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!

**Antibiotic Stewardship Guidance**

Part of the new Requirements of Participation (effective November 28, 2017) relate to a facility’s Infection Prevention and Control Program, which includes antibiotic use protocols for monitoring antibiotic use. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections and reduce adverse events with a goal of slowing the emergence of resistant bacteria and preventing the spread of resistant infections.

The Centers for Disease Control and Prevention (CDC) has found that antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70 percent of nursing home residents receiving at least one course of antibiotics per year. In addition:

- In nursing homes, approximately 20 percent of health care providers account for 80 percent of antibiotics prescribed.
- Forty percent to 75 percent of antibiotics prescribed in nursing homes may be unnecessary or inappropriate.
- Antibiotic resistance is associated with two million resistant infections, 23,000 deaths and $20 billion in costs annually.

The CDC has developed Core Elements of Antibiotic Stewardship for Nursing Homes to serve as a guide for progressively implementing such a program in a skilled nursing facility. Furthermore, CMS has referenced the Core Elements in the most recent revisions to the guidance section of the State Operations Manual.

The core elements of antibiotic stewardship for nursing homes are:

1. **Leadership Commitment**: Dedicating necessary human, financial and information technology resources responsible for program outcomes
2. **Accountability**: Appointing a single leader (successful programs show that a physician leader is effective) responsible for program outcomes
3. **Drug Expertise**: Appointing a single pharmacist leader responsible for working to improve antibiotic use
4. **Action**: Implementing at least one recommended action, such as systemic evaluation of ongoing treatment need after a set period of initial treatment (e.g. “antibiotic time out” after 48 hours)
5. **Tracking**: Monitoring antibiotic prescribing and resistance patterns
6. **Reporting**: Regularly reporting information on antibiotic use and resistance to doctors, nurses and relevant staff
7. **Education**: Educating clinicians about resistance and optimal prescribing

Nursing home regulations by CMS have included requirements to review and monitor antibiotic use (previous F-tags 441, 329, and 428, along with future F-Tags 880, 757, and 756). F-Tag 881 has been assigned to the Antibiotic
Stewardship Program with recent updates to the State Operations Manual, effective November 28, 2017. Utilizing the survey pathway for Tag F-881, surveyors will be assessing antibiotic stewardship programs for:

- Written antibiotic use protocols
- Protocols to review clinical signs, symptoms and laboratory reports
- A process for periodic review of antibiotic use by prescribers
- Protocols to optimize the treatment of infections
- A system for provision of feedback on antibiotic use, outcomes and prescribing practices

These elements, while broad, offer the opportunity to design a program to meet the regulatory needs of the Final Rule while taking into account the resources available at your facility. Remember, there is no one way to implement an Antibiotic Stewardship Program; the program will be specific to each facility.

Most Antibiotic Stewardship Programs will start small and grow in a step-wise fashion as further policies, procedures and interventions are implemented.

One of the easiest and most effective first steps to take when developing your program is to implement an antibiotic prescribing policy. Ideally, this policy would outline the decision-making process that your facility's prescribers would follow prior to writing an order for an antibiotic and delineate the documentation required, such as rationale, indication, dosage, duration, etc. Standardized documentation and communication templates, if available, can also be utilized to promote adherence to your antibiotic prescribing policy amongst both nursing staff and prescribers.

This policy could also incorporate the use of facility-specific resident assessment, diagnostic testing and infection-specific treatment algorithms while serving the dual purpose of also optimizing the treatment of infections, another component surveyors will be assessing. The algorithms can be developed from national guidelines published by well-known infectious disease organizations such as the IDSA and SHEA but further refined by applying an antibiotic resistance tool known as an antibiogram.

An antibiogram is a summary of culture and sensitivity reports for a specific region, facility or other locality. Its primary purpose is to aid clinicians in selecting appropriate initial empiric antibiotic therapy based upon local bacterial resistance patterns while culture and sensitivity results are pending. They can often be obtained from your laboratory provider or a local hospital and are commonly updated on a biannual basis.

Assistance with this article from Sonja Quale at Pharmerica.

Emergency Communication Plan
For nursing homes and other institutional long-term care facilities, severe weather events such as the devastating tornadoes and flooding test even the most robust emergency communications plans. And while long-term healthcare providers have dedicated significant resources to preparing for external emergency events, CMS was less confident the healthcare industry was prepared if a disaster or emergency happened directly to them.

