is a voluntary program. Participation allows a facility to admit and provide care for clients who are eligible for Medicare and/or Medicaid. Facilities providing long term care that are located within and operated by a licensed hospital are not required to have an additional state license under the Illinois Nursing Home Care Act. Facilities operated as intermediate care facilities for the intellectual/developmentally disabled by the Illinois Department of Human Services are also not required to have an additional State license under the Nursing Home Care Act.

Please click here for the most recent IDPH Long-Term Care Statistical Report.

Summary of Surveys Conducted by LTC Field Operations in 2015 – approximately 11,000 surveys conducted

- Annual Licensure/Certification Surveys and Follow-up Surveys – 5436
- Licensure/Certification Complaint Investigations – 5668
- Licensure Probationary/Initial Surveys/Change of Ownerships – 67
- Replacement Facilities - 1
- New Facilities - 2
- Bed/Service Change – 48
- Closures – 23
In 2015, there were approximately 39,971 incident reports received by IDPH from LTC facilities.

In 2015, IDPH imposed more than $2.2 million in licensure fines against facilities and collected $1,452,613, as compared to $1,067,596 collected in 2014. The amount collected would not necessarily be from those fines imposed in 2015, since most fines are contested by facilities and go through a hearing process before collection.

Under federal Medicare/Medicaid federal certification, $1,096,397 in penalties were imposed on certified facilities in 2015.

**Total Licensure Violations Issued***

<table>
<thead>
<tr>
<th>Violation Level</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>“AA” Violation</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>“A” Violation</td>
<td>99</td>
<td>69</td>
</tr>
<tr>
<td>Repeat “A” Violation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>“B” Violation</td>
<td>413</td>
<td>376</td>
</tr>
<tr>
<td>Repeat “B” Violation</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

* Violations issued from all survey types, including annual, complaint, and re-inspections

There have been some changes in supervisory staff within IDPH LTC Central and Regional Offices. Click here to view the most recent Regional and Central Office contact numbers.

**Reducing Hospital Readmissions**

What are the best interventions a long term care facility can put in place to reduce re-hospitalizations and avoid the 2 percent Medicare withhold? First, be sure to know and track your re-hospitalization rates. If your risk adjusted rate is less than 12 percent, you are probably in good shape at this point in time. The percentage before penalty will probably be lower in the future. If your rate is greater than 20 percent, you are definitely at risk of having a 2 percent withhold. A great free Excel tool that you can use is found on the Advancing Excellence website.

One of the most effective strategies is to implement the INTERACT program. This will ensure that you have a robust transitions-of-care program in use. LTC facilities/centers using INTERACT are showing significant improvement in reducing rehospitalizations. As a system, it requires that you focus on the purpose of each component. Make sure that the Stop & Watch and SBAR tools are used consistently, and don’t forget to include families.

Treat rehospitalizations as triggers to have end-of-life discussions. Helping families and residents to clarify their goals, to understand the complexities of their condition and the capabilities of the facility/centers staff has proved to be an essential component to reducing needless re-hospitalizations.

For more information, please click here. Information in this article was provided by Dr. David Gifford, senior vice president of quality and regulatory affairs, AHCA/NCAL.

**AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 9 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: Cause Identification

Key Takeaways: Cause Identification

- Cause identification refers to finding the reason(s) for an event or a situation.
- Finding causes allows us to intervene and figure out whether and to what extent we can correct the underlying issues related to a problem, situation, or symptom.
- By gathering information systematically to clarify issues or problems, organizations can make improvements to avoid potential near misses in the future.
- Cause identification methods should be built in to everyday processes so they are used in real time throughout the day, as well as retroactively to analyze situations that already occurred.

<table>
<thead>
<tr>
<th>Probing Questions for Team Reflection and Discussion:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What processes do we have in place currently to support cause identification? How can we make it better?</td>
</tr>
<tr>
<td>2. How are lessons from investigations and cause analysis activities communicated with all staff and acted upon?</td>
</tr>
<tr>
<td>3. Do staff from all disciplines participate in cause analysis?</td>
</tr>
</tbody>
</table>

Visit the AHCA Clinical Practice website to learn more about the element of “Clinical Foundation: “First of All, Do No Harm” Thinking Built Into 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.

**IDPH Division of Life Safety and Construction – Field Services Section**

This IDPH Division is responsible for conducting life safety code nursing home surveys and life safety code/ physical environment complaint surveys on behalf of the CMS. Field Services conducted 1,859 surveys and cited 7,105 deficiencies; this was a 50 percent reduction in the number of deficiencies cited in the previous year. The Division attributes this reduction of deficiencies to the mandated CMS sprinkler requirement effective 08/13/13. In 2014 many facilities were cited for sprinkler installation deficiencies, and providers have since corrected those issues resulting in a significant decrease in the number of citations. This includes 968 annual surveys for life safety, 835 life safety code follow up to annual surveys, 26 complaint surveys, seven complaint survey follow ups, four initial CMS certification
surveys and nine licensure complaint surveys. In addition, the section completed reviews of 968 Plans of Correction (POCs) in conjunction with the onsite inspections.

