May 30, 2017 Edition

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!

Illinois Regulatory Reform Initiative – Cutting The Red Tape

On October 17, 2016, Governor Rauner issued Executive Order 2016-13, which instructs all state agencies to undertake a comprehensive review of existing rules and regulations. The goal is to determine which ones are outdated, repetitive, confusing, unnecessary or harmful to the economy. The Executive Order also establishes the Illinois Competitiveness Council to oversee this important review.

The goal of the Illinois ‘Cutting the Red Tape Initiative’ is to make getting to work easier for our small businesses, and for people like principals and teachers, nurses and doctors and even state employees who process permit applications. Cutting the red tape will break down unnecessary hurdles hindering economic growth. Illinois’ goal is to reduce the amount of red tape, paperwork and regulatory burden by at least 25 percent over the course of the next two years, and save people from paying at least $250,000,000 in government fees. Illinois is proposing a new policy that if one new rule is proposed, two existing rules need to be removed. Specifically, the Governor has asked his state agencies to consider the following questions:

- What regulations or policies are confusing, outdated or repetitive?
- Are regulations consistent across different agencies?
- How can we streamline the process of interacting with state agencies, including reductions in paperwork requirements or wait times to have applications processed?
- How can the state make the professional licensing process more efficient or reduce barriers to entry in professions?
- Is there is a clear need (public health, safety or welfare) for the rule?
- What processes can agencies put in place to save taxpayers’ time and money?

Each Agency shall complete their review of their administrative rules by May 1, 2017. Each Agency shall provide the Competitiveness Council established by this Executive Order with quarterly reports until such review is complete. Any current or proposed Regulation that does not meet each of the above criteria should be revised or repealed. Upon completion of the Agency’s review, the Agency shall submit all revisions and repeals of administrative rules to the Joint Committee on Administrative Rules and the Secretary of State in accordance with the Administrative Procedure Act (5 ILCS 100). For any internal agency policy not required by the Administrative Procedure Act to be submitted to the Joint Committee on Administrative Rules and the Secretary of State, the Agency shall promptly process all revisions and appeals in accordance with Agency procedure.
From a practical standpoint, there is so much state and federal regulation that it is difficult to know where to begin streamlining the code. The U.S. Code of Federal Regulations is over 178,000 pages long and includes over 1 million restrictive words (like "shall" and "prohibited"). Meanwhile, Illinois' code has over 259,000 restrictive words, double that of neighboring states like Missouri and Kentucky. Complexity becomes a problem when the rules that are unnecessary red tape distract from the important rules that are vital for protecting public health and safety.

A simple guiding principle for red tape reduction is the "worst things first" principle, which has been advanced in the field of public health but is also relevant when eliminating regulations. When rolling back rules, regulators should look for those that have three unsavory characteristics:

First, many regulations don't address real problems. Analysis by my Mercatus Center colleague Jerry Ellig finds that only about 13 percent of the analyses for the biggest federal regulations demonstrate significant evidence of a real problem. When there is no clear need for a regulation, it's unlikely to produce any meaningful benefits.

Second, many regulations are regressive. Broadly speaking, this means they make the poor worse off. Occupational licensing regulations make it harder to get good jobs as barbers, florists, contractors, interior designers and countless other professions. Zoning regulations tend to be regressive because they make it harder to build housing, thereby raising the price of rent. Environmental regulations often raise the price of energy, which consumes a disproportionate part of a poor person's budget.

Third, many regulations inhibit small businesses and new startups. Big firms that already have large compliance departments may not mind another rule or two added to the books. But for someone just thinking about getting a business off the ground, the costs of learning and complying with every requirement may be too much to overcome. Reformers should look for regulations that enact barriers to startups and create a moat around large, incumbent businesses by protecting them from competition.

If Illinois wants to stay competitive with neighboring states, it will have to make its regulatory environment less complex. The same is true at the federal level. To keep businesses from moving abroad, regulators in Washington will have to recognize that other countries are working hard to keep regulatory burdens at a manageable level. We can do the same without jeopardizing health and safety. Following the "worst things first" principle is a good way to get started. The Illinois Health Care Association (IHCA) will be heavily involved in this initiative as it moves forward. We will be providing the Governor’s Illinois Competitiveness Council with suggestions for cutting the overly burdensome long term care regulations. We will be challenging IDPH at the LTC and DD/ID Advisory Boards about new regulations and looking for ways to cut or revise current regulations. Please share with us or the Illinois Competitiveness Council any ideas or suggestions the help cut the red tape in Illinois.

**Antibiotic Stewardship Mandate Demands Better LTC Facility Leadership and Training**

Improving the use of antibiotics in LTC facilities to protect residents and reduce the threat of antibiotic resistance is a national priority and a new requirement in Phase 2 of the new CMS Requirements of Participation (ROPs). Each Medicare/Medicaid certified facility must have an antibiotic stewardship program in place and effective by November 28, 2017. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.

There are three ‘key ideas’ with regard to the antibiotic stewardship protocol: understanding the root cause of antibiotic resistance; syndrome-focused prescribing audit and feedback; and using an alternative pathway, such as observation, for handling common prescribing scenarios. Overall, creating an antibiotic stewardship program and combating the spread of antibiotic resistance is a transition away from ‘just in case’ prescribing.

Antibiotics are among the most frequently prescribed medications in LTC facilities, with up to 70 percent of residents in nursing homes receiving one of more courses of systemic antibiotics when followed over a year. Studies have shown that 40-70 percent of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harm from antibiotic overuse is significant for the frail and elderly receiving care in nursing homes. These harms include risk of
serious diarrheal infections from *Clostridium difficile*, increased adverse drug events and drug interactions and colonization and/or infection with antibiotic-resistant organisms.

The Centers for Disease Control and Prevention (CDC) recently announced 7 Core Elements of Antibiotic Stewardship for Nursing Homes (click here). A summary of the core elements for antibiotic stewardship in nursing homes is as follows:

- **Leadership Commitment.** Antibiotic stewardship success starts with facility leadership, both owners and administrators, demonstrating strong support and commitment to safe and appropriate antibiotic use in their facilities. LTC providers need to make sure that their medical director, director of nursing, infection preventionist, consulting pharmacist and other key nursing staff are all involved. Demonstration of support should incorporate the following:
  - Write statements in support of improving antibiotic use to be shared with staff, resident and families.
  - Include stewardship-related duties in position descriptions for the medical director, clinical nurse leads and consultant pharmacists in the facility.
  - Communicate with nursing staff and prescribing clinicians the facility’s expectations about use of antibiotics and the monitoring and enforcement of stewardship policies.
  - Create a culture through messaging, education and celebrating improvement, which promotes antibiotic stewardship.

