August 8, 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!

CMS Revises Their Civil Money Penalty (CMP) Policies and Their CMS Analytic Tool

Effective July 17, 2017, the Centers for Medicare and Medicaid Services (CMS) has revised their Civil Monetary Penalty (CMP) policies and their CMP Analytic Penalty Tool. This new Survey and Certification Letter 17-37 replaces Survey and Certification Letter 15-16. When noncompliance exists, enforcement remedies, such as civil money penalties (CMPs), are intended to promote a swift return to substantial compliance for a sustained period of time, preventing future noncompliance. To increase national consistency in imposing CMPs, the CMS is revising the CMP analytic tool in the following areas, which are further explained within the S&C 17-37 policy memorandum:

- Past Noncompliance;
- Per Instance CMP is the Default for Noncompliance Existed Before the Survey;
- Per Day CMP is the Default for Noncompliance Existing During the Survey and Beyond;
- Revisit Timing; and
- Review of High CMPs.

CMS imposes two types of CMPs: Per Day and Per Instance. Per Day CMPs are divided into lower and upper level ranges. The upper level range CMPs must be used when facility noncompliance puts resident health and safety in immediate jeopardy. Lower level CMPs must be used for facility noncompliance that results in actual harm to residents or poses the potential for more than minimal harm to residents.

When selecting an enforcement remedy, CMS Regional Offices (ROs) and the State Survey Agency (IDPH) are to review the survey findings to determine which remedy is most appropriate to address the noncompliance. The statute and regulations (488.406) outline a variety of federal remedies (CMP, directed plan of correction, directed in-service training, etc.). CMS encourages the use of the remedy that will best achieve swift and sustained compliance with federal health and safety requirements. If the RO determines, either based on an IDPH recommendation or their own review of a survey, that imposition of a CMP will best achieve the goal, the CMS Chicago RO and IDPH are to use the new CMS analytic tool to calculate the amount imposed based on the type of noncompliance. Notwithstanding the type of noncompliance, CMP amounts can vary based on factors such as the date of the noncompliance and the timing of the revisit survey to certify compliance. To reduce this variation, CMS is making several changes to the CMP analytic tool (see CMP Analytic Tool User’s Guide Version 1.3 which is included in S&C 17-37).

The revised CMP Analytic Tool instructs ROs how to use Per Day and Per Instance CMPs depending on the timing of the noncompliance in relation to the survey, whether residents were harmed or abused, whether the facility has a good compliance history, and whether the noncompliance was an isolated event or persistent deficient practices were
identified. To increase national consistency in imposing CMPs, CMS is revising the CMP analytic tool in the following manner:

- **Past Noncompliance**: ROs will impose a per-instance CMP for past noncompliance – something occurred before the current survey, but has been fully addressed and the facility is back in compliance with that area.

- **Per Instance CMP is the Default for Noncompliance that Existed before the Survey**: CMS ROs will generally impose a Per Instance CMP retroactively for noncompliance that still exists at the time of the survey, but began earlier. However, a Per Day will be used to address noncompliance that occurred where: (1) a resident suffers actual serious harm at the immediate jeopardy level; (2) a resident was abused; (3) or the facility had persistent deficient practices violating federal regulations.

- **Per Day CMP is the Default for Noncompliance Existing during the Survey and Beyond**: In contrast, Per Day CMPs will be the default CMPs for noncompliance identified during the survey and beyond, because there is an urgent need to promote a swift return to substantial compliance for a sustained period of time, preventing future noncompliance. Exceptions allowing Per Instance CMPs will be made for facilities with good compliance histories and where a single isolated incident causes harm to a resident, unless abuse has been cited.

- **Revisit Timing**: CMS ROs should consider the timing of the revisit survey to certify compliance when imposing the final CMP amount. CMS has added language specifying this consideration.

- **Review of High CMPs**: CMS Central Office will Review CMPs of $250,000 or greater.

More information on CMP amounts and ranges can be found in 42 CFR 488.408, and on the CMS website (click here).

**Also**, CMS S&C 17-36 stated that it will provide a one-year restriction of enforcement remedies for specific Phase 2 requirements. The listing of specific Phase 2 requirements associated with enforcement delays will be shared at a later date. In general, CMS will identify those requirements that are associated with a unique and separate tag and where specialized efforts and technical assistance may be needed (e.g., antibiotic stewardship, facility assessment, QAPI plan). Enforcement for other existing standards (including Phase 1 requirements) would follow the standard enforcement process.

**Fire Watch Guidelines**
The primary role of the Fire Watch personnel is to serve as a “human smoke detector” and to notify the proper authorities/fire department, staff and residents at the first sign of smoke/fire. The frequency of rounds for a watch vary depending on the type and severity of the deficiency/problem they are compensating for. The designated individual(s) can have no other duties other than the fire watch and must have undergone training in fire watch procedures. Some fire watches must be conducted continuously, without interruption.

The designated fire watch individual must continuously walk the impaired area looking for fire and the potential for fire to occur, without leaving the area. This means the individual may not leave the impaired area to use the restroom, take a lunch break or any other function unless they are relieved by someone else. Again, this relief person can have no other duties while performing the fire watch. The ‘continuous’ fire watch must be conducted for the duration that the impairment is present (24/7).

Section 3.3.104 of the 2012 Edition of the NFPA 101 – Life Safety Code states:

“Fire Watch. The assignment of a person or persons to an area for the express purpose of notifying the fire department, the building occupants, or both of an emergency; preventing a fire from occurring; extinguishing small fires; or protecting the public from fire or life safety dangers.”
A fire watch is specifically required when the fire alarm system is out of service for more than 4 hours in a 24-hour period or the sprinkler system is out of service for more than 10 hours in a 24-hour period. The fire watch must continue, without interruption, until the problem is resolved.

Fire Watch Guidelines/Duties

- Each facility should ensure that fire watch personnel are familiar with the facility specific policies and procedures/emergency plans for dealing with fires and other emergencies.
- Each facility must provide clear and complete instructions to the fire watch personnel as to the routes to be covered and their specific functions to be carried out in covering the route.
- Each facility should ensure that the fire watch personnel are familiar with the procedures to follow with regard to communicating/reporting an emergency.
- Each facility must develop a Fire Watch Log Sheet to record the dates, times and reports of each round of the fire watch.
- A facility should post a notice that a fire watch is in progress to alert staff, residents and visitors.
- A fire watch patrol frequency depends on the deficiency/problem.
- Fire watch personnel must conduct a patrol of the entire impaired area (as determined by the facility administration) including corridors, hallways, laundry rooms, basement, lobby, concealed areas (such as attics and unoccupied storage areas), stairwells, recreation/common rooms, lounges and any other common areas. Fire watch personnel need to remain alert to any signs of smoke and/or fire.
- Being a “Human Smoke Detector,” the fire watch personnel should:
  - Remain attentive.
  - Listen for in-room smoke detectors sounding.
  - Look for observable signs of smoke and/or fire.
  - Enter all stairwells – open doors and look into each stairwell.
  - Enter all common areas including basement, lounges, laundry room and dining areas.
  - Pull the nearest fire alarm if smoke and/or fire is noted.
  - Follow facility policies and procedures with regard to communication and implementing the facility’s emergency plan.
  - Look for conditions that reduce the effectiveness with which a fire could be controlled, such as closed sprinkler valves, obstructed sprinkler heads, impaired water supplies or misplaced or nonfunctioning portable fire extinguishers.
  - Check affected area is clear of discarded packaging or other nonessential materials and/or equipment.
  - Check the affected area for a clear path of egress.
  - Be observant of doors and windows that should be closed.

