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!

**Facility Assessment – New RoP Phase 2 Requirement (483.70(e))**

The purpose of the new Facility Assessment (effective November 28, 2017 as part of the Phase 2 requirements) is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. LTC providers are to use this assessment to make decisions about their direct care staff needs, as well as their capabilities to provide services to the residents in their facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental and psychosocial well-being. The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require.

Long term/post-acute care providers may be thinking of the facility assessment as just another paper regulation that detracts from the day-to-day business of providing care to the increasingly frail and acute population. Alternatively, providers can approach it as an opportunity to identify gaps between the care needs of the residents being treated and the facility competencies and environment. In turn, this could help to avoid an adverse event, or to focus on the center’s Quality Assurance & Performance Improvement (QAPI) plan.

The latter requires a deep dive into the needs of residents, staff competencies and physical environment. The biggest gaps are often not in the areas where the center specializes and has the greatest strengths, but in the care areas provided less frequently.

For example, centers that provide care for numerous residents with dementia are more likely to have competencies in dementia care and a physical plant that works well for individuals with dementia. The same could be said for centers that provide care for many post-acute stroke admissions or those in need of orthopedic rehabilitation.

One of the most widely demonstrated relationships in health care is the relationship between volume of care and outcomes for that type of care, and studies have found this relationship persists in skilled nursing facilities (SNFs). Centers that treat a significant volume of any type of problem tend to be better at treating that problem. Not surprisingly, through specialization they gain experience in it and, over time, build the competencies and the facilities to treat it.

The challenge for most nursing centers is that they generally admit many types of residents, and that the residents they admit have a multiplicity of problems. Centers often treat a mix of post-acute and long term residents with various medical, cognitive and functional problems. As the population of nursing center residents has become increasingly frail and acutely ill, the challenge of being competent in care for all types of residents has become greater.
This is where the facility assessment can help. Start by looking over the prior year at the residents that have been treated and at the volume of different types of care provided. Pay attention not only to the care provided most frequently, but also to the care provided less often.

Next, determine whether there is an adequate number of staff who are competent at providing care to many of the residents. Pay special attention to the care provided less frequently, as the center may contract for these services or depend on only a few staff members. Finally, identify gaps in services, and then develop a QAPI plan to fill those gaps.

This challenge even extends to cultural competencies of staff in caring for residents of different ethnicities. Here again, some centers provide care to a range of ethnic groups in small numbers, while others treat primarily one ethnic group. Whatever your ethnic mix, cultural competence can be a challenge, a challenge faced throughout health care. Pay particular attention to basic needs such as life-long foods and routines, as well as varying cultural views and practices that arise toward the end of life.

To assist LTC facilities in developing their Facility Assessment, federal CMS and Telligen (the Quality Innovation Network National Coordinating Center) collaborated on developing a Facility Assessment Tool (http://qioprogram.org/facility-assessment-tool). This tool is NOT mandated by CMS, but developed to assist LTC providers in developing their Facility Assessment. It is also important to note that the Facility Assessment must be in written form and will be asked for and reviewed by the survey team.

This optional template/tool is provided for use by LTC nursing facilities, and if used, it may be modified. Each facility has flexibility to decide the best way to comply with the Facility Assessment requirement.

The tool is organized in three parts:

1. **Resident profile** including numbers, diseases/conditions, physical and cognitive disabilities, acuity and ethnic/cultural/religious factors that impact care

2. **Services and care offered** based on resident needs (includes types of care your resident population requires; the focus is not to include individual level care plans in the facility assessment)

3. **Facility resources needed** to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training, physical environment and building needs and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and other information that you may choose

This assessment asks you to collect and use information from a variety of sources. Some of the sources may include but are not limited to MDS reports, Quality Measures, 672 (Resident Census and Conditions of Residents) and/or 802 (Roster/Sample Matrix Form) reports, the Payroll-Based Journal, and in-house designed reports.

**Guidelines for Conducting the Assessment**

1. To ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include the administrator, a representative of the governing body, the medical director, and the director of nursing. The environmental operations manager and other department heads (e.g., the dietary manager, director of rehabilitation services or other individuals including direct care staff) should be involved as needed. Facilities are encouraged to seek input from residents, their representative(s) or families, and consider that information when formulating their assessment.

2. While a facility may include input from its corporate organization, the facility assessment must be conducted at the facility level.

3. The facility must review and update this assessment annually or whenever there is/the facility plans for any change that would require a modification to any part of this assessment. For example, if the facility decides to
admit residents with care needs who were previously not admitted, such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., meet the needs of those residents and any areas requiring attention, such as any training or supplies required to provide care. It is not the intent that the organizational assessment is updated for every new person that moves into the nursing home, but rather for significant changes such as when the facility begins admitting residents that require substantially different care. Likewise, hiring new staff or a director of nursing or even remodeling should not require an update of the facility assessment, unless these are actions that the facility assessment indicated the facility needed to do.

4. The facility assessment should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources, and may include the operating budget necessary to carry out facility functions.

5. Appendix PP provides surveyor guidance through Interpretive Guidelines in the State Operations Manual. With regard to the facility assessment, Appendix PP states, “If systemic care concerns are identified that are related to the facility’s planning, review the facility assessment to determine if these concerns were considered as part of the facility’s assessment process. For example, if a facility recently started accepting bariatric residents, and concerns are identified related to providing bariatric services, did facility staff update its assessment before accepting residents with these needs to identify the necessary equipment, staffing, etc., needed to provide care that is effective and safe for the residents and staff?”

6. For a suggested process for conducting the assessment, including synthesis and use of findings, see Attachment 2 of the Facility Assessment Tool.