The Field Services Section tracks reports of fire incidents. In this reporting period, 24 fires were reported to the Division. No deaths were reported due to these incidents, one staff suffered an ankle injury and four residents suffered smoke inhalation. The statistics on those fire incidents are as follows:

<table>
<thead>
<tr>
<th>Cause fire/number</th>
<th>Detection type/number</th>
<th>Extinguishment type/number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrical</td>
<td>Staff</td>
<td>Staff</td>
</tr>
<tr>
<td>Arson</td>
<td>Fire alarm</td>
<td>Fire Department</td>
</tr>
<tr>
<td>Unknown</td>
<td>Resident</td>
<td>Sprinkler</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td>Resident</td>
</tr>
<tr>
<td>Mechanical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitchen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical</td>
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<td></td>
</tr>
</tbody>
</table>

The maintenance of smoke and fire detection systems, fire extinguishment systems and the practice of fire drills, as part of staff education which familiarizes staff with the procedures to follow in an emergency situations, can be attributed to the reduction in the severity of fire incidents and reported injuries. Staff architects, electrical systems specialists, and mechanical/fire protection specialists review initial construction and major remodeling plans to ensure compliance with state licensure rules and the National Fire Protection Association (NFPA) Life Safety Code.

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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 16-35 – LSC** - Revisions to the State Operations Manual (SOM), Appendix I. Revisions to the SOM, Appendix I, Task 4: CMS is reinstating guidance that was inadvertently removed to Life Safety Code (LSC) surveyors regarding the survey procedures for Task 4, Information Gathering, within Appendix I of the SOM. Updating Appendix I with information regarding sharing of deficiency tags during Exit Conference: CMS is also updating Appendix I, Task 6 with more specific information regarding sharing specific regulatory references or tags during the exit conference. This information was previously outlined in and is consistent with Survey and Certification policy memorandum (S&C 16-11-ALL).

- **S&C 16 -36 – HHA** - Extension and Expansion of the Provider Enrollment Home Health Agency (HHA) Moratoria. Effective July 29, 2016: CMS extended the previous HHA moratoria to encompass the entire states of Illinois (IL), Florida (FL), Michigan (MI) and Texas (TX) for a period of six months. No initial HHA Medicare surveys may be conducted in the above states and all activities on initial certification actions in progress at the State Survey Agency (SA) or Regional Office (RO) as of that date must cease. Any prospective HHA provider that had an initial application still in progress on July 29, 2016 and received an enrollment denial notification from the Medicare Administrative Contractor (MAC) must reapply as a new applicant once the moratorium is lifted. In conjunction with the extension of the moratoria, CMS will initiate a Provider Enrollment Moratoria Access Waiver Demonstration (PEWD) for HHAs in moratoria-designated geographic locations. These waivers will be evaluated by the Center for Program Integrity (CPI). Any waivers issued by CPI will be made on a case by case basis in response to access of care concerns. If a waiver is issued, CPI will notify the applicable SA and RO to confirm that a survey may be conducted within the moratorium area pursuant to the waiver. SAs and ROs should refer all questions regarding the moratoria to the applicable MAC.
CMS releases final rule to increase civil monetary penalties. Maximum civil monetary penalties for skilled nursing providers will more than double under a final rule released by the Department of Health and Human Services and CMS. The rule, which implements the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, adjusts the penalties to reflect inflation and “maintain their deterrent effect.” The final rule is set to become effective upon its publication in the Federal Register on September 6. The adjustments will raise the maximum penalty for out-of-compliance skilled nursing facilities from $10,000 per day to $20,628. This marks the first time that the CMPs have been adjusted since 1987. Additional CMPs that will increase under the rule include penalties for individuals who notify skilled nursing facilities when a survey is going to be conducted, a penalty for improper billing and penalties per instance of a skilled nursing facility failing to meet certification requirements. The penalties adjustment act, included as a provision of the Bipartisan Budget Act of 2015, earned criticism from provider groups when it was first unveiled in November for placing an undue burden on providers “striving to do the right thing.” Click here to read the full list of CMPs that will increase under the final rule. (McKnight’s)

CMS Plans to Release Final Version Of Rule Governing Nursing Homes By End Of September. Congressional Quarterly reports that CMS plans to release the final version of a proposed rule update that could impose new costly requirements on nursing homes and other long term care centers by September 30. The article mentions the American Health Care Association as one of the “organizations that helped drive the debate over the proposed rule.” David Gifford, the American Health Care Association’s senior vice president for quality and regulatory affairs, said, “We anxiously await to see if CMS took into consideration any of the several thousand comments they received and how they will phase in the proposed changes once finalized.”

Final Emergency Preparedness Rule For Medicare, Medicaid Providers Expected In December or possibly sooner. The White House Office of Budget and Management completed a review Monday of a rule that could update emergency preparedness requirements for Medicare and Medicaid providers. The update would require providers to ‘adequately plan for both natural and [manmade] disasters,’ according to reginfo.gov. Final action on the rule is expected in late December. Click here to review the original rule. Basically, this rule tells providers to track the location of staff and patients, and ensure that medical records are secure and available in the event of an emergency. In addition, providers will have to decide which emergency planning information can be shared with residents and families, along with considering power needs and such during emergencies.

ICD-10 Information

- CMS: Grace Period for ICD-10 Switch To Expire Oct. 1 As Planned. CMS said last week that the “12-month grace period meant to ease providers’ transition to Medicare ICD-10 will officially come to a close on October 1.” In order to prepare for the end of the grace-period, CMS “encouraged providers to avoid unspecified ICD-10 codes whenever documentation supports a more detailed code.” The agency “also noted that many providers have made the switch from ICD-9 to ICD-10 with ‘essentially no adverse effects on coding accuracy.’”