Driven by that concern, CMS put the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers rule into effect November 16th, 2016. Affected healthcare providers and suppliers were given one year to comply and implement all regulations. The CMS rule, enforceable as of November 15th, 2017, establishes a consistent framework that mandates incorporation of best practices and lessons learned in emergency preparedness.

Medicare and Medicaid participating providers and suppliers must evaluate their compliance posture for the four core elements of an Effective Emergency Preparedness Framework: 1) Emergency plan, 2) Policies and procedures, 3) Communications plan; and 4) Training and testing program.
Each is critical, but for purposes of this article we will focus on developing and maintaining a communication plan that complies with both federal and state law. Below are five strategies to improve your organization’s emergency communications plan:

1. Establish easily activated communication channels for reaching others both on and off-site. During widespread emergencies, communication becomes a serious challenge very quickly. Cellular signals, email servers, and traditional phone lines can fail. However, it’s critical that your communication plan includes processes that would allow for communication with staff, care providers, families, and others who may or may not have alternative forms of technology such as HAM and satellite systems. This is why it is critical to expand beyond the traditional means of sharing information among both your internal and external constituents. Your Emergency Mass Notification System (EMNS) platform should be multimodal, meaning that all messages can be sent in multiple ways through the platform. It should also support one message being sent out as a phone call (to cell phones or landlines), SMS text message, email message, desktop alert, app notification, RSS feed, and pager.

2. Follow ‘Chain of Command’ protocol for the order in which alerts are sent. It’s instinctive to know that local emergency response teams should be contacted and summoned before patient’s families are notified of a situation, but it’s much harder to execute, especially in urgent, chaotic situations. The best way to overcome it? Plan in advance and automate the process. The contact information for those you need to reach in a crisis (internal and external) should be kept securely within your mass notification system account, or should be able to be linked to an existing database for continuous updating. This provides the ability to create groups of contacts either in advance or on-the-fly (by using filters).

3. Your contingency plan should establish backup resources. Plans should be aligned to your current vulnerability threat risk assessment. Backup resources should be established across everything from power to medical supplies to food and water reserves. Additionally, patient care must be well coordinated across healthcare providers, and with state and local public health departments and emergency systems. EMNS platforms can allow for your messages and contacts can be hosted on secure servers which are redundant and backed up regularly, ensuring that your data is safe and secure. Other things to consider include the ability to send alerts to all devices simultaneously; receive responses back and track results and mobilize emergency personnel or other staff instantly to respond to urgent or unexpected situations.

4. Maintain coordination with other healthcare facilities. The CMS has maintained the critical importance of coordination with other healthcare facilities and public health officials. Coordination among healthcare facilities in a large-scale crisis is of utmost concern for patient safety and continuance of care.

   Your healthcare alliance, whether it is formal or informal, can communicate swiftly and easily through your mass notification service. Text messages can be used for urgent messages, phone calls for urgent messages that include instructions, and email for longer messages and sharing documents (attachments). All of this can be done through the service, all at one time.

5. Account for constituents in a crisis and evacuation. Many healthcare providers dedicate a great deal of their emergency planning efforts towards accounting for constituents during a crisis or evacuation. Every situation is different, but here are a few key steps that are critical to include in your plan:

   - Break down the facility and staff into manageable groups.
   - Determine coordinators and leaders.
   - Identify locations and evacuation points.
   - Compile employee lists.
   - Make coordinators/leaders easily identifiable.
   - See OSHA's workbook on accountability in a crisis for additional tips and details.
A sound emergency communications plan helps not only ensure compliance with the CMS rule, but also protects your people and property.

Assistance with this article from Ann Pickren.

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### Illinois Quality Measures Compared to Achievable Benchmarks

The NHQR quality measures are compared to achievable benchmarks, which are derived from the top-performing States. Better performance of a State can mean higher or lower values of a measure, depending on the desired outcome. For example, low values are desirable for measures such as infant mortality, whereas high values are desirable for measures such as preventative screening. The categories of achievement have been standardized across the measure definitions so that:

- **Orange: Far away from benchmark** - a state's value for a measure has not achieved 50% of the benchmark.
- **Blue: Close to benchmark** - a state's value for a measure is between 50% and 90% of a benchmark (i.e., worse than the benchmark but has achieved at least half of the benchmark but not as much as 90% of a benchmark).
- **Green: Achieved benchmark or better** - a state's value for a measure is no worse than 90% of the benchmark value, the measure has achieved the benchmark. This category also includes the case in which the measure’s value is equal to or better than the benchmark.