Again, this is an optional tool as CMS has not required any specific methodology for facilities to use for the Facility Assessment. Due to the significant variations in types of LTC facilities, resident populations and resources among the LTC facilities, CMS believes facilities need the flexibility to determine the best way for each facility to comply with this requirement and conduct that assessment, as long as it addresses or includes the factory or items set forth in Section 483.70(e) (https://www.law.cornell.edu/cfr/text/42/483.70).

IHCA is also currently developing some tools that should assist facilities in the development of their Facility Assessment. These tools should be available shortly and we will get them to our members.

How To Address Progress In Therapy Documentation

McKnight's recently published an excellent article, “Poor documentation crippling providers with Medicare denials.” The article, written by Elizabeth Newman, states that when Marilyn Mines was asked to assist with a therapy denial, the therapy documentation was sub-standard. However, I wanted to clarify how the documentation indicated how “…No progress had been made; there was no change in a plan of treatment.” While the article makes several valid points, “progress” is not and never has been the determinant of skilled care, and this was confirmed by Jimmo vs Sebelius (2013).

According to Chapter 8 of the SNF Manual, “Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care.” One of the fallacies that we suffer under as therapists in SNFs is the mythology of the “Plateau.”

How many times have you heard a case manager, insurer, reviewer, or even a therapist say “This patient doesn't require skilled therapy anymore. Her progress has plateaued.”

While we all agree that poor documentation is frequently the reason that a skilled service is denied (if it's not documented, it didn't happen, right?), the documentation should not just show progress, it must show the skilled service that was delivered.
It's not enough to state that the patient walked 50 feet with a walker last week with minimal assist and this week is walking 75 feet. Gaining endurance is rarely a skilled service. The “skilled” part that's missing from that note is what the therapist did to gain that improvement. The correct documentation would read "Patient walked 75 feet with a walker and minimal assist of one person. During the walk the patient required verbal cues for proper hand placement, weight bearing was manually facilitated through the patient’s right upper extremity by the therapist in order to promote proprioception and decrease neglect on the affected side." In other words, it's less important what the patient did; it's more important to document what the therapist did that was skilled.

I've often told therapists that we can deliver skilled therapy to a comatose patient who has no expectation of recovery. How? Where's the progress? We can offer skilled services because we do caregiver education, spasticity inhibition and flaccidity facilitation, positioning, etc. Because we're therapists, we have a very individualized toolbox. That is our specialty.

As therapists, we possess a skill-set that cannot be replicated by any other person in the facility. If the documentation shows repetition of exercises (e.g. patient performed alternating straight-leg raises with 2-pound weights to promote strength), the claim will likely be denied because anyone can monitor those exercises. If our documentation does not show the specifics that only therapists can deliver, we are in danger of losing the claim. We all know documentation is everything. We just need to do it right.

*Article reprinted in part out of McKnight’s and authored by Jean Wendland Porter, PT, CCI, WCC, CKTP.*

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**Trending Statistics**

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

**HIPAA: Five Steps to Ensuring Your Risk Assessment Complies with OCR Guidelines**

*Risk analysis: Five steps to getting it right*

HIPAA and health care technology have changed significantly over the past 20 years. Today, more than ever, covered entities and their business associates face an evolving risk environment in which they must safeguard electronic protected health information (ePHI).

Often, HIPAA risk assessment reports do not meet the guidance defined by the Office of Civil Rights (OCR) or support a complete review of the security rule controls. Checklists of policies and procedures, penetration test results and IT assessments barely scratch the surface of the data security safeguards.

Baker Tilly HIPAA and cybersecurity specialists developed a whitepaper that highlights the required components of a HIPAA risk analysis as defined in the security rule and also shares a cost effective approach to completing a risk analysis annually ([click here](#)).

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

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

- **S&C 17-44 – All Hospitals** - Advanced Copy- Revisions to State Operations Manual (SOM) Hospital Appendix A. CMS is clarifying guidance under Appendix A of the State Operations Manual (SOM) to address the following:
The Social Security Act, (the Act) Section 1861(e) defines the statutory definition of a hospital. A hospital is primarily engaged in providing inpatient services under section 1861(e)(1) of the Act when it is directly providing services to inpatients. In order to qualify for a provider agreement as a hospital under Medicare and Medicaid, an entity must meet and continue to meet all of the statutory provisions of §1861(e) of the Act, including the Condition of Participation (CoP) requirements. See also 42 CFR 488.3(a)(1) and 42 CFR 489.12. (Note: This requirement does not apply to Psychiatric Hospitals or Critical Access Hospitals (CAH), as defined at section 1861(f) of the Act) A hospital must have inpatients at the time of survey in order for surveyors to directly observe the actual provision of care and services to patients, and the effects of that care. The use of benchmarks for average daily census (ADC) and average length of stay (ALOS) data for the hospital will be two factors, in addition to other factors, utilized to determine if the hospital is primarily engaged.

- **S&C 17-45 – NH** - Electronic Staffing Submission - Payroll-Based Journal (PBJ) Public Use File. CMS will begin posting Payroll-Based Journal public use files which will be accessible at [https://data.cms.gov/](https://data.cms.gov/) on November 1, 2017. The Nursing Home Compare website indicates whether providers have submitted data by the required deadline, and if providers have submitted, complete, incomplete or inaccurate data. We are updating the data submission specifications to give providers the ability to link employee IDs for an employee that has changed employee IDs within a facility. CMS will post an updated PBJ policy manual and related information by October 1, 2017 [here](https://data.cms.gov/).

