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!

Update and List of Resources for the New Requirements of Participation (ROPs)

On Wednesday, September 28, 2016, CMS released a final rule entitled Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. The final rule was published in the Federal Register on October 4, 2016. The final rule can be located here. The final rule revises requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs. The revisions to the requirements reflect substantial advances that have been made in the practice of service, quality of health care and patient safety over the last several years. It reaffirms some existing requirements, such as existing resident rights, and finalizes a wide range of new requirements, from comprehensive person-centered care planning to compliance and ethics.

The regulations are effective on November 28, 2016. However, in response to comments by AHCA and our members, CMS is implementing the regulations using a phased approach. The phases are as follows:

- **Phase 1**: The regulations included in Phase 1 must be implemented by November 28, 2016.
- **Phase 2**: The regulations included in Phase 2 must be implemented by November 28, 2017.
- **Phase 3**: The regulations included in Phase 3 must be implemented by November 28, 2019.

Some regulatory sections are divided among more than one phase, and some of the more extensive new requirements have been placed in later phases to allow facilities time to successfully prepare to achieve compliance. 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.

RESOURCES

• IHCA’s in-depth review of each Section of the ROPs (click here) presented on November 10, 2016 via webinar.

• Visit https://educate.ahcanecal.org/ - This is the AHCA/NCAL education website. AHCA is working on:
  o Short Action Steps that provide summary for each change with steps and tips to comply
  o Template documents to help with implementation:
    ▪ Draft Policies and Procedures
    ▪ Draft Forms
    ▪ Checklists to assess your compliance
    ▪ A compliance Playbook
    ▪ Infection Control Preventionist Certificate program

• CMS Survey and Certification Letter 17-03 – NH (click here). This S&C Letter allows for LTC providers to see and review the same training that the State LTC surveyors are receiving to implement and survey against the new ROPs. This training will be available to both surveyors and providers starting on November 18, 2016.

As additional information is available, IHCA will communicate this immediately to our members. Please don’t hesitate to contact Bill Bell with any questions.

It’s Prime Time for Nursing Homes: New AHRQ Antimicrobial Stewardship Guide Available
Antimicrobial medications, including antibiotics, are a classic double-edged sword. Used properly, antibiotics save lives, fighting life-threatening infections by killing the bacteria that cause them. But used improperly, antibiotics can be ineffective, and even harmful, and can render the drugs powerless for future use.

Antimicrobial stewardship programs (ASPs) are a proven method to improve the use of antibiotics. An ASP is a coordinated program within a health care setting that promotes the appropriate use of antimicrobials, thereby improving patient outcomes, reducing antibiotic resistance, and decreasing the spread of infections caused by antibiotic-resistant organisms.

A new guide from AHRQ addresses challenges in creating and implementing ASPs in nursing homes. This is important because it’s estimated that up to 75 percent of antibiotics used in nursing homes are prescribed unnecessarily. The Nursing Home Antimicrobial Stewardship Guide was developed to optimize the use of antimicrobials in nursing homes and decrease the harms that can be caused by inappropriate antibiotic prescribing.

The guide is based on four AHRQ-funded toolkits developed to improve use of antibiotics in nursing homes as well as additional tools to complement the existing four toolkits. The evidence-based guide was pilot-tested in nine nursing homes; so it’s ready for prime time.

Critically, all the toolkits are customizable, allowing nursing homes to pick and choose the interventions and modules within each of the four toolkits to fit their needs. In addition, the Guide is consistent with CDC’s core elements of antibiotic stewardship for nursing homes and can help staff implement many of those elements. And, it can help health care providers meet CMS’ new Infection Prevention and Control Program requirement. The Web-based toolkits offer
step-by-step instructions to help nursing homes improve antibiotic use and decrease infection. The guide’s four toolkits
are designed to do the following:

- Implement, monitor, and sustain an antimicrobial stewardship program.
- Determine whether it is necessary to treat a potential infection with antibiotics.
- Help prescribing clinicians use an antibiogram to choose the right antibiotic to treat a particular infection.
- Educate and engage residents and family members.

This isn’t AHRQ’s first venture into ASPs. Four years ago, we developed the Toolkit for Reduction of Clostridium difficile Infections Through Antimicrobial Stewardship. We’re committed to ASPs because they’re essential to our broad national effort to maintain the effectiveness and safety of the Nation’s antibiotics. They are an important part of the White House’s National Strategy and National Action Plan for Combating Antibiotic-Resistant Bacteria (collectively known as the CARB).

The new guide is the latest way that AHRQ is supporting CARB—and we’re doing so in several ways, including two currently active Funding Opportunity Announcements (an R01 and an R18) that speak directly to the CARB effort.

Also, this week, infection prevention specialists are assembling in New Orleans for IDWeek, the annual conference convening four infectious disease organizations. If you’re attending IDWeek, I hope you’ll visit the AHRQ exhibit at Booth 1102, where you can learn more about the Nursing Home Antimicrobial Stewardship Guide and other AHRQ projects to combat healthcare-associated infections.

