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!

**Monitoring Quality of Care for Contracted Services**

Regulatory and accrediting agencies such as Centers for Medicare & Medicaid Services and The Joint Commission expect health care organizations to monitor the activities of their external contractors to ensure the quality of care, treatment and services they provide. It is important to put performance expectations for the services to be provided into writing, perhaps as part of the actual contract. Examples of external contractors include pharmacy services, medical equipment companies, mobile imaging services, food services, housekeeping and dietary services.

A centralized contract management process is recommended. Once all contracts have been identified, develop a log that includes the contract names, the services provided, the hospital-defined performance measures, how often the measures will be assessed and reported and the person responsible at the hospital.

Any contract service that provides clinical care for patients presents a unique risk management challenge for a hospital and its medical staff. According to CMS, the hospital’s governing body must ensure that contracted services comply with all applicable conditions of participation and standards related to licensure. The best strategy to ensure that clinical services provided through a contract service do not increase potential risks to the hospital is to review the service with a focus on risk management and risk prevention.

The written contract/agreement should describe or reference the following items:

- The services provided and the responsibilities of the parties
- The approval of the governing body
- Required compliance with state and federal licensing laws and regulations
- Participation in the organizational quality improvement plan
- The professional liability coverage for the service/providers, including the policy limits and whether or not those limits are shared with other hospitals
  - Maintain a copy of the contractor’s current certificate of insurance
  - Appropriate hold harmless and indemnification provisions
- The worker’s compensation coverage information for the contracted employees
- Agreement for contractor to provide personnel profiles upon request

There should be an annual review and performance report for each contract with input from those departments or individuals who regularly interact with the contracted service. For those individuals who will be providing services on-site, there should be a documented orientation process. Develop measurable performance standards for timeliness,
quality and safety to determine if the contract service is meeting the contract expectations. Areas to consider for inclusion as part of the performance monitoring include:

- Accreditation or certification status
- Direct observation of the provision of care
- Review of documentation, including electronic health records
- Review of incident reports, patient/family complaints and patient satisfaction surveys
- Review of performance reports based on indicators required in the contractual agreement

Inclusion of contracted services in your organization-wide Quality Improvement Program leads to a more comprehensive approach and will meet regulatory and accrediting body standards as well. If quality and performance issues are identified, remedial actions should be taken in a timely fashion, to minimize additional risk exposure for the organization.

*Authored in part by Betty Norman and reprinted partially out of McKnight’s.*

**Falls: A Closer Look**
Part of Eleanor Feldman Barbera’s job as a geropsychologist is to conduct reviews of falls with her patients after they occur.

Through discussion with the resident, she analyzes what happened and assess how they’re doing after what can be a traumatic event. Together, they identify ways they can prevent future falls.

This exercise can be very revealing not only about the particulars of a situation but also about why falls occur in general.

**The trauma of falls**
Falls can be traumatic for a number of reasons. Sometimes an individual is badly hurt in the event, leading to a hospitalization and/or a decline in their physical and mental condition.

Occasionally, a person isn't found immediately, resulting in a period of time on the floor in pain with negative thoughts about themselves, staff, the facility and life in general. A spill can also trigger thoughts about similar past distressing episodes, such as a reminder of a fall at home that precipitated hospitalization and placement.

In addition, falls can decrease residents' confidence in their physical abilities, leading them to become overly cautious in rehab and resulting in increased physical dependence.

**Why residents fall**
There are many reasons that people fall, including forgetting their inability to walk, dizziness due to medication side effects, pain and restlessness.

*This 2014 article in Managed Healthcare Connect* provides excellent examples of how to conduct a thorough “root cause analysis” and a discussion of many of the elements that contribute to falls and how to address them.

Falls are typically multifactorial, but my own experience with residents over the years — bearing in mind that I speak only with residents who are cognitively intact and able to benefit from psychological services — suggests one major cause of falls in this cohort: not getting help in a timely fashion.

Of course, what is for one resident a timely interlude is to another individual an infuriating and anxiety-provoking wait. Nevertheless, it's a reasonable expectation that when a person in a healthcare facility presses a button for help, relief will arrive quickly. When this doesn't occur, residents try to help themselves.
Recommendations
While speedy assistance should be the norm, the reality is that it's frequently a rarity. The staff is often stretched too thin; one person in need can't be abandoned to attend to another.

What can be done, aside from ensuring adequate staffing, is to reduce residents' anxiety, frustration and impatience and therefore make it less likely that they'll try to get up on their own if they're unable to do so.