- **S&C 17-46 – CLIA** - Clarification Regarding the Use of Control Materials as Calibrators to Determine Test Cut-off Values. Controls provided by manufacturers in a test kit are considered to be calibration materials if they are used to calculate the cutoff value of a test or a patient test result. If the manufacturer’s instructions include a formula that uses the positive and/or negative controls included in the kit to determine the cutoff, additional external positive and/or negative controls must also be tested. The laboratory director is responsible for the determination of what control materials to use in his/her laboratory. Surveyors will ensure that the laboratory is following its own established policies, specifically its Quality Control (QC) procedures.

- **S&C 17-47 – All** - Advance Notice Solicitation Deadline - National Background Check Program. The goal of the program is to prohibit the hiring of employees who have histories of abuse or relevant criminal violations to serve the vulnerable long term care population. CMS is providing advance notice that the deadline for states to apply to the ninth (and final) solicitation for the NBCP will be December 15, 2017. The solicitation is posted at: [https://www.grants.gov/](https://www.grants.gov/).

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

- CMS will begin posting public use files of providers' Payroll Based Journaling data on November 1, the agency said in a memo posted Monday (see S&C 17-45 above). The first public use file to go live will cover data submitted by nursing homes for quarters 1 and 2 in calendar year 2017, which were due on May 15 and August 14. The file will include the total number of hours submitted for jobs in the nursing services job categories, such as registered nurses and nurse aides, for every day of the quarter. Providers' census for each day in the quarter will be included in the data. Posting the staffing information will “ensure transparency of the data submitted” and allow for viewing by providers, stakeholders and the general public, CMS said. The data will be available at [https://data.cms.gov/](https://data.cms.gov/). CMS' memo also stated that the agency will continue to post indicators on Nursing Home Compare to show whether providers have submitted their staffing data. Those indicators may undergo an update to “encourage more complete and accurate submissions,” the memo reads. CMS also plans to replace the staffing measures used in the Five-Star rating system and the Nursing Home Compare with PBJ data sometime in 2018, the memo states. Click [here](https://data.cms.gov/) to read the full memo from CMS, which also includes information on changing employee identifiers and PBJ resident census.

- A video recording of the Skilled Nursing Facility (SNF) Review and Correct Reports Refresher Webinar, which took place on Monday, August 7, 2017, is now available. The focus of the webinar was to provide additional training and guidance on how Review and Correct Reports fit within the overall SNF QRP. Additionally, the
training provided information on timelines and quarterly submission deadlines. The video recording can be accessed via YouTube.

- **Hospice Provider Preview Reports Available through September 28.** Hospice Provider Preview Reports are now available through September 28. Preview your quality measure results, based on first to fourth quarter 2016 data, prior to the November 2017 Hospice Compare refresh. For More Information:
  - Hospice Quality Public Reporting webpage
  - Preview Report Access Instructions

- **October 2017 Average Sales Price Files Available.** CMS posted the October 2017 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks on the 2017 ASP Drug Pricing Files webpage.

- **Quality Payment Program: New Resources Available.** CMS posted new and updated resources on the Quality Payment Program website:
  - Quality Performance Category Fact Sheet: Overview of the Quality performance category under the Merit-based Incentive Payment System, including how to submit performance data for the 2017 transition year
  - How to Design an APM Toolkit (updated): Comprehensive set of resources for organizations or individuals interested in developing ideas for Alternative Payment Models (APMs)
  - Quality Payment Program Key Objectives (updated): Summary of the seven strategic objectives for the Quality Payment Program

  Additional resources are available on the Resource Library webpage.

- **Transition to New Medicare Numbers and Cards.** CMS, through the Medicare Administrative Contractors (MACs), recently mailed letters to all Medicare Fee-For-Service providers about our work to assign new numbers (known as Medicare Beneficiary Identifiers or MBIs) and issue new Medicare cards to all people with Medicare beginning in April 2018. Our top priorities are to make sure:
  - Your Medicare patients have continuous access to care.
  - You have the tools and information you need for a smooth transition. Starting in June 2018, you can look up your patients’ new Medicare numbers through your MAC’s secure web portal.

  Carefully review the letter and accompanying fact sheet and find out how to prepare to accept the new number beginning in April 2018. Your letter will contain specific information for your MAC. You can also view a sample letter and print-friendly fact sheet.

  They also recently unveiled the new Medicare card design and issued a press release with more information about the project.

- **CMS Innovation Center New Direction RFI:** Submit Comments by November 20. On September 20, the CMS Innovation Center (Innovation Center) issued an informal Request for Information (RFI) seeking feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The Innovation Center welcomes stakeholder input. Submit comments online or to CMMI.NewDirection@cms.hhs.gov through November 20 at 11:59 pm ET. Visit the New Direction webpage for more information.

- **IMPACT Act Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the September 6 call on the Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act). During this call, CMS and measure developers present information on the Medicare Spending per Beneficiary Post-Acute Care resource use measures, focusing on the components of each measure, as well as public reporting.

• **Nursing Home Call: Audio Recording and Transcript — New.** An [audio recording](https://www.medicare.gov/MLN/MRN/MLN-301505.pdf), [transcript](https://www.medicare.gov/MLN/MRN/MLN-301506.pdf) and [clarification](https://www.medicare.gov/MLN/MRN/MLN-301507.pdf) are available for the September 7 call for nursing homes. 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.

