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!

IMPORTANT NOTICE

The federal Centers for Medicare and Medicaid Services (CMS) recently released two new Survey and Certification Letters of major importance to all LTC providers.

- **S&C 17-06** - CMS has completed the FY 2015 MDS Focused Surveys and is providing an overview of the results. The FY 2015 MDS Focused Survey Summary outlines the background for the MDS Focused Surveys, the types of deficiencies and errors identified on these surveys, and also provides technical resources for providers to help improve accuracy and help providers maintain compliance to enhance the safety and quality of care nursing home residents receive.

- **S&C 17-07** - Advance Copy - Revisions to State Operations Manual (SOM), Appendix PP-Revised Regulations and Tags
  - **Revised Regulations**: On September 28, 2016, CMS released revised Requirements for Participation for Medicare and Medicaid-certified nursing facilities. Most regulations groups were re-designated and have new numbers.
  - **Advance Copy - Revisions to SOM Appendix PP**: CMS has incorporated revised regulation text into the SOM Appendix PP. The regulation text is effective November 28, 2016; the Interpretive Guidance has not been updated. **Interpretive Guidance will be revised at a later date.**
  - **Revised F-Tags**: The current F-Tags have been revised to include the requirements and regulation text as is presented in the final rule.

Department of Labor’s Fair Labor Standards Act and Overtime Pay

On May 18, 2016, the U.S. Department of Labor (DOL) announced the publication of a final rule that amends the “white-collar” overtime exemptions to the Fair Labor Standards Act (FLSA) to significantly increase the number of employees eligible for overtime pay. The final rule will go into effect on December 1, 2016. The health care industry will be impacted as much as any other industry by the amendments affecting these exemptions. Special enforcement suspension will be granted to providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds.

Background

Amendments to the white-collar overtime exemptions have been in the works for some time. In March 2014, President Obama directed the DOL to “enhance” the white-collar exemptions. Last summer, the DOL issued its Notice of Proposed Rulemaking (NPRM), in which it proposed more than doubling the salary threshold for the executive, administrative and
professional exemptions, as well as significantly increasing the threshold for the highly compensated employee exemption.

Specifically, the NPRM proposed increasing the salary threshold for the executive, administrative and professional exemptions from $455 per week to $970 per week—or from $23,660 per year to $50,440 per year. And it proposed increasing the salary threshold for the highly compensated employee exemption from $100,000 to $122,148 annually. Nearly a year after issuing its NPRM and having received almost 300,000 comments regarding the proposed changes, the DOL announced the publication of the final rule. While the final rule does not increase the salary thresholds for the executive, administrative and professional exemptions to the levels proposed in the NPRM, it nevertheless significantly increases those thresholds. And the final rule includes an even higher threshold for the highly compensated employees than that proposed last summer.

As a result of the final rule, employers throughout the country will need to confirm whether the compensation for employees currently treated as exempt would satisfy the new thresholds. If not, employers would need to determine whether to increase the compensation for those individuals to satisfy the new thresholds, or to convert those employees to non-exempt status such that they become eligible for overtime compensation.

What Is New
The final rule provides for the following changes to the executive, administrative, and professional exemptions:

- The salary threshold for the executive, administrative, and professional exemptions will increase from $23,660 ($455 per week) to $47,476 ($913 per week), which represents the 40th percentile of full-time salaried workers in the lowest-wage census region (currently the South). This threshold is approximately $3,000 less per year than that proposed last summer in the NPRM.
- The total annual compensation requirement for “highly compensated employees” subject to a minimal duties test will increase from the current level of $100,000 to $134,004, which represents the 90th percentile of full-time salaried workers nationally. This threshold is approximately $12,000 more per year than that proposed last summer in the NPRM.
- The salary threshold for the executive, administrative, professional, and highly compensated employee exemptions will be automatically updated every three years to maintain the standard salary level at the 40th percentile of full-time salaried workers in the lowest-wage census region to “ensure that they continue to provide useful and effective tests for exemption.”
- The salary basis test will be amended to allow employers to use non-discretionary bonuses and incentive payments, such as commissions, to satisfy up to 10 percent of the salary threshold.

What Allowance the Health Care Industry Is Being Afforded
With its publication of the final rule, the DOL announced a time-limited non-enforcement policy (Policy) for providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds. Under the Policy, from December 1, 2016 (the effective date of the final rule), until March 17, 2019, the DOL will not enforce the updated salary threshold of $913 per week for employers providing these services.