1. The most essential action is to train nurses to answer the call bell immediately, preferably through an intercom system that makes it easy to communicate with residents while continuing with their other tasks. This allows nurses to quickly reassure residents that help is available, direct aides to the most urgent situations and to answer questions that don't necessitate the time and attention of the aides. The bell is pressed, the response comes and the resident is reassured and can tolerate a wait.

2. Train workers to answer requests for help with a pleasant demeanor and the understanding that their demeanor affects the likelihood of an incident. In my experience, the second most-likely reason that a resident doesn't wait for help is that they don't want to “bother” the staff, particularly if the staff tends to seem bothered.

3. Refer cognitively intact residents for psychological services, especially after a fall. While virtually all residents find admission to a rehab or nursing home stressful and can benefit from psychological support, residents who have had a fall at home or in the facility should be evaluated for psychological trauma and to address the personal components that contributed to the incident.

4. Enlist other residents as mentors. A resident who fell and was injured because they didn't wait for help can be as much of a mentor as a resident who patiently and successfully made it through rehab. See if they'll share their stories. Hold a group for residents to discuss techniques they've used to be as independent as possible considering their need for help, or use the "Working with the Staff" chapter or the “Don't be foolishly independent” section in the Rehab chapter of my book as conversation starters. Empowering residents to support each other can minimize the powerlessness they feel waiting in bed for assistance.

Given the damage falls can bring to residents, families, staff and facilities, it's worth investing time in staff training and in employing creative approaches to fall prevention.

Article partly authored by Eleanor Feldman Barbera, PhD out of McKnight’s.

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

SNF Deficiencies Declining, but Staffing Still Lower Than Recommended: Report
The average number of deficiencies per nursing home has dropped in recent years, but staffing levels are still falling short of what some experts recommend, according to a new report from the Kaiser Family Foundation.

Kaiser’s “Nursing Facilities, Staffing, Residents and Facility Deficiencies” report, published Tuesday, outlines recent trends in skilled nursing facilities across the United States using data from the On-line Survey, Certification, and Reporting (OSCAR) system and Survey Provider Enhanced Reports.

Among the findings: Data show that deficiencies, for the most part, declined in the 2009-2015 time frame. Between 2009
and 2013 the average number of citations per facility fell from 9.33 to 7.28. That average jumped back up slightly between 2013 and 2015, reaching 8.6 that year.

The percentage of nursing facilities that received no deficiencies followed a similar pattern, rising from 7% in 2011 to 8% in 2013, before dropping again to 7% in 2015. In 2015 more than one-fifth of facilities had a deficiency for actual harm or Immediate Jeopardy, Kaiser found.

The most commonly cited deficiencies were reported in the areas of infection control, accident environment, food sanitation, quality of care and pharmacy consultation.

The report also showed total nursing hours averaged 4.1 hours per resident day in 2015, a slight bump from 3.9 hours in 2009. But despite the increase, the level still falls short of recommendations from some experts, Kaiser noted. That includes a panel of University of California researchers that suggested levels of 4.55 hours per resident day in an article in The Gerontologist.

The Kaiser report also found:

- Nursing staff training may not be adequate to properly care for high-need residents or those with behavioral conditions, the report’s authors said, citing limited training on conditions such as dementia
- Nursing home capacity has stayed relatively flat, but occupancy rates have declined from 83.7% in 2009 to 81.7% in 2015
- The percentage of facilities owned by for-profit or chain companies grew slightly between 2009 and 2015, from 67% to 68%

The report's authors said that future research into facility and resident characteristics should focus on “whether and how new requirements are affecting care and outcomes and to identify additional areas of concern for future policy changes.”

Click here to read the full Kaiser report.

**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 17-41 – NH** - Notification of Final Rule Published—Survey Team Composition and Investigation of Complaints. On July 31, 2017, the Federal Register issued the final rule Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition and Correction of the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020. These regulations are effective on October 1, 2017. The Final Rule published on August 4, 2017 and can be found here.

- **S&C 17-42 – All** - Termination Notices Available via the Survey & Certification Website. As of October 1, 2017 (for Ambulatory Surgical Centers [ASCs], Federally Qualified Health Centers [FQHCs], Rural Health Clinics [RHCs] and
2) Federal HHS/CMS released the following notices/announcements:

- **Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call** — Thursday, September 7, 12:30 – 2 p.m. CST. [Click here](#) to 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.