• **SNF Consolidated Billing Web-Based Training Course — Reminder.** With Continuing Education Credit. The Skilled Nursing Facility (SNF) Consolidated Billing Web-Based Training (WBT) course is available through the [Learning Management System](https://www.medicare.gov/MLN/MRN/MLN-301508.pdf). Learn about:
  - Payment information for services provided in a Medicare-covered SNF stay, including most services provided by entities other than the SNF
  - Bundled prospective payments made through the Fiscal Intermediary or Medicare Administrative Contractor

• **Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised.** An MLN Matters Special Edition Article on [Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program](https://www.medicare.gov/MLN/MRN/MLN-301509.pdf) is available, including these revisions:
  - Upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing
  - Key ways to promote compliance with QMB billing rules
  - Types of providers that may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt

• **CMS has issued two Survey and Certification memos that clarify and support their expectations for compliance:**
  - **Fire Door Inspections:** Most recently issued was S&C 17-38-LSC “Fire and Smoke Door Annual Testing Requirements in Health Care Occupancies.” The adoption of the 2012 Life Safety Code® by CMS on July 5, 2016 originally meant that the required annual door inspections and testing would be expected by July 6, 2017. However, there was so much confusion and misunderstanding regarding this requirement that 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 now required by January 1, 2018. But don’t delay; if you haven’t completed the required fire door inspections, you should get started with a plan! Click here to view a summary outlining the issues and the requirements.

  - **Emergency Preparedness Basic Surveyor Training Online Course is now available to Providers:** Learn now what surveyors will be looking for! On September 1, 2017 CMS issued [S&C Memo 14-24-ALL](https://www.medicare.gov/MLN/MRN/MLN-301510.pdf) to all its State Survey Agency Directors, State Training Coordinators and Regional Office Training Administrators. This memo advised them of the following:
    - That the Emergency Preparedness Basic Surveyor Training online course, developed by the CMS Survey & Certification Group (SCG), is now available.
    - The State Survey Agency (SA) and Regional Office (RO) surveyors and reviewers, who conduct or review health and safety or LSC surveys for emergency preparedness requirements, are required to take this training by November 15, 2017, the implementation date of the new regulation.

CMS also wants providers to understand the purpose and process of survey and certification. The S&C process is a collaborative effort between CMS and providers to ensure that Medicare and Medicaid beneficiaries are receiving quality health care. Therefore providers can now access CMS-provided Web-based training, video webcasts and archived webinars on many topics, including the new Emergency Preparedness standards via the
Surveyor Training Website. We recommend our clients use this tool to be prepared for the upcoming survey. This is a long training program, but valuable for all 17 provider types. To access the training:

- Go to the Surveyor Training Website: [https://surveyortraining.cms.hhs.gov](https://surveyortraining.cms.hhs.gov)
- Select “I AM A PROVIDER”
- Select “Course Catalog”
- Type the course name in the “Search Courses” field, then type: "Emergency Preparedness Basic Surveyor Training"
- Select the “Launch the Course” button

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

- **Analysis Finds Significant Rise in Common Corporate Ownership Across Health Systems.** Cases in which the same corporate investors have ownership stakes in multiple U.S. health systems have nearly doubled since 2005, according to an AHRQ-funded study recently published in *Health Affairs*. The study appears to provide the first description of common investor ownership trends in health care. Researchers used data from the Centers for Medicare & Medicaid Services’ Provider Enrollment, Chain, and Ownership System to identify common investor ownership across acute care, post-acute care and hospice providers within the same geographic markets within the United States. They found that the percentage of acute care hospitals having common investor ties to the post-acute or hospice sectors increased from about 25 percent in 2005 to 49 percent in 2015. The authors suggested that these trends have important antitrust, regulatory and policy implications. This research was funded by AHRQ’s [Comparative Health System Performance Initiative](https://www.ahrq.gov), which studies how health care delivery systems promote evidence-based practices and patient-centered outcomes research in delivering care. Access the abstract.

- **AHRQ Releases First Public Database on Nation’s Health Systems.** Information about the size, structure and other characteristics of 626 health care organizations is included in AHRQ’s new [Compendium of U.S. Health Systems, 2016](https://www.ahrq.gov), the nation’s first publicly available database that gives researchers, policymakers and health care administrators a snapshot of the nation’s health systems. The online resource was developed by the agency’s Comparative Health System Performance (CHSP) Initiative, a [collaborative](https://www.ahrq.gov) to examine systems’ use of evidence-based medicine and explore factors that contribute to high performance. The new compendium defines systems as networks of at least one hospital connected via ownership to one or more groups of physicians. Hospitals in these health systems account for roughly 88 percent of U.S. hospital beds and 92 percent of U.S. hospital discharges. The compendium identifies system characteristics such as the number of hospitals, acute care beds and physicians, as well as whether a system serves children. For more information, access Deputy Director Sharon B. Arnold’s AHRQ Views [blog post](https://www.ahrq.gov), “With AHRQ’s New Compendium, Researchers and Policymakers Gain Fresh Insights into Nation’s Health Systems.”

- **AHRQ Releases Health Care Facility Design Safety Risk Assessment Toolkit.** A [safety risk assessment toolkit](https://www.ahrq.gov) from AHRQ can help designers ensure that new or renovated health care facilities support workflow, procedures and capability while keeping patients and staff safe from harm. The toolkit targets six areas of safety – infections, falls, medication errors, security, behavioral health and patient handling – as required by the [Facility Guidelines Institute](https://www.fgi.org). The toolkit addresses more than 200 potential environmental considerations for the built environment and provides a quality check tool for prioritizing risks within budget constraints.

