Nursing Home Quality Assurance & Performance Improvement (QAPI)

QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving.

- QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is ongoing, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.

- PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

As a result, QAPI amounts to much more than a provision in federal statute or regulation; it represents an ongoing, organized method of doing business to achieve optimum results, involving all levels of an organization.

QAPI is based on five key elements of effective quality management. They include:

- **Element 1: Design and Scope** - A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or residents’ agents). It utilizes the best available evidence to define and measure goals. Nursing homes will have in place a written QAPI plan adhering to these principles.

- **Element 2: Governance and Leadership** - The governing body and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes
designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment and technical training as needed. The governing body should foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as opportunities for improvement.

- **Element 3: Feedback, Data Systems and Monitoring** - The facility puts systems in place to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

- **Element 4: Performance Improvement Projects (PIPs)** - A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

- **Element 5: Systematic Analysis and Systemic Action** - The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes and implications of a change. The facility uses a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

Nursing Homes surveyed after November 28, 2017 must have a QAPI Plan available to present to the state or federal surveyors. Beginning on November 28, 2019, nursing homes must document and demonstrate evidence of an ongoing QAPI program.

There are many resources available regarding QAPI. The Centers for Medicare and Medicaid Services (CMS) has several at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html). The American Health Care Association (AHCA) also has several tools and resources found at [https://www.ahcancal.org/quality_improvement/QAPI/Pages/default.aspx](https://www.ahcancal.org/quality_improvement/QAPI/Pages/default.aspx). The Lake Superior Quality Innovation Network (which is the Quality Improvement Organization for Michigan, Minnesota and Wisconsin) developed (through a grant from CMS) a QAPI Written Plan: How-To-Guide which is an excellent resource for LTC facilities to use and develop a QAPI plan that meets all of the federal requirements. This How-To-Guide can be found at [https://www.lsqin.org/wp-content/uploads/2017/01/LS3-QAPIPlanHow-To-Guide.pdf](https://www.lsqin.org/wp-content/uploads/2017/01/LS3-QAPIPlanHow-To-Guide.pdf).

**Understanding and Responding to PTSD – Treating the Individual and Not the Symptoms**

*(a new requirement under the ROPs in Phase 3)*

To effectively manage these residents, it is critical that skilled nursing staff understand trauma reactions, why they persist and how to differentiate them from other mental health issues. Post-trauma reactions have multiple contributing factors, and helpful clinical responses must take them all into account and integrate not only medical management, but also psychological, interpersonal and environmental efforts into the daily care routine.

Recognizing the need, the Centers for Medicare & Medicaid Services have initiatives that continue to set the expectation that nursing homes develop more robust behavioral health services. These expectations go far beyond the better
management of psychotropic medication. For example, new guidance will require facilities to train staff about trauma-informed approaches to care (CMS 483.40, (a)). The primary goal is to minimize triggers, avoid re-traumatization and identify unique needs to achieve person-centered care.

This guidance will require that facility personnel recognize and understand trauma reactions. The challenge is that acute and chronic post-traumatic stress reactions present with a range of symptoms that can be difficult to manage in a skilled nursing environment. The constellation of symptoms involved in post-trauma include neurological, physiological, behavioral and psychological reactions.

In the case of chronic PTSD, these symptoms are unbound by time and can persist for years after the initial trauma, frequently becoming worse as time passes. Chronic PTSD is often complicated by a significant disturbance in mood, avoidant behaviors, exaggerated reactions and an overlay of chronic substance abuse developed to alleviate painful symptoms, particularly anxiety.

The interdisciplinary care team should identify many red flags. Individuals who have experienced trauma will frequently experience sleep disturbance, depression, panic episodes, combativeness and social withdrawal. These reactions are often physiologically driven and can be induced by seemingly ordinary occurrences.

While psychotropic medication may have some benefit in managing acute trauma reactions, their helpfulness in managing chronic PTSD is limited. A failure to recognize and properly address trauma symptoms can lead to overmedicating a resident in attempts to treat each symptom separately, or generating multiple care plans when the resident needs a comprehensive care plan focused on emotional/behavioral issues related to trauma.