Written by James I. Cleeman, M.D., Director, Division of Healthcare-Associated Infections, AHRQ Center for Quality Improvement and Patient Safety

AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 13 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: Individualized Care Approaches Reflected in Care Planning

What does this mean?
The interdisciplinary team (IDT) process is responsible for the overall daily care of the people we serve. Every resident/patient must be assessed systematically and risk areas and causes of symptoms and conditions must be
identified for each individual. The IDT then creates the individual patient care plan that reflects relevant risks, underlying causes, and likes, dislikes and what is important to the individual.

- Experience shows that “knowing” the person enriches their care and supports positive outcomes.
- Interventions are more effective because they are relevant to their underlying risks and causes, because they have meaning to the person, and because staff understand “who” the person is and “how” the person may think.

The common approach to creating a blueprint or roadmap for each individual’s care is via a care plan. While there are many care plan models (e.g. “I” Care Plans; Nursing diagnosis care plans...), what matters most is that the plan is individualized based on understanding the person and what is important for their quality of life and quality of care.

- Every team member must know their responsibilities on the care plan and follow the process.
- All goals and interventions in a care plan must be in the proper context—not in silos—and must reflect an understanding of the “big picture” including the individual’s physical, functional, and psychosocial dimensions. For example, weight issues do not just involve the dietitian or food preferences, but may involve medical issues and medication-related side effects of dry mouth or anorexia.
- The care plan becomes our principal guidance for structure and process related to this individual’s outcomes.

Some approaches are the same for all individuals, for example, with pressure ulcers. All individuals will have skin assessments, weekly wound measurements and reassessments, and interventions to try to reduce risk factors. Individualization would involve such items as management of specific risk factors, what support surfaces to use, and what might motivate the individual to comply if they do not keep their heels floated.

**Why is this important?**
- Individualized care plan approaches that are based upon a systematic process including thorough assessment and accurate cause identification will help the person reach their highest practicable level of function and well-being.

This plan comes from the interdisciplinary team (IDT) process driven by the individual resident/patient as well as adequate and timely documentation of why decisions were made, whether and to what extent the decisions made a difference, and monitoring that leads us to reassess and refine the plan effectively, as needed.

The MDS was originally designed as a tool to assess and document key information on each LTC patient as the foundation for a care plan that identifies risks and identifies interventions to minimize the risk to the patient in various care areas. However, the MDS alone does not provide enough information to individualize most aspects of care.

**What are some examples?**
- An individual with dementia was “bothering” other patients with dementia by frequently trying to direct their actions. This was leading to altercations and raising the distress levels on the unit. The IDT had tried many interventions with no improvement. The exasperated IDT was about to give up when a nursing assistant who cared for this individual and often spoke with the visiting family members said, “Why don’t you get him a big calculator? He was an accountant for 40 years in charge of a department.” The IDT realized that they had omitted the step of identifying “who” this person was and “what” he was like before the memory loss. After giving the resident charts with dollar amounts and a calculator and asking him to total up the columns for the business office, the altercations decreased.
- A care plan said that the resident would maintain a pulse oximetry above 93. Staff kept worrying when it fell even slightly below 93, even though the resident was not noticeably dyspneic, so they tried to make him wear oxygen that he did not want. But once it was recognized that the resident had COPD and that the pulse oximetry result was less important than the respiratory rate and other vital signs, they changed the care plan and he did fine without nasal oxygen.
What is my part (as an individual employee, manager, or practitioner)?

- As a manager, help develop and implement systematic approaches to assessment and interpretation in the proper context of information based on the assessment, to yield an individualized care plan.
- Continually remind everyone to avoid jumping to premature conclusions about what is going on and what to do about it, to think about whether they have enough information to draw conclusions, and to seek additional information if they do not.
- Promote a culture that promotes asking questions, challenging assumptions, and identifying and rethinking situations where the results may not be optimal.
- Managers can also review care plans with the staff for accuracy and pertinence, and point out ways that they can be consolidated and individualized.
- As practitioners, verify and validate diagnoses; incorporate input from the resident, staff, and families into our treatment decision making, review the medication regimen and look for connections between current symptoms and adverse consequences related to existing medications, explain to staff what symptoms or consequences they might expect and the medical foundation for those resident’s symptoms, explain and document the rationale for treatments to staff, residents, and families; coordinate a periodic review of the care plan with the staff, and adjust treatments based on staff monitoring and reporting of resident responses.
- As staff members, avoid “canned” care plans, think carefully about whether current care plans are accurate and relevant, point out when care plans may not make sense or are not working, follow the care plan once it is finalized or updated, and identify and offer suggestions to overcome barriers to implementing desired interventions.
- Focus on improving efforts to identify links between causes and consequences before going to care planning. Look for multiple causes of individual symptoms (behavior, falling, weight loss, etc.) and common causes of multiple symptoms. Engaging in this thinking is important to identifying relevant interventions and to avoid fruitless “symptom chasing.”

What can my organization do?

- Support resources and processes that help familiarize staff more readily with each person’s care plan; for example, through daily rounding; weekly IDT rounds at report time; point-of-care devices, and other means.
- Promote a culture of sound clinical reasoning, good problem solving, enhanced diagnostic quality, knowledge of potential treatment complications, and improved coordination and communication with practitioners.

Resources/Tools:
- HATCh Change Package
- Shared Decision Making
- Shared Decision Making HealthIT
- Resident Assessment Instrument/Minimum Data Set Manual
- Teaching Clinical Reasoning (American College of Physicians, 2015).