- **AHRQ Report Highlights Agency Research on Health Information Technology.** An [annual report](https://www.ahrq.gov) from AHRQ showcases the agency’s 2016 research in the area of health information technology (IT). AHRQ’s health IT research focuses on easing provider burden from using health IT, understanding how patient-reported outcomes can be integrated into health IT to inform practice and research, and bringing evidence from patient-centered outcomes research to the point of care for use by doctors, nurses and other providers. AHRQ’s health IT research also explores new technologies such as natural language processing and artificial intelligence.
- **AHRQ-Funded Researchers Outline Methods to Reduce Urinary Tract Infections in Nursing Homes.** Improving hand hygiene, reducing and improving catheter use, managing incontinence without catheters and increasing use of gloves and gowns appear to reduce catheter-associated urinary tract infections (CAUTIs) in nursing home residents, according to AHRQ-funded research. An article recently published in *Journal of Hospital Medicine* reviewed strategies to reduce CAUTIs among nursing home residents and found that many of these strategies, often implemented in bundles, could reduce UTIs, CAUTIs and catheter use. The article’s authors were part of a larger team that helped develop AHRQ’s [Toolkit To Reduce CAUTI and Other HAIs in Long-Term Care Facilities](#). Access the [abstract](#).

- **New AHRQ Training Program Helps Hospital Leaders, Staff and Patients Prevent Falls.** A new AHRQ training program is available to help acute-care hospitals prevent patient falls, a leading cause of hospital-acquired conditions. AHRQ’s evidence-based [Fall Prevention in Hospitals Training Program](#) is designed for hospital quality improvement staff, patient safety officers and others who seek to reduce falls via a structured fall prevention initiative based on quality improvement principles. Data from 10 hospitals that used the program showed a 14 percent decrease in the average number of falls and a 20 percent decrease in falls with injury during the 1-year period post implementation. Reductions were significantly greater for rehabilitation and geriatric/psychiatric units. Access the [training program and implementation guide](#).

4) Recently Released or Updated ASPR TRACIE Resource include:

- [Tips for Retaining and Caring for Staff after a Disaster](#)
- [HIPAA and Disasters: What Emergency Professionals Need to Know](#)
- [ASPR TRACIE Website Tutorials](#)

ASPR TRACIE has developed a dedicated [CMS EP Rule landing page on our website](#) and the [ASPR TRACIE CMS EP Rule: Resources at Your Fingertips](#), which includes key planning considerations and links to relevant additional resources.

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

- **08/31/17 Public Notice - Clarification ID/DD Facility Rates - Wage Increase.**

- HFS has posted a new provider notice regarding [Reimbursement Rate Increase Effective July 01, 2017](#). You may view the notice [here](#).

- HFS posted a new provider notice regarding [Wage Rate Increase Effective August 1, 2017 for Specified Personnel Serving Individuals with Developmental Disabilities in Institutional and Community-Based Settings](#). You may view the notice [here](#).

- HFS posted a new provider notice regarding the [Fiscal Year 2018 Provider Assessment Program](#). You may view the notice [here](#).

- HFS posted a new provider notice regarding [Fiscal Year 2018 Long Term Care Provider Assessment](#). You may view the notice [here](#).

- HFS posted a new provider notice regarding [Due Date for Payment of the Quarterly Licensed Bed Assessment](#). You may view the notice [here](#).

- HFS posted a new provider notice about [Information Regarding the Implementation of the Personal Needs Allowance (PNA) Increase Effective July 1, 2017](#). You may view the notice [here](#).
HFS posted a new provider notice regarding **Utilization Review Update Effective October 1, 2017.** You may view the notice [here](#).

**HCBS Waiver for persons with HIV or AIDS**

**Proposed Payment Rate Change**

HFS posted a new provider notice regarding **Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures – Reissue.** You may view the notice [here](#).

**Public Notice - HCBS Waiver for Persons who are Elderly**

The new **LTC Reimbursement rates for October** have been posted to the HFS LTC [website](#).

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.
  - October 24, 1-3 PM | Knox County Nursing Home I 800 North Market Street, Knoxville, IL
  - 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:**

- **AHCA Offers a New Emergency & Disaster Preparedness Kit.** The new kit includes three main components:
  - Online Emergency Document Storage and Portal. This service makes it easy and fast to organize, store, and have online/offline emergency access to "must have" documents, such as emergency contact lists, evacuation and resident relocation plans, emergency staffing plans, valve shut-off instructions, etc.
  - Step-by-Step Video. A 26-minute video that provides an excellent overview of CMS’ new emergency preparedness requirements, including their background and context, the timeline for compliance, and the elements every emergency planning effort must include.
  - Emergency Preparedness Checklist. A 28-page companion that will give your emergency prep coordinator an easy-to-follow, 15-step framework to help shape and guide an effective compliance program.

  The cost is $179 per location for a 12-month prepaid subscription. Order at [www.AHCApublications.org](http://www.AHCApublications.org) or call 800-321-0343

- **Check Out Your Quarter 3 Top-Line Publication.** On **September 13**, you should have received in your email inbox the latest **Your Top-Line** publication, produced by **LTC Trend Tracker**. The report will be sent with the subject line **LTC Trend Tracker Quarter 3 Publication**. This resource highlights metrics and graphics outlining your facility's progress on **Five-Star** performance, the **AHCA/NCAL Quality Initiative**, and other necessary data to help you achieve your desired goals. The 2017 Quarter 3 edition of Your Top-Line publication will also include each facility's current **Quality Award** status, and information regarding the eligibility criteria for all levels of the Quality Award Journey.

- **Announcing the 2018 Quality Initiative Recognition Program.** The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) is pleased to announce the relaunch of the **Quality Initiative Recognition Program** to honor skilled nursing and assisted living members for their individual work in achieving the goals of the AHCA/NCAL Quality Initiative. All achievers will be recognized at the AHCA/NCAL **Quality Summit** in New Orleans, March 12-14, 2018.
• **Recording of Webinar: Preparing for the New Survey Process and Requirements of Participation Phase 2 is ready.** The archived recording of Preparing for the New Survey Process and Requirements of Participation Phase 2 is now ready for you to view at your convenience.