- **CMS Releases Hospice Compare Website to Improve Consumer Experiences, Empower Patients.** On August 16, as part of their continuing commitment to greater data transparency, CMS unveiled the [Hospice Compare](#) website. The site displays information in a ready-to-use format and provides a snapshot of the quality of care each hospice facility offers to its patients. CMS is working diligently to make health care quality information more transparent and understandable for consumers to empower them to take ownership of their health. By ensuring patients have the information they need to understand their options, CMS is helping individuals make informed health care decisions for themselves and their families based on objective measures of quality. The Hospice Compare site allows patients, family members, caregivers and health care providers to compare hospice providers based on important quality metrics. Currently, the data on Hospice Compare is based on information submitted by approximately 3,876 hospices. For More Information:
  - [Fact Sheet](#)
  - [Hospice Quality Public Reporting](#) webpage

See the full text of this excerpted [Press Release](#) (issued August 16).

- **CMS Overhauling Medicare Fraud Audit Process.** CMS utilizes Medicare Administrative Contractors (MAC) to review clinical documentation in order to prevent improper payments. MACs choose claims for review based on many factors, such as the service specific improper payment rate, data analysis and billing patterns of the provider. CMS is cognizant that this type of review can be burdensome to providers and we are always working to improve the process.

- **CMS Releases Updated Data on Medicare Hospice Utilization and Payment.** CMS announced the second annual release of the Medicare Hospice Utilization and Payment Public Use File, a comprehensive resource for information on hospice utilization, payments, submitted charges, diagnoses and beneficiary demographics organized by hospice provider and state. The public data set includes information on 4,232 hospice providers, over 1.38 million hospice beneficiaries, and over $15.9 billion in Medicare payments for 2015. For more information visit the [Medicare Provider Utilization and Payment Data: Hospice Providers](#) webpage.

- **SNF Quality Reporting Program Web-based Training Module Available.** CMS offers a refresher [web-based training module](#), addressing areas that generated the most questions from the 2016 Skilled Nursing Facility (SNF) Quality Reporting Program Provider Trainings. Visit the [SNF Quality Reporting Training](#) webpage for more information.

- **Beneficiary Notices: Large Print Forms Available.** The following forms and notices that you issue to your Medicare patients are now available in a large print Word version as well as the PDF and original Word format in English and Spanish on the web:
  - CMS-R-131 - [Advance Beneficiary Notice of Non-coverage](#)
  - CMS-10124 - [Detailed Explanation of Non-Coverage](#)
  - CMS-10123 - [Notice of Medicare Non-Coverage](#)
  - CMS-10611 - [Medicare Outpatient Observation Notice](#)
For more information see the Beneficiary Notification Initiative website.

- **Inpatient Skilled Nursing Facility Denials.** According to the 2015 Comprehensive Error Rate Testing (CERT) Report, the denial rate for Skilled Nursing Facilities (SNFs) increased from 6.9 percent in 2014 to 11 percent in 2015 due to missing or incomplete certification/recertification:
  - Statement must contain need for skilled services that can only be provided in SNF/swing-bed on a daily basis for a condition patient was treated for in prior hospital stay
  - Must include physician’s dated signature (printed name if signature is illegible)

  In addition, recertifications should include:
  - Expected length of stay
  - Explanation if continued need for services is for a condition that arose after SNF admission
  - Any plans for home care

**Resources:**
- CERT: SNF Certifications and Recertifications MLN Matters® Special Edition Article
- SNF Billing Reference Fact Sheet
- Medicare Fee-For-Service 2014 Improper Payments Report, page 19
- Medicare Fee-For-Service 2015 Improper Payments Report, page 18

- **2018 ICD-10-CM Coding Guidelines and Conversion Table Available.** The 2018 ICD-10-CM Coding Guidelines and Conversion Table are posted on the [2018 ICD-10 CM and GEMs](#) webpage.

- **Medicare Parts A & B Appeals Process Booklet— Revised.** A revised Medicare Parts A & B Appeals Process Booklet is available. Learn about:
  - Original Medicare's (Part A and Part B) five levels of claim appeals
  - New option for a level three on-the-record review
  - Available forms and helpful tips for filing an appeal

- **New Medicare Card: Webpage Updates.** CMS updates the New Medicare Card pages on a rolling basis. Check the [New Medicare Card](#) homepage and [Provider](#) webpage frequently for changes. This week, we added a new [exception](#) for claim status queries.