Key Takeaways: Individualized Care Approaches Reflected in Care Planning

✓ The care plan is the principal guidance for structures and processes related to each individual’s outcomes.
✓ Individualized care plan approaches based upon a systematic process help the person reach their highest practicable level of function and well-being.
✓ Resources and processes that help familiarize staff more readily with each person’s care plan is essential.
✓ The care plan must be done in the proper context, without discipline-specific or topic-specific “silos.

Probing Questions for Team Reflection and Discussion:

1. How do we breathe life into care plans?
2. What do we do well to know each person? What can we do better?
3. Do our care plans reflect an understanding of the “big picture” and are all goals pertinent and in the proper context?
4. Are we helping each person reach their highest practicable level of function and well-being? How do we know?
Trending Statistics

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

Nursing Home Survey on Patient Safety Culture 2016 User Comparative Database Report

The Nursing Home Survey on Patient Safety Culture is an expansion of AHRQ’s Hospital Survey on Patient Safety Culture to the nursing home setting. The nursing home survey (click here) is designed to measure the culture of resident safety in nursing homes from the perspective of providers and staff. The Nursing Home Survey on Patient Safety Culture 2016 User Comparative Database Report consists of data from 209 nursing homes and 12,395 nursing home staff respondents who completed the survey between January 2014 and April 2016.

This comparative database report was developed as a tool for the following purposes:

- **Comparison**—To allow nursing homes to compare their patient safety culture survey results with other nursing homes.
- **Assessment and learning**—To provide data to nursing homes to facilitate internal assessment and learning in the patient safety improvement process.
- **Supplemental information**—To provide supplemental information to help nursing homes identify their strengths and areas with potential for improvement in patient safety culture.

The 2016 Nursing Home Survey on Patient Safety Culture, released last week by the Agency for Healthcare Research and Quality, surveyed staff members in 209 skilled nursing facilities on 12 different items relating to organizational culture and patient safety.

Most nursing home staff that completed the survey reported that their overall perceptions of resident safety, as well as the feedback and communication about incidents, were positive. Eighty-six percent of respondents said they felt residents were well cared for and safe, while 85 percent said they felt positively in the way their facilities talked about and reported potentially harmful incidents.

The survey found two measures to have the most potential for improvement for nursing homes: staffing, and nonpunitive response to mistakes. Less than half of those surveyed (48 percent) positively responded about their facilities’ staffing levels, while 54 percent said staff are treated fairly — not blamed — when they make and report a mistake.

The way in which staff responded to the safety measures also varied by their positions, with administrators or managers submitting the highest number of positive responses. Nursing assistants and aides had the lowest number of positive responses. The two groups of employees differed the most on the survey components regarding communication openness, with a gap of 30 percentage points.

The survey report’s authors recommended facilities pledge to “take the next steps” to turn the survey’s results into real improvements.

Survey Content

The nursing home survey includes 42 items that measure 12 composites of organizational culture pertaining to patient safety culture:

1. Communication Openness
2. Compliance With Procedures
3. Feedback and Communication About Incidents
4. Handoffs
5. Management Support for Resident Safety
6. Nonpunitive Response to Mistakes
7. Organizational Learning
8. Overall Perceptions of Resident Safety
9. Staffing
10. Supervisor Expectations and Actions Promoting Resident Safety
11. Teamwork
12. Training and Skills

The survey also includes two questions that ask respondents whether they would tell friends that this is a safe nursing home for their family (also called “willingness to recommend”) and to provide an overall rating on resident safety for their nursing home.

**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 17-02 – ESRD** - Release of the Fiscal Year (FY) 2017 Dialysis Facility Reports (DFR) and End Stage Renal Disease (ESRD) Core Survey Materials. CMS announces the release of the materials used for ESRD surveys that have been updated for FY 2017. The FY 2017 DFR, Pre-survey DFR Extract files and state profiles are available to authorized State Survey Agency (SA) personnel on the dialysisdata.org web site. The ESRD Core Survey Data Worksheet and other ESRD Core Survey materials have been revised for FY 2017 to align with the FY 2017 DFR. The FY 2017 survey materials for the ESRD Core Survey are available on the CMS ESRD Survey and Certification page of the CMS.gov website ([click here](#)).

   - **S&C 17-03 – NH** - Save the Date: Training for Phase 1 Implementation of New Nursing Home Regulations. CMS is developing an online training for Regional Offices (RO), State Survey Agencies (SA) providers and other stakeholders on the new Nursing Home Regulations. The online training will include information about Phase 1 of new Nursing Home Regulations, and will be available to all parties starting November 18, 2016. All Long Term Care (LTC) surveyors are required to complete this training in order to be able to conduct any LTC surveys after November 28, 2016.

   - **S&C 17-04 – Transplant** - Transplant Centers: Clinical Experience Requirements. *Citing Non-Compliance with Clinical Experience*: Transplant programs are required per 42 CFR 482.80 (b) to generally perform 10 transplants within the past 12 months for initial certification with Medicare. Programs applying for initial Medicare certification that performed at least eight but less than 10 transplants in the previous 12 months should be cited at the Standard level. The program may still be certified with an acceptable plan of correction for clinical experience requirements if all Conditions of Participation (CoPs) are in compliance. *For re-approval*: Programs are required per 42 CFR 482.82 (b) to perform an average of 10 transplants per year during the prior three years. Programs not meeting this average should be cited at the Standard level, and the program must submit an acceptable plan of correction. The program may be reapproved if all CoPs are in compliance. Voluntary program inactivity does not affect these evaluation periods.