2. Once the page opens, click on the "**View Archived Recording**" button on the right hand side of the page. The presentation will open in a new window for you to view and hear the program.
3. Click on the Handout tab to download your copy of the handouts and other available materials.

For questions or support, please email ahca@commpartners.com.

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

9) Kaiser **Surveys Section 1115 Pending and Approved Waivers.** If someone asked you about a state's Medicaid waiver, could you answer? Well, now you can, thanks to the Kaiser Family Foundation's recent survey of Section 1115 waivers. Even if you're not sure what an 1115 waiver does, Kaiser has you covered. See the [survey](https://www.telligenqinqio.com/).

10) **Springer** reports on **Is Compromised Oral Health Associated With a Greater Risk of Mortality Among Nursing Home Residents?** The objective of this controlled clinical study was to evaluate the association between oral health and 1-year mortality among nursing home residents with or without oral health intervention.

11) **MedicalXpress** reports that **Older Adults Who Are Frail More Likely to Have Negative Outcomes After Trauma.** Frailty is associated with negative outcomes among older patients who suffered trauma, a new study has found. More so than age, other health issues or the severity of the injury, pre-admission frailty is associated with in-hospital death and transfer to another acute-care hospital or to a long term care facility, according to the study published today in the *Journal of the American College of Surgeons.* "Older trauma patients, in general, have worse outcomes than younger patients, with higher mortality, higher complication rates, longer hospital stays, and an increased likelihood of being transferred to a long-term care facility," said Dr. Camilla Wong, a geriatrician at St. Michael's Hospital and senior author on the paper. "Worse outcomes in this population cannot solely be explained by their advanced age. We found that the increased vulnerability to negative outcomes among older trauma patients is likely due in large part to frailty."

12) **ScienceDaily** reports on **New Treatment for Osteoporosis Provides Better Protection Against Fractures.** A new treatment for osteoporosis provides major improvements in bone density and more effective protection against fractures than the current standard treatment. These are the findings of a study published in the New England Journal of Medicine (NEJM). The study is the first that compares the effect of two osteoporosis medicines on fractures. "With the new treatment, we could offer significantly better protection against fractures and could thereby help many patients with severe osteoporosis," says co-author of the study Mattias Lorentzon, Professor of Geriatrics at the Institute of Medicine, Sahlgrenska Academy, and Senior Physician at Sahlgrenska University Hospital.

13) **HealthinAging** reports on **Talking to Older Adults About Health Prognosis May Be Helpful.** Prognosis is the term for the most likely outcome of a medical condition. When it comes to health care, talking about your prognosis can be difficult for you, your family/friends, and even your health care providers. However, many of us prefer to talk to our health care providers about the expected course of an illness and about our life expectancy when living with a chronic or terminal illness. This is according to new research on advanced care planning (the technical term for having early conversations with our healthcare providers about our care needs, preferences, and expectations). In a new study published in the *Journal of the American Geriatrics Society,* researchers examined how older adults with disabilities later in life might react to learning their prognosis, and how they evaluated their own prognosis compared to “official” estimates.

14) **HealthLine** reports that **Asthma in Older Adults Is Often Misdiagnosed and Undertreated.** Asthma can strike people of any age. But when it happens at an advanced age, the ailment can be severe and relentless. Elderly asthmatics are more likely to be underdiagnosed and undertreated and at a higher risk for mortality. These are some of the findings in a
recent study on the effects of asthma on older adults conducted at National Jewish Health (NJH) in Colorado. “Asthma has been underdiagnosed in older people because some people with asthma were told they had COPD [chronic obstructive pulmonary disease],” he told Healthline. “The general population is getting older and, as it ages, asthma is still with them. Also, it’s a combination of better diagnosis and the aging of younger people who have asthma. Most people think of asthma as a young person’s disease, so they don’t think of shortness of breath as asthma.”

15) The AP reports:

- **Demand for Caregivers Rising as Number of Caregivers Has Dwindled.** The AP reported on the shortage of caregivers in nursing homes in Minnesota and nationally, as an estimated 60,000 Minnesotans will turn 65 each year until the year 2030. Vacancy rates for registered nurses in the state reached 17.4 percent, while the rate for licensed practical nurses rose to 21.1 percent, and nursing assistants to 19.9 percent, even though state legislators passed legislation changing how nursing homes were reimbursed so that average wages would increase. The piece added that another element is the fact that more and more people want care in their homes, leading to an explosion in demand for home health aides.

- **Long Term Care Costs Rose by 4.5 Percent This Year.** The AP reports that the median cost of long term care rose by "an average of 4.5 percent this year," according to a new Genworth Financial survey. The AP says it is "the second-highest increase since Genworth started its survey in 2004." Genworth researchers attribute the increase to rising labor costs and longer-living patients with greater medical needs and expect the trend to continue. The article adds that Joe Caldwell of the National Council on Aging, which is not affiliated with the study, said "there is this aging baby-boom population that's going to be really hit hard in the coming decade" because many Americans fail to plan for long-term care and don’t understand Medicare’s limits.

16) **Reuters** reports that **For Nursing Home Residents, Mobility Increases Risk of Fracture.** Reuters reports a new study published in The Journals of Gerontology: Series A found that for nursing home residents, "risk factors for fracture included the ability to walk independently, wandering the halls, dementia and diabetes." The study was based on data from "419,668 nursing home residents, including 14,553 who experienced hip fractures." Lead author Dr. Sarah Berry of the Institute for Aging Research and Harvard Medical School in Boston said, "Frail nursing home residents that are still mobile and independent have opportunity to fall."