The DOL issued the Policy in response to interagency discussion between the DOL and the U.S. Department of Health and Human Services (HHS) about the concern that the final rule would frustrate the HHS’ goal of providing services to individuals with intellectual or developmental disabilities in integrated settings that support full access to the community and the provision of services through small, community-based settings that maximize individuals’ autonomy, quality of life, and community participation.

What This Means
While it is certainly good news for employers that the duties tests for the various exemptions will not be augmented in the final rule, the significant increase to the salary threshold is expected to extend the right to overtime pay to an estimated 4.2 million workers who are currently exempt. This change will not only affect labor costs but also require employers to rethink the current structures and efficiencies of their workforces, including assessing how the reclassification of workers from exempt to non-exempt will affect their fundamental business models. In addition, to the
extent exempt employees are reclassified as non-exempt, employers will have to consider implementing policies and procedures to both comply with overtime laws and control overtime worked, such as proscription against off-the-clock work and proper maintenance of accurate record-keeping.

The apparent trade-off for scaling back the salary threshold from the proposed $50,440 to $47,476 for the executive, administrative, and professional exemptions is the increase in the highly compensated employee salary threshold from the proposed $122,148 to $134,004 announced in the final rule. That, of course, is a substantial increase to the current $100,000 threshold and will likely result in employers relying less than they had previously on this exemption. The permitted use of non-discretionary bonuses and incentive payments, such as commissions, to satisfy up to 10 percent of the salary threshold may help soften the impact of the increase to the salary threshold. Employers should proceed carefully, however, if they wish to take advantage of that provision. For example, employers should make sure that the 10 percent maximum allowance is not exceeded, which could otherwise lead to misclassification claims. Also, employers should be mindful of maintaining a proper distinction between discretionary and non-discretionary bonuses and only attribute the latter to satisfy the salary threshold.

With respect to the DOL’s Policy delaying enforcement against providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds, employers should take heed that that the Policy applies only to DOL investigations and enforcement actions. Because the FLSA provides employees with the right to bring a private cause of action, the Policy provides no apparent protection against private lawsuits that may be brought by employees who are treated as exempt but paid less than the updated salary threshold of $913 per week, effective December 1, 2016. Although difficult to predict, plaintiffs’ attorneys may not pursue private litigation until the March 17, 2019 end date of the Policy to evaluate whether the DOL will issue a NPRM addressing the application of the final rule to providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities, and also to maximize the potential value of a lawsuit since the statute of limitations under the FLSA is two years (or three years if willful).

Resistance to the final rule can be expected. There is little doubt that the DOL modified its proposed salary threshold increase of $50,440 to $47,476 in response to nearly 300,000 comments, many of which were from employers and advocacy groups providing thoughtful commentary on the practical issues and repercussions of implementing such a significant increase to the salary threshold. Because of the severity of the final rule, a Congressional challenge may be in the offing. Subject to the Congressional Review Act, the final rule will be scrutinized by the next Congress to be seated in 2017.

**What Employers Should Do Now**

Employers should not delay in auditing their workforces to identify employees currently treated as exempt who will not meet the new salary threshold. For such workers, employers will need to determine whether to increase workers’ salaries or convert them to non-exempt.

If an employee’s salary need only be increased slightly to satisfy the final rule, it may be an easy decision for the employer simply to provide the employee with that salary increase. So, too, might an employer have an easy decision to reclassify an employee as non-exempt if it would have to provide a substantial salary increase to meet the new threshold.

Many difficult decisions, however, will likely need to be made by employers. Converting employees from exempt to non-exempt implicates a number of other issues that employers should carefully analyze, such as estimating how much overtime an individual is expected to work to determine what an employee’s new hourly rate will be to ensure compliance with the overtime laws. These decisions may be particularly difficult for health care employers that wish to take advantage of the DOL’s Policy delaying enforcement against providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds—those employers will need to weigh the risks of private litigation by employees whose salaries are not increased to meet the new threshold.
Possibility of Changes or a Delay?
The House passed two pieces of legislation before they left before the election. One bill put this off until June and the other phases it in over a three year period. The Senate took up two companion pieces that are somewhat similar. The first, from Sen. Lamar Alexander would phase in the new salary threshold over five years, and would require the GAO to conduct a report during the rule’s first year to assess its economic effects. Should these be unfavorable, then nonprofits, colleges and universities, state and local governments and health care organizations (us) that received more than half their funding from Medicare and Medicaid would be exempted from the rule. The second bill, from Sen. David Vitter would delay the rule’s implementation two years.