Staff also must be prepared for oppositional or combative behavior. Combativeness is often the result of fear and avoidance of perceived threats. Anxiety and anticipatory anxiety are significant components of trauma reactions. A resident's physiological response drives and shapes perceptions and behaviors. The person is simply trying to maintain or escape to what they perceive as a safe environment. This maladaptive pattern contributes to social withdrawal and self-imposed isolation. As a result, trauma residents are often perceived as peculiar or difficult.

In this scenario, it is important to impress upon staff that anxiety and panic responses are not based on rational thought, therefore reasoning with a resident or asking them to calm down is usually little help when managing a difficult behavioral episode. There is a need to frequently remind staff that, as the intensity of emotions increase, the role of rational thought decreases. A better approach is to acknowledge the resident's feelings and provide non-judgmental support and reassurance.

The Substance Abuse and Mental Health Services Administration has provided some helpful guidance in improving how facilities anticipate and manage victims of trauma (Concept of Trauma and Guidance for a Trauma Informed Approach, July 2014). The overall emphasis is on understanding the effects of trauma, recognizing the symptoms, learning how to respond and especially avoiding the re-traumatization of the resident. Start a dialogue to raise the level of awareness of staff about trauma symptoms, and to avoid treating trauma responses as separate symptoms.

Other central recommendations involve establishing an environment that fosters a sense of trust and safety. Staff members sometimes take for granted safety and trust, whereas residents who have experienced trauma are often hypervigilant and misinterpret ordinary interactions as potential threats. This explains why trauma residents are often anxious and can be combative in an effort to preserve personal safety. Essentially, their world view of a safe environment has been disrupted, and they perceive potential threats and safety concerns where staff do not. These reactions are not just based on a belief, but driven by physiology, which leads to heightened arousal states that then shape perceptions.

Skilled nursing staff members who are well-versed in recognizing trauma can also provide the type of support that trauma residents require. Patients will often express a feeling that they are going “crazy.” Empower staff to identify trauma reactions, build trust and help the resident develop the correct interpretations and attributions of their
symptoms. Here, as in the management of many complex behavioral issues in the SNF environment, psychologists are instrumental in driving staff education and training.

Effectively caring for SNF residents with post-traumatic stress is complex and can be challenging for facilities. It requires both an enhanced understanding of post-trauma reactions and an interdisciplinary approach to care that includes integrated medical, psychological, interpersonal and environmental efforts. This article was modified from an article in McKnight’s written by Robert W. Figlerski, Ph.D. who is the director of behavioral health services, New York Region, TeamHealth.

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**Trending Statistics**

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

**National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015: Interim Data From National Efforts To Make Health Care Safer**

![Trending Statistics Image]

*Patients Safer as Hospital-Acquired Conditions Decline*

From 2010–2015, more than 3 million hospital-acquired conditions (HACs) were prevented, saving approximately 125,000 lives and more than $28 billion in health care costs. Learn more in the AHRQ report “National Scorecard on Rates of Hospital Acquired Conditions.”

Summary:
Preliminary estimates for 2015 show a 21 percent decline in hospital-acquired conditions (HACs) since 2010. A cumulative total of 3.1 million fewer HACs were experienced by hospital patients over the 5 years (2011, 2012, 2013, 2014 and 2015) relative to the number of HACs that would have occurred if rates had remained steady at the 2010 level. The preliminary 2015 rate is 115 HACs per 1,000 discharges, down from 2013 and 2014, which had held at 121 HACs per 1,000 discharges. It is estimated that nearly 125,000 fewer patients died in the hospital as a result of HACs and that approximately $28 billion in health care costs were saved from 2010 to 2015 due to the reductions in HACs.

Although the precise causes of the decline in patient harm are not fully understood, the increase in safety has occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events. This effort has been spurred in part by Medicare payment incentives and catalyzed by the U.S. Department of Health and Human Services (HHS) Partnership for Patients (PfP) initiative, which was started in 2011. See https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html for the full report.

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

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

- **S&C 17-21 – All** - Information to Assist Providers and Suppliers in Meeting the New Training and Testing Requirements of the Emergency Preparedness Requirements for Medicare & Medicaid Participating Providers and Suppliers Final Rule. CMS is providing information to assist providers and suppliers in meeting the Training and Testing requirements of the new Emergency Preparedness Final Rule that was published on September 16, 2016 (81 FR 63860) and became effective on November 15, 2016. This S&C Memo states that LTC Providers must meet the requirements of the two (2) exercise training and testing programs by November 1, 2017.