It is the responsibility of management to ensure that fire watch personnel are capable of performing all functions of a fire watch as noted above.

Control Your Claims: Pressure Ulcer/Wound Care Management

One of many dreaded tags from a CMS Survey is F-Tag 314 — Pressure ulcers. CMS writes, “Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.”

Based on the Comprehensive Assessment of a resident, the facility must ensure that:

1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable; and
2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.”

Our loss trending experience has shown us that the same issues that result in F-tags during a survey can also result in a patient event or claim.

Examples of wound related incidents that became problematic include:

- A Certified Wound Care Nurse provided a debridement of a Stage III pressure ulcer. The debridement was completed without a signed Physician's order and the wound became infected. The lack of physician's order did not meet the standard.
- Four months after the initiation of home hospice services, the patient developed a Stage IV ulcer on her heel, requiring amputation of the leg. The patient died several days after surgery. Documentation did not support that the medical director had prescribed treatment of the ulcer based on an examination of the patient.

Lessons learned:

Most wound management and pressure ulcer incidents/events are related to the failure of following existing protocols. To help manage this risk:

1. Review pressure ulcer prevention and wound management policies and procedures on a regular basis to assure they are current with recommended guidelines.
2. Provide consistent documentation of wound assessment and note changes (improvement or worsening).
3. Communicate with the attending physician.

A newly updated clinical practice guideline, “Prevention and Treatment of Pressure Ulcers” was published by the National Pressure Ulcer Advisory Panel in 2014.

Identified best practices include:

1. The organization has a pressure ulcer prevention and treatment policy/protocol that reflects the current best practices.
3. Current information on pressure ulcer prevention and treatment is available for patients/residents and their caregivers in their own language.
4. The organization's pressure ulcer prevention and treatment protocol addresses the provision, allocation and use of pressure redistribution support surfaces.

Pressure sores can be debilitating to your patients, and the claims can be troubling for your facility and its reputation. Be sure that your staff understands the importance of following protocols in wound prevention. Your patients and organization will thank you.

This article was written by Betty Norman and printed in McKnight’s.

---

Trending Statistics

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

Type 2 Diabetes Statistics: Facts and Trends
Diabetes mellitus, or diabetes, is a disease that causes high blood sugar. It occurs when there is a problem with insulin.
Insulin is a hormone that takes sugar from foods and moves it to the body's cells. If the body does not make enough insulin or does not use insulin well, the sugar from food stays in the blood and causes high blood sugar.

There are several different types of diabetes, but the most common is type 2. According to the Centers for Disease Control and Prevention's (CDC) National Diabetes Report, 2014, 90 to 95 percent of people with diabetes in the United States have type 2. Just 5 percent of people have type 1.

Key facts about diabetes in the U.S.
Diabetes is at an all-time high in the U.S. The CDC's Division of Diabetes Translation states that 1 percent of the population, which is about a half of a million people, had diagnosed diabetes in 1958.

Today, nearly 10 percent of the population has diabetes, according to the American Diabetes Association (ADA). That's 29.1 million Americans, and more than a quarter of these people do not know they have it.

The ADA report that the number of people who have diabetes increased by 382 percent from 1988 to 2014.

The risk of developing diabetes increases with age. The CDC report that 4.1 percent of people age 20-44 have diabetes, but the number jumps to 25.9 percent for people over 65 years old.

As obesity has become more prevalent over the past few decades, so too has the rate of type 2 diabetes. An article in the Journal of Diabetes Science and Technology states that 25.6 percent of Americans are obese, much higher than the 15.3 percent of obese people in 1995. In that same period, the incidence of diabetes increased by 90 percent.

Although the link between obesity and diabetes is well known, the reasons they are connected remain unclear. A report in the Journal of Clinical Endocrinology and Metabolism poses the question of why all obese people do not develop diabetes, given the established link between the two conditions.

The report also states that the location of body fat does play a role. People with more fat in the upper body area and around the waist are more likely to get diabetes than those who carry their body fat around the hips and lower body.

Diabetes and ethnicity
There are clear differences in diabetes rates among different ethnic groups and races. The reasons for these differences are a combination of factors, including:

- genetics
- health conditions
- lifestyle
- finances
- environment
- access to health care

The CDC's National Diabetes Statistics Report, 2014, found:

- 7.6 percent of Non-Hispanic whites aged 20 or older have diabetes
- 9.0 percent of Asian Americans aged 20 or older have diabetes
- 12.8 percent of Hispanics aged 20 or older have diabetes
- 13.2 percent of Non-Hispanic blacks aged 20 or older have diabetes
- 15.9 percent of American Indians and Alaska Natives aged 20 or older have diabetes

Why diabetes is serious
Diabetes can have serious health consequences. The ADA's report states that more Americans die from diabetes every year than from AIDS and breast cancer combined. In 2010, diabetes was listed as a cause of death on more than 69,000 death certificates.
However, the CDC reports that the actual number may be much higher and that deaths related to diabetes are underreported.

Why and how does diabetes damage the body and cause complications? The ADA say:

- Adults with diabetes are significantly more likely to die from a heart attack or stroke.
- More than a quarter of all Americans with diabetes have diabetic retinopathy, which can cause vision loss and blindness.
- Each year, nearly 50,000 Americans begin treatment for kidney failure due to diabetes. Diabetes accounts for 44 percent of all new cases of kidney failure.
- Each year, diabetes causes about 73,000 lower limb amputations, which accounts for 60 percent of all lower limb amputations (not including amputations due to trauma).

**Diabetes costs**

Because of its high prevalence and link to numerous health problems, diabetes has a significant impact on healthcare costs.

The productivity loss for reduced performance at work due to diabetes is 113 million days, or $20.8 billion, according to the ADA.

Diabetes cost the U.S. $245 billion in 2012. But, the ADA believes this number may be lower than the actual cost because it does not include:

- the millions of people who have diabetes but are undiagnosed
- the cost for prevention programs for people with diabetes, which are not counted under standard medical costs
- over-the-counter medications for eye and dental problems, which are more common in people with diabetes.
- administrative costs for insurance claims
- the cost of reduced quality of life, pain and suffering, lost productivity of family members, and other factors that cannot be measured directly

Because diabetes affects various parts of the body, the medical costs span different areas of specialty. The ADA report that:

- 30 percent of medical costs associated with diabetes are for circulation problems that reduce blood flow to the limbs
- 29 percent of medical costs associated with diabetes are for kidney conditions
- 28 percent of medical costs associated with diabetes are for nervous system conditions

Despite its complications, people can manage their diabetes with a comprehensive plan that includes lifestyle changes and proper medical care. If they control their blood sugar levels well, many people with diabetes can lead full, active lives.