   - **S&C 17-05 – All** - Information on the Implementation Plans for the Emergency Preparedness Regulation. The CMS Survey and Certification Group is providing general information regarding the implementation plans for the new Emergency Preparedness Rule. The information addresses the implementation date for providers and suppliers, the development of Interpretive Guidelines (IGs), surveyor training and resources available to assist in the implementation of this regulation. The regulation affects all 17 providers and suppliers and must be fully implemented by November 15, 2017.

2) Federal HHS/CMS released the following notices/announcements:

   - **Provider Compliance Fact Sheets — New** - New Provider Compliance Fact Sheets are available with tips for:
     - Skilled Nursing Facility Inpatient Services
- **Ordering Oxygen Supplies and Equipment**
- **Laboratory Tests – Other – Urine Drug Screening**
- **Inpatient Rehabilitation Facility – Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units**

- **IMPACT Act Call: Audio Recording and Transcript — New** - An audio recording, transcript, updated presentation and post-call presentation clarification are available for the October 13 call on the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act): Data Elements and Measure Development. During this call, find out how information from assessment instruments is used to calculate quality measures.

- **PECOS FAQs Fact Sheet — Revised** - A revised PECOS FAQs Fact Sheet is available. Learn about:
  - Information you need before you begin the enrollment via the Provider Enrollment, Chain and Ownership System (PECOS)
  - Enrollment application issues
  - Revalidations

- **Antipsychotic Drug use in Nursing Homes: Trend Update** - CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure is the percentage of long-stay nursing home residents who receive an antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington’s disease or Tourette’s syndrome. In the fourth quarter of 2011, 23.9 percent of long-stay nursing home residents received an antipsychotic medication; since then there has been a decrease of 31.8 percent to a national prevalence of 16.3 percent in second quarter of 2016. Success varies by state and CMS region; some states and regions have seen a reduction greater than 30 percent. A four-quarter average of this measure is posted on the Nursing Home Compare website. For More Information:
  - Visit the National Partnership webpage
  - Send correspondence to dnh_behavioralhealth@cms.hhs.gov
  - Register for the December 6 call

- **Early Recognition and Management of Sepsis in Nursing Homes** - On December 7, 2016, noon – 4 p.m. CST, CMS Regional Offices V (Chicago, Illinois) and VII (Kansas City, Missouri) will be hosting a two-part collaborative meeting focusing on early sepsis identification and treatment in nursing homes. During the first part of the collaborative, we will have a guest speaker, Dr. Steven Q. Simpson, Professor of Medicine and Director of the Medical Intensive Care Unit at the University of Kansas Medical Center. CMS will soon be sending out invitations to the State Survey Agencies, various long term care provider associations and medical director associations, and we hope that all of these groups and individual nursing homes will participate either in-person in the CMS Regional Offices or by webinar.

- **CMS/Hospice Cost Data**: They published the Hospice Utilization and Payment Public Use File last week. It breaks down hospice costs and usage data by geographic location, beneficiary demographics, costs and individual provider characteristics. In 2014 alone, 1.3 million Medicare beneficiaries received a total of 92.3 million hospice care days, with each stay averaging about $11,393 per beneficiary. CMS says that releasing the state and individual provider data will help improve data transparency and help providers make informed decisions about their location and the patients they serve.

- **CMS/QAPI**: CMS recently released a Volume 2 QAPI Brief, which focuses on adverse events for the first time since 2013. It includes a list of potentially preventable adverse events and a medication related adverse events case study. The next QAPI brief is expected to be on care and infection related adverse events.

- **SECTION GG**: Beginning October 1, 2016 skilled nursing centers are required to report information to CMS for the SNF Quality Reporting Program required under IMPACT (Improving Medicare Post-Acute Care Transformation) Act of 2014. Section GG (self-care and mobility) will be added to MDS 3.0 and required to complete on the PPS 5 day and PPS Part a Discharge Assessments. Information from Section GG will be used to
calculate the standardized measure of Percent of Residents With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function” (NQF #2631). This measure reports the percentage of residents with both an Admission and a Discharge functional assessment and an activity (self-care or mobility) goal that addresses function. Section GG items focus on admission performance, discharge goals and discharge performance. CMS has not specified who should complete Section GG, but has emphasized the importance of collaboration among members of the interdisciplinary team. Final direction and guidance on coding Section GG has not been released yet from CMS, however AHCA has developed a two-page introduction with a section on what you can do to prepare for Section GG. For more information and resources, visit the AHCA website here.