- **Accountability.** Nursing homes must identify individuals accountable for the antibiotic stewardship activities who have the support of facility leadership. This includes:
  - Empower the medical director to set standards for antibiotic prescribing practices for all clinical providers credentialed to deliver care in the nursing home and be accountable for overseeing adherence.
  - Empower the director of nursing to set the practice standards for assessing, monitoring and communicating changes in a resident’s condition by front-line nursing staff.
  - Engage the consultant pharmacist in supporting antibiotic stewardship oversight through quality assurance activities such as medication regimen review and reporting of antibiotic use data.
  - Infection prevention coordinators have key expertise and date to inform strategies to improve antibiotic use.
  - Nursing homes contracting laboratory services can request reports and services to support antibiotic stewardship activities.

- **Drug Expertise.** Nursing homes should establish access and a working relationship with individuals with antibiotic expertise to implement antibiotic stewardship activities. These can include:
  - Working with consulting pharmacist who has received specialized infectious diseases or antibiotic stewardship training.
  - Partnering with antibiotic stewardship program leads at the hospitals within your referral network.
  - Developing relationships with infectious disease consultants in your community interested in supporting your facility’s stewardship efforts.

- **Take Action Through Policy and Practice Change to Improve Antibiotic Use.** Nursing homes should implement prescribing policies and change practices to improve antibiotic use. The introduction of new policies and procedures that address antibiotic use should be done in a step-wise fashion so staff become familiar with and not overwhelmed by new changes in practice.
  - Ensure that current medication safety policies, including medication regimen review are being applied to antibiotic prescribing and use.
  - Standardize the practices that should be applied during the care of any resident suspected of an infection or started on an antibiotic.
  - Integrate the dispensing and consultant pharmacists into the clinical care team as key partners in supporting antibiotic stewardship in nursing homes.
  - Identify clinical situations that may be driving inappropriate courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use.
Implement at least one policy or practice to improve antibiotic use.

- **Tracking and Reporting Antibiotic Use and Outcomes.** These two core elements are directly related to one another and are described together. Nursing homes should monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship.
  - Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices.
  - Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions.
  - Monitor clinical outcomes such as rates of C. difficile infections, antibiotic-resistant organisms or adverse drug events to demonstrate that antibiotic stewardship activities are successful in improving resident outcomes.
  - Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use in your facility.
  - Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff.

- **Education.** Nursing homes should provide antibiotic stewardship education to clinicians, nursing staff, residents and families. Effective educational programs address both nursing staff and clinical providers on the goal of an antibiotic stewardship intervention, and the responsibility of each group for ensuring its implementation.
  - Nursing homes sustain improvements by incorporating both education and feedback to providers.
  - Nursing home engage residents and their family members in antibiotic use and stewardship educational efforts to ensure clinicians have their support to make appropriate antibiotic use decisions.
  - Provide resources to clinicians, nursing staff, resident and families about antibiotic resistance and opportunities for improving antibiotic use.

Nursing homes are encouraged to select one or two activities to start with and over time, as improvements are implemented, expand efforts to add new strategies to continue improving antibiotic use. Commit now to ensure antibiotic stewardship policies and practices are in place to protect residents and improve clinical care in nursing homes.

CDC had developed a [Checklist for Core Elements of Antibiotic Stewardship in Nursing Homes](#) that can be a useful tool as a baseline assessment of policies and practices that are in place. Then use the checklist to review progress in expanding stewardship activities on a regular basis. Over time, implement activities for each element in a step-wise fashion.

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**Trending Statistics**

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

**Out-of-Pocket Spending Among Seniors**

Among seniors with Medicare and additional public coverage such as Medicaid, inflation-adjusted out-of-pocket payments for medical care decreased from an average of $1,253 in 2000 to $427 in 2014. (Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Statistical Brief #500: *Out-of-Pocket Health Care Expenses for Medical Services, by Insurance Coverage, 2000-2014.*)
Introduction
Out-of-pocket medical expenses are important to study because of their effect on financial burden and potential impact on access to and use of health care. The level of annual out-of-pocket expenses is affected by several factors, including whether a person is insured, the type of insurance, health status, frequency of health care use, and types of medical services received. In addition, changes in the health insurance market and in public programs affect trends in out-of-pocket payments. Since the early 2000s, deductibles and copayments have increased, high-deductible plans have become more frequent, use of generic drugs has increased, and Medicare Part D legislation and the Affordable Care Act have taken effect.

This Statistical Brief presents data from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC) to examine levels of out-of-pocket payments made by individuals and families for the U.S. civilian noninstitutionalized population, focusing on those with expenses for health care during 2000 to 2014. The estimates exclude spending on health insurance premiums. Three estimates are examined: the percentage of persons with an out-of-pocket payment among those who had an expense; the out-of-pocket payment as a percentage of a person's expenses; and the average amount paid out of pocket per person. Estimates are shown separately for the non-elderly and elderly populations and by type of insurance coverage because levels of out-of-pocket payments vary substantially according to these characteristics. All dollar amounts for 2000 to 2013 are inflated to 2014 dollars. All differences between estimates discussed in the text are statistically significant at the 0.05 level or better.

Highlights
- Among the U.S. civilian noninstitutionalized population with an expense, the percentage of persons with any out-of-pocket payment for medical care decreased between 2000 and 2014.
- The average percentage of expenses paid out of pocket also decreased between 2000 and 2014 for all categories of insurance coverage examined.
- The average annual out-of-pocket payment decreased or remained unchanged compared to 2000 for all categories of insurance coverage examined except for persons under age 65 with any private insurance, whose average annual out-of-pocket payment increased from $592 in 2000 to $656 in 2014.
- Among categories of insurance coverage examined, the most substantial change in the average annual out-of-pocket payment occurred for the elderly with Medicare and other public coverage, decreasing from $1,253 in 2000 to $427 in 2014.