**Type 1 and type 2: What's the difference?**

In type 1 diabetes, the immune system attacks the cells in the pancreas that make insulin. As a result, the body does not produce insulin, and people with this condition must take insulin by injection or pump every day.

Type 1 diabetes usually develops in children or young adults, but it can occur at any age. There is no known way to prevent type 1 diabetes, and there is no cure.

People with type 2 diabetes may still have insulin in their bodies, but not enough for proper blood sugar control. Or, the body may not be able to use the insulin it has properly. As a result, blood sugar levels can become too high.

Typically, adults are diagnosed with type 2 diabetes, but children can get it too. Certain factors increase a person's risk of getting type 2 diabetes, including:
• obesity
• older age
• a family history of diabetes
• lack of exercise
• problems with glucose metabolism

---

**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 17-38 – LSC** - Fire and Smoke Door Annual Testing Requirements in Health Care Occupancies. In health care occupancies, fire door assemblies are required to be annually inspected and tested in accordance with the 2010 National Fire Protection Association (NFPA) 80. Non-rated doors assemblies including corridor doors to patient care rooms and smoke barrier doors are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. Non-rated doors should be routinely inspected as part of the facility maintenance program. Full compliance with the annual fire door assembly inspection and testing is required by **January 1, 2018**. Life Safety Code (LSC) deficiencies associated with the annual inspection and testing of fire doors should be cited under K211 – Means of Egress - General.

- **S&C 17-39 – CMHC** - Community Mental Health Centers (CMHC) - Clarification on the Provision of Services. Provision of CMHC Services: 42 CFR 485.918(b)(1)(iii) Provision of Services requires that a CMHC provide either day treatment, (the provision of partial hospitalization services other than in an individual’s home or in an inpatient or residential setting), or psychosocial rehabilitation services. The certified CMHC must provide one of the above referenced services to be in compliance with the Standard. Medicare Provider Agreements: However, 42 CFR 489.2(c)(2) states that CMHCs may enter into provider agreements under Medicare only to furnish partial hospitalization services. Therefore, a CMHC may not enter into or continue a provider agreement with CMS unless the CMHC provides, at a minimum, partial hospitalization services consistent with the requirements in §485.918(f).

- **S&C 17-40 – AO** - FY 2016 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program. The 2016 annual RTC details the review, validation, and oversight of the FY 2015 activities of the approved AOs Medicare accreditation programs as well as the CLIA Validation Program. Section 1875(b) of the Social Security Act (the Act) requires CMS to submit an annual report to Congress on its oversight of national AOs and their CMS-approved accreditation programs. Section 353(e)(3) of the Public Health Service Act (PHSA) requires CMS to submit an annual report of the CLIA validation program results.

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

- **CMS Updates Medicare Payment Rates, Quality Reporting Requirements** ([click here](#)). CMS has issued three final rules outlining 2018 Medicare payment rates for skilled nursing facilities, hospice and inpatient rehabilitation facilities. The final rules are effective for fiscal year (FY) 2018 and reflect a broader Administration strategy to streamline administrative requirements for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.
  - Fact Sheet - FY 2018 Skilled Nursing Facility Prospective Payment System final rule (CMS-1679-F)
  - Fact Sheet - FY 2018 Hospice Update (CMS-1675-F)
  - Fact Sheet - FY 2018 Inpatient Rehabilitation Facility Prospective Payment System Final Rule (CMS-1671-F)
• **Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information.** The IMPACT Act of 2014 requires the Secretary to implement specified clinical assessment domains using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF and HHA providers. The Act further requires that CMS develop and implement quality measures from five quality measure domains using standardized assessment data. In addition, the Act requires the development and reporting of measures pertaining to resource use, hospitalization and discharge to the community. Through the use of standardized quality measures and standardized data, the intent of the Act, among other obligations, is to enable interoperability and access to longitudinal information for such providers to facilitate coordinated care, improved outcomes, and overall quality comparisons.

• **Fire and Smoke Door Annual Testing Requirements in Health Care Occupancies** (See S&C 17-38 above). In health care occupancies, annual inspection and testing in accordance with the 2010 NFPA 80 is required for all fire door assemblies. Non-rated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. But, non-rated doors should be routinely inspected as part of the facility maintenance program as all required life safety features and systems must be maintained in proper working order. LSC deficiencies associated with the annual inspection and testing of fire doors should be cited under K211 – *Means of Egress - General.* CMS regulatory adoption of the 2012 LSC regulation was July 5, 2016, therefore the required annual door inspections and testing would be expected by July 6, 2017. However, considering the level of reported misunderstanding of this requirement, CMS has extended the compliance date for this requirement by six months. Full compliance with the annual fire door assembly inspection and testing in accordance with 2010 NFPA 80 is required by January 1, 2018.

• **Home Health Agencies: CMS Proposes 2018 and 2019 Payment Changes.** On July 25, CMS issued a proposed rule that would update payment rates and the wage index for Home Health Agencies (HHAs) serving Medicare beneficiaries in 2018 and proposes a redesign of the payment system in 2019. The Home Health Prospective Payment System (HH PPS) proposed rule is one of several proposed rules that would be effective for CY 2018 that reflect a broader strategy that CMS is pursuing to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care. Under the proposed rule, the home health payment update percentage for HHAs that submit the required quality data for the Home Health Quality Reporting Program would be 1 percent in 2018. The proposed rule also includes:
  - Proposals to refine the HH PPS case-mix adjustment methodology, including a change in the unit of payment from 60-day episodes of care to 30-day periods of care, to be implemented for periods of care beginning on or after January 1, 2019
  - Proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program
  - A Request for Information to welcome continued feedback on the Medicare program.

For More Information:
  - [Proposed Rule](#)
  - [Fact Sheet](#)
  - [HH PPS website](#)
  - [HHA Center website](#)
  - [Home Health Value-Based Purchasing Model webpage](#)
  - [Home Health Quality Initiative Spotlight webpage](#)

See the full text of this excerpted [Press Release](#) (issued July 25).

• **New Medicare Card (formerly called SSNRI).** CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, we said that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, we referred to this
work as the Social Security Number Removal Initiative (SSNRI). Moving forward, we will refer to this project as the New Medicare Card. To help you find information quickly, we designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1.

- **SNF Quality Reporting Program: Reconsideration Period Ends August 13.** CMS notified Skilled Nursing Facility (SNFs) that are non-compliant with SNF Quality Reporting Program (QRP) requirements for Quarter 4 of CY 2016, which will affect their FY 2018 annual payment update. CMS mailed non-compliance letters and placed them in the Quality Improvement and Evaluation System (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 14. Providers that received a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59 pm PST, August 13. See the instructions in your notification letter and on the SNF Quality Reporting Reconsideration and Exception & Extension webpage.

