Feature Focus

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

CMS Adopts New LTC Requirements of Participation

Well…..CMS done did it!! The Centers for Medicare & Medicaid Services (CMS) issued a final rule to make major changes to improve the care and safety of the nearly 1.5 million residents in the more than 15,000 long term care facilities that participate in the Medicare and Medicaid programs. The policies in this final rule are targeted at reducing unnecessary hospital readmissions and infections, improving the quality of care and strengthening safety measures for residents in these facilities. These changes are an integral part of CMS’ commitment to transform our health system to deliver better quality care and spend our health care dollars in a smarter way, setting high standards for quality and safety in long term care facilities. The health and safety of residents of long term care facilities are our top priorities,” said CMS Acting Administrator Slavitt. “The advances we are announcing today will give residents and families greater assurances of the care they receive.”

The final rule is available on the Federal Register website (click here).

As the first comprehensive update since 1991, this rule will bring best practices for resident care to all facilities that participate in Medicare or Medicaid, implement a number of important safeguards that have been identified by resident advocates and other stakeholders and include additional protections required by the Affordable Care Act. CMS received nearly 10,000 public comments, which were considered in finalizing this rule.

Changes finalized in this rule include:

- Strengthening the rights of long term care facility residents, including prohibiting the use of pre-dispute binding arbitration agreements.
- Ensuring that long term care facility staff members are properly trained on caring for residents with dementia and in preventing elder abuse.
- Ensuring that long term care facilities take into consideration the health of residents when making decisions on the kinds and levels of staffing a facility needs to properly take care of its residents.
- Ensuring that staff members have the right skill sets and competencies to provide person-centered care to residents. The care plans developed for residents will take into consideration their goals of care and preferences.
- Improving care planning, including discharge planning for all residents with involvement of the facility’s interdisciplinary team and consideration of the caregiver’s capacity, giving residents information they need for follow-up after discharge and ensuring that instructions are transmitted to any receiving facilities or services.
- Allowing dietitians and therapy providers the authority to write orders in their areas of expertise when a physician delegates the responsibility and state licensing laws allow.
• Updating the long term care facility's infection prevention and control program, including requiring an infection prevention and control officer and an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

Along with the pre-dispute arbitration ban, the final rule also mandates nursing home operators 1) provide “nourishing, palatable” dietary options that meet residents’ nutritional needs and preferences, 2) create an infection prevention and control program and 3) develop a comprehensive, person-centered care plan for each resident within 48 hours of admission. A nurse aide and a member of the dietary staff must contribute to that care plan, the rule reads. The rule also includes new and updated regulations on elder abuse, staff competency and discharge planning.

The rule becomes effective on November 28, 2016, but will be implemented in phases. Phase 1 is to be implemented by November 28, 2016. Phase 2 is to be implemented on November 28, 2017 and Phase 3 on November 28, 2019. A summary of what is required to be phased in and when can be found here.

To help you navigate through this rule, IHCA will have monthly member conference calls starting October 27, 2016 at 2 p.m. (central). Bill Bell will lead this initial call – he should be done reading the whole 713-page rule by then! We hope to have a member of the AHCA/NCAL Quality Team on the call as well. The October call will concentrate on the priorities needed so you can be ready for this rule to go into effect on November 28. This one-hour call will feature a Q&A session as well. Please call in to 866-754-8248 using passcode 790-694-5265 at 2 p.m. on October 27. Going forward, we will have these member calls on the fourth Thursday of the month, unless there are conflicts and we will reschedule as necessary. We will also break down the new requirements in future issues of Regulatory Beat and possibly some special email blasts.

The summary handout from the ANCA Webinar regarding the Requirements of Participation can be found here. The AHCA Final Rule Summary can be found at here.

Summary of Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
This final federal CMS rule establishes national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to plan adequately for both natural and man-made disasters, and coordinate with federal, state, tribal, regional and local emergency preparedness systems. It will also assist providers and suppliers to adequately prepare to meet the needs of patients, residents, clients and participants during disasters and emergency situations. Despite some variations, the regulations will provide consistent emergency preparedness requirements, enhance patient safety during emergencies for persons served by Medicare- and Medicaid-participating facilities and establish a more coordinated and defined response to natural and man-made disasters. These regulations are effective on November 15, 2016 and are to be implemented by November 15, 2017. The rule was released on Friday, September 16, 2016, and can be found here.