### All Measures

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- Benchmarks are available for 144 measures including 37 measures that are far away from the benchmark, 55 measures that are close to the benchmark, and 52 measures that achieved the benchmark or better.
- Benchmarks are unavailable for 20 measures (12 percent of all possible measures).

Review underlying data

The National Healthcare Disparities Report (NHDR) focuses on “prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations” (42 U.S.C. 299a-1(a)(6)). Therefore, data summaries are provided below to facilitate comparison of these factors. Links to summaries of all individual quality measures are available in the National View banner above.

### Measures by Race and Ethnicity

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• **Benchmarks for Whites** are available for 82 measures including **19 measures that are far away from the benchmark**, **39 measures that are close to the benchmark**, and **24 measures that achieved the benchmark or better**.

• **Benchmarks for Blacks** are available for 78 measures including **36 measures that are far away from the benchmark**, **25 measures that are close to the benchmark**, and **17 measures that achieved the benchmark or better**.

• **Benchmarks for Hispanics** are available for 65 measures including **18 measures that are far away from the benchmark**, **25 measures that are close to the benchmark**, and **22 measures that achieved the benchmark or better**.

• **Benchmarks for Native Hawaiian or Other Pacific Islanders** are available for 28 measures including **4 measures that are far away from the benchmark**, **13 measures that are close to the benchmark**, and **11 measures that achieved the benchmark or better**.

### Measures by Community Income

• **Benchmarks for People with Low Incomes** are available for 23 measures including **13 measures that are far away from the benchmark**, **6 measures that are close to the benchmark**, and **4 measures that achieved the benchmark or better**.

• **Benchmarks for People with High Incomes** are available for 23 measures including **3 measures that are far away from the benchmark**, **11 measures that are close to the benchmark**, and **9 measures that achieved the benchmark or better**.

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

1) No new federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat.

2) Federal HHS/CMS released the following notices/announcements:
CMS Comprehensive Care for Joint Replacement (CJR) Change. CMS announced last week that they had finalized the cancellation of the mandatory hip fracture and cardiac bundled payment models that were to be operated by the CMS Innovation Center and implemented changes to the Comprehensive Care for Joint Replacement (CJR) Model. These changes will offer greater flexibility and choice for hospitals in providing care to Medicare patients. The final rule is available online here. There are several parts of the final rule that are especially pertinent.

- This final rule cancels the most recent mandatory bundling program. This is the program that would have added two cardiac episodes to mandatory bundling and gave hospitals the bundle. CMS had previously delayed this program until January 1, 2018 and has now eliminated it.
- The final rule also makes major changes to the initial mandatory bundle, the Comprehensive Care for Joint Replacement (CJR). Specifically, the rule reduces the number of Metropolitan Statistical Areas (MSAs) included in the demonstration from 67 to 34. Low-volume and rural hospitals also will not be required to participate. For the 33 that MSAs that are eliminated, bundling can continue but only on a voluntary basis. A complete list of the MSAs that are included is online here.
- CMS states that it expects to roll out additional opportunities for providers to participate in voluntary initiatives instead of mandatory bundled payment models.
- In addition to the final rule, CMS issued an interim final rule with a comment period establishing and seeking comment on a policy to provide flexibility in determining episode costs for providers located in areas impacted by extreme and uncontrollable circumstances, such as the hurricanes that occurred earlier this year.

Click here to read the notice. Click here for more on the changes to the final rule and here for information on the Comprehensive Care for Joint Replacement Model.

CMS Quality Measure Proposal. Typically, CMS proposes a full list of Medicare quality measures. Last week they unveiled their proposal and it only had one (1) addition for long term care. CMS' list of measures was pared way. There is a single measure under the Skilled Nursing Facility Quality Reporting Program: the American Health Care Association's CoreQ measure for short-stay discharges. The measure includes a discharge questionnaire, and would calculate the percentage of residents discharged within 100 days of nursing home admission who were satisfied with their care. The discharge questionnaire covers four questions regarding how the resident would recommend the facility to family and friends, how they would rate the staff, how they would rate the care and how well they perceived their discharge needs to be met.