- **Antipsychotic Drug use in Nursing Homes: Trend Update.** CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's disease or Tourette’s syndrome. In the fourth quarter of 2011, 23.9 percent of long-stay nursing home residents received an antipsychotic medication; since then there has been a decrease of 34.1 percent to a national prevalence of 15.7 percent in the first quarter of 2017. Success varies by state and CMS region; some states and regions have a reduction greater than 35 percent. A four-quarter average of this measure is posted on the Nursing Home Compare website.

For More Information:
- Visit the National Partnership webpage
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov

- **Vaccines are Not Just for Kids.** National Immunization Awareness Month (NIAM) is an annual observance to highlight the importance of vaccinations. All adults should get vaccines to protect their health. Even healthy adults can become seriously ill and can pass certain illnesses on to others. Talk to your Medicare patients about vaccines they may need, including influenza, pneumococcal, and hepatitis B.

For More Information:
- Medicare Preventive Services Educational Tool
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Educational Tool
- Mass Immunizers and Roster Billing: Simplified Billing for Influenza Virus and Pneumococcal Vaccinations Fact Sheet
- Vaccine and Vaccine Administration Payments Under Medicare Part D Fact Sheet
- Centers for Disease Control and Prevention NIAM website
- NIAM Toolkit

Visit the Preventive Services website to learn more about Medicare-covered services.

- **Medicare Part B Immunization Billing Educational Tool — Revised.** A revised Medicare Part B Immunization Billing Educational Tool is available. Learn about:
  - Administration and diagnosis codes
  - Vaccine codes and descriptors
  - FAQs

- **Quality Payment Program: Explanation of Special Status Calculation.** CMS has new information on the Quality Payment Program website that indicates whether clinicians have “special status” and can be considered exempt
from the Quality Payment Program. These circumstances are applicable for rural, non-patient facing and hospital-based clinicians, as well as clinicians in Health Professional Shortage Areas and small practices.

- **Updated CMS Measures Inventory Posted.** Updated CMS Measures Inventory and the Measures under Development (MUD) list are posted on the Measures Inventory webpage:
  - The Inventory includes 30 programs, 2,180 unique measures - including the addition of the eCQMs, and is accompanied by the CMS Measures Inventory User Guide
  - The MUD List contains 30 programs and 535 unique measures

  The next public posting will be in February 2018. For questions, contact MMSSupport@battelle.org.

- **2018 ICD-10-CM POA Exempt Codes Available.** The 2018 ICD-10-CM Present on Admission (POA) Exempt Codes are posted on the 2018 ICD-10-CM and GEMs webpage.

- **Quality Payment Program 2017 MIPS: Improvement Activities Performance Category Web-Based Training Course — New (With Continuing Education Credit).** A new Quality Payment Program 2017 Merit-based Incentive Payment System (MIPS): Improvement Activities Performance Category Web-Based Training (WBT) course is available through the Learning Management System. Learn about:
  - Improvement Activities performance category requirements
  - How this category fits into the larger Quality Payment Program
  - Steps you need to take to report Improvement Activities data to CMS
  - Basics about scoring

- **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

- **ICD-10 GEMS for 2018 Available.** The 2018 General Equivalence Mappings (GEMs) are available:
  - Diagnosis: 2018 ICD-10-CM and GEMs webpage
  - Procedures: 2018 ICD-10-PCS and GEMs webpage

  This is the last year that the GEMs will be produced. The 2018 ICD-10-CM Guidelines and Conversion Table will be posted once the Centers for Disease Control and Prevention finalizes them.

- **SNF Quality Reporting Program: Review and Correct Reports Refresher Training Webinar — Monday, August 7 from 2 to 3 pm ET.** CMS is hosting a webinar for Skilled Nursing Facility (SNF) providers. Visit the August 7 Webinar webpage for more information and to register.

- **Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — Thursday, September 7 from 1:30 to 3 pm ET.** Register for Medicare Learning Network events. During this call, learn about the new Facility Assessment Tool to help identify and develop the specific assessment of your facility. Also, find out about frequently asked questions related to revision of the State Operations Manual Appendix PP for Phase 2 of the Reform of Requirements for Long-Term Care Facilities final rule. A question and answer session follows the presentation.
3) The HHS Agency for Healthcare Research and Quality (AHRQ) released the following:

- **Improving Antibiotic Use: Helping Health Care Professionals Preserve Life-Saving Treatments for Tomorrow and Beyond** ([click here](#)). National and international action plans from the United States, other countries and the World Health Organization have made it a priority to slow the emergence and spread of drug-resistant bacteria through the use of antibiotic stewardship. That means using the right antibiotics for the right infections at the right time and in the right manner. Countries worldwide are cooperating in the global effort to fight antibiotic resistance, recognizing that proper stewardship of antibiotics—a precious resource—is essential.

- **New Interactive Map Highlights State-Specific Trends in Opioid-Related Hospital Stays**. A new [interactive map](#) from AHRQ allows users to explore state-specific information about opioid-related hospital stays. Users may find, for example:
  - Opioid-related hospitalizations have increased most dramatically in Georgia, where rates nearly doubled between 2009 and 2014
  - West Virginia reported the highest hospitalization rate for women in 2014—371 per 100,000 people
  - Louisiana was the only state in which the highest-income communities had the highest opioid-related hospitalization rate in 2014

The map, which includes information on 44 states and the District of Columbia, highlights data from AHRQ’s [FastStats](#), an online tool that offers national and state-specific data on hospital stays and emergency department visits, including data by age, gender, community-level income and urban versus rural residency. The map is the most recent example of AHRQ’s ongoing efforts to address the nation’s opioid epidemic.

- **AHRQ Analysis Estimates Costs of Adverse Drug Events in Hospitals**. A new article by AHRQ researchers estimates that adverse drug events (ADEs) associated with anticoagulants and hypoglycemic agents each added about $2.5 billion to annual hospital costs in 2013. Adverse events are common among hospital patients who are treated with anticoagulants to encourage blood clotting or hypoglycemic agents to manage blood sugar levels. Researchers used nationally representative hospital data from the agency’s Healthcare Cost and Utilization Project and the Medicare Patient Safety Monitoring System to identify adverse events and calculate associated additional hospital costs. They estimated that in 2013 there were 250,000 ADEs from anticoagulants and 600,000 ADEs from hypoglycemic agents. Anticoagulant ADEs added more to the cost of hospital stays than hypoglycemic ADEs ($10,250 versus $4,300). Access the [abstract](#) of the article, which was published in the journal *Medical Care*.

- **New AHRQ Publications Support Management of Insomnia Disorder**. New evidence-based publications from AHRQ can help clinicians and patients effectively manage insomnia disorder, defined as a long-term condition in which a person has trouble sleeping at least three nights each week for at least three months. The research summary for clinicians, *Management of Insomnia Disorder in Adults: Current State of the Evidence*, highlights findings from an AHRQ-funded [evidence review](#) that showed cognitive behavioral therapy can be effective and safe as a treatment for insomnia. Some short-term studies found that medications were also effective for treating insomnia, but they have potential side effects. Also available is *Managing Insomnia Disorder: A Review of the Research for Adults*, a companion guide for patients to support shared decision-making between clinicians, patients and caregivers.