- **Hospice Quality Reporting Program: Reconsideration Period Ends August 17.** CMS notified hospice providers that are non-compliant with Hospice Quality Reporting Program (HQRP) requirements for CY 2016. Any hospice determined to be non-compliant may be subject to a two percentage point reduction in their FY 2018 annual payment update. Non-compliance letters were dated July 18, 2017, and sent by mail and via the Quality Improvement and Evaluation Systems (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system. Check your CASPER folder to determine if your hospice received this letter. If so, you may submit a request for reconsideration to CMS no later than 11:59 p.m. PST on August 17. See the instructions in your notification letter and on the [Hospice Reconsideration Requests](#) webpage. Failure to submit a reconsideration by the deadline means acceptance of your non-compliance with HQRP requirements.

- **Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician.** Medicare Fee-For-Service beneficiaries are now able to login to [MyMedicare.gov](#) and select their primary clinician, the practitioner the beneficiary believes is responsible for their overall care coordination. Selection of a primary clinician does not affect the beneficiary’s benefits; ability to choose a doctor; or change Medicare Part A or Part B billing and payment policies. CMS believes that the selection of a primary clinician will strengthen beneficiary engagement in their health care and empower clinicians to better coordinate care. CMS will begin using beneficiary selection in Performance Year 2018 to hold Medicare Shared Savings Program Accountable Care Organization clinicians responsible for the quality of care and overall medical costs (this process is also referred to as voluntary alignment).
• **Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available.** The 2018 guidance manual for the OASIS-C2 version of the Outcome and Assessment Information Set (OASIS) data set is available. This version corrects errata from the previous version and contains clarifications about the One Clinician Rule. The effective date is January 1, 2018. Visit the OASIS Data Sets and OASIS User Manuals webpages for more information.

• **Home Health Care: Proper Certification Required.** Physicians or non-physician practitioners are required to have face-to-face encounters with beneficiaries before they certify eligibility for the home health benefit. One aspect of the certification is for the certifying physician to certify (attest) that the face-to-face encounter occurred and document the date of the encounter. For medical review purposes, Medicare requires documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records to be used as the basis for certification of patient eligibility. This documentation must include the clinical note or discharge summary for the face-to-face encounter. Avoid home health claims payment denials or improper payment recoveries by understanding Medicare’s requirements.

Resources:
- CY 2015 Home Health Prospective Payment System Final Rule
- Medicare Benefit Policy Manual, **Chapter 7, Section 30.5.1**
- **Certifying Patients for the Medicare Home Health Benefit** National Provider Call

MLN Matters® Articles:
- **Certifying Patients for the Medicare Home Health Benefit**
- **Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services**

• **IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — Thursday, August 17 from 12:30 to 2 pm CST.** Register for Medicare Learning Network events. The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities and long term care hospitals for specified domains. During this call, CMS and measure developers will present the Drug Regimen Review (DRR) quality measure for the home health Quality Reporting Program (QRP), which was adopted to fulfill the medication reconciliation domain requirement. A question and answer session follows the presentation.

Agenda:
- Review the goals of the DRR measure
- Review guidance and walk through scenarios for coding the Outcome and Assessment Information Set (OASIS) items used to calculate the measure

You may email questions in advance of the call to PACQualityInitiative@cms.hhs.gov. Questions received in advance of the call may be addressed during the call or used for other materials following the call.

• **The August 2017 Catalog is available.** Learn about:
  - Products and services that can be downloaded for free
  - Web-based training courses; some offer continuing education credits
  - Helpful links, tools and tips

• **Long Term Care Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the July 25 call on the Revised Interpretable Guidance for Nursing Homes and New Survey Process, effective November 28, 2017. Learn about the major components of Phase 2 implementation, changes to the survey process and training resources available to the public.
• **ESRD Listening Session: Audio Recording and Transcript — New.** An audio recording and transcript are available for the July 26 listening session on the End-Stage Renal Disease (ESRD) Quality Improvement Program Proposed Rule for Payment Year (PY) 2021. Learn about provisions in the proposed rule, including plans for PY 2019, 2020, and 2021.

• **Medicare Secondary Payer Web-Based Training Course — Revised.** With Continuing Education Credit. A revised Medicare Secondary Payer Web-Based Training (WBT) course is available through the Learning Management System. Learn about:
  - Common situations when Medicare may pay first or second
  - When Medicare makes conditional payments
  - Ongoing Responsibility for Medicals provision
  - The role of the Benefits Coordination & Recovery Center

• **Medicare Secondary Payer Booklet — Revised.** A revised Medicare Secondary Payer Booklet is available. Learn about:
  - Common situations when Medicare may pay first or second
  - Medicare conditional payments
  - The Coordination of Benefits rules
  - The role of the Benefits Coordination & Recovery Center

3) The U.S. Food and Drug Administration (FDA) **Warns of Potential Contamination in Multiple Brands of Drugs, Dietary Supplements.** The U.S. Food and Drug Administration is advising consumers and health care professionals not to use any liquid drug or dietary supplement products manufactured by PharmaTech LLC of Davie, Florida, and labeled by Rugby Laboratories, Major Pharmaceuticals and Leader Brands, due to potential contamination with the bacteria Burkholderia cepacia (B. cepacia) and the risk for severe patient infection. The drug and dietary supplement products made by PharmaTech include liquid docusate sodium drugs (stool softeners), as well as various dietary supplements including liquid vitamin D drops and liquid multivitamins marketed for infants and children.