These new regulations will impact on Skilled Nursing Facilities (SNF), Nursing Facilities (NF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). This final rule is NOT required for Assisted Living Providers. Long term care facilities must share information from the emergency plan with residents and family members or representatives.

The four main components of the requirements are consistent with the National Preparedness Cycle. The emergency plan, policies and procedures, communication plan and the training and testing program ALL must be reviewed and updated at least annually. Annual reviews will allow a center to identify gaps and areas for improvement to the center’s emergency plan. Policies and procedures are to be based on the emergency plan, risk assessment and the communication plan. The policies and procedures will operationalize a center’s emergency plan. Components of the final requirements focus on an integrated response during a disaster or emergency situation. Surveyors will be provided training on the emergency preparedness requirements and interpretative guidance will be developed for each provider and supplier types. The four elements of the emergency preparedness program are summarized as follows:
Risk assessment and planning: This rule will require that prior to establishing an emergency plan, a risk assessment would be performed based on utilizing an “all-hazards” approach. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the provider and supplier considering the particular types of hazards that may most likely occur in their area. Review and update annually.

Policies and procedures: CMS is requiring that facilities develop and implement policies and procedures based on the emergency plan and risk assessment. Review and update annually.

Communication plan: This rule will require a facility to develop and maintain an emergency preparedness communication plan that complies with both federal and state law. Patient care must be well coordinated within the facility, across health care providers and with state and local public health departments and emergency systems to protect patient health and safety in the event of a disaster. Review and update annually.

Training and testing: CMS is requiring that a facility develop and maintain an emergency preparedness training and testing program. A well organized, effective training program must include providing initial training in emergency preparedness policies and procedures. CMS will require that the facility ensure that staff can demonstrate knowledge of emergency procedures and provide this training at least annually. CMS would require that facilities conduct drills and exercises to test the emergency plan. Review and update annually.

Federal CMS has estimated that the cost to implement these new requirements will be $4383 for SNFs/NFs and $3419 for ICF/IIDs.

Emergency Plan – Risk Assessment and Planning
The final rule states that the emergency plan must be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. Strategies for addressing emergency events identified by the risk assessment, resident population and the type of services the center has the ability to provide in an emergency; continuity of operations must be included in the plan. For ICF/IID members, the rule explains that the emergency plan must address the special needs of its client population. Centers will need a process for cooperation and collaboration with local, tribal, regional, state or federal emergency preparedness officials. Centers will need to include documentation of their efforts to contact officials and of their participation in collaborative and cooperative planning efforts.

Next steps: Review your emergency operation plan (EOP). Does it reflect the specific high-risk hazards for your area and the needs of your unique population (i.e. secured perimeters, technology-dependent residents/clients). Contact your local emergency preparedness and response agencies and ask to speak to the contact for the medical-health emergency planning in your area. Ask for a copy of the local hazard vulnerability analysis so you can be aware of the hazards identified for your surrounding community. Start a business continuity plan if you don't have one. A template is available here.

Policies and Procedures
The final rule outlines the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, will need to include: 1) food, water, medical and pharmaceutical supplies; and, 2) alternate sources of energy to maintain- temperatures, emergency lighting, fire detection, extinguishing, alarm systems and sewage and waste disposal.

The final rule clarified that centers will need to include a system to track the location of on-duty staff and sheltered residents in the center’s care during and after an emergency, as well as a system for medical documentation. Safe evacuation and shelter in place procedures will need to be included. Evacuation policies and procedures will need to consider care and treatment needs of evacuees, staff responsibilities, transportation and identification of evacuation
Centers will also need to include arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations.

Next steps: Identify potential LTC centers, other providers and community resources that your center has a relationship with or will need to establish a relationship with to develop arrangements in the event of an emergency. Develop procedures for the care of multiple emergency admits including staff, space and equipment. This is called "Surge Capacity" and planning tools are available here.

Communication Plan
A center’s emergency preparedness communication plan must comply with federal, state and local laws. The communication plan must include name and contact information for nine key groups including volunteers. The final rule states that centers will need to provide a primary and alternate way for communicating with center staff and federal, state, tribal, regional or local emergency management agencies. The communication plan in the final rule outlines eight components the plan must include and does not require specific timeframes for center communications in the emergency preparedness requirements. Proper sharing of medical records and other patient information must be considered.