The Senate is widely expected to take this up when they return. They move slow, especially in light of last week’s election. There will be a lot of jockeying for leadership positions. Once the Senate passes it, then it’ll need to go to reconciliation and then off to the President.

Here’s the kicker...the President has said he will veto all measures dealing with this. So even if it passes both Chambers (and you know it will come down to the December 1 deadline) the President will veto and Congress may not have enough votes or time to override.

Best guess...this is going to pass and get vetoed. Once January 20 hits, the new President could knock it back down again though.

Parts of this article provided by Michael Kun and Jeffrey Ruzal of the Epstein, Becker and Green Law Firm.

CMS announced a final rule to update health care facilities’ fire protection guidelines to improve protections for all Medicare beneficiaries in facilities from fire that was effective on July 5, 2016, but not enforced until just recently. The new Life Safety Code (LSC) survey booklets were just released and made available to the fire safety inspectors/surveyors. The new K-Tag survey booklets can be found at:

- ICF/IID Small Facilities (16 person or less)

- ICF/IID Large Facilities (Including MC/DD’s)

- Nursing Homes (Health Care - Medicare & Medicaid)

The new guidelines apply to long term care (LTC) facilities; hospitals; critical access hospitals (CAHs); inpatient hospice facilities; programs for all-inclusive care for the elderly (PACE); religious non-medical healthcare institutions (RNHCI); ambulatory surgical centers (ASCs); and intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

This rule adopts updated provisions of the National Fire Protection Association’s (NFPA) 2012 edition of the Life Safety Code (LSC) as well as provisions of the NFPA’s 2012 edition of the Health Care Facilities Code. CMS strives to promote health and safety for all patients, family and staff in every provider and supplier setting. Fire safety requirements are an important part of this effort.

“This final rule meets health care facilities’ desire to modernize their environments while also ensuring the necessary steps to provide patients and staff with the appropriate level of safety,” said Kate Goodrich, MD MHS, Director Center for Clinical Standards and Quality, CMS. “Health care facilities can now be more home-like while ensuring that the most modern fire protection practices are in place.”
The provisions in this final rule cover construction, protection and operational features designed to provide safety for Medicare beneficiaries from fire, smoke and panic. Some of the main requirements laid out in this final rule include:

- Health care facilities located in buildings that are taller than 75 feet are required to install automatic sprinkler systems within 12 years after the rule’s effective date.
- Health care facilities are required to have a fire watch or building evacuation if their sprinkler systems is out of service for more than ten hours.
- The provisions offer LTC facilities greater flexibility in what they can place in corridors. Currently, they cannot include benches or other seating areas because of fire code requirements limiting potential barriers to firefighters. Moving forward, LTC facilities will be able to include more home-like items such as fixed seating in the corridor for resting and certain decorations in patient rooms (such as pictures and other items of home décor).
- Fireplaces will be permitted in smoke compartments without a one hour fire wall rating, which makes a facility more home-like for residents.
- Cooking facilities now may have an opening to the hallway corridor. This will permit residents of inpatient facilities such as nursing homes to make food for themselves or others if they choose to, and, if the patient does decide to make food, facility staff is able to provide supervision of the patient.

ICF-IIDs have expanded sprinkler requirements to include habitable areas, closets, roofed porches, balconies and decks in new facilities. All attics must have a sprinkler system if they are used for living purposes, storage or housing of fuel-fired equipment. If they are not used for these purposes, attics may have heat detection systems instead. Hazardous areas are to be separated from other parts of the building by smoke partitions. Existing ICF-IIDs must include certain fire alarm features when they choose to update their fire alarm systems.

The LSC is a compilation of fire safety requirements for new and existing buildings and is updated every three years. Previously, CMS was using the 2000 edition of the LSC to survey for health and safety compliance. With this new rule, CMS is adopting provisions of the 2012 edition of the LSC and provisions of the 2012 edition of the Health Care Facilities Code to bring CMS’ requirements more up to date. In addition, the 2012 edition of the NFPA’s Health Care Facilities Code gives more detailed provisions specific to different types of health care facilities.

CMS is also allowing providers access to the LSC Transition Course (click here), which is a web-based, self-paced course that will take approximately 20 hours to complete. All existing state agency surveyors that conduct LSC surveys are required to complete the transitional course before conducting LSC surveys using the 2012 LSC and Health Care Facilities Code (HCFC).

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**Trending Statistics**

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

**Workplace Injury Rates in Nursing Homes Continue to Drop**
Nonfatal occupational injury rates in both private and government-owned skilled nursing facilities decreased in 2015, according to data recently released by the Bureau of Labor Statistics.