Findings
- The percentage of persons with an out-of-pocket payment among those who had an expense. Not everyone who has an expense for medical care necessarily makes a payment out of pocket. During the period 2000 through 2014, the percentage of persons with an expense who had an out-of-pocket payment varied by age and insurance coverage. Among the non-elderly who were uninsured or privately insured, the percentage with an out-of-pocket payment decreased from 95.6 percent to 91.5 and 90.9 percent of persons with an expense, respectively (figure 1). Among the non-elderly with an expense and public insurance only, the percentage with an out-of-pocket payment was substantially lower, and decreased from 67.9 percent in 2000 to 52.2 percent in 2014. Among the elderly population with an expense and covered by Medicare and private insurance (figure 2), the percentage with an out-of-pocket payment remained between 97 percent and 99 percent from 2000 to 2014. The percentage of the Medicare-only population with an out-of-pocket payment was at similar levels but decreased from 99.1 percent to 97.4 percent. The percentage with an out-of-pocket payment among those covered by Medicare and other public insurance was generally lower, ranging between about 94 percent and 98 percent.
- The out-of-pocket payment as a percentage of a person's expenses. One measure of the level of out-of-pocket payments is to express it as the percentage of a person's total expenses. (This estimate is calculated by generating the percentage paid out of pocket of total expenses for each person, then averaging this percentage across people). Estimates from the MEPS-HC show that the average percentage of a person's annual expenses paid out of pocket among the non-elderly population with any expense is highest for the uninsured, lowest for...
those with public insurance only, and generally decreased during 2000 through 2014 across all insurance categories (figure 3). For the uninsured non-elderly, the average percentage paid out of pocket during 2000 to 2014 decreased from 75.2 percent to 61.0 percent; for those covered by any private insurance, the average percentage decreased from 34.8 percent to 27.7 percent; and for those covered by public insurance only, from 17.1 percent to 8.5 percent.

Similarly, among the elderly population with an expense, the average percentage paid out of pocket decreased for all insurance categories, primarily beginning in 2006, the same year Medicare Part D legislation went into effect, making prescription drug coverage available to everyone with Medicare (figure 4). Elderly persons covered only by Medicare had a percentage of annual expenses paid out of pocket of 44.1 percent in 2000, decreasing to 22.9 percent in 2014. The population covered by Medicare and private insurance paid a lower proportion out of pocket than the Medicare-only population during 2000 through 2005; the average percentage then decreased from 30.9 percent in 2005 to 22.3 percent in 2014. Among the elderly, those covered by Medicare and other public insurance paid the lowest proportion out of pocket every year from 2000 to 2014, decreasing to 8.3 percent at the end of the period.

The average amount of expenses paid out of pocket per person. An average of $1,106 was paid out of pocket for non-elderly uninsured persons who had expenses in 2005, decreasing to $752 in 2014, an amount not statistically different from 2000 ($832). The average out-of-pocket payment for the non-elderly with any private insurance decreased from $843 in 2006 to $656 in 2014, but remained above the 2000 level ($592). For the non-elderly with public insurance only, the average out-of-pocket payment decreased from $525 in 2005 to $236 in 2014, lower even than 2000 ($445).

For the elderly, the average out-of-pocket payment for those covered only by Medicare decreased from $2,438 in 2005 to $1,231 in 2014, lower than the 2000 level ($1,586). For elderly covered by Medicare and private insurance, the average out-of-pocket payment decreased from $2,005 in 2003 to $1,438 in 2014, a level not statistically different from 2000 ($1,497). Those covered by Medicare and other public insurance had out-of-pocket payments averaging $1,318 in 2003, decreasing to $427 in 2014, substantially lower than the 2000 level ($1,253), and in all years since 2001 a lower average than those covered by Medicare only or by Medicare and private insurance.

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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 17-27 - NH** - Implementation Issues, Long-Term Care Regulatory Changes: Substandard Quality of Care (SQC) and Clarification of Notice before Transfer or Discharge Requirements. New Definition for SQC: A new regulatory definition was published in the CMS 2016 Final Long-term Care Rule and became effective on November 28, 2016. The new regulatory definition will affect which F-tags and regulatory groupings are considered to be SQC in both Phase 1 and Phase 2 of the Final Rule implementation process. Notice Before Transfer or Discharge Requirements: CMS is also providing clarification in advance of formal interpretive guidance of 42 CFR §483.15(c)(3)(i), which requires facilities to send a copy of the notice of transfer or discharge to the Office of the State Long-Term Care Ombudsman. See summary below in item #2, first dot point.

- **S&C 17-28 – PRTF** - Psychiatric Residential Treatment Facilities (PRTF) Frequently Asked Questions (FAQs). During the recent PRTF training courses many questions were received from attendees regarding survey expectations in applying the PRTF Condition of Participation (CoP) and regulatory requirements. PRTF FAQs: Attached to the notice is a list of the questions we received and our responses which are provided to support surveyor consistency nationwide.
Federal HHS/CMS released the following notices/announcements:

- **CMS Clarifies SQC and Transfer/Discharge Notifications (NF):** CMS issued the memo S&C: 17-27-NH: Implementation Issues, Long Term Care Regulatory Changes: Substandard Quality of Care (SQC) and Clarification of Notice Before Transfer or Discharge Requirements.
  
  - **New Definition for SQC:** A new regulatory definition was published in CMS’ 2016 Final Long-term Care Rule and became effective on November 28, 2016.
  
  - **Implementing SQC:** Starting November 28, 2017 the new regulatory definition will affect which F-tags and regulatory groupings are considered to be SQC in both Phase 1 and Phase 2 of the Final Rule implementation process. The F-tags affected will be spread across different regulatory groups, but the problem of having certain F-tags with both SQC and non-SQC regulations associated within them should be resolved. It will continue to be the surveyors’ responsibility to determine if the regulation they are citing meets the criteria for SQC.

- **Notice Before Transfer or Discharge Requirements:** CMS is also providing clarification in advance of formal interpretive guidance of 42 CFR §483.15(c)(3)(i), which requires facilities to send a copy of the notice of transfer or discharge to the Office of the State Long Term Care Ombudsman. The memo clarifies that nursing centers must send a copy of the transfer or discharge notice in the following instances:
  
  - **When the facility decides to discharge a resident while the resident is still hospitalized.** In these instances, the notice to the Long Term Care (LTC) Ombudsman must occur at the same time the notice is provided to the resident and their representative.
  
  - **For all other types of facility-initiated discharges.** In these instances, the notice to the LTC Ombudsman must be provided at the same time the notice is provided to the resident and resident representative - at least 30 days prior to discharge or as soon as possible, as specified in 42 CFR 483.15(c)(4).
  
  - **When a resident is temporarily transferred on an emergency basis to an acute-care facility.** In these instances, the notice must be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the LTC Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.
  
  - **For resident-initiated transfers or discharges,** sending a copy of the notice to the LTC Ombudsman is not required.

Additional information can be found on the CMS website here. Any questions may be submitted to the NH Survey Development mailbox here.