Next steps: Review the eight components and the nine key groups and begin to plan how to incorporate this information into your EOP. Also consider the question of alternate ways for communication with staff and emergency agencies you will use should cell phone service be unavailable.

Training and Testing
Centers will need to conduct initial training in emergency preparedness policies and procedures to all new and existing staff, contract staff and volunteers. Training must be documented and staff must be able to demonstrate knowledge of the emergency procedures.

Centers must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. Centers will need to participate in a full-scale exercise that is community-based if not accessible then an individual, facility based. An additional exercise will need to be conducted by the center, such as a second full-scale exercise that is community-based or individual, facility-based or a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario and a set of problem statements, directed messages or prepared questions designed to challenge an emergency plan. Testing will need to include an analysis of the center's response to emergency procedures and centers will need to maintain documentation of all drills, tabletop exercises and emergency events, and revise the emergency plan as needed.

Emergency and Standby Power Systems *Does not Apply to ICF/IID Communities.*
The final rule adopts the Health Care Facilities Code (NFPA 99, Life Safety Code NFPA 101 and NFPA 110) for the location of the emergency generator and the Health Care Facilities Code, NFPA 110, and Life Safety Code for the emergency power system inspection, testing and maintenance requirements. For centers that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during an emergency.

NOTE: There is confusion with the language in this section. The regulations do not specifically require a generator for SNFs and NFs, but they imply that one will be required. The other confusion deals with what the generator will be required to cover. If heating and air conditioning are included, the size of the generator will be significant. We are trying to get clarification on this issue.

Next steps: Identify your center’s emergency power source and identify its capacities such as will it power the entire building, including HVAC, refrigeration, medical equipment needed for life support etc.
**Integrated Healthcare Systems**

The final rule added that if a center is part of a health care system consisting of multiple separately certified health care facilities that elects to have a unified and integrated emergency preparedness program, the LTC facility may choose to participate in the health care system's coordinated emergency preparedness program. If the center chooses to utilize an integrated emergency preparedness program the program must show that each participating facility actively participated in the development of the emergency preparedness program. The program must take into account each separately certified facility's unique circumstances, patient populations and services offered. All participants must demonstrate that they are capable of using the program and that it is in compliance with the policies and procedures, communication plan and training and testing components of the emergency preparedness regulation.

**Next steps:** Explore the availability of full-scale exercises planned for your community in which your center could participate. The local emergency planner for medical/health response should be able to help with this. Additionally, the local acute care hospitals may know of up-coming exercises that are open to your participation. Templates for drills and exercises are available [here](#).

**Helpful Resources**

- CMS, Medicare Learning Network hosted a webinar on the new requirements on Wednesday, October 5, 2016 at 1:20 ET. This webinar/handout is available on the MLN Connects webpage.
- Overview session at AHCA/NCAL National Convention entitled, "The New CMS Rules: Raising the Bar on Emergency Preparedness" on Tuesday, October 18 at 10:00 AM - 11:00 AM ET by Jocelyn Montgomery, RN and Director of Clinical Affairs, California Association of Health Facilities, Sacramento, California
- CMS will create a webpage for the rule [here](#). Additionally, the Office of the Assistant Secretary for Preparedness & Response (ASPR) has also created a [resources webpage](#) for the final rule.

For more information about emergency communication planning:

- [Emergency Planning: Health Care Sector](#)
- [Government Emergency Telecommunications Service (GETS)](#)
- [Healthcare Preparedness Capabilities - National Guidance for Healthcare System Preparedness](#)
- [ASPR Tracie: Healthcare Emergency Preparedness Information Gateway](https://asprtracie.hhs.gov/)

Additional information and resources regarding the application of the HIPAA Privacy Rule during emergency scenarios can be located at:

- [Summary of the HIPAA Privacy Rule](#)
- [HIPAA Privacy in Emergency Situations](#)
- [Emergency Situations: Preparedness, Planning, and Response](#)

CMS is in the process of developing the Interpretive Guidelines which will assist in implementation of the new regulation. CMS anticipates that the Interpretive Guidelines will be available in early 2017. The Interpretive Guidelines will be formatted into one Appendix as opposed to updating all 17 provider/supplier types. CMS also anticipates that checklists will be developed and training sessions offered.

**AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 11 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: Effective Monitoring**

**Key Takeaways: Effective Monitoring**

- Effective monitoring is key to refining and improving processes and performance.
- Effective monitoring requires gathering enough details to be able to draw appropriate conclusions.
- Effective monitoring is important for system integrity.

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<tr>
<th>Probing Questions for Team Reflection and Discussion:</th>
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<td>1. How do we know if the monitoring systems and processes in our center are optimal?</td>
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<td>2. How do we know if we are effectively monitoring? What outcomes do we expect?</td>
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<td>3. Are the monitoring systems and processes dependent on an individual? If so, do we have a plan to continue monitoring if that individual is absent?</td>
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Visit the AHCA Clinical Practice [website](#) to learn more about the element of “Clinical Foundation: Effective Monitoring” 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.*

**'Concerning' drop seen in the number of older adults getting flu vaccinations (CNBC)**

Fewer older people got vaccinated for the flu during the last season than for the prior one, health officials said Wednesday, calling that trend “concerning” because those people have more risk from the virus.

Nationally, 45.6 percent of the nation's population, or about 144 million people, got vaccinated for the 2015-16 flu season, a drop of 1.5 percentage points from the previous season, according to the federal Centers for Disease Control and Prevention.
But among people age 50 to 64 years, there was a drop of 3.4 percentage points, leaving 43.6 percent of that group vaccinated. And among people 65 years or older, there was a drop of 3.3 percentage points, down to 63.4 percent.

Officials stressed that elderly people are at highest risk from flu. Seventy to 90 percent of deaths from flu annually occur among people 65 or over, according to officials. Women are about six times more likely to die if they get flu while pregnant.

The highest vaccination coverage last season was among kids age 6 months up to 23 months, at 75 percent. Those children are the only group to exceed national health officials' goal of vaccination rates of 70 percent.

Health officials said everyone over the age of 6 months should be vaccinated for flu. "Get a flu shot, no excuse not to get them," said Dr. Tom Frieden, director of the CDC, who also urged everyone 65 years old and above to get pneumococcal vaccination as well.

"Getting a flu vaccine is important for all of us, for our own protection and for the protection of those around us who may be more vulnerable to flu, such as young children, people with certain chronic health conditions and the elderly," said Frieden. "Flu can strike anyone and it can strike hard. I'm getting vaccinated today and I ask that you join me."

Frieden then got himself vaccinated during a press conference on the upcoming flu season.

Last season was a relatively mild one for flu. This season, it is too early to know which strain of flu will be dominant, said Frieden. The vaccinations produced for this season do "match the flu strains we've seen so far, but it's still too early to predict what the rest of the season will hold," he said.

This year, officials said, nasal sprays are not recommended for delivering vaccinations because they have been found to be not as efficient as injectable doses.

For the 2016-17 flu season, as many as 168 million doses of injectable influenza vaccine will be available, according to vaccine manufacturers. Officials said more than 93 million doses have already been delivered.

"We do not think there will be any shortage," Frieden said.

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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 16-41 – ICF/IID** - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Appendix J, Part II - Clarifications to the Interpretive Guidance (IG) at Tag W154 for §483.420(d)(3). CMS has revised the IGs for 42 CFR §483.420(d)(3) at Tag W154 within the State Operations Manual (SOM) Appendix J for ICF/IIDs to clarify the review of incident reports and/or investigative reports.

- **S&C 16-42 – NH** - Notification of Final Rule Published - Reform of Requirements for Long-Term Care (LTC) Facilities. See lead article. Reform of LTC Requirements: On September 28, 2016 the Federal Register posted the notice of the final rule Reform of Requirements for Long-Term Care Facilities. The scheduled publication date is October 4, 2016. The regulation goes into effect on November 28, 2016. LTC providers affected by this rule must comply and implement these regulations based on staggered effective dates, which is outlined in the final rule. Additional information will be provided in further guidance through release of the interpretive guidelines and future Survey & Certification policy memorandums.
2) Federal HHS/CMS released the following notices/announcements:

- **Reporting Changes in Ownership** - A 2016 Office of the Inspector General (OIG) report noted that providers may not be informing CMS of ownership changes. Providers must update their enrollment information to reflect changes in ownership within 30 days. Owners are individuals or corporations with a 5 percent or more ownership or controlling interest. Failure to comply could result in revocation of your Medicare billing privileges.
  