Privately owned nursing facilities had an injury incidence rate of 6.8 per 100 workers for 2015, down from 7.1 in 2014. The private nursing sector had a total of 171,900 recordable injury or illness incidents in 2015.

Skilled nursing facilities operated by local governments had an injury and illness incidence rate of 7.2 for 2015, while those run by state governments clocked in at a rate of 12 injuries per 100 workers. While the latter rate is a .6 percent decrease from last year, state-run facilities still rank as the only sector across all industries with double-digit incidence rates.
Local government-run facilities reported 4,200 employee injuries in 2015, according to the BLS data. State-run facilities had 13,700 recordable injury or illness cases.

Click [here](#) to see the BLS’ full workplace injury and illness report for 2015.

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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 17-06 – NH** - Fiscal Year (FY) 2015 Minimum Data Set (MDS) Focused Survey Summary. CMS has completed the FY 2015 MDS Focused Surveys and is providing an overview of the results. The FY 2015 MDS Focused Survey Summary outlines the background for the MDS Focused Surveys, the types of deficiencies and errors identified on these surveys, and also provides technical resources for providers to help improve accuracy and help providers maintain compliance to enhance the safety and quality of care nursing home residents receive.

- **S&C 17-07 – NH** - Advance Copy - Revisions to State Operations Manual (SOM), Appendix PP-Revised Regulations and Tags. Revised Regulations: On September 28, 2016, CMS released revised Requirements for Participation for Medicare and Medicaid-certified nursing facilities. Most regulations groups were re-designated and have new numbers. Advance Copy - Revisions to SOM Appendix PP: CMS has incorporated revised regulation text into the SOM Appendix PP. The regulation text is effective November 28, 2016; the Interpretive Guidance has not been updated. Interpretive guidance will be revised at a later date. Revised F-Tags: The current F-Tags have been revised to include the requirements and regulation text as is presented in the final rule.

- **S&C 17-08 – NH** - Civil Money Penalty (CMP) Reinvestment Resource Web Page. A web page to house general information on the reinvestment of State CMP funds is now available [here](#). This web page serves as a location to house pertinent information for entities interested in applying for State CMP funds, States and Regional Offices (ROs) and other stakeholders.

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

- **CMS/Common Deficiencies From the MDS Focused Surveys (See S&C 17-06)**: Deficiencies in MDS accuracy and posted nurse staffing information were the most commonly cited among MDS 3.0 Focused Surveys conducted in fiscal year 2015, according to a [new report](#). The top three most common deficiencies among the 56 cited were: MDS accuracy (F-278), posted nursing staffing information (F-356) and develop comprehensive care plans (F-279). The list also includes:
  - Free from unnecessary drugs (F-329)
  - Treatment/services to prevent/heal PUs (F-314)
  - No catheter/prevent urinary tract infections/restore bladder (F-315)
  - Comprehensive assessment after significant change (F-274)

The surveyors also noted trends among the types of coding errors that caused providers to receive an MDS accuracy citation, including coding inconsistencies for residents receiving antipsychotics or having a restraint, failing to code for UTIs in accordance to the RAI Manual, and not coding pressure ulcers at the correct stages. For posted staffing-related deficiencies the most common culprit was having posted staffing information that was not up-to-date, and not retaining staffing records for 18 months.

Fifty-six percent of the deficiencies were cited at scope and severity level D, or no actual harm with potential for more than minimal harm that is not immediate jeopardy. An additional 25 percent of citations were level E. To read the full summary report, and see the resources CMS suggests for improving MDS accuracy and compliance, [click here](#).
CMS/Sepsis Collaborative Seminar: *Early Recognition and Management of Sepsis in Nursing Homes* will be held on December 7, 2016 from 12:00 noon to 4 p.m. (Eastern) and you are invited to participate. The guest speaker is University of Kansas Professor of Medicine Dr. Steven Q. Simpson. *CMS has applied to provide CEUs.*

Registration is a two-step process. **Step One:** Send an email to RaShelle.brooks@cms.hhs.gov with your name, address, employment in a nursing home (just yes or no) and answer the question of whether you’ve started a sepsis early recognition program. Please let her know if you plan on attending in person in either Chicago or KC.

**Step Two:** Registration for the WebEx Link: Only one individual needs to register for each computer that will access the WebEx, regardless of the number of people who will view the meeting from that computer. To register for the WebEx link to connect on the day of the collaborative: [Click here](#) and register. Once the host approves your registration, you will receive a confirmation email with instructions for joining the session. Please contact RaShelle with any questions.