- **Social Security Number Removal Initiative Reminder: Get Your Systems Ready.** As you know, beginning in April 2018, CMS will start mailing Medicare cards with new Medicare Beneficiary Identifiers (MBIs) to all people with Medicare. The MBI will replace the Social Security Number (SSN)-based Health Insurance Claim Number for transactions like billing, eligibility status, and claim status after a transition period. Make sure your systems are ready:
  
  - Visit the Social Security Number Removal Initiative (SSNRI) Home and Provider webpages for the latest details about the transition. Subscribe to the weekly MLN Connects newsletter for updates and new information.
  
  - Verify your patients’ addresses. Your patients will not get a new card if their address is not correct. If the address you have on file is different than the Medicare address you get in electronic eligibility
transaction responses, ask your patients to correct their address in Medicare’s records through Social Security. This may require coordination between your billing and office staff.

- Attend our quarterly calls to get more information. We will let you know when calls are scheduled in MLN Connects.

- Work with us to help your Medicare patients with the change to the MBI. This fall (2017), we will be in touch with ways to help.

- Get ready to use the new MBI Format. Ask your billing and office staff if your system will be ready to accept the 11 digit alpha numeric MBI. If you use vendors to bill Medicare, ask them about their MBI practice management system changes and make sure they are ready for the change. Make and internally test changes to your practice management systems and business processes by April 2018, before we mail the new Medicare cards.

- If you are a vendor who partners with Medicare providers to bill Medicare, communicate with them about your system readiness and what they should expect to see from you beginning April 2018.

- **SNF Quality Reporting Program: Submission Deadline Extended to June 1.** The reporting deadline for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) FY 2018 payment determination is extended to June 1, including Minimum Data Set assessment data for the fourth quarter of CY 2016. Visit the SNF QRP Data Submission Deadlines webpage for a list of required measures.

- **SNF QRP Quality Measure User’s Manual.** The new Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Measure Calculations and Reporting User’s Manual presents methods used to calculate quality measures, including quality measure definitions; inclusion and exclusion criteria; and measure calculation specifications. For information on calculating measures for the Nursing Home Quality Initiative, see the MDS 3.0 Quality Measures User’s Manual.

- **Administrative Simplification: Get the Basics.** HIPAA Administrative Simplification rules can save time and costs across the health care system through adopted standards, operating rules, unique identifiers, and code sets. Get the basics with our new fact sheet and infographic.

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

- **2018 ICD-10-PCS Files Available.** The 2018 ICD-10-PCS (procedure) code update files are available on the 2018 ICD-10 PCS and GEMs webpage. General Equivalence Mappings (GEMs) will be posted on this webpage in August 2017. The 2018 ICD-10-CM (diagnosis) updates will be available in June 2017.

- **National Partnership to Improve Dementia Care and QAPI Call — Thursday, June 15, 1:30 - 3 pm ET.** To register or for more information, visit MLN Connects® Event Registration. During this call, learn about appropriate assessment and evaluation for the accurate diagnosis of schizophrenia and other mental disorders. Also, find out
about the DICE Approach™ - Describe, Investigate, Create, and Evaluate, a simple but comprehensive method to understand and support individuals living with dementia. 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 follows the presentations.


- **Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised.** An MLN Matters Special Edition Article on Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program is available. Learn about the prohibition on billing beneficiaries enrolled in the QMB program for Medicare cost-sharing.

- **HHS Update: International Cyber Threat to Healthcare Organizations.** An urgent incident-related message is being sent to the ASPR TRACIE listserv on behalf of the ASPR Critical Infrastructure Program. Ransomware can infect computers multiple ways and may or may not require user interaction. This message outlines several vectors of attack and what users can do to help protect themselves. The most up-to-date information from the U.S. Governments can be found at www.us-cert.gov.

3) The U.S. Office of the Inspector General recently released two reports:

- **Medicare Could Save Millions by Eliminating the Lump-Sum Purchase Option for All Power Mobility Devices.** In the future, Medicare could save millions if CMS seeks legislation to eliminate the lump-sum payment option and requires all power mobility devices (PMDs) be provided to beneficiaries on a monthly rental basis.


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

- **Nearly 6 of 10 Hospital-Based Surgeries in 2014 Occurred in Outpatient Settings.** In 2014, 58 percent of the nation’s 17.2 million hospital-based surgical visits took place in outpatient settings, according to a new AHRQ statistical brief. The report from AHRQ’s Healthcare Cost and Utilization Project helps to quantify ongoing shifts toward more outpatient and fewer inpatient hospital-based surgical procedures. Among the most common outpatient surgeries in 2014 were lens and cataract procedures (nearly 100 percent performed in outpatient settings), cartilage removal in the knee (99 percent), tonsillectomy (96 percent), peripheral nerve decompression (95 percent), and hernia repair (92 percent). Private insurance was the most common payer for ambulatory surgery visits, while Medicare was the most common payer among inpatient surgical stays. For more data on inpatient and outpatient hospital-based surgery trends, access the statistical brief.

- **Study Shows 54 Percent Drop in Infections Among Nursing Home Patients.** Rates of catheter-associated urinary tract infection (CAUTI) dropped by 54 percent across more than 400 nursing homes that participated in an AHRQ-funded patient safety project, according to a new study in JAMA Internal Medicine. CAUTI, a type of healthcare-associated infection common in nursing homes, can lead to serious illness and significant expenses for antibiotics and hospitalizations. The safety project adapted AHRQ’s Comprehensive Unit-based Safety
Program (CUSP) for use in long term care facilities. Previous AHRQ efforts to implement CUSP and other safety programs in hospitals have led to significant reductions in CAUTIs and bloodstream infections. As part of the project to help doctors, nurses and other leaders prevent CAUTIs in nursing homes, AHRQ has released a Toolkit To Reduce CAUTIs and Other HAIs in Long-Term Care Facilities. For more information about the reduction of CAUTIs in nursing homes, access the study abstract or AHRQ’s press release.

5) The U.S. Comptroller General Reiterates GAO Recommendation That Medicare Add RAC Prepayment Reviews. Recently, while testifying before the House Budget Committee regarding the current scale of government improper payments, the U.S. Comptroller General Gene Dodaro reiterated recommendations that CMS should implement a permanent Recovery Audit Contractor Prepayment Review Program. The Comptroller General said: “We recommended that CMS seek legislative authority to allow RAs to conduct prepayment claim reviews. HHS did not concur with this recommendation, stating that CMS has implemented other programs as part of its efforts to move away from the “pay and chase” process of recovering overpayments. We continue to believe that seeking authority to allow RAs to conduct prepayment reviews is consistent with CMS’s strategy to pay claims properly the first time.”