17) The **Washington Post** reports on **Analysis: Nurses Have One of America’s Most Dangerous Jobs.** The Washington Post featured an article about the viral video of Salt Lake City nurse Alex Wubbels "getting roughed up" by a detective is "business as usual" for nurses who are "routinely yelled at, spat at, pummeled, kicked, scratched and even stabbed by the people they're trying to save." A Government Accountability Office report from last year showed that the rates of workplace violence in health care and social assistance settings are five to 12 times higher than the estimated rates for workers overall. The article discusses several recent incidents where nurses were pushed down a flight of stairs, stabbed multiple times, or taken hostage and beaten and assaulted. The piece states that there are "no broad, federal standards" for health care workplace policies with respect to violence against nurses, but there are at least 26 states with "workplace safety standards for health-care facilities approved by OSHA."

18) The **Wall Street Journal** reports that **Loneliness can be Hazardous to Health.** The Wall Street Journal reports that medical experts are calling for a public health campaign to address loneliness and social isolation based on research showing they can lead to an early death. The article examines some senior living facilities’ programs to address social isolation, including setting up child care services, adopting co-housing where homes are near each other surrounding a common shared space, hotlines, and intergenerational social activities.

19) **Medscape** reports that **Hospitals Impacted by Factors That “Significantly” Increase 30-Day Readmission Rates.** Medscape reports researchers wrote in an article in the September 14 issue of the New England Journal of Medicine about factors that can "significantly" contribute to hospitals’ 30-day readmission rates. The two-part study drew from the Centers for Medicare & Medicaid Services hospital-wide 30-day readmission measures cohort, and found among random samples of 3,455,171 discharges and 2,741,289 patients at 4738 hospitals that the overall "mean risk-standardized readmission rate was 15.6 percent." For the second group of "37,508 patients who had two or more
admissions for similar diagnoses within a year and who were treated at more than one of the 4272 hospitals," the readmission rate among the worst-performing quartile of hospitals compared with the best-performing quartile was "significantly higher": 25.1 percent versus 23.1 percent. Study authors say they received support from CMS and the FDA.

20) Supply Chain 24/7 reports that Number of Knee Replacements to Increase by 400% by 2030. Supply Chain 24/7 reports that an American Academy of Orthopaedic Surgeons study "found more than 600,000 knee replacements are performed each year in the United States," and that number will rise to three million by 2030, "an increase of 400 percent." The US "is not alone in this dramatic surge in full knee replacements" – the global market for knee devices "was valued at $8.8 billion during 2015 and is projected to grow at an annual rate of 4 percent. United States manufacturers dominate the market, according to Kalorama Information, with the three industry leaders – Zimmer Biomet, DuPuy Synthes (part of the Johnson & Johnson family of companies), and Stryker – accounting for 75 percent of global market share."

21) The Pittsburgh Tribune Review reports that a Study Suggests High-Dose Flu Vaccine Used by Elderly Could Benefit Adults With Chronic Conditions. The Pittsburgh Tribune-Review reports on a study published online in the journal Vaccine that found that the high-dose flu vaccine favored as a treatment for the elderly may also be helpful for persons aged 50 to 64 with chronic illnesses such as heart disease, as their conditions place them at a greater risk for a serious flu infection. Lead author Jonathan Raviotta said in a statement, "The growing proportion of middle-aged adults with chronic health conditions coupled with the modest effectiveness of the standard-dose influenza vaccine prompted us to explore whether existing vaccines already recommended for the elderly also could protect younger people. ... Sure enough, expanding the recommendation does seem like a good policy. ... Before making such a recommendation, real world clinical trials are needed."

22) U.S. News & World Report reports Voice-Command Devices Can Help Seniors Age in Place, Prevent Loneliness. U.S. News & World Report examines how "new and emerging technologies," such as "voice-command devices like the Amazon Echo," can help older adults age in place and "allow seniors to stay in touch with loved ones, access transportation more readily, keep up with appointments and diminish the hazards of falls." Describing some new "senior-friendly tech" developments, U.S. News notes the AARP Foundation "has distributed 100 Amazon Echo devices to older adults living in senior housing communities in Baltimore and the District of Columbia" as part of "a pilot program to explore how hands-free, voice-controlled technology might help reduce or delay isolation – and its negative impact on health – among adults over 60." The article cites Emily Allen, senior vice president of programs with the AARP Foundation, as saying: "We see older adults are eager to learn and use new technologies but need additional support at the onset in order to build confidence and troubleshoot problems as they arise. For many, voice-controlled technology is providing them their first experience in using the internet and is giving them open access to information that is less intimidating than using a computer or smartphone."

23) Provider Nation reports that Medical Orders for End-Of-Life Intervention Could Improve Upon Current POLST Paradigm. Provider Nation reports the Medical Orders for End-of-Life Intervention (MOELI) plan offers a "new model" for the existing Physician’s Orders for Life-Sustaining Treatment (POLST) "because it allows for more flexibility and [is]...a more effective way to document and communicate patient wishes in institutional and community settings, according to" the University of Washington in Seattle’s Richard Stuart. He authored an editorial in the September issue of JAMDA that explained how MOELI improves upon the POLST Paradigm and encouraged collaboration between POLST organizations to implement the new model.