**PBJ:**

- Last week, CMS, through its Quality Technical Support Office, emailed a notice to all providers related to PBJ submissions. CMS has addressed several technical questions related to the PBJ submission process and, most notably, has indicated they will accept data submission past the deadline and will not impose penalties for providers that have not met the deadline at this time. AHCA has been raising many of your concerns with CMS. AHCA understands providers have had questions regarding their submitting data into the PBJ system. Here are some of the more frequently asked questions from CMS to help facilitate the process for you.

1. **System Access:** Submissions have exceeded the amount of planned network capacity and has resulted in high network utilization which is subsequently causing slowed system response times as well as an inability to access the system for some users. CMS encourages users to pull down their validation reports during off peak times to relieve system congestion and allow more bandwidth for data submissions and less user frustration.

2. **Deadline for Submission:** CMS will accept data submission past the deadline and will not impose penalties for providers that have not met the deadline at this time. However, they expect providers to still make a good faith effort to submit data as soon as possible for Fiscal Year 2016 Q4 (July 1 - September 30, 2016).

3. **Facility IDs:** CMS understands several providers are confused about what number to use when PBJ asks for the Facility ID (FAC_ID). The list of FAC_IDs can be found by logging on to CMSNet, clicking "QIES Systems for Providers" and then under "PBJ Submissions" click "Look Up Facility ID".

4. **Hire/Rehire Dates:** For questions related to entering the hire and rehire dates for employees, please see Section 8.4 ("Manual Data Entry and XML Submission Rehire Process") of the PBJ User Manual, which can be found here, [https://www.qtso.com/pbjtrain.html](https://www.qtso.com/pbjtrain.html)

5. **Saving and Submitting Data:** CMS is aware that some facilities may be confused on the use of the "save" button in the PBJ system. The save button is the same as submitting your data. Additionally, you can save and submit as often as you’d like throughout the quarter, such as every two weeks, and you can always go back and edit your data for previous weeks. Do not wait until the end of the quarter to save and submit. CMS will not collect any files until after November 14th.

6. **CMS 671 Form and PBJ Submission Discrepancies:** Some providers are concerned that PBJ data will be compared to the information submitted on their CMS-671 form. CMS acknowledges that there are differences between how staffing data is submitted in comparing the instructions and policies of PBJ and the CMS-671, and they cover very different time frames. Therefore, in general, CMS does not expect PBJ data to match the data from the CMS-671.
During a CMS Open Door Forum phone call, CMS staff reported that 90 percent of providers have submitted their 3rd quarter (July 1 - September 30) 2016 staffing data to the PBJ system. CMS noted that those providers who have not submitted data yet for the 3rd quarter should do so by December 1, 2016.

After December 1, 2016, CMS will provide an indicator on Nursing Home Compare to report which providers have and have not submitted the PBJ data. All providers should do their best to submit their PBJ data as soon as possible if they have not already done so.

More information on the PBJ submission requirements can be found on the CMS PBJ website.

- **Compliance Program Basics.** Do you need assistance setting up a compliance program for your practice or facility to help you comply with Medicare law and policies? Watch a brief video on Compliance Program Basics from the Office of the Inspector General (OIG) on the seven fundamental elements of an effective program. This video is part of the OIG Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training initiative to prevent fraud, waste, and abuse. The video originally aired in 2012, but the information is current.

- **National Partnership to Improve Dementia Care and QAPI Call — Thursday, December 6 from 1:30 to 3 pm ET.** To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. During this call, learn about the reform of requirements for long-term care facilities, highlighting the Behavioral Health Services & Pharmacy Services sections. A Tennessee nursing home will also discuss innovative approaches that they implemented to dramatically reduce the use of antipsychotic medications. Additionally, CMS experts share updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations. Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

- **Long Term Care Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the October 27 call on Long Term Care Facilities: Reform of Requirements. Find out about the changes included in the final rule; implementation and survey process; and provider training and resources.

- **Power Mobility Devices Fact Sheet — Revised.** A revised Power Mobility Devices Fact Sheet is available. Learn about:
  - Basic coverage criteria
  - Documentation requirements
  - Detailed coverage guidelines for specific types

- **IMPACT Act Videos — Reminder.** The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires that patient assessment data used in post-acute care settings be standardized to improve quality of care. Watch MLN Connects videos to learn more about this important legislation:
  - Introduction to the IMPACT Act: Moderated by Dr. Patrick Conway, CMS Principle Deputy Administrator and Chief Medical Officer
  - CMS Quality Conference 2015: Industry Leaders Discuss IMPACT Act: Industry leaders share their thoughts on the relevance and importance to the health care delivery system.
Visit the IMPACT Act website for more information.