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

- A revised Institutional Invoice Claim Submission Direct Data Entry Manual has been posted to the Department’s website. You may view the manual here.
- The HFS 2016 Annual Report can be found here.
- HFS/Provider Tax Update: They updated and extended some deadlines for the Monthly Occupied Bed Provider Assessment. Click here to see the notice.
  - January 2017 assessment period/October 2016 reporting period, originally due March 15, 2017, has been extended to June 15, 2017.
  - February 2017 assessment period/November 2016 reporting period, originally due April 17, 2017, has been extended to June 15, 2017.

7) The Illinois Department of Public Health (IDPH) reports:

- The 2017 IDPH Town Hall Meeting schedule. Letters will be sent to the individual facilities in the regions prior to each meeting. Instructions for responding (will be included in the letter) or you can RSVP (at least three days before the scheduled meeting) to Lisa Reynolds via email at: lisa.reynolds@illinois.gov. Please include the date and location of the meeting in the Subject Line.
  - June 13, 1-3 PM | Marion Regional Office | 2309 W. Main St., Marion, IL 62959
  - July 13, 1-3 PM | CCNH/Brookens Building-Champaign | 500 South Art Bartell Drive, Urbana, IL 61802
  - August 30, 1-3 PM | Willows Health Center | 4054 Albright Lane, Rockford IL 61103
  - September 19 or September 21 (PENDING) | Friendship Village | 350 W. Schaumburg Road, Schaumburg, IL 60194
  - September 28, 1-3 PM | Washington County Hospital | 705 South Grand Ave, Nashville, IL
  - October 24, 1-3 PM | Knox County Nursing Home
  - November 30, 1-3 PM | Dupage Convalescent Center | 400 North County Road, Wheaton IL 60817

- 2017 Crisis Standards of Care Conference. Since July 2013, the Illinois Department of Public Health (IDPH) and Chicago Department of Public Health (CDPH) have jointly developed Crisis Standards of Care for our state. On June 12, public health, hospital and EMS partners from around Illinois are invited to join the statewide planning committee to learn more about the Catastrophic Incident Response (CIR) Annex.

The CIR Annex supports the IDPH ESF #8 Plan by providing guidance to Illinois emergency response stakeholders.
on crisis care and resource allocation for patients during a catastrophic incident. It also outlines the state-level response when local, regional or state healthcare systems are incapacitated. Through the conference’s workshops, experts will teach participants how to apply the concepts of the CIR Annex to ensure they are prepared to care for Illinois’ most vulnerable residents in an emergency situation.

8) The Illinois Department on Aging soon will be releasing a **Questionnaire for Consumer Choice Website**. The IL Dept. of Aging will soon be sending out a letter and questionnaire to all long term care centers in Illinois. Filling out this form is mandatory and meets the requirement of the Illinois Act on the Aging 20 ILCS 105/1) (from Ch. 23, par. 6101) (c-5). This information will be housed on the Consumer Choice Website in an effort to provide consumers with information when making a choice for a long term care setting. Click here to see the initial version of the site. The website has many amenities that provide you the opportunity to explain all of the services and activities provided. Plus, you’ll be able to link your own website to it. Questions about the website may be directed to Chuck Miller, Deputy State Long-Term Care Ombudsman.

9) The **American Health Care Association (AHCA)** recently reported:

- **Implementing CARES Online Dementia Training & Alzheimer’s Association EssentiALZ Certification.** This unique learning opportunity at the 68th Annual AHCA/NCAL Convention and Expo in Las Vegas is back by popular demand (5.5 Administrator CEUs). Attendees will complete the CARES® Dementia Basics Training curriculum and learn about tools, techniques, and activities to implement the CARES® Approach within your organization utilizing the CARES® Classroom Guide™ for Administrators and Educators. The CARES® content includes video vignettes and interviews of real people living with dementia, their families, professional caregivers and dementia experts (no actors). In addition, the session offers excellent networking opportunities. Learn from your dementia care colleagues from across the nation! The CARES® Dementia Basics Training is a separate ticketed event. The registration fee is only $199.95. As an added bonus, attendees will receive a complimentary copy of the CARES® Classroom Guide™ for Administrators and Educators - a $199.95 value - which offsets the entire cost of the session. Register for the AHCA/NCAL Convention & Expo and add the CARES® Dementia Basics Training to your registration package.

- CMS recently finalized the rule, "**Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR).**" The two new cardiac EPMs, the acute myocardial infarction (AMI) EPM and the coronary artery bypass graft (CABG) EPM, will be implemented in 98 selected markets across the country. The orthopedic surgical hip/femur fracture treatment (SHFFT) EPM will be added in the 67 markets currently participating in the CJR demonstration. The new start date for all three EPMs will be January 1, 2018. You can view AHCA’s comment letter on the IFC, which also includes our full comments on the original proposed rule, here. All CMS resources on the new EPMs are available here.

- The **Annual AHCA/NCAL Annual Reports** can be found at the links below:
  - NCAL Report - Persistent Progress.

- The **AHCA/NCAL Update on the 2017 Goals** can be found here.

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

11) The **American Medical Association (AMA)** reports on **Persistent Gaps in Use of Advance Directives Among Nursing Home Residents Receiving Maintenance Dialysis**. Patients with end-stage renal disease receiving dialysis have a symptom burden and prognosis comparable to patients with incurable cancer. They frequently and increasingly receive intensive procedures near the end of life. Because the benefits of these interventions remain controversial, a key question is whether increasing intensity of end-of-life care reflects changes in the extent to which patient preferences are elicited and documented with advance directives. Nursing homes offer an important setting to evaluate advance directive use because they accept full responsibility for care during patient stay. To shed light on a potentially
Given directly to patients can be highly effective in empowering older adults to plan for their future medical care without the need for significant health system resources, according to a new study from UC San Francisco. Researchers found that between 25 and 35 percent of older adults and up to 72 percent among middle aged adults occur outdoors.

**12) Baker Tilly** composed a white paper entitled, *HIPAA: Five Steps to Ensuring Your Risk Assessment Complies With OCR Guidelines*. HIPAA and health care technology have changed significantly over the past 20 years. Today, more than ever, covered entities and their business associates face an evolving risk environment in which they must safeguard electronic protected health information (ePHI). Often, HIPAA risk assessment reports do not meet the guidance defined by the Office of Civil Rights (OCR) or support a complete review of the security rule controls. Checklists of policies and procedures, penetration test results and IT assessments barely scratch the surface of the data security safeguards. Baker Tilly HIPAA and cybersecurity specialists developed a whitepaper that highlights the required components of a HIPAA risk analysis as defined in the security rule and also shares a cost effective approach to completing a risk analysis annually.