4) The HHS Office of the Inspector General's (OIG) work planning process is dynamic and adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available. Previously, OIG updated its public-facing Work Plan to reflect those adjustments once or twice each year. In order to enhance transparency around OIG’s continuous work planning efforts, effective June 15, 2017, OIG will update its Work Plan website monthly. For more information about OIG’s Work Plan, how they plan our work and how they update the work plan, please see [https://oig.hhs.gov/reports-and-publications/workplan/](https://oig.hhs.gov/reports-and-publications/workplan/).

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

• MEDI/DDE has been modified to allow for entry of the Place of Service Code 02 at the claim and service line levels. You may view this update [here](https).

• The Calculations and amounts for the hospital ACA Access Payments for the period of August 2017 through October 2017 have been posted to the Department’s new web site and can be viewed [here](https).

• **Updated Practitioner Fee Schedule — click 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.
7) The **American Health Care Association (AHCA) and Illinois Health Care Association (IHCA)** recently reported on:

- **Summary of CMS Call on HCBS Setting Rule.** CMS had an hour-long open door forum on the HCBS setting rule. They provided some clarification relevant for those affiliates working on the rule implementation.

- **CMS Proposes Cancelling Most Recent Mandatory Bundling Program, Proposes Major Modifications to Original Mandatory Bundling Program.** There is significant, positive news from D.C. today. Our efforts to get the new Administration to reduce our regulatory burden continue to bear fruit. CMS announced major changes to the mandatory post-acute bundling programs. You may recall that these are the large-scale demonstrations created by the Obama Administration that forced bundling in large parts of the country and gave the bundles to hospitals. The full proposed rule is online [here](#).

- **An Update on Skilled Nursing Facility (SNF) Value Based Purchasing (VBP).** On July 31, 2017, CMS issued a final rule [CMS-1679-F] outlining fiscal year (FY) 2018 Medicare payment rates and quality programs for skilled nursing facilities (SNFs). In that rule, CMS finalized some key components of the SNF Value Based Purchasing (VBP) program, which impacts reimbursements starting next year. As a reminder, starting on October 1, 2018 for FY 2019, CMS will adjust Medicare payments to providers based on how well they manage hospital readmissions based on performance in this calendar year (CY) 2017 compared to CY 2015. Some SNFs will see some sort of payment reduction, which can be as high as two percent for all of their Part A Medicare payments for an entire fiscal year. There is a potential for some SNFs who achieve low hospitalization rates to see an increase in reimbursements, but how many and by how much will not be determined until the performance period of calendar year 2017 concludes.

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

9) **Chicago Tonight** reports that **Chicago Entrepreneurs Shine Light on Preventing Elderly Falls.** One in four older adults reported falling in 2014, with more than 7 million of those falls requiring medical treatment or restricted activity for at least a day, according to the Centers for Disease Control and Prevention. That same year, a local company was founded with the goal of reducing the number of falls in older adults while allowing them to maintain their independence. The team developed an automatic lighting system that illuminates a pathway along the floor when a person gets out of bed. A thin, pressure-sensing mattress pad detects when a person gets up and triggers the battery-operated lights to turn on. The lights remain on until the individual returns to bed.

10) **Argentum** reports that **Asthma, More Deadly With Age, Takes Heavy Toll on Older Adults.** Death rates for older adults with asthma are five times that of younger patients, according to a new review of asthma among seniors. And medical complications are more common. As the prevalence of asthma climbs in people 65 and older, more seniors will grapple with its long-term impact. Estimates vary, but up to 9 percent of older adults are thought to have asthma — a respiratory condition that inflames the lungs and interferes with breathing. With the advance of years, physical changes take a toll. People’s lungs become less elastic, their chest walls more rigid, and the muscles that help power the respiratory system less strong, exacerbating breathing problems, explained Dr. Michael Wechsler, a professor of medicine and co-director of the Cohen Family Asthma Institute at National Jewish Health, and co-author of the new review.