  **Resources:**
  - [Timely Reporting of Provider Enrollment Information Changes](http://www.cms.gov) MLN Matters® Article
  - [42 CFR 424.516](http://www.gpo.gov) OIG Report
  - [Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure](http://www.cms.gov) OIG Report
  - [PECOS Enrollment Tutorial - Change of Information for an Individual Provider](http://www.cms.gov)
  - [PECOS Enrollment Tutorial - Change of Information for an Organization/Supplier](http://www.cms.gov)

- **Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Fact Sheet — Revised** - A revised [Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs Fact Sheet](http://www.cms.gov) is available. To order a hard copy, visit the Learning Management and Product Ordering System. Learn about:
  - Prohibited billing of Qualified Medicare Beneficiary individuals
  - Medicare assignment

- **Social Security Number Removal Initiative** - What do you need to do to get ready? The [Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)](http://www.cms.gov) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new randomly generated Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number on new Medicare cards for transactions like billing, eligibility status, and claim status. Prepare for this change by visiting the new overview and provider webpages, which include:
  - Transition period
  - Characteristics of the MBI
  - How to obtain the MBI

  It’s time to look at your practice management systems and business processes and determine what changes you need to make to use the new MBI.

- **Updated ICD-10 Flexibility FAQs and 2017 Codes** - 2017 ICD-10 codes become effective October 1, 2016. Visit the [ICD-10 website](http://www.cms.gov) for official resources, including:
  - Updates to the Clarifying Questions and Answers related to the July 6, 2015, CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
  - [Step-by-step resource list](http://www.cms.gov) to help you quickly locate contacts
  - [2017 ICD-10-CM diagnosis code set](http://www.cms.gov) and guidelines
  - [2017 ICD-10-PCS inpatient procedure code set](http://www.cms.gov) and guidelines

- **SNF Quality Reporting Program Webcast: Audio Recording and Transcript — New** - An audio recording and transcript are available for the September 14 webcast on the Skilled Nursing Facility (SNF) Quality Reporting Program. Learn about the reporting requirements for this new program, effective October 1, 2016.

- **Dementia Care and QAPI Call: Audio Recording and Transcript — New** - An audio recording and transcript are available for the September 15 call on the National Partnership to Improve Dementia Care and Quality Assurance and Performance Improvement (QAPI). This call focused on effective care transitions between long-term and acute care settings, highlighting transitions that involve residents with dementia.

- **IMPACT Act: Data Elements and Measure Development Call — October 13** - Thursday, October 13 from 1:30 to 3 p.m. ET. To register or for more information, visit [MLN Connects® Event Registration](http://www.cms.gov). Space may be limited, register early. During this call, CMS experts discuss how data elements are used in measure development. Find out how information from assessment instruments is used to calculate quality measures. The Improving...
Medicare Post-Acute Care Transformation Act of 2014 (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.

**Agenda:**
- Overview of National Quality Strategy and CMS Quality Strategy
- Why do we have quality measures?
- How do data elements fit within measure development?
- How is provider data used in the development process?
- Example: pressure ulcer measure
- Question and answer/discussion session

**Target Audience:** PAC providers, health care industry professionals, clinicians, researchers, health IT vendors, and other interested stakeholders.

- **Long-Term Care Facilities: Reform of Requirements Call — October 27** - Thursday, October 27 from 1:30 to 3 p.m. ET. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. During this call, learn about the final rule to reform the requirements for long term care facilities. These requirements are the federal health and safety standards that long term care facilities must meet in order to participate in the Medicare or Medicaid programs. Find out about the changes included in the final rule; implementation and survey process; and provider training and resources. A question and answer session will follow the presentation.

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

- **Medicare Parts A & B Appeals Process Booklet — Revised** - A revised Medicare Parts A & B Appeals Process Booklet is available. Learn about:
  - Original Medicare's (Part A and Part B) five levels of claim appeals
  - How the Medicare appeals process applies to providers, participating physicians, and participating suppliers
  - The available appeals-related resources

- **CMS releases new prescription drug cost data** - The 2014 data set contains information from over one million distinct health care providers who collectively prescribed approximately $121 billion in prescription drugs paid for under the Medicare Part D program. This represents a 17 percent increase compared to the 2013 data set.
  - CMS Fact Sheet
  - Part D Prescriber Data 2014

3) **HHS Needs to Strengthen Security and Privacy Guidance and Oversight** according to a new U.S. Government Accountability Office (GAO) report. GAO is making five recommendations, including that HHS update its guidance for protecting electronic health information to address key security elements, improve technical assistance it provides to covered entities, follow up on corrective actions, and establish metrics for gauging the effectiveness of its audit program. HHS generally concurred with the recommendations and stated it would take actions to implement them.