3) The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) Work Plan for fiscal year (FY) 2017 summarizes new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations during the current fiscal year and beyond. Work planning is an ongoing and evolving process, and the Work Plan is updated throughout the year. This edition of the Work Plan describes OIG audits and evaluations that are underway or planned, and certain legal and investigative initiatives that are continuing. It also notes items that have been completed, postponed, or canceled and includes new items that have been started or planned since April 2016.

- Download the FY 2017 Office of Inspector General Work Plan
- Text-based Version

4) The Agency for Healthcare Research and Quality (AHRQ) recently reported:


- **Nursing Home User Comparative Database Reports.** Many nursing homes using the AHRQ Nursing Home Survey on Patient Safety Culture have expressed interest in comparing their results to other nursing homes. In response, the AHRQ has established the Nursing Home Survey on Patient Safety Culture Comparative Database (click here). This database is a central repository for survey data from nursing homes that have administered the AHRQ patient safety culture survey instrument.

5) The Centers for Disease Control and Prevention (CDC) published additional information of adults 65 and older with regard to fighting the flu (click here). People’s immune systems become weaker with age placing people 65 years and older at high risk of serious, flu-related complications. While flu seasons can vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease. It’s estimated that between about 70 percent and 85 percent of seasonal flu-related deaths in the United States have occurred among people 65 years and older. For seasonal flu-related hospitalizations, people 65 and older account for between about 50 percent and 70 percent of the estimated total.

6) The Illinois Department of Healthcare and Family Services (HFS) posted the following notice:

- HFS posted a new provider notice regarding an Epinephrine Auto Injector Update to Preferred Drug List (PDL). You may view the notice here.

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

8) The ECRI Institute recently published an Executive Brief entitled Top Ten Health Technology Hazards for 2017. ECRI Institute is providing this abridged version of its 2017 Top 10 list of health technology hazards as a free public service to inform health care facilities about important safety issues involving the use of medical devices and systems. The full report including detailed problem descriptions and ECRI Institute’s step-by-step recommendations for addressing the hazards is available to members of certain ECRI Institute programs through their membership web pages.

9) Provider Magazine reports Delirium May Complicate Pain Assessment, Management, Study Suggests. Provider Magazine reported a study suggested that the presence of delirium may complicate pain assessment and management. Researchers conducted "a retrospective study comparing health care workers’ pain judgement regarding older patients who had advanced cancer with and without a diagnosis of delirium” and found that "determinations of pain control could be influenced or clouded by the presence of delirium." The findings were published in the American Journal of Hospice & Palliative Medicine.

10) The National Institutes of Health’s National Center for Advancing Translational Sciences (NCATS) reports on Research on New, Rapid Screening Test Identifies Potential Therapies Against Drug-Resistant Bacteria. Researchers at
the National Institutes of Health’s National Center for Advancing Translational Sciences (NCATS), Clinical Center and National Institute of Allergy and Infectious Diseases (NIAID) have created a new way to identify drugs and drug combinations that may potentially be useful in combating infections that are resistant to many different antibiotics. They developed an assay (test) to rapidly screen thousands of drugs to determine how effective they were against a variety of types of resistant bacteria. The screening method provides a potential new approach to repurpose known drugs and compounds to potentially help deal with powerful, hospital-borne infections, as well as emerging infectious diseases.

11) Medscape reports on FAQs on Antibiotic Myths: The Debate Goes On. A recent Medscape article, Antibiotics: 5 Myths Debunked, has attracted a large number of Medscape readers who have so far posted more than 100 comments. While most of these have been favorable, a few specific, repeated themes have challenged some of the busted myths. We asked the article's author to respond to these frequently asked questions (FAQs).

12) The Pharmacy Practice News published an article Updates and Tips on Pharmaceutical Waste. Although the EPA appears to have no immediate plans to publish a final rule, the issue of managing hazardous pharmaceutical waste has been on the agenda for some time. This article from Pharmacy Practice News provides a concise update on the problem and an overview of the proposed rule.

13) News: Medical Life Sciences reports High Daily Doses of Vitamin D Can Help Reduce Incidence of ARI in Older, Long-Term Care Residents. Researchers at the University of Colorado Anschutz Medical Campus have found that high doses of vitamin D reduce the incidence of acute respiratory illness (ARI) in older, long term care residents. The findings of the clinical trial, published today in the Journal of the American Geriatrics Society, could help reduce one of the leading causes of serious illness, debilitation and death among patients in nursing homes and other long term care facilities.