3) The federal Agency for Healthcare Research and Quality (AHRQ) posted a couple of articles recently:

- **New AHRQ Guide Helps Nursing Homes Tackle Antimicrobial Stewardship** - AHRQ’s new Nursing Home Antimicrobial Stewardship Guide (See second article in this issue) is a research-based resource that offers step-by-step instructions and materials to help nursing homes improve antibiotic use and decrease harms caused by inappropriate prescribing. The guide, which is consistent with the Centers for Disease Control and Prevention’s core elements of antibiotic stewardship, can also help health care providers meet CMS’ new Infection Prevention and Control Program requirements. That program requires providers to have a system to prevent, identify, report, investigate and control infections and communicable diseases for all facility residents, staff, volunteers and visitors. AHRQ’s stewardship guide, which is customizable to meet facilities’ specific needs, includes four toolkits designed to implement, monitor and sustain an antimicrobial stewardship program; determine whether it is necessary to treat a potential infection with antibiotics; help prescribing clinicians use an antibiogram to choose the right antibiotic to treat a particular infection; and educate and engage residents and family members. Access additional AHRQ tools to prevent healthcare-associated infections and an AHRQ Views blog post, “It’s Prime Time for Nursing Homes: New AHRQ Antimicrobial Stewardship Guide Available.”

- **AHRQ Updates Hospital Guide to Reducing Medicaid Readmissions** - AHRQ has updated its Hospital Guide to Reducing Medicaid Readmissions, a resource to help hospitals design and deliver transitional care that addresses medical, social and behavioral needs of Medicaid patients and other vulnerable populations. The resource provides guidance as summarized by the ASPIRE acronym: Analyze your data to understand existing readmission patterns and root causes; Survey your current readmission reduction efforts; Plan a multifaceted, data-informed portfolio of strategies; Implement whole-person transitional care; Reach out to collaborate with cross-setting partners; and Enhance services for high-risk patients. The guide includes 13 customizable tools and content for six webinars to support training on how to use the guide.

4) The federal Office of Occupational Safety and Health Administration (OSHA) released recommendations for creating a safety and health plan. Click here to go to their website which tries to help employers establish a methodical approach to improving safety in their workplaces. This update OSHA’s 1989 and includes leadership from the top to send a message that safety and health is critical to business operations; worker participation in finding solutions; and a systematic approach to find and fix hazards. OSHA, also released their list of the ten most frequently cited safety and health violations for the fiscal year. This was compiled from nearly 32,000 inspections of workplaces by OSHA. This Top 10 list is mainly related to the construction industry, but also pertains to our profession as well:

1. Fall protection
2. Hazard communication
3. Scaffolds
4. Respiratory protection
5. Lockout/tagout
6. Powered industrial trucks
7. Ladders
8. Machine guarding
9. Electrical wiring
10. Electrical, general requirements
5) **Cutting Illinois’ Red Tape** - Governor Bruce Rauner today announced a comprehensive plan to promote economic growth and job creation by cutting the red tape in Illinois. He signed Executive Order 16-13 to review all agency rules and regulations by the newly-created Illinois Competitiveness Council. In order to have the greatest impact, the Illinois Competitiveness Council is seeking input from the public on which rules and regulations are the biggest hindrance to people and businesses. Anyone can submit feedback to cut the red tape at [www.illinois.gov/cut](http://www.illinois.gov/cut).

6) The **Cook County Board of Commissioners** enacted an ordinance ([Click here to view](http://www.cook-county-il.gov)) requiring employers throughout Cook County, Illinois to provide paid sick leave to employees. We should also mention that Cook County raised its minimum wage and it starts to ratchet up July of next year. So here’s how it plays out (Cook County only):

- $10/hr. effective 7/1/17;
- $11/hr. effective 7/1/18;
- $12/hr. effective 7/1/19; and finally
- $13/hr. effective 7/1/20

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

- HFS posted a new provider notice regarding the Dis-Enrollment of Health Alliance Connect Family Health Plan (FHP) Program Enrollees. You may view the notice [here](http://www.hfs.state.il.us).

- HFS has identified a system issue impacting hospital and hospice claims with the assigned Document Control Number (DCN) date of 6274 (September 30, 2016). Claims were rejected erroneously with various error messages. The system issue was fixed immediately (October 4, 2016) and only applies to the specific DCN date. Providers must rebill these rejected claims. HFS encourages providers to rebill electronically. If a claim is now past timely filing or requires other special overrides, providers should submit a paper UB-04 with an [HFS 1624A UB-04 Override Request Form](http://www.hfs.state.il.us) to HFS staff for review. Questions may be directed to a billing consultant in the Bureau of Hospital and Provider Services at 1-877-782-5565.

- HFS has posted **Error Codes** as an Additional Resource for Providers. To view the Error Codes please click [here](http://www.hfs.state.il.us).

- The Technical Assistance call for November 11, 2016 has been rescheduled for November 18, 2016. The call in information is posted on the LTC Direct Billing webpage. In addition, a document listing the proposed specifications for a monthly report of facility residents has been posted on the webpage. This report will replace the monthly pre-payment report that facilities currently receive ([click here](http://www.hfs.state.il.us)).

- HFS has posted a new provider notice regarding Chapter K-200, Handbook for Hospice Agencies – Reissue. You may view the notice [here](http://www.hfs.state.il.us).

8) The **Illinois Department of Public Health (IDPH)** posted the following information:

- The remaining **2016 IDPH Town Hall** regional meeting date is below. These 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.