11) **United Press International (UPI)** reports CB: **Americans Would Save $7B Buying Prescription Drugs from Canada.** A Congressional Budget Office analysis estimates that a bill proposed by Sen. Bernie Sanders that would allow Americans to buy prescription drugs from Canada and other countries would save taxpayers nearly $7 billion over the next 10 years.
12) Medpage Today reports on Meta-analysis: Tai Chi Keeps Seniors from Falling. Tai chi may reduce the rate of falls and injury-related falls during the first year by about half in older and at-risk adults, according to a new meta-analysis. Pooled data from 10 randomized controlled trials showed a significant 43 percent reduction in the risk of falls compared with other interventions at 12 months or less, and a reduction in the risk of injurious falls by 50 percent over the short term, Rafael Lomas-Vega, PhD, from the University of Jaén in Spain, and colleagues reported online in the Journal of the American Geriatrics Society.

13) ProPublica reports that Accreditors Can Keep Their Hospital Inspection Reports Secret, Feds Decide. Federal health officials have backed down from a controversial proposal that would have required private accreditors to publicly release reports about errors, mishaps and mix-ups in the nation’s hospitals and health care facilities. CMS had proposed in April that accreditors publicly detail problems they find during inspections of hospitals and other medical facilities, as well as the steps being taken to fix them. Nearly nine in 10 hospitals are directly overseen by these accreditors, not the government. But in a notice released recently, the government withdrew the proposal. CMS said that federal law prohibits the agency from disclosing the results of inspections performed by the accrediting organizations and that the proposal — though it required accreditors, not the agency, to release the reports — “may appear as if CMS was attempting to circumvent” the law.

14) Medline Plus reports:
- Blood Pressure Fluctuations Tied to Dementia Risk in Study. If your blood pressure varies from day-to-day, you may be at higher risk for dementia or Alzheimer’s disease, new research from Japan suggests. People whose systolic blood pressure (the top reading) fluctuated from day-to-day were more than twice as likely to develop any type of dementia or Alzheimer’s disease compared to those with more stable day-to-day blood pressure, the researchers found. And the study -- which was based on home-monitorings -- also reported that the participants were nearly three times more likely to develop vascular dementia, caused by hardening of the arteries.

- Singing May Be Good Medicine for Parkinson’s Patients. Singing? To benefit people with Parkinson’s disease? It just may help, researcher Elizabeth Stegemoller says. Singing uses the same muscles as swallowing and breathing control, two functions affected by Parkinson’s disease. Singing significantly improves this muscle activity, according to Stegemoller’s research. Other benefits noted by patients, their families and caregivers include improvements in mood, stress and depression, she said.

- U.S. Antidepressant Use Jumps 65 Percent in 15 Years. The number of Americans who say they’ve taken an antidepressant over the past month rose by 65 percent between 1999 and 2014, a new government survey finds. By 2014, about one in every eight Americans over the age of 12 reported recent antidepressant use, according to a report released recently from the U.S. Centers for Disease Control and Prevention. Women are nearly twice as likely as men to be taking the medications, the report found, with antidepressants used by 16.5 percent of females compared to just under 9 percent of males.

15) Skilled Nursing News reports on Long Term Health Care Industry Struggling to Recruit, Retain Skilled Workforce. Skilled Nursing News reported that a study conducted by LeadingAge found the number of employment opportunities in the long term services and supports sector will "grow substantially" by 2030, underscoring an industry-wide concern for recruiting and retaining "frontline caregivers." LeadingAge managing director and senior research associate Natasha Bryant, who produced the study, discussed factors influencing turnover and prohibitions to attract workers. A report by the American Health Care Association found the "overall median turnover in SNFs was 43.9 percent in 2012; among direct care staff, certified nursing assistants (CNAs) had the highest median turnover at 51.5 percent, while licensed practical nurses/licensed vocational nurses (LPNs/LVNs) had the lowest turnover rate at 36.4 percent."