- **S&C 17-22 – All** - Save the Date– Medicare Learning Network (MLN) Conference Call National Provider Call (NPC) for Emergency Preparedness Requirements for Medicare & Medicaid Participating Providers and Suppliers Final Rule. CMS MLN will host a NPC for the Emergency Preparedness Requirements for Medicare & Medicaid Participating Providers and Suppliers Final Rule. The calls are open to providers, suppliers, State Survey Agencies (SAs), Regional Offices (ROs) and the general public.

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

- **HHS Launches Webpage Highlighting Administrative Actions to Empower Patients.** The Health and Human Services Department launched a new page on HHS.gov highlighting the regulatory and administrative actions the Department is taking to relieve the burden of the current health care law and support a patient-centered health care system. “We’re taking action to improve choices for patients, stabilize the individual and small-group insurance markets, and expand access to more affordable coverage,” said Secretary Tom Price, M.D. “This page will be the place to go for updates on our ongoing efforts.” The actions are part of a broader plan to repeal and replace the Affordable Care Act. Click here to see the newly launched webpage explaining the Department’s actions.

- **Preventive Services CMS Provider Minute Video.** Proper payment and sufficient documentation go hand in hand. The CMS Provider Minute: Preventive Services video includes pointers to help you avoid claim denials. Learn how to submit the correct documentation for:
  - Time spent providing a service
  - Record of billed service
  - Physician signature
This video is part of a series to help providers of all types improve in areas identified with a high degree of noncompliance.

- **Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call** — Thursday, April 6 from 12:30 to 2 p.m. CST. To register or for more information, visit [MLN Connects® Event Registration](#). During this call, learn about the Medicare Shared Savings Program and find out how to prepare for the January 1, 2018, program start date, including the Medicare Accountable Care Organization (ACO) Track 1+ Model and Skilled Nursing Facility (SNF) 3-Day Rule Waiver. Topics:
  - Introduction to the Shared Savings Program
  - Shared Savings Program requirements, including Tracks 1, 2, and 3
  - Medicare ACO Track 1+ Model
  - SNF 3-Day Rule Waiver
  - Antitrust and ACOs
  - Preparing to apply
  - Application process

If you are planning to apply, you should also attend the call on April 19. Visit the [How to Apply](#) webpage to review important information, dates, and materials prior to the call.

- **Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call** — Wednesday, April 19 from 12:30 to 2 p.m. CST. To register or for more information, visit [MLN Connects Event Registration](#). During this call, learn helpful tips to complete a successful application for the 2018 Medicare Shared Savings Program, the Medicare Accountable Care Organization (ACO) Track 1+ Model, and/or Skilled Nursing Facility (SNF) 3-Day Rule Waiver. Topics:
  - Completing an application
  - ACO participant lists and agreements
  - SNF affiliate lists and agreements (Applicable to the SNF 3-Day Rule Waiver)
  - Beneficiary assignment

Visit the [How to Apply](#) webpage to review important information, dates, and materials prior to the call. And, review materials from our April 6 call on Preparing to Apply.

- **Emergency Preparedness Requirements Final Rule Training Call** — Thursday, April 27 from 1:30 to 2:30 p.m. CST. To register or for more information, visit [MLN Connects Event Registration](#). Is your facility prepared to meet the new emergency preparedness requirements by the November 15, 2017, compliance date? During this call, learn about implementation of the final rule, including an overview of the regulation and training and testing requirements. A question and answer session follows the presentation.

- **SNF Consolidated Billing Web-Based Training Course — Revised** (With Continuing Education Credit). A revised Skilled Nursing Facility (SNF) Consolidated Billing (CB) Web-Based Training (WBT) course is available through the [Learning Management System](#). Learn about:
  - SNF coverage and payment guidelines
  - Bundled prospective payments
  - Services that are excluded from SNF CB

- **Medicare Home Health Benefit Booklet — Revised**. A revised [Medicare Home Health Benefit](#) Booklet is available. Learn about:
  - Qualifying for home health services
  - Consolidated billing
  - Therapy services
  - Physician billing and payment
- **MLN Learning Management System FAQs Booklet — Revised.** A revised [Medicare Learning Network (MLN) Learning Management System (LMS) FAQs](https://www.medicare.gov/MLN/MLN_Learning_Management_System.html) Booklet is available. Learn about:
  - Answers to the most frequently asked questions
  - Step by step instructions on how to use the MLN LMS