4) The Occupational Safety and Health Administration (OSHA) launched an application, the Injury Tracking Application (ITA), to electronically submit injury and illness data on August 1, 2017. The Web-based form allows employers to electronically submit required data from their completed 2016 OSHA Form 300A. The application will be accessible from
the ITA webpage. Last month, OSHA published a notice of proposed rulemaking to extend the deadline for submitting 2016 Form 300A to December 1, 2017, to allow affected entities sufficient time to familiarize themselves with the electronic reporting system, and to provide the new administration an opportunity to review the new electronic reporting requirements prior to their implementation. The data submission process involves four steps: (1) Creating an establishment; (2) adding 300A summary data; (3) submitting data to OSHA; and (4) reviewing the confirmation email. The secure website offers three options for data submission. One option will enable users to manually enter data into a web form. Another option will give users the ability to upload a CSV file to process single or multiple establishments at the same time. A third option will allow users of automated recordkeeping systems to transmit data electronically via an application programming interface. The ITA webpage also includes information on reporting requirements, a list of frequently asked questions and a link to request assistance with completing the form.

5) 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 Monthly Occupied Bed Provider Assessment.
- HFS posted new public notices to our Public Notice Webpage. You may view the notices here.

6) 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.

  o August 30, 1-3 PM | Willows Health Center | 4054 Albright Lane, Rockford IL 61103
  o September 19 or September 21 (PENDING) | Friendship Village | 350 W. Schaumburg Road, Schaumburg, IL 60194
  o September 28, 1-3 PM | Washington County Hospital | 705 South Grand Ave, Nashville, IL
  o October 24, 1-3 PM | Knox County Nursing Home
  o November 30, 1-3 PM | Dupage Convalescent Center | 400 North County Road, Wheaton IL 60817

7) The American Health Care Association (AHCA) and Illinois Health Care Association (IHCA) recently reported on:

- CMS Issues FY18 SNF PPS Final Rule. CMS issued the final rule [CMS-1679-F] for Fiscal Year (FY) 2018 Medicare payment rates and quality program provisions for skilled nursing facilities (SNFs). Of note, comments on the separately released Advanced Notice of Proposed Rulemaking (ANPRM) [CMS-1686-ANPRM], or "pre-rule," are due on August 25, 2017. CMS may, or may not, act on the Resident Classification System proposal discussed in the pre-rule. The final rule for FY 2018 establishes a net market basket increase of 1.0 percent. CMS also revised and rebased the market basket index by updating the base year from FY 2010 to FY 2014 (see below). Based on proposed changes contained within this proposed rule, CMS projects aggregate payments to SNFs will increase in FY 2018 by $370 million, or 1.0 percent, from payments in FY 2017. The $370 million amount differs from the estimated $390 million in the proposed rule. Please find here a highlights section and preliminary overview of the payment updates, the SNF Value-Based Purchasing (VBP) program new components, and the IMPACT Act quality reporting additions. To view the FY18 Final Rule click here, the fact sheet is available here, and the FY18 SNF PPS wage index will be posted here in the coming weeks. Please contact Mike Cheek if you have comments, suggestions and questions.

- Updates from CMS on RoP Final Rule and Phase 2 Interpretive Guidance. On July 13, 2017, CMS released a final rule with corrections for technical and typographical errors made in the final rule revising the Long-Term Care Requirements of Participation (RoP), which was released on October 4, 2016. CMS made corrections to the preamble and the regulations text, including changes to incorrect cross-references and inconsistent use of terms such as infection preventionist and infection prevention and control officer. CMS has also made available a set
of ten videos outlining key topics related to changes in the long term care regulations and IG scheduled to be implemented for Phase 2, such as the facility assessment and Quality Assurance and Performance Improvement plan (QAPI). These videos are available to surveyors, providers, and other stakeholders. Click here to view these videos. AHCA will continue to review these materials and provide further information as it becomes available. For questions regarding the survey process and CMS training resources, please contact CMS at NHSurveyDevelopment@cms.hhs.gov. For other question or concerns, please contact AHCA’s Sara Rudow.

- **SNF Quality Reporting Program Update & Opportunities for Action.** The Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) was established by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. It requires that providers complete certain uniform data elements in the Minimum Data Set (MDS) that can also be found within the assessment instrument used by long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), and home health agency (HHA) providers. These data elements will be used in the calculation of three quality measures currently used in SNF QRP:
  - Application of Percent of Residents Experiencing One or More Falls with Major Injury
  - Percent of Patients or Residents with Pressure Ulcers that are New or Worsened
  - Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Function Assessment and a Care Plan that Addresses Function

CMS requires SNFs complete all the MDS items necessary to calculate the three measures for at least 80 percent of assessments used for the quality measure. Providers that fail to meet this 80 percent data completeness threshold will have their Medicare annual payment update (APU) reduced by two percentage points each fiscal year (FY) beginning with FY 2018.

- **IHCA Education Update** ([click here](#)).

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

9) **Modern Healthcare** reports that [Drug Prices Expected to Rise Nearly 8 Percent Next year](#). Health systems can expect drug prices to increase by 7.61 percent next year, largely due to the [surging prices of branded](#), specialty medications, a group purchasing organization said recently. Vizient said in its [drug pricing forecast](#) that it’s seen a spike in purchases for products not offered on its contract, most of which are patented, branded pharmaceuticals. Those specialty drugs also see sharper price increases, which force providers to find alternatives to optimal treatments and cause patients to avoid taking costly medication.

10) **The Atlantic** reports that **The U.S. is Running Out of Nurses**, which is just one reason why the prospect of a national nursing shortage is so alarming. The U.S. has been dealing with a nursing deficit of varying degrees for decades, but today—due to an aging population, the rising incidence of chronic disease, an aging nursing workforce and the limited capacity of nursing schools—this shortage is on the cusp of becoming a crisis, one with worrying implications for patients and health care providers alike. America’s 3 million nurses make up the largest segment of the health care workforce in the U.S., and nursing is currently one of the fastest growing occupations in the country. Despite that growth, demand is outpacing supply. According to the Bureau of Labor Statistics, 1.2 million vacancies will emerge for registered nurses between 2014 and 2022.* By 2025, the shortfall is expected to be “more than twice as large as any nurse shortage experienced since the introduction of Medicare and Medicaid in the mid-1960s,” a team of Vanderbilt University nursing researchers wrote in a 2009 paper on the issue.