24) Pharmacy Times reports that Supplement Use Among Older Americans Very High. Dietary supplement use among Americans who are 60 and or older is widespread, according to a study conducted by researchers from the National Institutes of Health, Purdue University, and Tufts University. The researchers undertook this study to determine how older adults use dietary supplements. Although dietary supplements may address undernutrition in older adults, they may be associated with other potentially dangerous outcomes, they noted. Areas of concern include supplementation with nutrients that are already fortified in the American food supply, drug interactions, and adverse reactions. Overall, the results determined that 70% of older Americans use 1 or more dietary supplements. This is a slight increase from data reported between 1999 and 2000. Women were almost twice as likely to take supplements as men.
25) **ModernHealthcare** reports:

- **CMS Expects Few Hospitals to Participate in Readmissions Pilot.** *ModernHealthcare* reports that the Centers for Medicare and Medicaid Services expects no more than 100 of the 3,000 hospitals receiving Medicare payments will participate in its pilot program to "track unplanned readmissions and their causes." The pilot is a "precursor for a mandatory change in how hospitals are penalized" for readmissions that is expected to be applied in 2021. Observers speculated that hospitals may be "overwhelmed" by the quality data that they are already required to report and may not be interested in voluntarily reporting additional measures.

- **CMS' Proposed Home Health Payment Model Alarms Providers.** *ModernHealthcare* reported that CMS’ proposed "home health groupings model" would base Medicare payment based on patient characteristics rather than the number of visits for various services. CMS administrator Seema Verma explained, "We’re redesigning the payment system to be more responsive to patients’ needs and to improve outcomes." The changes "would boost payment for skilled-nursing and home health aide visits for medically complex patients." Critics point out that CMS’ projections show that the new model would "result in a home health spending cut of $950 million, or 4.3 percent, in 2019, when it would take effect." Public comments on the proposed rule are due by September 25.

26) **HealthDay** reports:

- **U.S. Seniors Getting Healthier, Especially When Wealthy and White.** American seniors are getting healthier overall, but the well-educated, rich and white are seeing the greatest gains, a new study finds. Researchers reviewed federal government data on more than 55,000 older adults. They found that between 2000 and 2014, there was a 14 percent increase in the rate of those who reported good health. However, those with graduate degrees had the most improvement -- 56 more healthy people per thousand -- while the rate remained flat among those with only a high school diploma. Rich seniors had the best rate of good health throughout the study period, with the rate increasing from 490 per 1,000 to 603 per 1,000. Overall, 52 percent of older adults with good health had high incomes. Just 31 percent of those with poor health had high incomes.

- **Most Seniors Never Receive EOL Hospice Care, Or They Wait Until Last Few Weeks of Life.** *HealthDay* reports that research suggests "most seniors never receive end-of-life hospice care – or they delay doing so until their last few weeks of life." Investigators found that "in the final year before dying (at an average age of 87), just 43 percent of” study "participants had availed themselves of hospice care." Moreover, most participants "only initiated hospice shortly before they died, with the total duration of hospice care averaging less than 13 days." The findings were published in the *Journal of the American Geriatrics Society*.

- **Nursing Home Assistants Often Fail to Change Gloves.** *HealthDay* reports that certified nursing assistants (CNAs) frequently "fail to change their gloves when they should," resulting in a greater "risk of patient infections," according to a new study. The article says the CNAs "wore gloves for 80 percent of touches"; however, they "failed to change gloves at 66 percent of glove change points" and "more than 44 percent of the gloved touches were contaminated." Linda Greene, president of the Association for Professionals in Infection Control and Epidemiology (APIC), said proper glove use is "especially important in long term care, where residents are more vulnerable to infection and stay for extended periods."

27) **MedlinePlus** reports:

- **Is Dementia Declining Among Older Americans?** Here’s some good news for America’s seniors: The rates of Alzheimer’s and other forms of dementia have dropped significantly over the last decade or so, a new study shows. The analysis of nearly 1,400 men and women 70 and older found that the number of dementia cases dropped from 73 among those born before 1920 to just 3 among those born after 1929. The reasons for the decline aren’t clear, researchers said. But one factor stands out: The rates of stroke and heart attack decreased across generations. The rate of diabetes, however, has increased.
Uptick in U.S. Stroke Deaths Sets off Alarms. Progress in preventing stroke deaths in the United States has stalled after 40 years of decline, and may even be reversing, government health officials say. Stroke deaths increased significantly among Hispanics and in the South between 2013 and 2015, the U.S. Centers for Disease Control and Prevention reported recently. "This report is a wake-up call because 80 percent of strokes are preventable," said lead author Quanhe Yang, a CDC research scientist. "More than ever, we need to direct our efforts to reduce stroke risk factors and improve the quality of care," he said. According to prior research, high blood pressure is the most important preventable and treatable risk factor for stroke. But high cholesterol, smoking and physical inactivity play a role, too.

Which Single Behavior Best Prevents High Blood Pressure? You probably already know that certain healthy lifestyle behaviors can reduce your risk of developing high blood pressure, but is any one behavior more important than the others? Maybe, as new research suggests maintaining a healthy weight is the No. 1 behavior to prevent unhealthy blood pressure levels. "Our results indicate by maintaining a healthy body weight into middle age, you can help preserve low blood pressure," said the study's lead author, John Booth III. He's a postdoctoral fellow at the University of Alabama at Birmingham. "There have been increases in blood pressure at younger ages, which are linked to heart disease and stroke," Booth said. "We evaluated the long-term impact of maintaining healthy behaviors on [high blood pressure]."

Stopping Aspirin Tied to Quick Rise in Heart Attack, Stroke Risk. People who stop following their doctor's advice to take a daily aspirin may see their risk of heart attack and stroke quickly rise, a new study suggests. Low-dose aspirin is a standard therapy for people at increased risk of a heart attack or stroke. But many eventually stop taking it, or at least consider quitting, said Dr. Johan Sundstrom, the lead researcher on the new study.

28) Interesting Fact: October is associated with autumn or fall. It ends on the same day of the week as February every year and January in common years only. On the last week of October, it is the only time of the entire year when all four major American sports have games at the same time: the MLB, NHL, NFL and NBA.