- 2017 ICD-10-CM and ICD-10-PCS Code Updates. The 2017 ICD-10-CM and ICD-10-PCS code updates, including a complete list of code titles, are available on the 2017 ICD-10-CM and GEMs and 2017 ICD-10-PCS and GEMs webpages. The posted files contain the complete versions of both ICD-10-CM (diagnoses) and ICD-10-PCS (procedures). The following resources are also available for 2017:
  - General Equivalence Mappings (GEMs) – Diagnosis Codes
  - ICD-10-CM Guidelines
  - General Equivalence Mappings (GEMs) – Procedure Codes
  - ICD-10-PCS Coding Guidelines
  - Present on Admission (POA) Exempt Codes

Visit the ICD-10 website for the latest news and official resources, including the Next Steps Toolkit, Quick Start Guide, and a contact list for provider Medicare and Medicaid questions.
ICD-10: Updated Questions and Answers. Updates to the clarifying Questions and Answers related to the July 6, 2015, CMS/AMA joint announcement and guidance regarding ICD-10 flexibilities are available. See the ICD-10 website for more resources, including Contacts for Medicare and Medicaid Questions.

ICD-10 Assessment and Maintenance Toolkit. The ICD-10 Assessment and Maintenance Toolkit can help you maintain your ICD-10 progress. This in-depth toolkit shows how you can manage your revenue cycle by:

- Assessing ICD-10 progress using Key Performance Indicators (KPIs) to identify potential productivity or cash flow issues
- Addressing opportunities for improvement
- Maintaining progress and keeping up-to-date on ICD-10

The toolkit is also available as an infographic with an accompanying fact sheet on KPIs to help you analyze and track your ICD-10 progress. Visit the ICD-10 website for the latest news and official resources, including the Quick Start Guide and a contact list for provider Medicare and Medicaid questions.

Programs of All-Inclusive Care for the Elderly. The Programs of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that provides comprehensive medical and social services that enable older adults to live in the community instead of a nursing home or other care facility. More than 34,000 older adults are currently enrolled in about 100 PACE organizations in 31 states, and enrollment in PACE has increased by over 60 percent since 2011. On August 11, CMS proposed a rule to update and modernize the PACE program, including:

- Strengthening protections and improving care for beneficiaries
- Providing administrative flexibility and regulatory relief for PACE organizations

For More Information:

- Proposed Rule: Comments are due October 17.
- Blog: Delivering on the Promise of Better Care for Older Adults
- PACE webpage

See the full text of this excerpted CMS Fact Sheet (issued August 11).

Hospice Claim Adjustments Will Correct Routine Home Care Day Count. Two recent systems issues caused routine home care days to be miscounted on hospice claims:

- Systems were not counting days that should receive high routine home care payments if a revocation was posted on the benefit period before the final claim was submitted. A correction was implemented on May 9, 2016.
- Systems were using the election date instead of the admission date when a prior hospice period was involved. A correction was implemented on July 25, 2016.
- Medicare Administrative Contactors are adjusting hospice claims to correct payment. Hospices do not need to take any action.

HIPAA

- Health Insurance Portability and Accountability Act (HIPAA) EDI Standards Web-Based Training Course — Revised. With Continuing Education Credit. The HIPAA Electronic Data Interchange (EDI) Standards Web-Based Training (WBT) course is available through the Learning Management and Product Ordering System. Learn about:
  - Standards and code sets mandated under HIPAA
  - Information regarding electronic billing and other health care transactions
  - The steps involved in the Medicare EDI process
HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Revised. A revised HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet is available. Learn about:

- Who must comply with HIPAA rules
- Covered entities
- Enforcement

PY 2015 Medicare ACO Results. On August 25, CMS announced the 2015 performance year results for the Medicare Shared Savings Program and the Pioneer Accountable Care Organization (ACO) Model that show physicians, hospitals and health care providers participating in ACOs continue to make significant improvements in the quality of care for Medicare beneficiaries, while achieving cost savings. Collectively, Medicare ACOs have generated more than $1.29 billion in total Medicare savings since 2012.

In 2015, Medicare ACOs had combined total program savings of $466 million, which includes 392 Shared Savings Program participants and 12 Pioneer ACO Model participants. The results show more ACOs shared savings in 2015 compared to 2014 and those with more experience tend to perform better over time.

All 12 participants in the Pioneer ACO Model improved their quality scores from 2012 to 2015 by more than 21 percentage points. Overall quality scores for nine out of 12 Pioneer participants were more than 90 percent in 2015.

ACOs in the Shared Savings Program also continued to show improvement, with ACOs that reported in both 2014 and 2015 improving on 84 percent of the quality measures that were reported in both years. Additionally, comparing 2014 and 2015 results, average quality performance improved by more than 15 percent on key preventive care measures.

For More Information:
- Medicare ACOs 2015 Performance Year Quality and Financial Results Fact Sheet
- Shared Savings Program website
- Pioneer ACO Model website

See the full text of this excerpted CMS press release (issued August 25).