11) **The Independent** reports that **Alzheimer’s Patients Could Recover ‘Lost’ Memories**. Research suggests the disease does not wipe memories, but makes them harder to access. New drugs could one day be developed to help **Alzheimer’s patients** recover memories believed to be lost forever, according to scientists who have reawakened forgotten memories in mice. Memory loss in people with Alzheimer’s disease, the most common form of dementia, is caused by the build-up of a toxic plaque in the brain that destroys nerve cells. This sticky substance, created by a protein called amyloid beta, is thought to completely erase memories – causing progressive amnesia that can be distressing for both patients and their families.
12) *The New York Times* reports on [Calls for Court Reform as Legal Guardians Abuse Older Adults](https://www.nytimes.com/2023/07/11/us/court-guardians-abuse-old-adults.html). The Government Accountability Office has found that state guardianship systems across the country are rife with exploitation. State courts appoint guardians to protect the vulnerable, but the G.A.O. has identified hundreds of cases of negligence, as well as physical and financial abuse. Though state laws differ, a judge who rules that a person is cognitively impaired can appoint a guardian, sometimes a company, to oversee the person’s well-being. The guardian can decide to sell the ward’s house and move him or her into a nursing home. The guardian can also choose which of the ward’s friends and relatives can visit. The National Center for State Courts, a nonprofit think tank, estimates that guardians across the country supervise 1.3 million adults and an aggregate of $50 billion of their assets. Brenda K. Uekert, the center’s principal court research consultant, said that with the “aging of the baby boomers and the onset of dementia, we expect those numbers to go up.”

13) The *Doctor's Lounge* reports that [Increased Dementia Risk with Hearing Loss in Older Adults](https://www.doctorlounge.com/2023/07/22/increased-dementia-risk-with-hearing-loss-in-older-adults/). The risk of dementia is increased for older adults with hearing loss, according to a study published online July 22 in the *Journal of the American Geriatrics Society.* "These findings are consistent with the rationale that correction of hearing loss could help delay the onset of dementia, or that hearing loss itself could serve as a risk indicator for cognitive decline," the authors write.

14) MedPage Today reports that [SNF is Not Always Most Cost Effective Choice for Post-Acute Care](https://www.medpagetoday.com/geriatrics/facilities/69276). According to a study published in the *Journal of Health Economics,* "hospitals spending intensively on inpatient care and sending patients home rather than to a SNF generated lower one-year mortality rates than hospitals that spend more intensively on post-acute-care at SNFs." The study compared similar patients who go to different hospitals, but the study's author stated that more research is needed before any conclusion can be made regarding the cost-effectiveness of post-acute care treatments.

15) Kaiser reports that [Few Older Americans Purchasing Long-Term Care Insurance as Premiums increase](https://kaiserfamilyfoundation.files.wordpress.com/2023/07/few-older-americans-purchasing-long-term-care-insurance-as-premiums-increase.pdf). The article stated that "more than 6 million older Americans" currently "have a 'high need' for long term care, according to a report from the U.S. Department of Health and Human Services," and HHS projects that "about 52 percent of adults reaching age 65 today" are expected to need long-term care at some point in the future. However, the article says "fewer than 10 percent of older adults have purchased long term care insurance" because of rising premiums and insurers leaving the market over the last ten years.

17) The *American Medical News* reports that [A Third of Dementia Cases Around the World May be Delayed or Even Prevented by Avoiding Key Risks](https://www.americanmedicalnews.com/article/a-third-of-dementia-cases-around-the-world-may-be-delayed-or-even-prevented-by-avoiding-key-risks). In continuing coverage, the AP reports that researchers "raised the prospect that a third of dementia cases around the world could be delayed or even prevented by avoiding key risks starting in childhood that can make the brain more vulnerable to memory loss in old age." The findings were published online July 19 in *The Lancet* and were presented at the Alzheimer’s Association International Conference.

18) PALTC reports that [Evacuations During Emergencies Put Older Adults at Greater Risk of Death Up to Six Months Later](https://www.paltc.org/2023/07/20/evacuations-during-emergencies-put-older-adults-at-greater-risk-of-death-up-to-six-months-later/). Older adults in nursing homes and other post-acute and long term care (PA/LTC) settings are at increased risk for harm from disasters such as hurricanes or floods because they are frailer, generally have more illnesses and disabilities, and rely on medications and supports such as oxygen. During Hurricane Katrina, for example, elders accounted for approximately one-half of all deaths directly related to the storm. A new study in the August issue of *JAMDA* suggests that, if nursing home residents are evacuated during an emergency, they have a higher risk of death up to 6 months afterwards.

19) *The Telegraph (UK)* reports on a study that [Suggests Loneliness Greater Risk of Early Death than Obesity](https://www.telegraph.co.uk/health/2023/07/21/suggests-loneliness-greater-risk-of-early-death-than-obesity/). In a recent article, *the Telegraph (UK)* discusses research presented at the annual meeting of the American Psychological Association that examined "218 studies into the health effects of social isolation and loneliness involving nearly four million people" and concluded that "loneliness is deadlier than obesity and should be considered a major public health hazard." Researchers found that "lonely people had a 50 percent increased risk of early death, compared to those with good social connections," contrasting with the 30 percent risk of increased death from obesity.

20) Skilled Nursing News reports that [Skilled Nursing Workforce May be Jeopardized by Immigration Bill](https://skillednursingnews.com/2023/07/20/skilled-nursing-workforce-may-be-jeopardized-by-immigration-bill/). Skilled Nursing News reports some skilled nursing industry members have expressed concern over the Senate Reforming American Immigration for a Strong Economy (RAISE) Act, saying it could strain the long-term care system by reducing the number
of legal immigrants eligible to work in the industry. The bill "could result in a 50% reduction in legal immigration" and would institute a "skills-based points system" to "prioritize immigrants that have higher levels of education, better English language abilities, and high-paying job offers." SNF executive Fred Benjamin, who "testified before a congressional subcommittee on behalf of the American Health Care Association," advocated for a visa program to admit low-skilled immigrants who could fill positions in senior housing. He said industry leaders "simply cannot find enough American workers to fill these jobs."

21) **HealthDay** reports:

- **Regular Exercise Does Little to Reduce Sedentary Time of Seniors.** HealthDay reported on a study published in *JAMA* that found regular exercise does not effectively reduce sedentary time in seniors. The findings showed that, "among seniors who were inactive for less than 60 minutes at a time, those who did moderate-intensity exercise – such as walking, or strength, balance and flexibility training – were inactive only a maximum of 12 minutes less per day than those who did not exercise."

- **High-Dose Flu Vaccinations May Reduce Instances of Hospitalization for Respiratory Illnesses Among Older Adults.** HealthDay reported that a study published in the journal *Lancet Respiratory Medicine* found older adults who receive high-dose flu vaccines with "four times the usual amount of immune-spurring antigens" have a 13-percent reduced likelihood of being hospitalized for the flu. Researchers sourced "Medicare claims data from more than 38,000 residents of 823 nursing homes in 38 states during the 2013-2014 flu season," and found that "hospitalization rates were 3.4 percent for residents who received the high-dose vaccine and 3.8 percent for those who received the standard dose."

22) **Medical News Today** reports:

- **How Physical Exercise Prevents Dementia.** Numerous studies have shown that physical exercise seems beneficial in the prevention of cognitive impairment and dementia in old age. Now researchers at Goethe University Frankfurt have explored in one of the first studies worldwide how exercise affects brain metabolism.