16) Wiley Online Library reports on The Variation of Statin Use Among Nursing Home Residents and Physicians: A Cross-Sectional Analysis. Statin prescribing was substantial within nursing homes, even among frail residents. After controlling for resident characteristics, the likelihood of statin prescribing varied significantly across physicians. Further studies are required to evaluate the risks and benefits of statin use, and discontinuation, among nursing home residents to better inform clinical practice in this setting.
17) **Modern Healthcare** reports that **Nursing Home Providers Concerned Federal Efforts to Reduce Antipsychotic Use Could Harm Patients**. **ModernHealthcare** reports that following "years of criticism," nursing homes are working to reduce the administering of antipsychotics. Their use by nursing homes for residents who have been in care for at least 100 days has fallen to 15.7 percent in 2017 from 23.9 percent in 2011, CMS data show. A partnership between CMS and nursing home leaders – including the American Health Care Association – has contributed to the drop, although some clinicians such as Dr. David Gifford, senior vice president of quality and regulatory affairs at the American Health Care Association, feel federal regulators expect to completely remove antipsychotic use, which they say could jeopardize the treatment of residents who need them. Dr. Gifford explained, "If there are people for which these drugs are indicated and they are not getting them, then you’ve crossed a line."

18) **FierceHealthcare** reports that **Discharging Hospitals Do Not Supply Patients With Quality Information on SNFs**. According to an article on **FierceHealthcare.com**, a study published in **Health Affairs** found that hospitals that are motivated to provide older patients with access to post-acute care and quality data skilled nursing facilities "typically fail to provide that quality information to patients when the time comes for them to choose a facility," with four of 98 patients at 14 SNFs interviewed for the study saying they received guidance from the hospital related to the quality of SNFs. Researchers found hospitals say they believe they avoid providing patients with information that could influence their selection. The study authors wrote "nothing" in federal law "precludes hospitals from helping patients make an informed choice," and that hospitals are permitted under CMS guidance to direct patients to the Nursing Home Compare website.

19) **Provider Magazine** reports **Op-Ed Offers Suggestions on Improving LT/PAC Provider Analytics**. Lee Kilmer, vice president of product management for MatrixCare, wrote an article for the August issue of **Provider Magazine**, "Seven Ways To Improve Analytics," saying that long term/post-acute care providers that "continue to struggle at getting meaningful return on investment from their data analytics initiatives" can benefit from implementing steps to improve collecting and sourcing analytics data. Kilmer recommended providers understand the requirements necessary for furnishing analytics data; understand "information assets"; consider data "in terms of domains"; account for "analytics maturity"; acknowledge and address limits to capability; utilize relevant visualizations; and facilitate trust with data users.

20) **mHealth Intelligence** reports on **CMS Studies Telemedicine to Curb Skilled Nursing Facility Hospitalizations**. **mHealth Intelligence** featured an article that reported that CMS is launching a federal study using a telemedicine platform at three Florida skilled nursing facilities to see if off-hours telemedicine can avoid hospitalizations of vulnerable seniors. One expert explained, "Studies show that approximately 60 [percent to] 70 percent of all nursing home transfers to the hospital are unnecessary," and using telemedicine can save money and reduce exposure to the many adverse effects that can arise from hospitalizations. The article says telemedicine technology allows physicians to address changes in condition that occur during off-hours without an emergency department visit.

21) **NBC News** reports that **Alexa Can Make Serious Impact on Quality of Life, Safety of Elderly**. In a recent article about the effects technology is having on the lives and safety of the elderly, **NBC News** says, "digital ‘personal assistant’ devices – like Amazon’s Alexa – will become more integrated into the home and thus more useful. Alexa can already store grocery lists, but someday it or something like it might, for example, monitor milk consumption in the home and order more to be delivered just before the carton is empty." The article details other benefits and activities technology brings to the elderly, including virtual vacations and "nostalgic visits" to familiar places through virtual reality.

22) **News-Medical Life Sciences** reports that **Smartphone Interventions May Help Middle-Aged, Older Adults Cope with Serious Mental Illness**. The use of new technologies in geriatric psychiatry shows promise for advancing personalized medicine and improving patient care. A new study in the **American Journal of Geriatric Psychiatry** describes the successful adaptation of an integrated medical and psychiatric self-management intervention to a smartphone application for middle-aged and older adults with serious mental illness.
23) **HealthDay** reports:

- **Standing Exercises May be Better Than Seated Exercises for Seniors.** *HealthDay* reports standing exercises may be more effective than seated exercises for seniors, according to a study published in *JAMA Internal Medicine*. Researchers found that study participants "who took part in a standing-exercise program were able to walk faster and farther than those in a seated-exercise program."

- **Middle-Aged People With Risk Factors for Health Attacks, Stroke May be More Likely to Develop Dementia in Old Age.** *HealthDay* reports that those whose systolic blood pressure "fluctuated from day-to-day were more than twice as likely to develop any type of dementia or Alzheimer’s disease compared to those with more stable day-to-day blood pressure," as well as "nearly three times more likely to develop vascular dementia, caused by hardening of the arteries." Ohara said, "Further studies are needed to clarify whether day-to-day blood pressure variation is an indicator of future dementia or a medical target for the prevention of dementia."