- **Medicare Enrollment for Institutional Providers Booklet — Reminder.** The [Medicare Enrollment for Institutional Providers](https://www.medicare.gov/Enroll/Enroll/providers.html) Booklet is available. Learn about:
  - Institutional providers
  - Enrolling in the Medicare program
  - Resources

- **Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder.** The [Safeguard Your Identity and Privacy Using PECOS](https://www.medicare.gov/Enroll/Enroll/providers.html) Booklet is available. Learn about:
  - Keeping your enrollment information up to date in the Provider Enrollment, Chain and Ownership System (PECOS)
  - Protecting your enrollment information
  - Privacy tips

- **Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article — Revised.** A revised MLN Matters Special Edition Article on [Provider Enrollment Revalidation – Cycle 2](https://www.medicare.gov/Enroll/Enroll/providers.html) is available. Learn about deactivations due to non-billing.

- **Medicare-Required SNF PPS Assessments Educational Tool — Revised.** A revised [Medicare-Required SNF PPS Assessments](https://www.medicare.gov/Enroll/Enroll/providers.html) Educational Tool is available. Learn about:
  - Assessment overviews for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS)
  - Factors affecting the assessment schedule
  - Assessment results reporting

- **Items and Services Not Covered under Medicare Booklet — Revised.** A revised [Items and Services Not Covered under Medicare](https://www.medicare.gov/Enroll/Enroll/providers.html) Booklet is available. Learn about:
  - Four categories of items and services not covered under Medicare and applicable exceptions
  - Advance Beneficiary Notices

3) The federal [Agency for Healthcare Research and Quality (AHRQ)](https://www.ahrq.gov/) reports on:

- **AHRQ Toolkit Designed To Reduce Urinary Tract Infections in Long Term Care.** A new [evidence-based toolkit from AHRQ](https://www.ahrq.gov/) can help long term care facilities reduce catheter-associated urinary tract infections (CAUTIs). The toolkit uses strategies from AHRQ’s Comprehensive Unit-based Safety Program (CUSP), which has reduced CAUTI as well as central line-associated bloodstream infections in hospitals. The toolkit is based on the experiences of more than 450 long term care facilities nationwide and resulted in a significant reduction of CAUTI rates. Toolkit modules, which are customizable to local needs, include Using the Comprehensive Long-Term Care Safety Toolkit; Senior Leader Engagement; Staff Empowerment; Teamwork and Communication; Resident and Family Engagement; and Sustainability. Access the [toolkit](https://www.ahrq.gov/) and a new AHRQ Views blog, “Help for Nursing Homes in Fighting HAIs.”

- **New AHRQ Grantee Profile Highlights Work of Boston University’s Brian Jack, M.D., To Help Prevent Avoidable Hospital Readmissions.** A new [grantee profile](https://www.ahrq.gov/) explores how the AHRQ-funded work of Brian Jack, M.D., a professor of family medicine at Boston University School of Medicine, lowered rates of return trips to the hospital. He developed the Re-Engineered Discharge, or RED, protocol, which uses strategies to promote safer patient care and reduce avoidable hospital readmissions. AHRQ also worked with Dr. Jack to develop an implementation-ready [toolkit](https://www.ahrq.gov/) and [guide for patients](https://www.ahrq.gov/) (in English and Spanish) to extend his work so that health providers can apply RED and address language barriers in health care communications. Check out the profile of Dr. Jack and other AHRQ grantees who have made major advances in health services research.
4) The federal Centers for Disease Control and Prevention (CDC) released their **Weekly U.S. Influenza Surveillance Report**.

5) The federal HHS Office of Inspector General (OIG) released **Measuring Compliance Program Effectiveness: A Resource Guide**. OIG developed the free educational resources listed on this web page to help health care providers, practitioners and suppliers understand the health care fraud and abuse laws and the consequences of violating them. These compliance education materials can also provide ideas for ways to cultivate a culture of compliance within your own health care organization.

6) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of **Regulatory Beat**:

- HFS posted a new provider notice regarding a **Point of Sale (POS) System outage and a new POS Payor Sheet**. You may view the notice [here](#).
- HFS posted a new provider notice regarding a **Point of Sale System Outage & New POS Payor Sheet**. You may view the notice [here](#).
- HFS posted a new notice regarding **Post Dental meeting agenda**. You may view the agenda [here](#).
- HFS posted a new provider notice regarding **Provider Drug Prior Approval Hotline – Extended Hours**. You may view the notice [here](#).
- HFS posted a new provider notice regarding **Chapter HK-200, Handbook for Providers of Healthy Kids Services – Re-issue**. You may view the notice [here](#).
- HFS posted a new provider notice regarding **Current Procedural Terminology (CPT) Codes and Reimbursement Rates for Physical and Occupational Therapy Evaluations Effective January 1, 2017**. You may view the notice [here](#).
- HFS posted two new **Public Notices on March 31, 2017** both dealing with **Proposed Changes in Methods and Standards for Establishing Medical Assistance Payment Rates**.
- HFS has temporarily extended the hours of operation for the **Department’s Drug Prior Approval Hotline**. The Hotline will remain open an additional two hours until 6:45 p.m. until Friday, April 7.

The temporary extension is in conjunction with the Department’s implementation of the new Pharmacy Benefit Management System (PBMS). This extension will provide increased customer service by allowing for greater access for pharmacies and prescribers to obtain assistance with prior authorization issues related to the implementation of the PBMS.

The Department would remind pharmacies and prescribers that drug prior authorization requests can also be submitted to the Department via fax and the new PBMS Provider Portal. For additional information regarding the Illinois Provider Portal, please visit the Department’s website.

The Provider Drug Prior Approval Hotline phone and fax numbers are listed below:
- Phone number – 800-252-8942
- Fax number – 217-524-7264

Questions regarding this provider notice should be directed to the Bureau of Professional and Ancillary Services’ pharmacy billing consultants at 877-782-5565.
HFS posted a new provider notice regarding the Pre-Admission Screening Process for Long Term Care Admissions. You may view the notice here.

On February 8 and 14, 2017, two webinars were presented by staff from the Illinois Department on Aging, Illinois Department of Healthcare and Family Services and the Illinois Department of Human Services’ Division of Mental Health, Division of Developmental Disabilities and Division of Rehabilitation Services. The February 8 webinar focused on the Choices for Care and PASRR screening processes and interagency collaboration; and included DOA CCU Care Coordinators, DMH PAS Agents, DDD ISC Agencies and local DRS staff. The February 14 webinar focused on the Choices for Care and PASRR screening processes and interagency collaboration with Nursing Facilities, Supportive Living Program providers, and Intermediate Care Facilities. It included NFs, SLPs, ICFs, CCUs and state Department staff.

The Choices for Care and PASRR FAQs and Handout Page of the Dept. on Aging Website provides answers to the questions that were compiled from both webinars.

If upon reviewing this document and you have additional or follow-up questions, please refer them to Lori Brannan via email at Lori.Brannan2@Illinois.gov.

7) News items from the American Health Care Association (AHCA):

- **HHS Issues Interim Final Rule Delaying New Mandatory Bundles.** The Department of Health and Human Services (HHS) issued an interim final rule delaying the effective date of the final rule, "Advancing Care Coordination through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model."

- **Nursing Centers with RNs certified in gerontological nursing by the American Nurses Credentialing Center (ANCC) are twice as likely to receive a 5-Star rating from CMS.** Recent analyses conducted by AHCA/NCAL show that nursing facilities with RNs who have been certified in gerontological nursing by the ANCC are twice as likely (48 percent as compared to 24 percent nationally) to have a 5-star rating from CMS. AHCA/NCAL Gero Nurse Prep is the first step toward achieving ANCC certification. Nurses who complete the Gero Nurse Prep course experience a 96 percent pass rate on the ANCC exam. Gero Nurse Prep is affordable and comes with 30 expertly developed CEUs for RNs.

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

9) **ModernHealthcare** reports that CMS Seeks to Attract More Patients, Physicians to ACOs. "The CMS is trying to boost patient and provider participation in accountable care organizations by automating the process to pair patients with doctors participating in the care models. In the coming weeks, a Medicare beneficiary can go to a website that contains their enrollment information and list his or her primary care doctor. If that doctor is in an ACO, they would be assigned to both that provider and their ACO starting next year." ModernHealthcare explains, "The idea of electronically pairing beneficiaries and ACOs was first proposed in the 2017 physician pay rule released last year. Providers greeted the news at that time with a mixed reaction."