Hospice Compare Search Function Alert. CMS is aware that the location search on Hospice Compare may return incorrect results. As a result, they have provided a message on the home page of Hospice Compare informing users that when searching by location, the list of agencies provided may not serve the zip code, city or state they entered. The message also recommends that consumers call hospice providers to confirm their service areas. CMS is currently working to improve the search functionality and will update the website as soon as possible. Please continue to monitor the Hospice Quality Public Reporting webpage for updates.

Hospice Provider Preview Reports Now Available. Hospice provider preview reports and Hospice Consumer Assessment of Healthcare Providers and Systems CAHPS® Survey ® provider preview reports are now available. These are two separate reports available in your Certification and Survey Provider Enhanced Reports (CASPER) folder. Hospice providers are encouraged to review their Hospice Item Set (HIS) quality measure results from Quarter 2- 2016 to Quarter 1-2017 and their facility-level CAHPS® survey results from Quarter 2, 2015 to Quarter 1, 2017. Providers have 30-days to review their HIS and CAHPS® results (December 1, 2017 through December 30, 2017). Should a provider believe the denominator or other HIS quality metric to be inaccurate or if there are errors within the results from the CAHPS® Survey data, a provider may request CMS review. Providers must adhere to the process outlined on the HQRP Public Reporting webpage and the Hospice Quality Public Reporting- CAHPS® Preview Reports and Requests for CMS Review of CAHPS® Data webpage. For more...
information on how to access these reports, view the [HIS Preview Report Access Instructions](#) and the [Hospice CAHPS® Provider Preview Reports Access Instructions](#).

- **Updated Medicare Part D Opioid Drug Mapping Tool.** On November 29, CMS released an updated version of the [Medicare Part D Opioid Prescribing Mapping Tool](#), an interactive, web-based resource that presents geographic comparisons of Medicare Part D opioid prescribing rates:
  - Includes extended-release opioid prescribing rates and county-level hot spots and outliers, which may identify areas that warrant attention
  - Presents Medicare Part D opioid prescribing rates for 2015 as well as the change in opioid prescribing rates from 2013 to 2015

The mapping tool offers local communities greater transparency into opioid prescribing in the Medicare Part D program. Communities can use this resource to understand how this critical issue affects their area, examine regional variation, and make informed decisions about how to allocate resources. The underlying data that feeds this tool is also used by CMS to monitor and manage high risk use of opioids in the Part D program. Prescription opioids can be prescribed by doctors to treat moderate to severe pain, however, they also can have serious risks including addiction and overdose. The majority of drug overdose deaths involve opioids, and since 1999, the number of overdose deaths involving prescription opioids has quadrupled. In 2015, more than 15,000 people died from overdoses involving prescription opioids. See the full text of this excerpted [Press Release](#) (issued November 29).

- **Quality and Cost Measures under Consideration: CMS Releases List for 2018 Pre-rulemaking.** CMS posted the [Measures under Consideration List](#) on the [Pre-Rule Making](#) webpage. Each year, CMS publishes a list of quality and cost measures that are under consideration for Medicare quality reporting and value-based purchasing programs and collaborates with the National Quality Forum (NQF) to get critical input from multiple stakeholders on the measures that are best suited for these programs. CMS is taking a new approach to coordinated implementation of meaningful quality measures focused on the most critical, highly impactful areas for improvement while reducing the burden of quality reporting on all providers so they can spend more time with their patients. For more information on public stakeholder review, visit the [NQF](#) website. See the full text of this excerpted [CMS Blog](#) (issued November 30).