24) **McKnight’s** reports:

- **Apathetic Nursing Home Residents Have Higher Mortality Risk, Study Suggests.** *McKnight’s Long Term Care News* reports a study by Dutch researchers published Wednesday in the Journal of the American Geriatrics Society "found that residents who displayed a lack of motivated, goal-oriented behavior, cognition and interest in activities of daily living had a higher risk of mortality over a four-month period." Researchers examined "more than 700 nursing home patients using a 10-point Apathy Evaluation Scale."

- **Poorer Medicare Beneficiaries Have Higher Risk Of Being Kept For Hospital Observation, Study Suggests.** *McKnight’s Long Term Care News* reports that a study published in *The American Journal of Medicine* found Medicare beneficiaries who are poorer than their peers were 24 percent more likely to be hospitalized three or more times under observation in a year. The study sourced Medicare claims data from 2013 and "included more than 67,000 patients with a total of more than 132,000 hospital stays for observation."

- **Female Nursing Assistants, Attendants May Have Higher Risk Of Rheumatoid Arthritis Than Women In Other Professions, Study Suggests.** *McKnight’s Long Term Care News* reported that a study published last week in *Arthritis Care & Research* found female nursing assistants and attendants may have a higher risk of rheumatoid arthritis than women in other professions. A team of Swedish researchers who examined more than 3,500 people with rheumatoid arthritis and 5,600 people without it found women who worked in nursing assistance and attendance had "a moderately increased risk of developing the disease, compared to women workers in other fields."

- **More Medicare Beneficiaries Taking Advantage Of End-Of-Life Care Coverage, Report Finds.** *McKnight’s Long Term Care News* reports that an analysis compiled by Kaiser Health News found almost twice as many Medicare beneficiaries are expected to participate in end-of-life care consultations than those who joined the program during its first year. The American Medical Association predicted 300,000 people would receive a Medicare-covered consultation in 2016, but Kaiser’s report "showed nearly 575,000 beneficiaries participated in an end-of-life care talk with their physician." Altogether 23,000 health care providers charged $93 million for the consultations, with $43 million covered by Medicare; but only about one percent of Medicare beneficiaries participated in consultations.

- **Post-Fall Assessments Need More Structure.** Post-fall assessments need to be standardized to examine and prevent future falls, a recent Canadian study found. PFAs allow clinicians to identify the cause for a fall and develop ways to prevent future falls. The study assessed the effectiveness of the PFAs in Canadian facilities. More than 92 percent of facilities reported that falling was an issue at their facility, and all used PFA reports. The majority also completed incident reports. However, the facilities lacked a standard format for how they should put together the reports, researchers found. Only 4 percent asked about information on environmental conditions or the neurologic profile of the resident. Six percent included information on resident footwear, and none listed mobility or balance issues in their reports.
• **3 Ways to Lower Readmission Rates.** This October, CMS will publish the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) on Skilled Nursing Compare. The SNFRM estimates the risk-standardized rate of unexpected readmissions within 30 days for patients with fee-for-service Medicare who were inpatients at PPS, critical access or psychiatric hospitals for any cause or condition. Long term care facility performance on readmission rates is a big deal. Public reporting of readmission rates impacts the facility's reputation for quality. Long-term care facilities with higher than expected readmission rates will be subject to financial penalties starting October 2018. In addition, hospital referral sources are actively narrowing their post-acute care networks and cutting facilities that have high readmission rates.

• **Lower-Performing SNFs Challenged In Implementing Resident-Centered Care, Study Suggests.** *McKnight’s Long Term Care News* reports that a study by the Veterans Health Administration found nursing homes with low performance tend to face difficulties in "delivering resident-centered care due to turnover" and may present a "lack of administrator guidance." The study, which focused on VHA Community Living Centers, "showed the five most cited barriers to resident-centered care were staffing, resources, resident acuity, regulations, and conflicts between resident-centered care and care quality." Within categories beyond the top five, facilities "began to diverge," with higher-performing facilities reporting fewer barriers to implementation and saying interdepartmental coordination was higher, while lower-performing facilities had "a more difficult time implementing person-centered care."

25) **Interesting Fact: Everyone in the continental U.S. was able to see at least a partial eclipse.** In fact, if you had clear skies on eclipse day, the moon covered at least 48 percent of the sun’s surface. And that’s from the northern tip of Maine.