SNF Quality Reporting Program Webcast — September 14. Wednesday, September 14 from 1:30 to 3 pm ET. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. Learn about the reporting requirements for the new Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), effective October 1, 2016. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) established the SNF QRP and requires the submission of standardized data. A question and answer session will follow the presentation.

Agenda:
- Overview of the IMPACT Act and the SNF QRP
- Resources for providers
- Three Quality Measures (QMs) finalized for SNF QRP in FY 16 SNF Prospective Payment System (PPS) Final Rule
- Four QMs Finalized in FY 17 SNF PPS Final Rule
- Data collection timeframe and data submission deadline for the FY 18 payment determination
- Consequences of not meeting the data submission deadline
- Reconsideration and exception and extension procedures

Target Audience: SNF providers.

National Partnership to Improve Dementia Care and QAPI Call — September 15. Thursday, September 15 from 1:30 to 3 pm ET. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. This call focuses on effective care transitions between long-term and acute care settings,
highlighting transitions that involve residents with dementia. This is critical for residents with dementia, as care transitions can cause heightened anxiety and aggression. Communication should be optimized, as care transitions are high-risk periods for nursing home residents. Additionally, CMS experts share updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations.

**Speakers:**
- Dr. Kevin Biese, University of North Carolina (UNC), Department of Emergency Medicine
- Tammie Stanton, UNC Health Care System
- Kathryn Weigel, Rex Rehabilitation & Nursing Care Center of Apex
- Scott Bartlett, Pikes Peak Area Council of Governments – Area Agency on Aging
- Michele Laughman and Debbie Lyons, CMS

**Target Audience:** Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

- **SNF Value-Based Purchasing Program Call — September 28.** Wednesday, September 28 from 1:30 to 3 pm ET. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. Learn how the implementation of the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program will affect your Medicare payment. During this call, CMS experts discuss the legislative background, along with the SNF 30-Day Potentially Preventable Readmission measure, performance standards, and scoring methodology finalized in the FY 2017 SNF Prospective Payment System final rule. Also, find out about the confidential quarterly feedback reports you will receive beginning on October 1, 2016. A question and answer session will follow the presentation. The SNF VBP Program rewards SNFs with incentive payments for quality of care, promoting better clinical outcomes for SNF patients. The program will begin in FY 2019.

  **Agenda:**
  - Legislative framework
  - Program measures
  - Performance standards and scoring methodology
  - Confidential quarterly reports
  - Where to find additional information about the Program

  **Target Audience:** SNFs, administrators, and clinicians.

3) **Prepare for the 2016-2017 Flu Season.** For the 2016-2017 season, CDC recommends use of the flu shot (inactivated influenza vaccine or IIV) and the recombinant influenza vaccine (RIV). The nasal spray flu vaccine (live attenuated influenza vaccine or LAIV) should not be used during 2016-2017. The 2016-2017 influenza vaccination recommendations are now available.

While current U.S. flu activity is low, some flu viruses circulate during the summer and influenza activity often begins increasing in October. CDC recommends a yearly flu vaccine for everyone 6 months and older by the end of October, if possible. Flu vaccination can reduce flu illnesses and prevent flu-related hospitalizations. Flu vaccines have been updated for the 2016-2017 season.

CDC also recommends that patients suspected of having influenza who are at high risk of flu complications or who are very sick with flu-like illness should receive prompt treatment with influenza antiviral drugs without waiting for confirmatory testing.

4) **The U.S. Equal Employment Opportunity Commission (EEOC) Issues Final Enforcement Guidance on Retaliation and Related Issues After Public Input Process.** The U.S. Equal Employment Opportunity Commission (EEOC) issued its final Enforcement Guidance on Retaliation and Related Issues, to replace its 1998 Compliance Manual section on retaliation. The guidance also addresses the separate "interference" provision under the Americans with Disabilities Act (ADA), which prohibits coercion, threats or other acts that interfere with the exercise of ADA rights. The Commission has also issued two short user-friendly resource documents to accompany the new guidance: a question-and-answer publication that summarizes the guidance document, and a short Small Business Fact Sheet that
condenses the major points in the guidance in non-legal language. "Retaliation is asserted in nearly 45 percent of all charges we receive and is the most frequently alleged basis of discrimination," said EEOC Chair Jenny R. Yang. "The examples and promising practices included in the guidance are aimed at assisting all employers reduce the likelihood of retaliation. The public input provided during the development of this guidance was valuable to the Commission in producing a document to help employers prevent retaliation and to help employees understand their rights."

5) The Illinois Department of Healthcare and Family Services (HFS) posted the following Notices:

- Claim examples for all long term care providers have been posted to the LTSS web page. The examples for the Skilled Nursing Facilities, which were posted previously, have been updated to account for a few corrections. The Receiver Name Identification Code and the Payer Name Payer Identifier have been updated in the X12 examples to show 37-1320188 rather than the number assigned by Medicare. In addition, the non-covered days for claims with discharges not due to death have been updated. The Department will be scheduling a series of Technical Assistance calls by Provider Type to allow providers to ask questions on the direct billing requirements. Please look for a notice in the next week detailing the dates and times of the calls. You may view the claim examples for all long term care providers by clicking here.

- HFS has posted a new Notice of Public Hearing on the 1115 Demonstration Waiver. You may view the Notice of Public Hearing – Section 1115 Demonstration – Update and Public Hearing Agenda here.