- **Quality Payment Program Hardship Exception Application Deadline: December 31.** The deadline to submit a Quality Payment Program [Hardship Exception Application](#) for the 2017 transition year is December 31. Merit-based Incentive Payment System eligible clinicians and groups may submit a hardship exception application for one of the following reasons:
  - Insufficient internet connectivity
  - Extreme and uncontrollable circumstances
  - Lack of control over the availability of Certified Electronic Health Record Technology

For More Information:
- [About Hardship Exceptions](#) webpage
- [Quality Payment Program](#) website

For questions, contact the Quality Payment Program Service Center at [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 866-288-8292 (TTY: 877-715-6222)

- **Medical Record Documentation: Helpful Clinical Templates and Data Elements.** Clinical templates and suggested Clinical Data Elements (CDEs) are available to assist you with data collection and medical record documentation:
  - **IT vendors:** Integrate the CDEs into Electronic Health Record (EHR) systems to remind providers what they need to document
  - **Providers:** If you are not using an EHR, you can print a template, fill it out, and file it in the patient’s medical record
Find Clinical Template and CDEs for:
- Home health
- Glucose monitors
- Oxygen
- Lower limb prosthesis
- Power mobility devices

- National Partnership to Improve Dementia Care and QAPI Call — Thursday, December 14, 1:30 - 3 pm ET.
  Register for Medicare Learning Network events. During this call, learn how to work with physicians to ensure compliance with the new psychotropic medication prescribing requirements for long term care facilities. Also, find out how nursing homes are putting the new Quality Assurance Performance Improvement (QAPI) requirements into practice. Additionally, CMS experts share updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes and QAPI. A question and answer session follows the presentations.

- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Revised. A revised Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool is available. Learn about:
  - Completing the Advance Beneficiary Notice of Noncoverage (ABN) which allows beneficiaries to make informed decisions about items or services that may not be covered by Medicare.

- Medicare Advance Written Notices of Noncoverage Booklet — Revised. A revised Medicare Advance Written Notices of Noncoverage Booklet is available. Learn about:
  - Issuing and completing advance written notices of noncoverage
  - Prohibitions and frequency limits
  - Collecting payment from the beneficiary
  - Financial liability
  - Claim reporting modifiers
  - When you should not use the notice

- Power Mobility Devices Booklet — Revised. A revised Power Mobility Devices Booklet is available. Learn about:
  - General coverage criteria
  - Provider and supplier requirements
  - Programs that may affect reimbursement

- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New. An audio recording and transcript are available for the November 16 call on the Skilled Nursing Facility (SNF) Value-Based Purchasing Program FY 2018 Final Rule. Learn how the program will affect your payments beginning October 1, 2018, and how CMS will translate performance scores into value-based incentive payments.

- SNF QRP: Assessment-Based Measures Confidential Feedback Report Webinar Information. CMS experts provided information on the Confidential Feedback Reports for the assessment-based measures adopted for the Skilled Nursing Facility Quality Reporting Program (SNF QRP). These reports will be made available to SNFs via providers’ Certification and Survey Provider Enhanced Reporting (CASPER) folders in late November of this year. CMS will present information on the assessment-based IMPACT Act measures included in the reports and direct participants to measure specifications. For more information, visit the SNF Quality Reporting Program Training webpage. The presentation has been posted to the SNF training page here.

3) The Federal HHS Office of the Inspector General reports on their Semiannual Report to Congress. The Inspector General Act of 1978 (Public Law 95-452), as amended, requires that the Inspector General report semiannually to the head of the Department and the Congress on the activities of the office during the 6-month periods ending March 31 and September 30. The semiannual reports are intended to keep the Secretary and the Congress fully and currently informed of significant findings and recommendations by the Office of Inspector General. This fall 2017 edition of the
Semiannual Report to Congress covers OIG activities from April 2017 through September 2017. Historically, about 80 percent of OIG’s resources are directed to work related to Medicare and Medicaid. This is mirrored in the organization and content of the report. Download the Fall 2017 Semiannual Report to Congress.


5) The federal U.S. Government Accountability Office (GAO) released a report entitled, CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework (click here). The approach that CMS has taken for managing fraud risks across its four principal programs—Medicare, Medicaid, the Children’s Health Insurance Program (CHIP) and the health-insurance marketplaces—is incorporated into its broader program-integrity approach. According to CMS officials, this broader program-integrity approach can help the agency develop control activities to address multiple sources of improper payments, including fraud. As the figure below shows, CMS views fraud as part of a spectrum of actions that may result in improper payments.