**13) Science News** reports that **Older Adults May Not Benefit From Taking Statins**. The benefits of statins for people older than 75 remain unclear, a new analysis finds. *Statins did not reduce heart attacks or coronary heart disease deaths, nor did they reduce deaths* from any cause, compared with people not taking statins, researchers report online May 22 in *JAMA Internal Medicine*. *Recently published guidelines* cited insufficient data to recommend statins for people older than age 75 who don’t have a history of cardiovascular disease. The new analysis considered a subset of older adults enrolled in a study of heart attack prevention and mortality conducted from 1994 to 2002. The sample included 2,867 adults ages 65 and older who had hypertension, 1,467 of whom took a statin. There was no meaningful difference in the frequency of heart attacks or coronary heart disease deaths between those who took statins and those who did not. There was also no significant difference in deaths from any cause, both overall and among participants ages 65 to 74 or those 75 and older.

**14) John Hopkins Medicine** reports on a study that **Shows One of the Deadliest Hospital-Acquired Infections is Preventable**. For some hospital patients, going on a ventilator is often the difference between life and death. About 800,000 hospital patients undergo mechanical ventilation each year in the United States due to a variety of illnesses or conditions, such as a brain injury, stroke or pneumonia. A ventilator can provide much-needed assistance to patients with their breathing. Being on a ventilator, however, also comes with risks and can lead to complications, or ventilator-associated events, such as blood clots, lung damage or ventilator-associated pneumonia — believed to be one of the most common and deadly hospital-acquired infections in the ICU. In a recent *paper* published online in the journal *Critical Care Medicine*, researchers at the *Johns Hopkins Armstrong Institute of Patient Safety and Quality* led a study that demonstrated that health care providers can take steps to curb ventilator-associated events.

**15) NYU** reports that a **Study Finds Need for Educating Older Adults on Outdoor Fall Prevention**. Many older adults have fallen outdoors but lack an understanding of the risks for falls and how to prevent them, warranting efforts for outdoor fall prevention, finds a new study by New York University researchers. The findings of this study, published in the *Archives of Gerontology and Geriatrics*, are being used to develop and pilot an outdoor fall prevention program, which is currently underway in New York City. Approximately 30 percent of adults age 65 and older fall each year, with serious consequences for both the individual and the health care system. Although falls have been well studied, the focus has been on indoor rather than outdoor falls. Yet, research shows that 48 percent of the most recent falls among older adults and up to 72 percent among middle aged adults occur outdoors.

**16) Forbes** reports that **According to Research, Here’s the Single Key to Improving Employee Engagement**. A large organization had a high level of employee engagement in 2009. They believed a workforce of highly engaged and committed employees is a key factor influencing business success and a positive culture. Everyone seemed pleased with the high level of engagement until one senior leader said, “If high engagement is good, wouldn’t an even higher level be better?”

**17) UCSF** reports that **User-Friendly Decision-Making Tools Help Older Adults Make Choices for Future Medical Care**. A user-friendly website and advance directive form given directly to patients can be highly effective in empowering older adults to plan for their future medical care without the need for significant health system resources, according to a new study from UC San Francisco. Researchers found that between 25 and 35 percent of older
adult patients had evidence of advance care planning in their medical records after receiving simple decision-making tools. In the study, one group was given an easy-to-read advance directive, a legal document that allows patients to record their wishes for future medical care. This group had a 25 percent increase in advanced care planning. A second group received the advance directive plus a user-friendly website called PREPARE For Your Care, producing a 35 percent increase. Neither intervention required any clinician involvement, training or education.

18) Levin Senior Care reports on Home Health vs. Seniors Housing. There has been a tremendous push for home-based supports and services for the elderly, including allocating state and federal funds to allow more elderly to remain in their homes rather than moving to a more institutional setting. In addition, with surgical advances, orthopedic patients are increasingly going straight from the hospital to home, bypassing the traditional skilled nursing stay for rehab therapy and receiving the needed care at home. As this becomes more common, how will it impact the value and demand for seniors housing and care settings? Will assisted living at home take away from the growing inventory of assisted living communities? Or will it mostly impact lower income seniors who can’t afford the higher-end assisted living communities that are mostly being built today?

19) ABC News reports that ‘Fat and Frail’ Seniors Benefit From Right Exercise Combo. Heavy seniors who want to lose pounds safely shouldn't skip the weight machines or the treadmill, new research suggests. Experts have worried about recommending weight loss to older, obese people because it speeds up bone and muscle loss, increasing the danger of falls and broken bones. Losing weight plus aerobic activity and strength training improved their health more than dieting plus either type of exercise alone. The results suggest a combination of exercises is the safest approach, and may have big implications for helping people continue to live independently as they age. Medicare, the U.S. health insurance program for people 65 and older, now covers behavioral therapy for weight loss and some plans offer gym memberships.

20) The Annals of Internal Medicine reports on Treatment of Low Bone Density or Osteoporosis to Prevent Fractures in Men and Women: A Clinical Practice Guideline Update From the American College of Physicians. This guideline updates the 2008 American College of Physicians (ACP) recommendations on treatment of low bone density and osteoporosis to prevent fractures in men and women. This guideline is endorsed by the American Academy of Family Physicians.

21) Medical News Today reports that Respiratory Infections Raise Heart Attack Risk by 17 Times. Every year, hundreds of thousands of people have a heart attack. New research suggests that both mild and severe respiratory infections might make some people more susceptible to heart attacks. The new study - published in the Internal Medicine Journal - found that respiratory infections such as pneumonia, the common influenza and bronchitis all seem to increase the chances of having a heart attack.

22) Science Daily reports that Dementia-Related Brain Changes Observed Before Memory or Thinking Problems are Noticeable. Scientists discover a potential predictor for early dementia that could inform the development of drug and therapeutic interventions to treat or slow down the disease.

23) CNN reports that New Hepatitis C Infections Triple Due to Opioid Epidemic. New hepatitis C virus infections in the United States nearly tripled between the years 2010 and 2015. The number of new nationally reported infections with the virus swelled from 850 in 2010 to 2,436 cases in 2015, with the highest rates among young people, mainly 20- to 29-year-olds, who inject drugs, according to a new report released by the Centers for Disease Control and Prevention. However, the CDC estimates the true number is much higher-- about 34,000 new infections nationally for 2015 -- since hepatitis C has few symptoms and most newly infected people do not get diagnosed.