4) The **Centers for Disease Control and Prevention** (CDC) has released a discussion guide to help health care organizations identify issues to address when responding to a cyber breach or attack. The guide includes scenarios and questions to facilitate small group discussions on the issue for cybersecurity preparedness and response planning.

5) **New U.S. Department of Labor (DOL) Mandatory Postings** – The DOL is mandating two new posting requirements for employers:
  - Polygraph posting has been updated and is required to be displayed on August 1, 2016.
6) The **Illinois Department of Healthcare and Family Services (HFS)** posted the following Notices:

- A document describing MEDI registration guidelines for providers, payees, and business entities has been posted to the [LTC direct billing webpage](#). In addition, the claim examples have been updated to account for the following changes:
  - Correction to the ISA segment on all the claims examples, ISA05 to reflect ZZ and ISA06 to reflect 37-1320188INT.
  - For PT33 skilled examples:
    - MC 5 removed occurrence code 70
    - MC 6 Change corrected service units on UB04
    - MC 7 change SBR from P to S
    - MC 9 Corrected claim example to reflect only the Medicare Cover period to be directly billed to HFS for recipient with LTSS

- HFS has posted a new provider notice regarding Hepatitis C Treatment. You may view the notice [here](#).

- HFS has also posted the following:
  - [Modifier Listing, Practitioner Fee Schedule and Practitioner Fee Schedule Key](#) to the Fee Schedule webpage.
  - [Pediatric Vaccine Reimbursement Rates](#) to the NIPS webpage.

- HFS has posted a Public Notice regarding Intermediate Care Facilities – Proposed Changes in Methods and Standards for Establishing Medical Assistance Payment Rates. You may view the notice [here](#).

7) The **Illinois Department of Public Health (IDPH)** remaining 2016 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. All reservations should be made via email to Lisa.Reynolds@illinois.gov. Please include the words “Town Hall Reservation” in the subject line.

- 10/19 – Brookens Building – Champaign – 1-3pm
- 11/15 - Friendship Village – Schaumburg – 10-12noon

8) **ISMS POLST Survey**: IHCA and the POLST Illinois Taskforce is aware of a lack of consistency across the state in use and understanding of the POLST. Below you will find a link to a ten-minute survey that will help us assess POLST use and identify potential educational needs. Only aggregate non-identified data will be reported. Please click on the following to take the survey: [https://www.surveymonkey.com/r/B3KGGRF](https://www.surveymonkey.com/r/B3KGGRF).

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

10) **Healthcare IT News** reports [End of ICD-10 Grace Period Finds Providers Still Working on Codes](#). According to the article, reports as of October 1, 2016, the CMS grace period for the first year of ICD-10 ended, and now CMS is “demanding greater specificity.” But, providers “still face issues in staffing enough qualified coders” in order to submit claims on time. They are also “looking at what is reimbursed and what is not,” as well as how much “detail” is necessary for reimbursement.

11) **CBS News** reports that [Falls Number One Cause of Fatal and Non-Fatal Injuries Among Adults Over 65, Report Finds](#). An article on the CBS News website states that researchers concluded that “falls are the number one cause of fatal and nonfatal injuries among adults over 65,” in a report published in the CDC’s [Morbidity and Mortality Weekly Report](#). The report found that “in 2014, older Americans fell 29 million times, leading to seven million injuries” that sometimes landed people in the emergency department. Unfortunately, “more than 27,000 falls led to death.” In a press statement,
CDC Director Tom Frieden, MD, MPH, said, “Older adult falls are increasing and, sadly, often herald the end of independence.” Dr. Frieden went on to emphasize that falls can be prevented.