- HFS has posted a new Provider Notice regarding the Expansion of the Supportive Living Program for Dementia Care. You may view the notice here.

- HFS has posted a new Provider Notice regarding Minimum Data Set (MDS) 3.0 Section S Changes Effective October 1, 2016. You may view the notice by clicking here.

- HFS has posted a new provider notice regarding the Extension of the Provisional Licensure Period for Specialized Mental Health Rehabilitation Facilities (SMHRFs). You may view the notice here.

- HFS has posted a new provider notice regarding IMPACT Provider Enrollment Revalidations. You may view the notice here.

- HFS has posted a new Provider Notice regarding the Medical Electronic Data Interchange (MEDI) system and the Medicaid Managed Long Term Services and Supports (MLTSS) Program. You may view the notice by clicking here.

- HFS is requesting LTC providers complete a short Readiness Survey for Long Term Care Direct Billing found on the LTSS Long Term Care Direct Billing webpage. Please respond no later than Friday, September 9, 2016, so that HFS can determine additional support that is needed. Click here for the survey.

- HFS has posted a new Notice of Public Information regarding the Section 1115 Research and Demonstration Waiver. You may view the public notice here.

- An HFS FAQ document and a document providing testing procedures have been posted to the LTSS Direct Billing webpage. Click here to view it.

6) The Illinois Department of Public Health (IDPH) remaining 2016 IDPH Town Hall regional meetings dates are as follows. They are very informal and an excellent opportunity to ask questions. Please have staff from each facility attend one of these Town Hall Meetings. All reservations should be made via email to Lisa.Reynolds@illinois.gov. Please include the words ‘Town Hall Reservation’ in the subject line.

9/14 – Alden Estates of Shorewood – Shorewood – 1-3pm
10/19 – Brookens Building – Champaign – 1-3pm
11/15 - Friendship Village – Schaumburg – 10-12noon
Ashkan Shoamanesh, of McMaster University in Ontario, said in a journal news release. "Identifying people who are at risk for stroke can help us determine who would benefit most from existing or new therapies to prevent stroke," study lead author Dr. Maristela Garcia, director of the inpatient geriatric unit at UCLA Medical Center in Santa Monica, said in a journal news release.

Canadian researchers measured levels of blood-borne chemical signals, or "biomarkers," in the blood of more than 3,200 people. The patients averaged 61 years of age and were tracked for an average of nine years. During that time, 98 of them did suffer a stroke. Elevated levels of four of the biomarkers were linked with increased stroke risk, the team reported in the Aug. 24 online edition of the journal Neurology. High blood levels of the chemical homocysteine indicated a 32 percent higher risk compared to people with the lowest levels, the researchers found. And high levels of three other biomarkers -- vascular endothelial growth factor, C-reactive protein, and tumor necrosis factor receptor 2 -- also indicated a similar heightening of stroke risk, the investigators said. "Identifying people who are at risk for stroke can help us determine who would benefit most from existing or new therapies to prevent stroke," study lead author Dr. Ashkan Shoamanesh, of McMaster University in Ontario, said in a journal news release.

The New York Times reports that Osteoporosis, a Disease with Few Treatment Options, May Soon Have One More. A large clinical trial of a new osteoporosis drug found that it stimulates bone growth and prevents fractures at least as well as the only other such drug on the market. The new drug, expected to win approval from federal regulators, would offer another much-needed treatment for some of the 10 million Americans, 80 percent of them women, who have a disease that weakens bones and often leads to years of pain, disability and early death. Experts agree that new drugs are urgently needed for this debilitating disease. People with osteoporosis have bones that are fragile and break easily. Bone is naturally lost with age. But osteoporosis is an extreme, abnormal bone loss that can cause devastating fractures, particularly of the spine and hip. Yet most with osteoporosis do not take medications to prevent fractures, according to the National Osteoporosis Foundation.

HealthDay reports that Blood Test Might Someday Predict Your Stroke Risk. In the doctor's office of the future, a simple blood test might gauge a patient's odds of suffering a stroke someday, new research suggests. A team of Canadian researchers measured levels of blood-borne chemical signals, or "biomarkers," in the blood of more than 3,200 people. The patients averaged 61 years of age and were tracked for an average of nine years. During that time, 98 of them did suffer a stroke. Elevated levels of four of the biomarkers were linked with increased stroke risk, the team reported in the Aug. 24 online edition of the journal Neurology. High blood levels of the chemical homocysteine indicated a 32 percent higher risk compared to people with the lowest levels, the researchers found. And high levels of three other biomarkers -- vascular endothelial growth factor, C-reactive protein, and tumor necrosis factor receptor 2 -- also indicated a similar heightening of stroke risk, the investigators said. "Identifying people who are at risk for stroke can help us determine who would benefit most from existing or new therapies to prevent stroke," study lead author Dr. Ashkan Shoamanesh, of McMaster University in Ontario, said in a journal news release.