24) MedicalXpress reports that a Study and New Tool Proves ‘All is Not Lost’ to Dementia. In marriage, good communication is key to a fulfilling and enduring relationship. For people with dementia, communicating needs, emotions and interacting with others becomes increasingly difficult as communication deteriorates as dementia progresses. Problems in communicating lead to misinterpretations and misunderstandings, which often cause considerable stress for family members, especially the spouse caregivers as well as the patient. But all is not lost
according to the first study to look at and measure communication outcomes in both the caregiver spouse and the patient with dementia. In fact, researchers from Florida Atlantic University have found that "practice makes perfect" with the right intervention and a tool that can accurately measure couples' communication. Results from the study are published in the journal *Issues in Mental Health Nursing.*

25) **Provider Magazine** reports Do-Not-Hospitize Orders Reduce Resident Transfers. *Provider Magazine* reports on new research into "how Do-Not-Hospitize (DNH) orders affect the movement of skilled nursing care residents shows those residents with such directives experienced significantly fewer transfers to hospitals or emergency departments (EDs)." According to the article, the researchers "said long term and post-acute care providers may see the information as evidence that considering DNH orders in end-of-life care plans could benefit residents and the nursing center in which they live." The study "examine[d] Minimum Data Set 2.0 information from more than 43,000 New York state skilled nursing care residents. Of that number, 61 percent of residents had do-not-resuscitate orders, 12 percent had feeding restrictions, and 6 percent had DNH orders."

26) **Modern Healthcare** reports that Nursing Homes, Hospice Providers Face Looming Emergency Preparedness Deadline. According to **ModernHealthcare**, "Many of the nation's health care providers are facing a deadline to implement new federal requirements that standardize how they handle natural disasters and terrorists' threats," due to a rule finalized by the Centers for Medicare and Medicaid Services in September. That rule "requir[es] 17 types of health care providers to set new policies that result in better coordination with emergency personnel and frequent tests and adaptations of emergency plans." According to ModernHealthcare, "while most experts support the regulations, others worry that many facilities, especially small and rural ones, will fall short on meeting the requirements," which could result in providers being dropped by Medicare and Medicaid.

27) The **Kansas City Star** reports that the U.S. Attorneys General Ask HHS for More Authority to Investigate Elder Abuse Outside of Nursing Homes. According to the article, Kansas attorney general Derek Schmidt and other attorneys general around the country are asking Department of Health and Human Services secretary Tom Price "for more authority to investigate elder abuse outside of care facilities." Currently, "regulations only allow state Medicaid Fraud Control Units to go after suspected abuse in health care and nursing facilities," despite the programs also paying for in-home caregivers. Former Obama administration official Kathy Greenlee is also working on finding "elder abuse solutions outside the government."

28) The **Wall Street Journal** reports that Nursing Home Residents “Especially Susceptible” to Developing Drug-Resistant Infections. The article states that between 11 percent and 59 percent of nursing home residents are "colonized" with a drug-resistant infection, according to an analysis by Columbia University School of Nursing. Researchers found the residents are "especially susceptible" to developing a full-blown infection because of their age and weaker immune system, and that nursing homes have trouble controlling infections due to "understaffing, fewer resources, insufficient training, and inadequate surveillance." The findings were published in the *American Journal of Infection Control.*

29) The AP reports on “Broken” U.S. Mental Health System Relying on Nursing Homes to House Mentally Ill. In a 2,100-word article, the AP reports that the United States' "broken mental health system...increasingly relies on nursing homes with secure wings to handle mental illness' most difficult cases" – a "national struggle, bred by widespread failure to adequately support the community mental health services that replaced the mass institutionalization of people with mental illness that had persisted into the early 1980s." According to the AP, "several factors" have influenced the trend: (1) "the facilities and services that make up the mental health system are underfunded and overburdened"; (2) psychiatric hospitals in some states "have almost no beds available beyond those occupied by people facing criminal charges"; (3) "local hospitals with psychiatric wards are pressed to discharge patients often before they are ready to leave, as crisis cases keep coming through the door"; and (4) "community mental health centers and the network of group homes and counseling programs can't keep up with the demand for services."

30) **Fierce Healthcare** reports on a New Patient Portal Designed to Help Elderly Patients Understand Medical Information. An article posted on FierceHealthcare reports University of Illinois researchers at its Beckman Institute for Advanced Science and Technology and the Carle Foundation Hospital’s Research Institute published a study earlier this month in the *Journal of Biomedical Informatics* showing how a "new approach to patient portals that seeks to help older
patients get a better grasp on their medical information" helps "improve comprehension and boost engagement for older adults with lower levels of health literacy." A statement from Daniel Morrow, lead author of the study, said the pilot project "allows patients to view test results on one side of the screen while a computer-generated physician reads a recorded script explaining what it means for the patient’s overall health, and any next steps that might be necessary."

31) HealthDay reports:

- **Many People May Be Prescribed Unnecessary Drugs Near End of Life.** HealthDay reported many people are "prescribed drugs of questionable benefit" near the end of their lives, according to a study published in the *American Journal of Medicine*. Researchers found not only that many patients were given many prescriptions "near the end of life to control symptoms," but also that "long-term preventive medications or disease-specific drugs were also continued until the end of life."

- **Your Doctor’s Age Might Affect Your Care.** Contrary to popular wisdom, an older, more experienced doctor may not always be the best choice. New research suggests that when treated by an older doctor, hospitalized patients 65 and older may face a slightly higher risk of dying within a month of their admittance than if treated by a younger physician. One exception to that finding is that no age-related difference was found when considering in-patients cared for by older physicians who handle a high volume of admitted patients, meaning 200 or more a year.

32) Medscape reports:

- **Music Therapy Improves Depressive Symptoms in Dementia Patients.** Medscape reported that "music therapy reduces depressive symptoms in patients with dementia," researchers found in a meta-analysis of "17 randomized controlled trials...with a total of 620 participants." They "also found little or no effect" of the therapy on aggression, "emotional well-being or quality of life, overall behavioral problems, or cognition." Lead author Jenny T. van der Steen, PhD, said that clinicians can now "prescribe a musical therapy intervention as a way to improve depressive symptoms in dementia patients." The findings were published in the Cochrane Database of Systematic Reviews.