- **Diet, Cholesterol and Lipoproteins Explained in Human Terms.** Few things in nutrition and public health are as controversial as cholesterol and heart disease risk, as well as how the two are affected by diet. There is an immense amount of research on this topic, but a lot of it is tainted by bias and commercial influences. This video explains better than anything I've ever seen how all of these things are related to diet and how they affect our risk of heart disease.

23) **Managed Healthcare Connect** reports:

- **Multidisciplinary Care Management May Benefit Patients with Dementia.** Dementia care management (DCM) by specially trained nurses as part of a multidisciplinary team could reduce symptoms of dementia while decreasing caregiver burden, researchers in Germany say. “Neuropsychiatric symptoms and caregiver burden are among the most important reasons for people with dementia being institutionalized,” Dr. Jochen Rene Thyrian of the German Center for Neurodegenerative Diseases in Greifswald, Germany told Reuters Health.

- **Frailty and Medication Use in New Nursing Home Residents With Dementia.** Findings from a study published in the *Journal of the American Geriatrics Society* found a high prevalence of older adults with cognitive impairment taking inappropriate medications upon admission to nursing facilities. They also found that frail individuals were started on these kinds of medications more often than nonfrail older adults.

24) **EurekAlert** reports:

- **Cognitive Impairment Toolkit Helps Providers With Detection, Earlier Diagnosis.** The Gerontological Society of America is now offering a free online toolkit to aid primary care providers in achieving greater awareness of cognition in their older adult patients, increasing cognitive detection of cognitive impairment, securing earlier
diagnostic evaluation, and referring to community services. The GSA-developed toolkit is focused on the KAER model, first introduced in a 2015 report from the Society’s Workgroup on Cognitive Impairment Detection and Earlier Diagnosis.

- **Tai Chi May Help Prevent Falls in Older and At-Risk Adults.** An analysis of published studies indicates that tai chi may help reduce the number of falls in both the older adult population and at-risk adults. The findings, which are published in the *Journal of the American Geriatrics Society*, offer a simple and holistic way to prevent injuries. Tai chi is an ancient Chinese practice focused on flexibility and whole body coordination that promotes harmonized motion in space. Previous research has shown that tai chi is an effective exercise to improve balance control and flexibility in older individuals. This suggests that the practice might help protect against falls, which are a primary cause of traumatic death for older adults.

- **Research Finds Increased Risk of Dementia in Patients Who Experience Delirium After Surgery.** Delirium is common in elderly hospitalized patients, affecting an estimated 14 – 56 percent of patients. It frequently manifests as a sudden change in behavior, with patients suffering acute confusion, inattention, disorganized thinking and fluctuating mental status. Pre-existing cognitive impairment or dementia in patients undergoing surgery are widely recognized as risk factors for postoperative delirium, increasing its likelihood and severity. However, little previous research has focused on whether delirium itself portends or even accelerates a decline into dementia in patients who showed no previous signs of cognitive impairment. Research published today in the *British Journal of Anaesthesia* focuses on patients over the age of 65 who were assessed as cognitively normal prior to surgery. This study, led by Professor Juraj Sprung of the Mayo Clinic in Minnesota, finds those who developed postoperative delirium were three times more likely to suffer permanent cognitive impairment or dementia.

25) *Provider Magazine* reports:

- **Medicaid Managed Care Organizations Increasingly Providing Long Term Services and Supports.** In an over 3,900-word cover story, *Provider Magazine* examines "how managed care is having an impact on provider contracting, reimbursement, and care coordination." Experts say that Medicaid managed care organizations (MCOs), which administer services for elders and people with disabilities under the formal name of managed long term services and supports (MLTSS), have "staying power as more states look to offload the management of Medicaid to MCOs and at the same time, presumably, save money." Some providers see the changes "as an opportunity to get a step ahead," but "a larger majority of providers" complain "of lengthy payment delays, redundant surveys, and convoluted prior authorization demands from insurers who may or may not fully grasp the marketplace for high-acuity beneficiaries." The American Health Care Association/National Center for Assisted Living (AHCA/NCAL) says there is a "limited pool of evidence" MLTSS’s impact, "leaving questions about the pace and scale of states making the shift." The group "asked the Centers for Medicare & Medicaid Services to protect Medicaid beneficiary access to quality care by stopping expansion of managed care ‘until more conclusive evidence concerning cost, quality, and outcomes is available.’"

- **CDC Report Finding Increase in Alzheimer's Mortality Contradicts Actual Rates, Expert Says.** *Provider Magazine* reports that a new study from the CDC found "Alzheimer's disease mortality increased significantly" – by 54.5 percent – "in 41 states and the District of Columbia from 1999 to 2014." An internist, geriatrician and author suggested that in examining the study figures more closely, the findings indicate "the increase actually is minimal" due to changes "over the years in terms of how death certificates are written" and "the visibility of and our focus on recognizing dementia."

- **AHCA, Long-Term Providers Cheer Veterans Access Bill.** *Provider Magazine* reported the Veterans Access to Long Term Care and Health Services, recently introduced to the Senate, "would enable the Department of Veterans Affairs (VA) to enter into provider agreements with non-VA long term care providers, including skilled nursing facilities (SNFs)," which LT/PAC providers "are applauding." American Health Care Association/National Center for Assisted Living President and CEO Mark Parkinson said the "crucial legislation ensures that America's
veterans have access to extended care services from providers who are closer to veterans’ homes and community support structures.” The bill received Senate Appropriations Committee approval on July 13.

26) **Medline Plus** reports:

- **Nearly 1 in 5 U.S. Adults Has Mental Illness or Drug Problem.** Nearly 1 in 5 American adults deal with a mental illness or substance abuse problem each year, a U.S. government study says. Oregon has the highest rate, and New Jersey the lowest, according to 2012-2014 data analyzed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Overall, almost 44 million Americans 18 or older had a diagnosable mental, behavioral or emotional disorder in the past year, researchers said. They reviewed national surveys on drug use and health.

- **Opioid Abuse Down in Younger Americans, But Up Among Older Adults.** While opioid abuse has fallen among younger Americans, the same cannot be said for older adults, a new government report shows. Opioid abuse includes either the use of heroin or illegal use of prescription opioid painkillers, such as oxycodone (Oxycontin, Percocet) and hydrocodone (Vicoprofen). Rates of opioid abuse among young adults -- aged 18 to 25 -- decreased from 11.5 percent in 2002 to 8 percent in 2014. But in adults 50 years and older, opioid abuse doubled, from 1 percent to 2 percent, according to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Overall, about 9.5 million adults had abused opioids in the past year, the 2014 National Survey on Drug Use and Health found.

- **Generic Eye Drops for Seniors Could Save Millions of Dollars a Year.** Prescribing generic drugs for seniors' eye problems could save the U.S. government hundreds of millions of dollars a year, a new study suggests. Conditions like glaucoma and dry eye that require daily eye drops are common in old age. University of Michigan researchers report that eye doctors caring for seniors prescribe brand-name medications in more than three-quarters of cases, compared to one-third of cases among nearly all other specialties.