10) **The Hill** reports on Accessing Right-To-Try Treatment Will Not Affect Eligibility for Hospice Care. Naomi Lopez Bauman, the director of health care policy at the Goldwater Institute, writes in The Hill’s "Congress Blog" that opponents of right-to-try legislation "are falsely claiming that terminal patients accessing treatments under Right to Try will be stranded without access to hospice care should they need it," which Bauman says "is simply not true." She notes that "eligibility for hospice care is largely set by the Center for Medicaid Services and neither the state nor proposed federal Right to Try laws would change this in the slightest." Bauman argues "this latest 'alternative fact' about Right to Try really deflects from the central issue" of whether terminally ill patients should "have to seek permission from Washington bureaucrats in order to try to save their own lives."
11) **The New York Times** reports that Older Americans Find It Harder to Get Dental Care. The *New York Times* reports that older Americans find it particularly difficult to obtain adequate dental care as "fewer than half of Medicare beneficiaries have visited a dentist in the past year, a rate that sinks to 26 to 28 percent at lower income levels." About 20 percent of Americans over age 65 have untreated cavities, the National Center for Health Statistics has reported, while "better hygiene and fluoridation means more older people have more teeth to preserve, over lengthened life spans, than in the past." Difficulties arise when most Americans leave the work force and lose employer dental insurance, if they ever had it. *The New York Times* reports, "Medicare offers no help, and Medicaid, varying by state, generally pays skimpily for limited procedures." The piece adds that preventative care lowers costs in the long run, according to researchers at the University of Maryland Dental School.

12) **Provider Nation** reports that a Medicare Per-Capita Cap Could Trigger Competition Between Medicaid Groups Within States. **Provider Nation** reports the GOP's plan to transition Medicaid to a per-capita cap "could leave long term and post-acute care (LT/PAC) providers much more focused on state policymaking moving forward," suggests Robin Arnold-Williams, partner of the Medicaid practice for Leavitt Partners in Salt Lake City. Under the plan, he explains, states will be tasked with deciding "who they are going to cover and for how long," which could set off an "intense period of competition between various Medicaid groups."

13) **The Los Angeles Times** reports that Global Warming May Result in 100,000 More Diabetes Cases in the U.S. Yearly. The *Los Angeles Times* reports that global warming causing a 1°C rise in environmental temperature could result in 100,000 additional cases of diabetes in American adults. Relying on recent studies linking insulin sensitivity to temperature, Dutch scientists and the Centers for Disease Control and Prevention gathered "data on the prevalence of diabetes in all 50 states" and their average temperatures "for each year between 1996 and 2013" and "found that the higher the average temperature in a particular time and place, the higher the age-adjusted incidence of diabetes." **CNN** notes that the "study simply reveals an association between climate and diabetes, not a causation." However, **MedPage Today** reports the researchers said "the results were unlikely to be merely due to interstate demographic, socioeconomic, or other differences," but added that "part of the association can be causally explained by brown fat activity." The **findings** were published in the journal *BMJ Open Diabetes Research & Care*.

14) The **AP** reports that Elderly People Suffering Concussions, Other Brain Injuries From Falls at Unprecedented Rates. "Elderly people are suffering concussions and other brain injuries from falls at what appear to be unprecedented rates," researchers found in a report released March 17 by the CDC in its Morbidity and Mortality Weekly Report. In addition, "the report, which explored brain injuries in general...found an increase in brain injuries from suicides and suicide attempts, mainly gunshot wounds to the head."

15) **ScienceDaily** reports on Dementia: The Right to Rehabilitation. Rehabilitation is as important for people with dementia as it is for people with physical disabilities, according to a leading dementia expert.

16) **Much Shelist News** reports Effective Now: New Data Breach Reporting Requirements in Illinois. On January 1, 2017, the recent revision of the Illinois Personal Information Protection Act, 815 ILCS 530, et seq., went into effect. The amendments include several key revisions which, taken together, have a significant impact on health care and other organizations vis-à-vis their obligations to secure the information they collect on patients, customers and clients.

17) **MedicalXpress** reports that Less Salt, Fewer Nighttime Bathroom Trips. Lowering your salt intake could mean fewer trips to the bathroom in the middle of the night, a new study suggests. Most people over age 60, and many even younger, wake up to pee one or more times a night. This is called nocturia. This interruption of sleep can lead to problems such as stress, irritability or tiredness, which can affect quality of life. There are several possible causes of nocturia, including—as this study found—the amount of salt in your diet. "This is the first study to measure how salt intake affects the frequency of going to the bathroom, so we need to confirm the work with larger studies," said study leader Tomohiro Matsuo, from Nagasaki University in Japan.