- **Nurses Love What They Do But Battle Fatigue.** The vast majority (93 percent) of registered nurses (RNs) in the United States are satisfied with their career choice, although fatigue is a pervasive problem, according to a national survey of employed RNs working in hospitals. "This survey shows that it’s time to care for the caregivers. It also confirms what we instinctively know – nurses are compassionate, hardworking professionals who love what they do," Susan Reese, director, healthcare practice group, Kronos Incorporated, said in a news release. Among the more than 250 RNs who responded to the online survey, 98 percent said their job is both physically and mentally demanding, and 93 percent said they are mentally and/or physically tired at the end of a typical day.

- **Hypothesis Busted: Depression Not a Risk Factor for Dementia.** There's no support for the hypothesis that depressive symptoms increase dementia risk, new research suggests. In a 28-year follow-up study, depressive symptoms in later life were significantly associated with development of dementia. However, depressive symptoms in midlife, even when chronic or recurring, were not significantly associated with development of dementia.

33) MedlinePlus reports:

- **New Hepatitis C Treatments More Effective, Tolerable.** Hepatitis C can be cured in about three months, allowing people with the viral disease to live longer, healthier lives, the U.S. Food and Drug Administration (FDA) says. Drugs used to clear the virus from the body are not only more effective than they once were but also more tolerable for patients, according to Dr. Jeffrey Murray, an internist at the FDA who specializes in infectious diseases.
Speed is Key When a Stroke Strikes. Every 40 seconds someone in America has a stroke. But fast action and quick treatment can save lives and reduce disability. "Stroke statistics are alarming. It's the fifth leading cause of death in the United States and the leading cause of serious adult disabilities," said Dr. Randolph Marshall, chief of the stroke division at NewYork-Presbyterian/Columbia University Medical Center. "The most effective method in saving a stroke victim's life is to diagnose and treat immediately after a stroke occurs," said Dr. Matthew Fink, neurologist-in-chief at NewYork-Presbyterian/Weill Cornell Medical Center. Both hospitals are in New York City.

Better Treatment Might Prevent Hundreds of Thousands of Strokes. Hundreds of thousands of strokes might be prevented in the United States each year if more people with a heart rhythm disorder called atrial fibrillation took blood-thinning medications, a new study estimates. Atrial fibrillation causes the heart to quiver instead of beating normally. This causes blood to pool and possibly clot, according to the American Heart Association. If one of those clots breaks free, it can go to the brain and cause a stroke. "Though not a life-threatening rhythm abnormality per se, atrial fibrillation can be associated with devastating life-altering consequences, namely disabling stroke," said one expert, Dr. Nicholas Skipitaris. He directs cardiac electrophysiology at Lenox Hill Hospital in New York City.

First-Try Antibiotics Now Fail in 1 in 4 Adult Pneumonia Cases. The first prescription of an antibiotic that the average U.S. adult with pneumonia receives is now ineffective in about a quarter of cases, a new study finds. In these cases, more or different antibiotics were needed, or the patient's condition worsened to require ER admission or hospitalization within a month of the antibiotics being taken, the research team said. The results are "concerning," because "pneumonia is the leading cause of death from infectious disease in the United States," said lead researcher Dr. James McKinnell, an infectious disease specialist at LA BioMed, a California-based research foundation.

Preventable Hospitalizations, Deaths Among Medicare Beneficiaries Dropped Since 2013. McKnight’s Long Term Care News reports that the United Health Foundation’s annual America’s Health Ranking Senior Report released last week says "potentially preventable hospitalizations among Medicare beneficiaries have dropped 25 percent over the past four years." What’s more, "hospital deaths among Medicare beneficiaries dropped 30 percent since 2013." The report also ranks states on nursing home quality, with Maine at the top of the list and West Virginia in last.

Nurse Specialist: Dementia Patients Do Feel Pain, Contrary to Some Assessments. PointRight Inc. executive vice president, chief clinical officer and gerontological clinical nurse specialist Steven Littlehale wrote in McKnight’s Long Term Care News that there is no scientific evidence to "support the idea that people with dementia do not feel pain." Littlehale argued such patients "may express pain differently, but they DO feel it." He raised the question of "why we are still challenged with identifying and treating pain in the elderly, particularly those with dementia," and asks also how skilled nursing facilities can reduce psychotropic drug use but "not tackle a probable reason for their misuse in this population." In a study he was involved in, the frequency of dementia patients being "assessed as pain free" was examined and compared with those without dementia. The study found that 75 percent of the population with dementia were assessed as having no pain.

Study Shows Assisted Living Makes Up 16 Percent of Housing for Seniors. McKnight’s Senior Living reports on the SK&A U.S. Elder Care Market Summary, which found that 16 percent of housing for seniors is comprised of assisted living. According to the study, skilled nursing made up 67 percent of the housing market for elders and independent living came in at just four percent of the market.

Opioids for Hospitalized Seniors Linked to Negative Outcomes. McKnight’s Long Term Care News reports a new study by researchers with New York’s Northwell Health suggests seniors who are prescribed opioid medications while hospitalized for non-surgical conditions could experience negative health outcomes. The researchers "analyzed data from more than 10,000 senior patients who were admitted to the hospital over a one year period..."
and found nearly 30 percent of them studied received opiates." According to McKnight’s, "the group of patients prescribed opioids were found to be twice as likely to be restrained, and more likely to be ordered on bed rest, have a bladder catheter, or not receive nutrition by mouth than patients who did not receive the drugs. The opioid group also had 50 percent longer hospital stays on average, and were more frequently readmitted within 30 days." The study is scheduled for presentation at the American Geriatrics Society Meeting in San Antonio.

- **Safety Program Cut UTIs by 54 Percent.** [McKnight’s Long Term Care News](https://www.mcknights.com) reports that new research shows a 54 percent drop in the rate of "catheter-associated urinary tract infections" among "a cohort of long term care facilities that took part in" the Comprehensive Unit-based Safety Program, or CUSP. The program was implemented in "400 nursing homes in 38 states between 2014 and 2016," funded by the Agency for Health care Research and Quality. A University of Michigan research team conducted the study, which found that "CUSP helped reduce catheter-associated UTI rates from 6.4 to 3.3 per 1,000 catheter days over the study period." Researchers have indicated that the minimal 40 percent reduction rate in 75 percent of participant nursing home "shows the CUSP project could benefit most providers."

35) **Interesting Fact:** Originally [Memorial Day](https://www.mcknights.com) was known as Decoration Day, meant to honor the Union and the Confederate soldiers who died during the American Civil War. By the 1900s it had become a day to celebrate all American soldiers who died while serving in the military. It wasn’t until 1967 that it was legally named [Memorial Day](https://www.mcknights.com).