- IDPH notified us that The Illinois Department of Financial and Professional Regulation is looking for qualified people to serve on its Nursing Home Administrator L&D Board. This is a Governor appointed board and currently in need of two or three nursing home administrators. The requirements are as follows: licensed for at least 5 years and IL resident. Board meets 2 or 3 times per year, majority held in Chicago. Each board member should count on an additional 3 days per year for disciplinary conferences. Some conferences are done by telephone and/or on the day of the board meetings. Others are scheduled for the Chicago office on non-meeting days. The L&D stands for licensure and disciplinary, meaning they advise the agency on these issues, both broadly and with regard to specific cases criteria and be willing to serve on the board (volunteer basis) would be welcomed.
Please feel free to make recommendations directly to Jessica.Baer@illinois.gov Acting Director, Division of Professional Regulation.

9) The American Health Care Association has succeeded in achieving at least a temporary halt to the government's ban on nursing homes' pre-dispute arbitration clauses. Judge Michael Mills said in a 40-page decision just released that while there might be sympathy for consumers' belief that such clauses might not be in their best interests, a solution lies with Congress, not a federal agency overstepping its authority. This echoes AHCA's argument against the ban, and for an injunction. “Congress' failure to enact positive legislation should not serve as an excuse for the executive branch to assume powers which are properly reserved for the legislative branch,” wrote Mills, a judge for the U.S. District Court for the Northern District of Mississippi.

10) The latest Telligen events/announcements can be found at https://www.telligenqinqio.com/.

11) MedlinePlus reports that More Than Half of Americans Have Chronic Health Problem. More than half of Americans have at least one chronic disease, mental illness or problem with drugs or alcohol, according to a new study. "The health of individuals in the U.S.A. is increasingly being defined by complexity and multimorbidity, the co-occurrence of two or more chronic medical conditions," said the study authors, Elizabeth Lee Reisinger Walker and Dr. Benjamin Druss. They emphasized that people with multiple health issues need more access to care and better coordination among their health care providers.

12) HCP Live reports, Risk For Developing Depression High In The Three-Month Period After Experiencing A Stroke. "In the three month period after experiencing a stroke, the risk for developing depression is as much as eight times higher," researchers found after analyzing data on "157,000 patients" who "had a first time hospitalization for a stroke between January 1, 2001 and December 31, 2011," and a matching "non stroke, hospitalized population" of controls. The findings were published in the October issue of JAMA Psychiatry.

13) Forbes contributor David DiSalvo writes New Study Shows it may be Possible to Design a Pill That Prevents Alzheimer’s Disease. There may be a way to prevent Alzheimer’s disease with a pill, based on a new study published in Neuron. DiSalvo argues that the study shows that it may be possible to create a pill that reduces the amount of toxic tau proteins around neurons thereby preventing the disease.

14) The University of California – San Francisco (UCSF) reports that 1-in-4 Older Adults Have Not Discussed Advance Care Planning. More than one in four older adults have not engaged in planning for end-of-life care or directives, despite significant public efforts to encourage the practice. This is especially true for African Americans, Latinos and those with less education and income, according to a study by researchers at UC San Francisco, who advocate finding better approaches to ensure these discussions occur. Advance care planning (ACP) includes discussions about preferences for end-of-life-care, completion of advanced directives and designation of a surrogate decision-maker in a durable power of attorney for health care. There is growing awareness of the benefits of such plans for both elders and their families, who can get mired in unexpected legal issues if no such plan exists. But until recently, it was unknown if all races/ethnicities, education levels and incomes have benefited, and if these discussions are greater among those in worse health and with poorer prognosis.

15) Provider Magazine reports:

- Ransomware Cyberattacks Are a Growing Threat for Health Care Providers. In an over 3,000 word article, Provider Magazine reports that ransomware cyberattacks are a growing threat for health care providers, including long term/post-acute care facilities. The article points out that HHS' OCR is increasingly holding health care providers accountable for HIPAA violations caused by cyberattacks, and that news of such attacks can also damage providers’ credibility.

- Noninvasive Test May Help Predict Which Patients React Favorably to Antidepressants. Provider Magazine reports on a study that "describes a noninvasive way to predict which patients will respond favorably to the most commonly used antidepressants." With winter and holidays approaching, health care providers often see
higher rates of depression. The article says that "skilled nursing and other long term care centers need to be aware of these concerns as patients, residents, and staff alike may be susceptible to depression during this time." The study found that a simple biomarker "can predict whether a person will enter remission after just one week of treatment with a particular medication."

- Providers Should Follow Checklist To Comply With Federal Regulations When Disposing Of Pharmaceutical Waste. Provider Magazine outlines a checklist for long term and post-acute care providers to follow when managing pharmaceutical waste. The article explains that providers have to dispose of such waste while complying with regulations from the EPA and DEA.

16) In a recent article, Reuters reports that many patients and their families may expect end-of-life care treatments that conflict with some of their self-reported values in such circumstances, according to a new study published in BMJ Supportive and Palliative Care. Researchers asked patients and their families about their values and preferred treatments for end-of-life care and often found conflicts between the values and treatment preferences. The study's lead author Dr. Daren K. Heyland of Kingston General Hospital in Canada said, "We are saying that when patients express a value of what's important to them, they don't understand how their goals may compete with each other."