Kaiser Health News reports:
- Healthcare Providers Partnering With Ride-Hailing Services To Transport Patients. Kaiser Health News reports some health care providers are partnering with ride-hailing services Uber and Lyft to transport patients who lack other options. The article lists several examples of such partnerships and mentions that in some cases the trips are covered by insurance.
- America’s Other Drug Problem: Copious Prescriptions for Hospitalized Elderly. An increasing number of elderly patients nationwide are on multiple medications to treat chronic diseases, raising their chances of dangerous drug interactions and serious side effects. Often the drugs are prescribed by different specialists who don’t communicate with each other. If those patients are hospitalized, doctors making the rounds add to the list — and some of the drugs they prescribe may be unnecessary or unsuitable. “This is America’s other drug problem — polypharmacy,” said Dr. Maristela Garcia, director of the inpatient geriatric unit at UCLA Medical Center in Santa Monica. “And the problem is huge.”
13) **Provider Magazine** reports:

- New Survey Successfully Measures Satisfaction Across Healthcare Settings. **Provider Magazine** reported the “COREQ” survey “provides a unique way of measuring satisfaction across all long term and post-acute settings, according to experts at the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL).” The survey “has successfully measured satisfaction among short-stay (100 days or less) residents and families in skilled nursing care centers across the state of Massachusetts.” Dr. David Gifford, the senior vice president of quality and regulatory affairs for AHCA, said, “The COREQ—consisting of three questions for long-stay residents and family members and four for short-stay—has been independently tested as a valid and reliable measure of customer satisfaction.”

- Women Taking Calcium Supplements May Be At Increased Risk Of Dementia, Study Suggests. **Provider Magazine** reports new research “suggests that calcium supplements may be associated with an increased risk of dementia in older women who have had a stroke or other signs of cerebrovascular disease.” The study “found that women who took regular calcium supplements and also had cerebrovascular disease were twice as likely to develop dementia than women who did not take supplements.” The findings were published in the journal Neurology.

14) **The Washington Post** reports:

- Family Relationships Appear Tied To Increased Life Expectancy, Study Suggests. In continuing coverage, the **Washington Post** reports seniors with family relationships “beyond spouses” tend to live longer, according to research presented at the American Sociological Association’s annual meeting. Researchers asked elderly people to list their five “closest confidants,” other than spouses, and to describe those relationships, and found that those with more family members in that group tended to live longer.

- Physician Says Elderly Patients Need To Discuss “Exit Strategy.” Samuel Harrington, who practiced medicine for more than 30 years in the Washington area, writes at the **Washington Post** that “painful, futile treatment continues to this day, particularly with elderly patients who often are not informed of the difference between palliative care, designed to minimize pain while trying to preserve quality of life at the end, and aggressive treatment more designed to prolong life at any cost, using such methods as surgery or chemotherapy.” Harrington says that “patients and their families need help thinking about the natural progression of aging and visualizing what they want at the end.” He concludes that “discussions with our trusted physicians should evolve from how to die later to how to die better, including with an exit strategy.”

15) **Argentum** reports:

- New Report from CEAL Highlights Quality Measures and Instruments for Assisted Living. Researchers from the University of North Carolina's Cecil G. Sheps Center for Health Services Research and School of Social Work, with funding from CEAL, completed a review of measures and instruments useful for maintaining and improving quality in assisted living. Learn more.

- CDC Launches Third Wave of Long-Term Care Providers Survey. CDC’s National Center for Health Statistics has launched the third wave of the National Study of Long-Term Care Providers, a biennial national study of the major sectors of paid, regulated providers of long-term care services. This data collection effort includes a representative sample of assisted living and similar residential care communities across the country. Learn more.

- U.S. Department of Labor Issues Revised Posters Effective August 2016. The Wage and Hour Division of the U.S. Department of Labor has issued updated posters under the Fair Labor Standards Act and the Employee Polygraph Protection Act. The posters have been updated in accordance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (IAA), requiring that the DOL and other federal agencies adjust penalties to reflect inflation. Learn more.

- Prescription Drug Spending Rises by 17 Percent. Overall prescription drug spending in the United States rose by 17 percent from 2013 to 2014, according to new data released by CMS. The new data set includes information from more than 1 million health care providers that collectively prescribed $121 billion in prescription drugs paid for under the Medicare Part D program. Overall prescription drug spending in the United States rose by 12.6 percent between 2013 and 2014. CMS also includes a list of the top 10 most prescribed drugs by claim counts.
and top 10 drugs (all brand name) by cost. All of the top 10 most prescribed drugs are generic drugs, and the top nine drugs were among the drugs with the highest claim counts in 2013. The claim counts for these drugs ranged from 22.1 to 38.3 million claims and the total drug costs for each drug ranged from $136 million to $748 million.

15) Medscape reports that CDC Puts Spotlight on Sepsis as ‘Medical Emergency’. Federal health officials are calling on health care providers to do more to prevent, recognize and treat sepsis before it can cause life-threatening illness or death. "We as a country could do much more to prevent patients from getting infections that lead to sepsis," Tom Frieden, MD, MPH, director, Centers for Disease Control and Prevention (CDC), said during a media briefing today discussing a report on sepsis published online August 23 in CDC Vital Signs. "This report is putting a face on sepsis and documenting that it is still a huge problem, and it doesn't have to be. Far too many people die from sepsis today. Sepsis is an unrecognized killer [and] a medical emergency," Dr Frieden said. "An infection that is getting worse and is not treated can lead to sepsis. We call on healthcare providers to take opportunities to prevent, identify, and rapidly treat patients with sepsis and to educate patients and family members about sepsis," he added.