"After studying these patients for a year, we found a 40 percent reduction in acute respiratory illness among those who took higher doses of vitamin D," said the study's lead author, Adit Ginde, MD, MPH, professor of emergency medicine at the University of Colorado School of Medicine. "Vitamin D can improve the immune system's ability to fight infections because it bolsters the first line of defense of the immune system." Ginde also said that in older people that first line of defense is often impaired. But vitamin D can reinforce it and prevent illnesses like pneumonia, influenza and bronchitis.

14) RevCycle Intelligence reports CMS Announces Medicare Improper Payment Rate Fell by 58.3 Percent Over the Past Two Years. RevCycle Intelligence reports the Centers for Medicare and Medicaid Services announced "the Medicare improper payment rate for inpatient hospital claims fell by 58.3 percent between 2014 and 2016." Two CMS officials said in a blog post that the decline in the improper payment rate decreased inappropriate Medicare reimbursement by $6.03 billion in 2016 and the article explains that CMS recently implemented changes aimed at reducing improper payments. The article notes that Ann Maxwell of HHS-OIG said earlier this year that CMS needed to do more to reduce improper payments.

15) Argentum reports NIH: Older Adults Also at Risk From Zika Virus. While the Zika virus has been in the news largely for its effect on pregnant women, older adults are also at risk, according to a new report from the National Institutes of Health. Zika, which is transmitted to people via the bite of an infected mosquito, can have specific implications for older adults. As people age, their immune systems weaken, making it harder to fight off illness and infection. The most common symptoms of Zika are fever, rash, joint pain and conjunctivitis. An older person may have a harder time recovering from Zika and the virus may make the body more susceptible to other illnesses. Guillain-Barré syndrome (GBS) is associated both with older age and Zika virus. GBS is a rare disorder that causes a person’s immune system to damage its own nerve cells, causing muscle weakness and paralysis, sometimes affecting the muscles that control a person’s breathing. In severe cases, GBS can result in death. Risk for GBS increases with age, and people age 50 and older are most affected. For more information about how older adults can stay safe form Zika, contact the Centers for Disease Control at cdc.gov/zika, 1-800-232-4636 or cdcinfo@cdc.gov.

16) USA Today reports Medicare, Medicaid Drug Spending Rose Last Year. USA Today reports that data released earlier this month by CMS shows that spending by Medicaid "on the 20 drugs with biggest cost increases more than doubled last year." According to CMS, "costs from these drugs alone went from $146 million in 2014 to $486 million in 2015 for Medicaid." The Hepatitis C drug Harvoni and the diabetes management drug Lantus, the "top two Medicare Part D drugs
based on spending were also in the top five drugs for Medicaid. Each of the drugs was "associated with more than $1 billion in Medicaid spending." USA Today adds that although the election of President-elect Trump has made the fate of the ACA uncertain, there is "bipartisan and broad public support for drug price reform."

17) **U.S. News & World Report** reports AHCA Official Says Family Members are Concerned When Seniors in Nursing Homes are Unhappy. *U.S. News & World Report* says it rates almost 16,000 nursing homes and long term care facilities "on safety, health inspections, staffing and more," and has found that some seniors are unhappy with their accommodations. Their family members typically notice, and may worry if loved ones "don't seem happy or they don't seem as happy as they want them to be," said Holly Harmon, a registered nurse and senior director of clinical services at the American Health Care Association. Harmon added, "The question is, 'What's going on? Why don't they seem happy? Why aren't they out and about throughout the facility?" The article goes on to discuss some possible answers to these questions, such as adjustment time and difficulties with social interaction.

18) The *Brown (RI) Daily Herald* reports Researchers to Study Infection Reduction With Help from AHCA-University Partnership. The *Brown (RI) Daily Herald* reports that the Centers for Disease Control and Prevention awarded researchers at Brown University a $2.7 million contract, which will allocate $500,000 in the first ear to study antimicrobial stewardship in nursing homes. The researchers will utilize facilities from the Center for Long-Term Care Quality and Innovation, a partnership between the American Health Care Association and Brown.

19) **Medical News Today** reports:

- **High-Protein Diet may Raise Heart Failure Risk for Older Women.** A number of studies have suggested that a diet high in protein is beneficial for health, boosting metabolism, and aiding weight loss. For older women, however, a high-protein diet may be more harmful than helpful; researchers suggest it may raise their risk of heart failure, particularly if the majority of protein comes from meat.