18) **Psych Central** reports that Exercise Can Slow Progression of Parkinson’s. New research finds that exercise can delay declines in mobility and help to maintain quality of life for individuals with Parkinson’s disease. Parkinson’s disease (PD) is a progressive condition that often results in mobility impairments and can lead to decreased health-related quality of
life (HRQL) and death. In the new study, researchers determined that people who exercised regularly had significantly slower declines in HRQL and mobility over a two-year period. Importantly, investigators determined that exercise can provide a significant benefit to those with advanced PD.

19) The Society for Post-Acute and Long Term Care Medicine reports on a New Tool Enables Quicker Assessment of Geriatriac Syndromes. The core of geriatric care has long been the geriatric assessment, which is often a time-consuming, complex effort. Researchers at St. Louis University recently developed a new screening tool to expedite and simplify this assessment. The Rapid Geriatric Assessment (RGA) takes 5-10 minutes to administer, and screens for frailty, sarcopenia, anorexia of aging, and cognitive impairment. The assessment also includes a question concerning the completion of an advance directive. The RGA is described in “Rapid Geriatric Assessment: A Tool for Primary Care Physicians,” an article in the March issue of JAMDA.

20) MedlinePlus reports that Many Talks on End-Of-Life Wishes End in Confusion. You've filled out a living will, and designated a surrogate to make medical decisions if you’re incapacitated. But, your end-of-life planning may not be done yet. That's because, according to a new study, your surrogate may still not have a clear idea about what you really want done in a crisis situation -- even after you've discussed your wishes with them. In the study, seven out of every 10 surrogates didn’t have an accurate understanding of their loved one's wishes regarding potentially life-altering medical treatment, even though both believed they had adequately discussed the topic.

21) Pharmacy Times reports that Talking to Senior Patients About NSAIDs: Change is Likely. Non-steroidal anti-inflammatory drugs (NSAIDs) are some of the most common and accessible medications available. More than 70 million NSAID prescriptions are written annually in the United States, and approximately 30 billion doses are sold over the counter. NSAIDs are included in the Beers criteria list as potentially inappropriate for older patients. Because they are so easily obtained, patients may be unaware of their potentially hazardous side effects, including hypertension, gastrointestinal bleeds, and kidney injury. Older patients are at an increased risk of experiencing these adverse reactions because of their impaired drug metabolism, comorbidities, or low health literacy.

22) Financial Review reports that Older Women on Statins at Greatly Increased Risk of Developing Diabetes. Older Australian women who take statins to control their cholesterol are putting themselves at significantly higher risk of developing diabetes type 2. A new Queensland study shows they have a 33 to 50 per cent increased chance of developing diabetes, depending on the dose. The authors say the "dose effect" is most concerning and these women should not be exposed to high doses. Statins have been in wide use for more than 25 years but in 2012, the US Food and Drug Administration advised their use may increase the risk of diabetes type 2.

23) Provider Magazine reports on Survey Finds Construction Gains in Assisted Living, Alzheimer Segments. "Lancaster Pollard recently released a survey of 300 seniors housing leaders that showed a healthy appetite for new construction and renovation projects, particularly in regard to assisted living and Alzheimer's disease/memory care." A senior managing director for the investment banker noted that "a majority of the respondents stated that they do plan to pursue a construction project in 2017, whether it is extremely likely or somewhat likely."

24) McKnight’s reports on several issues:

- Long Term Care Providers “Thrilled” With Republicans’ AHCA Failure. McKnight’s Long Term Care News reports that long term care providers are pleased that the Republicans’ AHCA legislation was pulled. In a statement, LeadingAge said its members are "thrilled" that the "deeply flawed" bill was finished and "urged lawmakers to open up any future changes to the Affordable Care Act to public input." Similarly, the American Health Care Association said it is "waiting to see" where health reform goes next, adding that lawmakers should "look for ways to protect the elderly and individuals with disabilities as they consider future Medicaid reform efforts." Other industry organizations including the National Association for the Support of Long Term Care and Center for Medicare Advocacy shared similar sentiments.