16) MedlinePlus reports:

- **Healthy Diet, Exercise May Help Keep Alzheimer’s at Bay.** A healthy diet and regular exercise might be the keys to keeping your brain free of changes that lead to Alzheimer’s disease, a small study suggests. Researchers studied 44 patients between the ages of 40 and 85 who had mild memory problems. The investigators found that the brains of those who followed a Mediterranean diet and were physically active had fewer plaques and tangles, a hallmark of Alzheimer’s, than those whose diet was less healthy and who were less active. "Alzheimer’s disease is known to be incurable, but it was not thought until recently that it can be preventable," said lead researcher Dr. David Merrill. He is an assistant clinical professor of psychiatry and biobehavioral sciences at UCLA David Geffen School of Medicine in Los Angeles. Numerous studies have suggested that a healthy lifestyle is related to reduced brain shrinkage and lower rates of brain tissue atrophy, he said.

- **Even a Little Exercise May Help Stave Off Dementia.** Seniors who get little to no exercise have a 50 percent greater risk of dementia compared with those who regularly take part in moderate or heavy amounts of physical activity, the researchers found. Moderate physical activity can include walking briskly, bicycling slower than 10 miles an hour, ballroom dancing or gardening, according to the U.S. Centers for Disease Control and Prevention. "It doesn't require intensive physical activity to decrease risk of dementia," said senior researcher Dr. Zaldy Tan. He is medical director of the Alzheimer’s and Dementia Care Program at University of California, Los Angeles. "Even moderate amounts are fine." Study participants aged 75 or older gained the most protective benefit from exercise against the onset of dementia, the findings showed.

17) Medical News Today reports:

- **Bacterial Pneumonia: Get the Facts.** Bacterial pneumonia is an inflammation of the lungs due to some form of bacteria. There are different types of bacteria that may lead to the infection. The lungs are made up of different sections or lobes. There are three lobes on the right and two on the left. Bacterial pneumonia can affect both lungs, one lung or even just one section of a lung. The lobes of the lungs are made up of small air sacs called alveoli. Normally, the air sacs fill with air. Oxygen is inhaled and carbon dioxide is exhaled. When a person develops pneumonia, the air sacs become inflamed, which can cause them to fill with fluid. If the air sacs are filled with fluid instead of air, it can make breathing difficult. In some cases, the lungs may not get enough oxygen.

- **Peritonitis: Causes, Symptoms, and Treatment.** Peritonitis is a problem with the peritoneum, a moist tissue around the inside of the belly wall. Usually, the reaction is due to it becoming infected by microbes such as bacteria. Peritonitis is a serious and urgent problem that doctors need to treat as soon as possible. Symptoms that could mean peritonitis include sudden, severe belly pain. Infection is often caused by a rupture, or "perforation." One example of this is when appendicitis develops into a ruptured appendix. When this happens, pus from the infection bursts from the gut into the peritoneum.
All You Need to Know About Nephritis. To understand kidney problems such as nephritis, it's helpful to start with some background on what the kidneys are, and what they do. The kidneys are two bean-shaped, fist-sized organs found just under the ribs on the left and right sides of the spine. They remove impurities and extra water from the blood, filtering 120-150 quarts of blood a day, according to the National Institute of Diabetes and Digestive and Kidney Diseases. Each kidney consists of thousands of structures called nephrons, where the actual blood filtering takes place. In the nephron, a two-step cleaning process separates what the body needs to keep from what it can get rid of. A filter called the glomerulus catches blood cells and protein, sending water and waste to a second filter, called a tubule. The tubule captures minerals. After that, what remains leaves the body as urine. Nephritis describes a condition in which the kidney's tubules and nearby tissues become inflamed, which can lead to kidney damage. When kidneys are damaged, they don't work properly. Waste builds up and causes serious health problems. If the condition is severe enough, or lasts long enough, it can result in kidney failure.

18) McKnight's reports:

- **F-Tag in Focus: F-431.** F-431 requires that facilities:
  1. Establish a system for recording the receipt and disposition of all controlled drugs, and maintain and routinely reconcile an accounting of all controlled drugs.
  2. Label all drugs and biologicals according to currently accepted professional principles, and include appropriate accessory and cautionary instruction as well as the expiration date, when applicable.
  3. Store and lock all drugs and biologicals in compartments under proper temperature controls to which only authorized personnel have access.

  While F-431 is one of the simplest tags to avoid during a survey, it remains one of the most commonly cites. In fact, 21.9 percent of facilities in the last standard health survey were cited, according to CASPER.

- **F-Tag in Focus: F-428.** The CMS State Operations Manual states that the medication regimen of each resident – including those receiving respite care, at end of life, or who have elected the hospice benefit – must be reviewed at least once a month by a licensed pharmacist. A medication review requires “A thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team.”

- **Common Painkiller May Help Reverse Alzheimer’s-Related Memory Loss.** An anti-inflammatory drug commonly used to treat pain associated from menstrual cramps may be able to reverse memory loss linked to Alzheimer's disease, new research shows.