- **Understanding Psychological Dimensions of Dementia can Improve Care.** To help people live well with dementia, we need a better understanding of its psychological impact, according to a new British Psychological Society report (BPS). The report stresses that dementia affects a person's sense of identity, how they think and behave, their mood and their personal relationships. So improving people's experience of dementia means improving the support they receive to process how they feel and how they understand the condition, their future and their relationships.

- **Sense of Smell May Predict Alzheimer's Risk.** New research published in the journal *Annals of Neurology* suggests an individual's sense of smell could be useful in determining whether they are likely to develop Alzheimer's disease. Principal investigator Dr. Mark Albers, of the Department of Neurology at Massachusetts General Hospital (MGH), and team found that by assessing the ability to recognize, recall, and distinguish different odors, they could accurately identify individuals who were at greater risk of Alzheimer's disease.

- **Good Bugs for Bad Bugs: Simple Changes to Antibiotic Treatment of MRSA May Help Beat the Bacteria.** Microbiologists have identified how MRSA may be more effectively treated by modern-day antibiotics, if old-fashioned penicillin is also used. The team from the University of Liverpool and the National University of Ireland Galway have shown that, although penicillin does not kill the bacteria, it does weaken their virulence, making it easier for our immune system and other antibiotics to eradicate the infection. The research findings, funded by the Health Research Board and the Medical Research Council, are published in the *Journal of Infectious Diseases.* MRSA infection is caused by a type of Staphylococcal bacteria that has become resistant to many of the antibiotics used to treat ordinary infections. This results in significant morbidity and mortality with up to 20 percent of patients infected with MRSA dying from systemic infections.

- **Dementia Rates Falling in the U.S.** Dementia is a generic term for a range of neurological disorders affecting millions of Americans every year. As the disease is more common in older age and the aging population is expected to increase in most countries, dementia has been predicted to increase exponentially. However, new research reports a decline in the prevalence of dementia in the United States.
20) **McKnight’s reports:**

- **Study: Infection Control Lapses Likely to Blame for Record-Setting SNF Hepatitis C Outbreak.** A 2013 hepatitis C outbreak at a North Dakota nursing home that made headlines as one of the largest outbreaks in U.S. history was likely due to “infection control lapses,” researchers reported last week.

- **Researchers Dissect End-Of-Life Care Practices, Issues Best Practices.** Making sure that residents’ care preferences are consistently recorded and updated in medical records is crucial to providing quality end-of-life care, researchers stress in a recently published report. Advanced care planning is an important step for patients and families to take, especially at a time when nearly a quarter of hospitalized older adults are not able to make their own end-of-life decisions. That's according to a team of researchers from the Regenstrief Institute, Indiana University Center for Aging Research and the Indiana University School of Nursing. But inconsistencies in the way care preferences are documented and carried out by nursing homes and hospitals may mean a patient's preferences are not honored. The team’s report, published online in the *Journal of Pain and Symptom Management*, set out to measure care consistency with documented care practices, and how health care providers can improve that consistency.

- **CDC: Contaminated Syringes May be Causing Blood Infections in Nursing Homes.** Contaminated syringes may have caused more than 150 bloodstream infections across several states, with long term care residents being disproportionately hit, the Centers for Disease Control said last week. The infections, caused by the bacteria *Burkholderia cepacia*, have been in 58 healthcare facilities, most of which are long term care. Symptoms of the infection include fever, chills, clammy skin, disorientation, shortness of breath and increased heart rate, the CDC said. The bacteria’s spread is believed to be caused by contaminated prefilled saline flush syringes from Nurse Assist. The company announced a recall of all such syringes in early October.

21) **Interesting Fact: TURKEY** may be eaten most often for Thanksgiving, but over the past 40 years, more Americans have enjoyed this protein year-round. In fact, in 1970 we consumed 50 percent of all turkey during the holidays, but today that number has dropped to 31 percent, as people eat this poultry throughout the year. Check out more facts from the most recent statistics we found about turkey production:

- Illinois farmers produce close to 3 million turkeys a year.
- The average turkey weighs 15 pounds and contains 70 percent white meat and 30 percent dark meat.
- The United States consumed 16.1 pounds of turkey per person, and turkey ranked as the No. 4 protein choice for American consumers.
- The turkey sector employs between 20,000 and 25,000 people in the United States.
- The most popular turkey product is the whole turkey.
- Exports make up more than 12 percent of total turkey production in the United States. The top markets include China, Hong Kong and Canada.