12) Modern Healthcare reports that CMS, State Medicaid Directors Working on Guidelines for Network Adequacy. According to Modern Healthcare, CMS and state Medicaid directors are collaborating to create “guidelines for managed Medicaid plans to ensure network adequacy.” Earlier this year, CMS “finalized a mega managed Medicaid rule meant to strengthen current regulations regarding network adequacy.” Under the rule, states are required to contract “with plans to develop and enforce minimum time and distance standards for providers.” Because some states may have difficulty in meeting these new requirements, CMS and Medicaid directors are working together “to create a guidance, which will read more like a best practice document, James Golden, director of the agency’s division of managed-care plans, said.”

13) Medscape reports Residents’ Views on Duties After Discharge Vary Widely. Just more than one fourth (26.1 percent) of internal medical residents in a nationwide survey said responsibility for patients ends at hospital discharge. A slightly smaller number (19.3 percent) said their responsibility extended 15 to 30 days post discharge. The variability of answers to the survey may have implications for implementing successful transitions of care and efforts to reduce 30-day readmissions.

14) MedlinePlus reports:

- **How Older People Can Head Off Dangerous Drug Interactions.** Potentially serious drug interactions are a daily threat to older people who take multiple medications and supplements, according to the U.S. Food and Drug Administration. One drug can affect the effectiveness of other drugs and how your body uses them. For example, your kidney and liver may not work as well, which affects how drugs are broken down and leave your body, the FDA said. "There is no question that physiology changes as we age. Many chronic medical conditions don't even appear until our later years," Dr. Sandra Kweder, an FDA medical officer, said in an agency news release. "It's not that people are falling to pieces; some changes are just part of the normal aging process."

- **Older Surgery Patients Should be Screened for Frailty.** Screening older surgery patients for frailty could improve their outcomes and chances for survival, researchers say. But frailty often goes unrecognized in these patients, according to a study published online Oct. 6 in The Annals of Thoracic Surgery. "Patients with frail health have less ability to overcome stressors such as illness, falls and injury, and have a higher risk of adverse effects from medications, procedures and surgery," study co-author Dr. Angela Beckert said in a journal news release. Beckert is an assistant professor in the division of geriatrics and gerontology at the Medical College of Wisconsin, in Milwaukee. "If a patient is more robust, with better physical performance and vigor -- in other words, less frail -- then I believe surgical outcomes would be better," she added.

- **New Clues to Age-Related Hearing Loss.** When background noise makes it hard to carry on a conversation, many older people chalk it up to hearing loss. But a new, small study finds that the problem may not just be in your ear, but also in your brain. Researchers from the University of Maryland in College Park have found that the brain's ability to process speech declines with age.

15) Medical News Today reports:

- **More Than Half of Persons with Alzheimer’s Disease Aged 90 Years or More Use Psychotropic Drugs.** Psychotropic drug use is rather common among persons aged 90 years of more diagnosed with Alzheimer's disease compared with those who were diagnosed at younger age, concludes study conducted at University of Eastern Finland. Persons aged 90 years or more used antipsychotics 5 times and antidepressants 2.5 times more often than those without the disease in the same age group. The results were published in Age and Ageing journal. 56 percent of persons aged 90 years or more with Alzheimer's disease use psychotropic drugs whereas the same figure was 48 percent among younger persons with Alzheimer's disease and 38 percent among those aged 90 years or more but without Alzheimer's disease. Psychotropic drugs include antipsychotics, antidepressants and benzodiazepines and related drugs which are used for anxiety and insomnia in short-term treatment. On the contrary, persons aged 90 years or more with Alzheimer's disease used less frequently anti-
dementia drugs (63 percent) when compared with younger persons with the same disease (72 percent). Psychotropic drugs are related to significant risk of adverse effects among older users and for this reason, very frequent use of these drugs among the oldest persons is concerning. The need and safety of drug use should be regularly assessed.

- **‘One-Punch’ Universal Flu Vaccine in Development.** Scientists may have found a way to protect against flu and all future and mutated strains of flu through the use of a novel universal vaccine that only needs to be given once.

16) **Provider Magazine** reports LTC Providers Adjust to Challenge of Caring for Short-Term Patients Alongside Long-Term Residents. In a nearly 3,000 word article, Provider Magazine reports many long term care providers are struggling to care for long term residents and short-stay patients in the same facilities. Lyn Bentley, the vice president of quality and regulatory affairs for the American Health Care Association said, “This is uncharted territory. Short-stay patients are a different population, and we need to be prepared to address their unique needs, goals, and issues.” Daniel Ciolek, the associate vice president of therapy advocacy at AHCA, said, “Based on realistic goals and expectations, the team works with the patient and family to develop a plan of care to help him or her achieve these goals and return home. Care planning really must occur in the first 24 hours, especially when the patient might only be there for three to five days. This requires a different mindset.”