- **Nursing Home Settlement Spurs HHS to Investigate Small Health Data Breaches.** A recent case involving a stolen iPhone containing nursing home residents’ medical records has prodded federal officials to place more scrutiny on smaller health care data breaches, according to the Department of Health and Human Services Office for Civil Rights. The OCR referenced five “small” breaches – involving the health data of fewer than 500 patients – in an email announcement sent recently. Among them is the case of Catholic Health Care Services of the Archdiocese of Philadelphia, which paid a $650,000 settlement after a phone with more than 400 residents’ information was stolen in 2014. Those smaller cases are typically investigated by OCR's regional offices, but beginning this month the agency will kick off a wider initiative into the “root causes” of such small breaches, the announcement said. Regional offices will still prioritize which breaches to investigate, but will ramp up efforts to address noncompliance and issue corrective actions.

- **What Do We Do When the Antipsychotics are Gone?** The agents referred to as “unnecessary drugs” or “chemical restraints” in skilled nursing facilities go by another name in hospitals and outpatient settings. They're called “medicine.” For some time, nursing homes have been under tremendous pressure to reduce or eliminate the use of antipsychotics, and now benzodiazepines are starting to receive similar attention. Obviously there are many benefits to reducing the use of medications that are not effective, especially those that cause deleterious
side effects. But the vast majority of residents in these facilities have significant psychiatric disorders, and staff members are confronted by challenging behaviors on a daily basis.

- **What OHSA’s New Ruling Means To You.** The final rule revision of the Occupational Safety & Health Administration’s regulation on Recording and Reporting Occupational Injuries and Illnesses (29 CFR 1904) is coming to fruition. Ask any health care provider what the revised ruling means and you will hear several different interpretations. Some spot on, others a little, well, spot off. The new rule requires certain employers to electronically submit injury and illness data to OSHA that they are already required to keep under OSHA regulations. The content of these establishment-specific submissions depends on the size and industry of the employer. Employers will need to review which form(s) and process is the correct one for their size and setting to assure data submission. The data will be made public but will not include personally identifiable associated with the data. In order to ensure the completeness and accuracy of injury and illness data collected by employers and reported to OSHA, the final rule also requires employers to inform employees of their right to report work-related injuries and illnesses free from retaliation. This new ruling impacts all healthcare settings. It is a little hidden, but when you dig deeper into the regulations, the high-risk industries are outlined and healthcare settings are described. The majority of the ruling goes into effect on January 1, 2017. Provisions around retaliation and informing employees of their right to report work-related injuries and illnesses will now be enforced November 1. You can learn more about this specific section by visiting this [U.S. Department of Labor link](#).

- **Feds Release Draft Interoperability Standards for Health IT.** The push for interoperability in health information technology continued with the release of draft standards for the industry by federal health IT officials. The draft [2017 Interoperability Standards Advisory](#), published recently, is a “coordinated catalog of standards and implementation specifications” for the health IT industry, according to the Office of the National Coordinator for Health Information Technology. The federally recognized standards will serve as a “key element” as the health IT industry moves toward interoperability, ONC officials said. They also support a [pledge](#) from IT companies, providers and professional associations to adopt national standards, guidance and practices for electronic health information. The draft standards include a call for feedback on several interoperability needs, including nursing assessments and interventions, functional status, and race and ethnicity. Industry stakeholders will be able to provide comments on the proposal through October 24.

- **Providers Could Face Five-Star Sanctions for Late PBJ Data.** Nursing homes that fail to submit electronic staffing data by the first required deadline may face sanctions and could see their Five-Star rating suffer as a result, CMS officials said late last month. Providers are required to submit their staffing data for the period lasting from July 1 to September 30 by November 14, 2016 — the first deadline since electronic submission became mandatory. CMS will be granting some leniency to providers who make an effort to submit data, but those who fail to meet the deadline could face consequences, agency officials told attendees at a recent Skilled Nursing Facility Open Door Forum.

- **Audits of Medicare Advantage Plans Find Rampant Overcharging for Elderly Patients.** Many Medicare Advantage plans overcharged the federal government for treating older beneficiaries, according to a [new report](#) from the Center for Public Integrity. The report included an analysis of 37 previously unreleased Medicare Advantage audits from 2007. Out of those 37 audits, 35 showed that the plan overcharged the government for treating elderly enrollees, often by overstating the severity of medical conditions. The overpayments — which typically amounted to several hundred thousand dollars — have since been paid back, but the high rate of overcharging “could signal millions in losses to federal taxpayers,” according to the report. The Center for Public Integrity also found that auditors were only able to confirm 60 percent of the medical conditions the insurance plans reportedly treated, with conditions like diabetes and depression scoring lower confirmation rates.

- **Antipsychotics May Increase Pneumonia Risk in Alzheimer’s Patients.** Commonly-used antipsychotic medications may increase the risk of pneumonia when given to people with Alzheimer’s disease, research has found. Researchers with the University of Eastern Finland studied more than 60,500 people with Alzheimer’s disease over a seven-year period to determine the link between antipsychotics and hospitalizations or deaths related to pneumonia. The three most commonly used antipsychotics — quetiapine, risperidone and haloperidol — all
showed similar associations with pneumonia risk. Results of the study, published in Chest, found that antipsychotic use doubled the risk of pneumonia in people with Alzheimer’s, and those without Alzheimer’s still showed a “somewhat higher risk.” The risk of pneumonia may even be higher than reported since the study only focused on cases that resulted in hospitalization or death, researchers noted.

19) **Interesting Fact:** Twelve million men (11.2 percent of all men 20 years and older) and 11.5 million women (10.2 percent of all women 20 years and older) have diabetes in the U.S.