- Opinion: Skilled Care Faces Several Challenges in Coming Years. Editorial director John O’Connor writes in McKnight’s Long Term Care News "daily editors’ notes" that long term care operators are facing several
challenges in the coming year. Along with dropping occupancy, staffing shortages, and threats to public funding, some providers "are looking to tap into the post-acute business." O’Connor adds, there may be a "skilled care facility shortage on the other side of 2020."

- **Bundled Payments Saved $120 Million of Medicare, Data Finds.** *McKnight’s Long Term Care News* reports that data released by software company Remedy Partners suggests that "the delay of a bundled payment final rule from the Centers for Medicare & Medicaid Services may be ‘misleading’ regarding the viability of the program." That data indicates the Bundled Payments for Care Improvements program "helped save 7.7% of episode-of-care costs" and "that money translated into more than $120 million in savings for the Medicare Trust Fund in 2017 alone."

- **CMS Urges Providers to Submit PBJ Data Ahead of Deadline.** *McKnight’s Long Term Care News* reports that officials with CMS advised skilled nursing providers to submit their payroll based journaling data for the next fiscal quarter ahead of the May 15 deadline "in order to catch and fix errors." Officials "also encouraged providers to submit feedback on whether patient-level data...should be included on quarterly value-based purchasing reports."

- **Facilities Must Pay Attention to Admission, Visitation, Grievance Policies Under New CMS Rule.** *McKnight’s Long Term Care News* reports that during a LeadingAge PEAK session, attorney Carol Rolf advised long term care providers to pay special attention to their admission, visitation and grievance policies under the new participation rule requirements from the Centers for Medicare & Medicaid Services. Regarding admission policies, Rolf said facilities should keep in mind incoming residents with substance abuse problems. Regarding visitation policies, Rolf said the new CMS rule allows more flexibility for visiting hours, noting, "There have been a number of issues that have arisen from the 24/7 policy. If you say, ‘We are open 24/7,’ I would strongly urge you to look at this issue." Concerning grievances, Rolf said, "It’s much more prescriptive than anything we have seen in the past." Providers must choose their grievance officer, who Rolf said "has to be someone who has time and who is a people person. And they need to keep good records."

- **Hand Washing Survey Released.** More than half of American adults said they are unlikely to return to a business after experiencing unpleasant restrooms, according to the Health Hand Washing Survey from Bradley Corp. Long term care providers should note that poor restroom maintenance in public restrooms can deter business. “Depending on their condition, public restrooms can become significant business liabilities – or ringing endorsements,” said Jon Dommisse, director of global marketing and strategic development at Bradley Corp., a manufacturer of commercial washroom products. “Good restrooms clearly give businesses a competitive edge. In addition to regularly scheduled maintenance, Dommisse said the survey found that the following were common restroom aggravations: Empty or jammed toilet paper dispensers (mentioned by 93 percent of respondents); clogged or unflushed toilets (87 percent); stall doors that don't latch (81 percent); bad smells (79 percent); and an overall appearance that’s old, dirty or unkempt (79 percent).

- **Flu Season Isn’t Over: 7 Tips to Help Prevent the Spread.** While flu season may have peaked, the Centers for Disease Control and Prevention says that 36 states continue to report widespread flu activity. Significant flu activity is expected to continue for several more weeks, and the amount of people seeing their health care provider for influenza-like illness has been at or above the national baseline for 10 consecutive weeks so far this season.

- **Measuring Compliance Program Effectiveness: A Resource Guide.** On January 17, 2017, a group of compliance professionals and staff from the Department of Health and Human Services, Office of Inspector General (OIG) met to discuss ways to measure the effectiveness of compliance programs. The intent of this exercise was to provide a large number of ideas for measuring the various elements of a compliance program. Measuring compliance program effectiveness is recommended by several authorities, including the United States Sentencing Commission (see, Chapter 8 of the United States Sentencing Guidelines). This list will provide measurement options to a wide range of organizations with diverse size, operational complexity, industry sectors, resources, and compliance programs.
• Congress Nullifies OSHA Recordkeeping Rule. The House of Representatives and Senate have passed a joint resolution to nullify an Occupational Safety and Health Administration rule that allowed the agency to cite employers that do not make and maintain accurate records of employee injuries and illnesses for up to six months after the five-year record-retention period expires.

25) Interesting Fact: All the blinking in one day equates to having your eyes closed for 30 minutes.