17) **McKnight’s** reports:

- **Feds Release Guide for Providers on Negotiating EHR Contracts.** Healthcare providers in the market for an electronic health record system can prepare and plan for their purchase with a new guide released Monday by federal health officials. “EHR Contracts Untangled,” published by the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology, lays out the issues surrounding EHR selection and contract negotiation so providers can “maximize the value” of their health technology investments. The guide also includes information on planning for EHR purchases, safety and security, data rights and managing liability. The release comes at a key time, with more long-term care providers migrating toward more sophisticated record-keeping systems in order to keep in line with federal mandates.

- **Proof of the Value of Palliative Care Consultations.** Everybody's looking for win-win scenarios, especially in healthcare. Because of such tight operating margins, that goes double for long-term care. That's what makes some of the newest palliative care research out of Brown University so intriguing. Investigators there spent about three years in labor-intensive analysis to determine that palliative care consultations in nursing homes lead to less burdensome care, fewer rehospitalizations, better pain management and — get this — don't cost the system more. That last part especially gets attention. It turns out discussing preferences of care really does make a difference in patients’ lives. People get their symptoms managed better, feel more in control and are ultimately subjected to less intensive treatments, which can have rippling positive effects.

- **Flu Vaccination Rates Up Among LTC Workers.** McKnight’s Long Term Care News reports officials from the Centers for Disease Control and Prevention and the National Foundation for Infectious Diseases said during a press conference Thursday that “more long-term care workers are getting vaccinated against flu than ever before, but inoculation rates among” seniors have “dropped significantly.” According to the data, “long term care workers showed an...increase in vaccination rates, reaching 69 percent during the 2015-2106 flu season, compared to 64 percent the previous season.” CDC Director Dr. Tom Frieden said the increase in vaccination rates among LTC workers was encouraging.

- **Technology is Aiding the Aging in Place Movement.** McKnight’s reports on the AARP-sponsored Longevity Economy, which explains how industry is becoming more invested in creating technology that helps keep seniors out of nursing facilities and in the home. Progress in this area includes remote monitoring devices and the Internet of Things (in which appliances and systems are controlled via wifi connection). The report notes that seniors who manage to avoid institutional settings have significantly more resources than those who live in
nursing facilities.

- **Report: CMS Needs to Improve Public Access to Nursing Home Expenditures.** Skilled nursing facilities' expenditure data needs to be made more accessible to public stakeholders, according to a new report from the Government Accountability Office. GAO investigators created the report to determine how CMS collects and shares skilled nursing expenditure data, as well as how facility costs vary by characteristics such as for-profit or nonprofit ownership. The report also looked into how staffing levels may vary based on facility characteristics and margins. The report's main finding was that while CMS collects expenditure reports from skilled nursing facilities and posts the data online, that information is not readily accessible to the public or checked to ensure it is accurate and complete. [Click here](#) to read the GAO's full report on skilled nursing facility expenditure data.

- **Let Public Have Say on Sex in SNFs, Researchers Say.** Current policies on how intimate relationships should be handled in nursing home settings have “failed” residents and the public alike, according to research published Wednesday. The topic of sexuality is one that's “seldom considered,” in nursing home environments due to barriers such as negative attitudes, lack of knowledge and few resources to develop policies and train staff, according to researchers at Kansas State University's Center on Aging. The topic is often further complicated when a sexual relationship involves a resident with dementia, “who may lack sexual consent capacity, or the ability to make ones' own sexual decisions.” The study's findings suggest that policymakers and nursing home administrators alike should consider “indicators” such as a loving relationship, the impact of ageism, risk and safety when developing policies regarding sexual relationships. “Taking this flexible, recommended approach can facilitate the development of policies and procedures that capture the resident/consumer voice, protect against harm and support safe sexual expression for individuals living in nursing homes,” Syme wrote. The full study was published online in Health Expectations, a journal covering the public's participation in shaping healthcare policy.

18) **Interesting Fact:** Each kidney contains 1 million individual filters. They filter an average of around 1.3 liters (2.2 pints) of blood per minute, and expel up to 1.4 liters (2.5 pints) a day of urine.