17) Kaiser Health News reports:

- California Rules About Violence Against Health Workers Could Become a Model. Workers in California’s hospitals and doctors’ offices may be less likely to get hit, kicked, bitten or grabbed under workplace standards adopted by a state workplace safety board. Regulators within the California Division of Occupational Safety and Health (Cal/OSHA) approved a rule recently that would require hospitals and other employers of health professionals to develop violence prevention protocols and involve workers in the process. The standard now will be reviewed by the Office of Administrative Law, which proponents expect will approve the new rules. The earliest they could take effect would be January 2017. “This is a landmark day for the entire country,” said Bonnie Castillo, a registered nurse who is director of health and safety for the California Nurses Association/National Nurses United, which represents 185,000 registered nurses across the U.S. There are no federal rules specifically protecting workers from violence, but some states, including California, New York, Illinois and New Jersey require public employers to take preventive measures, according to the American Nurses Association.

- Many Seniors Need Dental Care But Lack Coverage. Michelle Andrews writes in her "Insuring Your Health" column in Kaiser Health News that seniors need dental care, but most lack coverage because traditional Medicare does not cover dental care. According to an analysis by the American Dental Association, over a third of low-income seniors "had untreated tooth decay between 2011 and 2014." Some have proposed adding dental coverage to Medicare Part B to increase seniors’ access to dental care, while others advocate for seniors buying private dental coverage. Marko Vujicic, the vice president of the American Dental Association’s Health Policy Institute, said that private dental coverage often lacks values for seniors, because the premiums and copays exceed the benefits.

18) HealthDay reports:

- Less Than Half of Older Hip Fracture Patients Return to Former Level of Independence. HealthDay reports new research suggests that "for older adults, a fractured hip is often life-changing," with less than half being able to "return to their former levels of independence and physical activity." According to CDC reports, over "95 percent of seniors’ hip fractures are caused by falls, and three out of four hip fractures happen to women." The findings of the study were published in the Journal of General Internal Medicine.

- Regular Dental Cleanings May Reduce Risk of Pneumonia. HealthDay reports that investigators "reviewed the records of more than 26,000 people." The data indicated that individuals "who never saw a dentist were 86 percent more likely to get bacterial pneumonia compared to people who got dental checkups twice a year."
19) **Medscape** reports:

- **Antibiotics: 5 Myths Debunked.** After 80 years of experience, much is known about antibacterial agents. Unfortunately, some of what is "known" is incorrect. To paraphrase Osler, half of everything we’re taught is wrong—the problem is, which half? In this article, we seek to debunk five widely believed myths about antibiotics and resistance.

- **CDC: 2017 Vaccine Schedule Targets Immune-Compromised Adults.** A simpler yet more informative adult vaccination schedule has been approved for 2017. Meeting this week in Atlanta, the Centers for Disease Control and Prevention’s (CDC’s) Advisory Panel on Immunization Practices (ACIP) voted on changes to reflect updated recommendations and to make the document's graphics simpler and its wording both simpler and more consistent. The schedule will also contain fuller information on adults with immune-compromising medical conditions. The ACIP also approved changes to the 2017 schedule for children and adolescents.

20) **Medical News Today** reports:

- **Study Shows Low Vitamin D Levels are Associated With Increased Negative and Depressive Symptoms in Psychotic Disorders.** New research presented at this year's International Early Psychosis Association (IEPA) meeting in Milan, Italy (20-22 October) shows that low vitamin D status is associated with increased negative and depressive symptoms in psychotic disorders. The research is by Dr. Mari Nerhus, NORMENT Research Centre, Institute of Clinical Medicine, University of Oslo, Norway and colleagues. There are indications that low vitamin D levels are associated with increased disease severity in psychotic disorders. In these new studies, the authors investigated if low vitamin D status was associated with a specific symptom profile and if vitamin D deficiency was associated with cognitive deficits in young people with a psychotic disorder.

- **How to Get Rid of a Stye: Treatments and Home Remedies.** A stye is a very common condition that affects many people. It is also known as a hordeolum. Styres are red, swollen lumps that form along the edge of the eyelid, close to the lashes. Sometimes, a stye can occur inside or under the eyelid. Usually, stytes are a minor annoyance and only need treatment at home. There are some situations where it is important to consult a doctor, however. Read on for more information about ways to manage a stye and preventing them in the future.

- **New Guideline on Calcium and Vitamin D Supplementation.** A new evidence-based clinical guideline from the National Osteoporosis Foundation (NOF) and the American Society for Preventive Cardiology (ASPC) says that calcium with or without vitamin D intake from food or supplements that does not exceed the tolerable upper level of intake (2,000 to 2,500 mg/d) should be considered safe from a cardiovascular standpoint. Obtaining calcium from food sources is preferred, but supplements can be used to address dietary shortfalls. The guideline is published in *Annals of Internal Medicine*. Calcium supplements have been recommended for persons who do not consume adequate calcium from their diet as a standard strategy for preventing osteoporosis-related fractures. Conflicting reports have suggested that calcium intake, particularly from supplements, may have either beneficial or harmful effects on cardiovascular outcomes.