- **Americans Taking More Prescription Drugs than Ever.** A new survey finds 55 percent of Americans regularly take a prescription medicine -- and they're taking more than ever. Those who use a prescription drug take four, on average, and many also take over-the-counter drugs, vitamins and other dietary supplements, the survey done by Consumer Reports shows. But many of those pills may be unnecessary and might do more harm than good, according to a special report in the September issue of *Consumer Reports* magazine. Among those who take prescription drugs, 53 percent get them from more than one health care provider, which increases the risk of adverse drug effects. More than a third say no provider has reviewed their medicines to see if all are necessary. Forty-nine percent of survey respondents who regularly take prescription medicine asked their prescribers whether they could stop taking a drug, and 71 percent were able to eliminate at least one.

- **Yoga May Help Ease Depression.** If you've ever taken a yoga class, you probably know that it can help relax your body and your mind. Now, several new studies suggest that practicing yoga may also ease depression. But the leader of a session on yoga and depression held Thursday at the annual meeting of the American Psychological Association (APA) in Washington, D.C., emphasized the research is preliminary.

- **Protein at All 3 Meals May Help Preserve Seniors’ Strength.** Eating protein at all three daily meals, instead of just at dinner, might help seniors preserve physical strength as they age, new research suggests. The Canadian study found that protein-rich meals evenly spread throughout the day staved off muscle decline, but did not increase mobility, in older people. Study co-author Stephanie Chevalier said, for seniors, "The important point is to create three meal occasions with sufficient protein to stimulate muscle building and greater strength, instead of just one."

27) **McKnight’s** reports:

- **Experts Say Resident Focus Will Ease Requirements Of Participation Compliance.** *McKnight’s Long Term Care News* reports that Kathryn Anderson, clinical nursing support and culture change leader at Providence Mount St.
Vincent, recently discussed the importance of shared decision making during the Pioneer Network annual meeting. Other sessions also covered patient-centered care, as this philosophy is prevalent in the new requirements for participation.

- **Registered Nurses’ Salaries Rose About Three Percent In 2017, AHCA-Assisted Study Finds.** *McKnight’s Long Term Care News* reports that the Nursing Home Salary & Benefits Report 2017-2018 found registered nurses working in SNFs saw an increase of 3.33 percent in their hourly rate compared to 2016, bringing the average hourly compensation to $27.52 per hour. The American Health Care Association assisted in compiling the report, which is "the largest salary survey of its kind."

- **Nursing Home Administrators See About Three Percent Salary Increase From 2016, Report Finds.** *McKnight’s Long Term Care News* reports the Nursing Home Salary & Benefits Report 2017-2018 compiled and released by the Hospital & Health care Compensation Service with assistance from the American Health Care Association found salaries for nursing home administrators "increased nearly 3 percent over the past year to an average of $97,401 in 2017." Executive directors and CFOs for SNFs also saw 2.46 percent and 2.09 percent increases, respectively, while directors of nursing saw gains of 2.64 percent, "going from an average of $89,092 in 2016 to $91,444 in 2017."

- **Initiatives To Lower Hospital Readmissions Do Not Raise Patients’ Post-Discharge Mortality Rates, Study Says.** *McKnight’s Long Term Care News* reports that a study published online last month in JAMA "found that 30-day readmission rates' among Medicare beneficiaries hospitalized for conditions associated with heart failure, acute myocardial infarction, or pneumonia "were ‘weakly but significantly correlated’ with drops in mortality rates." Researchers analyzed the correlation between 30-day readmission rate trends and 30-day mortality rates following discharge from the hospital, determining that "efforts to lower readmission rates didn’t raise patients’ post-discharge mortality rates." The research "refutes concerns that hospitals working to reduce their readmission rates may have done so at the expense of patient safety."

- **CMS to Hold Public Hearing On Behavioral Health Payment Model.** *McKnight’s Long Term Care News* reports that CMS announced it is seeking public feedback for a proposed behavioral health payment model for patients with conditions such as dementia or Alzheimer’s. CMS will hold the meeting September 8. According to *McKnight’s*, "The announcement reinforces CMS officials’ assurances that value-based initiatives are ‘here to stay’ under the Trump administration," although the article notes HHS Secretary Tom Price "previously slammed" CMS’ Innovation unit – responsible for the new model – "for what he called a lack of demonstrated savings."

- **Opinion Recommends Strategies For SNFs To Address Aging Population.** Alan Abrams, MD, MPH, Assistant Clinical Professor of Medicine, HMS, Beth Israel Deaconess Medical Center, writes in *McKnight’s Long Term Care News* to advocate for the importance of SNF post-acute rehabilitation services in the midst of "a ballooning number of people within the largest category of total Medicare spend[ing] – those requiring costly, ongoing medical care." He cites several "performance pressures" the industry faces as the older patient population increases, such as "reducing length of stay and hospital readmission risk" and that CMS "requires SNFs to bear some financial responsibility for potentially preventable hospital readmissions, as well as for meeting competitive new quality measures."

- **A Place For Mom: 40 Percent Of Families Underestimate AL Costs.** *McKnight’s Senior Living* reports on findings from A Place for Mom that suggest 40 percent of families underestimate costs associated with assisted living. The median monthly budget allocated for assisted living among surveyed families was $3,500, compared to the real median cost of assisted living, which is over $3,800.

- **House Committee to Establish "Medicare Red Tape Relief Project."

  *McKnight’s Long Term Care News* reports that the House Ways and Means Committee announced recently that it will establish the "Medicare Red Tape Relief Project" in an effort to "reduce regulatory burdens within the Medicare program." The Ways and Means Health Subcommittee will oversee the program, which is divided into "three stages: requesting stakeholder
feedback, hosting roundtable discussions with stakeholders, and taking ‘Congressional action’ based on provider feedback.” The committee also is requesting feedback on questions related to Congress giving “providers statutory relief from mandates established in law” and working alongside “federal health officials, such as Centers for Medicare & Medicaid Services Secretary Seema Verma, to deliver regulatory relief through administrative action.”

- **Comment Opportunity To Open For Proposed Overtime Rule.** *McKnight’s Senior Living* reports that the *Federal Register* is expected to publish a proposed rule on overtime pay for certain workers, which was open for comment at the end of last month. The request for information explains that "the Fair Labor Standards Act generally requires employers to pay their workers at least the federal minimum wage (currently $7.25 an hour) for all hours worked as well as overtime pay that equals at least 1.5 times the employee’s regular rate of pay for any hours worked over 40 in a workweek." Exceptions to that rule could be modified under the proposed rule.

- **Long Term Care Industry to See Shortage of Workers, Industry Experts Say.** *McKnight’s Long Term Care News* reports an MIT expert predicts the long term care industry will see a national shortage of 151,000 workers by 2030 due to lower wages and "a lack of respect for direct care workers." The American Health Care Association estimates the industry will need four million workers by 2050.

22) **Interesting Fact:** Everyone knows that the sun is hot, but you might not know that the Earth is too. At its core, it is about the same temperature as the sun, as in, it’s really, really hot.