21) **McKnight’s** reports:

- **CMS: Overlapping Payment Models May Cause Confusion Among Providers As New Models Are Introduced.** McKnight’s Long Term Care News reports CMS Deputy Administrator Patrick Conway, MD, said recently at the America’s Health Insurance Plans’ Medicare conference that "health care providers who participate in more than one new payment model may face some confusion about the models’ results." Dr. Conway said the agency "is aware that overlap is becoming more common as more payment models are introduced" and the agency is "working to make results of the models more easily attributable so that providers know which program generated savings." In a letter to Conway and CMS Acting Administrator Andy Slavitt, "House lawmakers urged the agency to stop making new payment models mandatory and instead focus on 'prior testing on a smaller scale.'"
• **Study Finds Nurse Practitioners Improve Transfer Process At Nursing Homes.** *McKnight’s Long Term Care News* reports a recent study, conducted by the OPTIMISTIC project at Indiana University and published in *The Annals of Long-Term Care*, found that specially trained nurse practitioners can help "improve the resident transfer process and reduce errors" at nursing homes. The OPTIMISTIC project, which "embeds nurses and nurse practitioners at skilled nursing facilities in an effort to improve care quality and communication between providers," sent nurse practitioners to visit "with long-stay nursing home residents within 48 hours of returning to the facility from a hospital" to discuss "the resident’s hospital discharge summary, medication reconciliation, advance care planning, follow-up care and education for the residents’ family." The researchers found that "identifying potential care issues helped OPTIMISTIC cut hospitalizations by 21 percent in the early stages of the program." They plan to continue analyzing nurse practitioner visits to find other potential cost cutting opportunities.

• **Research Shows SNF’s Past Rehospitalization Rate Strong Predictor Of Ongoing Rate.** *McKnight’s Long Term Care News* reports new research indicates that rehospitalization rates are a valid predictor "of which skilled nursing facilities are likely to have residents readmitted to the hospital." Researchers "used Medicare data from 2009 through 2012 to calculate skilled nursing facilities’ risk-adjusted rehospitalization rates," and found that "patients in facilities that experienced an increase in rehospitalizations between 2009 and 2012 were more likely to be readmitted to a hospital in 2013." The findings were published in Health Services Research.

• **SNF Residents’ Preferences, POLST Forms Misaligned In 64 Percent Of Residents Surveyed.** *McKnight’s Long Term Care News* reports new research suggests that "skilled nursing facility residents’ current treatment preferences don’t always agree with forms detailing their preferences for life-sustaining medical orders." Researchers "examined the use of Physician Orders for Life-Sustaining Treatment [POLST] forms within nursing home settings" and found that "the POLST forms and residents’ own preferences were found to clash for 64 percent of the residents surveyed in the study." The findings were published in *Journal of Palliative Medicine*.

• **Defending Nursing Homes Cited With F-Tag 314.** As many long term care providers know, F-Tag 314 is a federal regulation that governs pressure injuries (previously called “pressure sores or pressure ulcers”) developed in nursing homes. This regulation mandates that, based on the comprehensive assessment of a resident, the facility must ensure that the resident who enters without a pressure sore does not develop one, unless the individual's clinical condition demonstrates that the pressure injury is unavoidable.

• **CMS: New Survey Process More Efficient, Combines best of Current Processes.** The new survey process for skilled nursing facilities is expected to be made more efficient by drawing on the strengths of two existing processes, CMS says. Creation of the new process, first announced in late September, included an analysis of the differences between the current Quality Indicator Survey and the traditional survey process, Shulman said. Those differences includes the computer-based QIS generally being better at identifying unnecessary medications, while traditional, paper-based surveys are better equipped to identify infection control issues.

• **High-Dose Flu Shot Cuts Hospitalization Risk for Long Term Care Residents.** A high-dose influenza vaccination helped reduce the number of hospitalizations among long term care residents with respiratory conditions during a recent flu season, researchers reported last week. The results of the study, presented at IDWeek 2016 in New Orleans by lead researcher Stefan Gravenstein, MD, MPH, found that the high-dose vaccine helped reduce both hospitalization risk and the number of hospitalizations for respiratory infections when compared to the standard vaccine group. Mortality rates between the two groups were similar, researchers said.

• **CMS Seeks To Lower Costs, Boost Efficiency Using New Care Model.** *McKnight’s Long Term Care News* reports that CMS "aims to lower care costs, boost efficiency, and improve quality by making participating hospitals accountable for the care that beneficiaries receive." CMS’ Comprehensive Care for Joint Replacement model "is now mandatory for all hospitals in 67 metro regions or metropolitan statistical areas across the country." In April of this year, "CMS introduced a proposal to expand the model to include surgical hip and femur fracture
treatments." The agency "also plans to launch episode payment models for cardiac care, specifically for Acute Myocardial Infarction and Coronary Artery Bypass Grafting, on July 1, 2017, for hospitals in 98 MSAs."

- Medicare Appeals Backlog May Be Eliminated By End Of FY 2019, HHS Said. *McKnight’s Long Term Care News* reports a court brief filed by the Department of Health and Human Services Monday said that the "overwhelming backlog of Medicare claims appeals may" be eliminated as "early as fiscal year 2019." The backlog "has been previously forecasted to not only persist until fiscal year 2020, but grow to a million appeals by then." However, with Congressional action on the agency’s side, HHS "said, that backlog will ‘continue to decrease until it is eliminated completely by the end of fiscal year 2019.’"

22) **Interesting Fact:** They can’t make artificial blood. You can get an artificial hip, knee, elbow, even ankle, and there are machines that can replace your heart and lungs, but there is no way to make synthetic blood substitutes in the laboratory.