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

   - The calculations and amounts for the hospital ACA Access Payments for the period of November 2017 through January 2018 have been posted to the Department’s new web site and can be viewed here.
   - HFS posted a new provider notice regarding LTC Monthly Occupied Bed Provider Assessment. You may view the notice here.
   - HFS posted a new provider notice regarding Prevention of Spousal Impoverishment Standards for 2018. You may view the notice here.
   - HFS posted a new provider notice regarding Room and Board Amounts for 2018. You may view the notice from here.
   - HFS posted a public notice regarding the Extension of the Behavioral Health Add-on through June 2018. You may view the notice from here.

7) The Illinois Department of Public Health (IDPH) reports that in the In the December 1, 2017 Illinois Register, there was an adopted rulemaking from IDPH for SNF/ICF/Sheltered Care. This rulemaking (page 14811 for SNF/ICF and page 14826 for Sheltered Care) deletes the requirement for including social security numbers on application and renewal forms, and cleans up language to more closely reflect the language of the Nursing Home Care Act.

8) The Illinois Department on Aging released their FY16 Annual Report.

9) The American Health Care Association (AHCA) and the Illinois Health Care Association recently reported on:
   - An Update From the AHCA Chair – November 2017. It’s hard to believe we are once again approaching the end of the year. Though successful, we have faced some great challenges with more to do as we approach the holiday season. The AHCA Board of Governors met for the final time in November to wrap up its 2017 business, approve the 2018 budget and finalize 2018 goals. We hope you will find this summary from the AHCA Board meeting helpful as we begin looking ahead. As always, IHCA and AHCA are here to support your efforts and ensure we continue to improve lives by delivering solutions for quality care.
   - AHCA’s Long Term Care Survey, Phase 2 Edition. It is imperative that every center have a copy of the new AHCA’s Long Term Care Survey Manual, Phase II edition. More than 800 pages of new guidance and updated F-tags have been added to this edition (www.AHCApublications.org). NOTE: The Phase II edition of the Long Term Care Survey comes in three formats: softbound, 3-ring binder with page inserts and as an e-book. Subscriptions
to the LTC Survey are no longer available. Subscriptions were sold only during the Phase I release and included updates for all three phases.

- **CMS Updates 2018 Medicare Part B Physician Fee Schedule File** ([click here](https://www.cms.gov)). AHCA is able to offer members the 2018 therapy fees for each CPT/HCPCS Code in each geographic area on their website under the “Medicare Part B Fee Schedules” heading. Please note that the fees effective January 1, 2018 are calculated based upon the Revisions to Payment Policies Under the Physician Fee Schedule (MPFS) and Other Revisions to Part B for Calendar Year (CY) 2018 Final Rule (CMS-1676-F) published in the *Federal Register* on November 15, 2017.

- **AHCA Summary of the Finalized Major Changes to the Mandatory Post-Acute Bundling Programs.** The final rule is available online [here](https://www.ahca.org). There are several parts of the final rule that are especially pertinent.

- **LTC Trend Tracker Quarter 4 Publication.** On December 12, [LTC Trend Tracker](https://lctrendtracker.com) users received the latest Your Top-Line publication, produced by LTC Trend Tracker. The report was sent with the subject line, "*LTC Trend Tracker Quarter 4 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 4 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. LTC Trend Tracker has a new and improved Five-Star Predictor Tool that allows users to see how potential changes in individual quality measures may impact that center's Five-Star QM rating. Users can enter potential rates for each individual QM to predict how that change will affect the facility's Five-Star QM total points and rating.

- **CMS Releases Finalized Version of Appendix PP.** CMS has released a [finalized version](https://www.cms.gov) of the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, dated November 22, 2017. This version of Appendix PP replaces the Advance Copy that was released on June 30, 2017. It contains Interpretive Guidance (IG) for all Phase 1 and Phase 2 Requirements of Participation (RoP) and is effective as of November 28, 2017. CMS made several technical corrections and minor revisions to the guidance, some of which were in response to questions and concerns raised by the American Health Care Association (AHCA). A complete list of these changes can be found in the chart [here](https://www.cms.gov). AHCA has prepared a summary for members here that highlights some of CMS' notable corrections and revisions.

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

11) The [National Institutes of Health](https://www.nih.gov) reports that a [New Forecast Shows 6 Million With Alzheimer’s Disease, Cognitive Impairment](https://www.nih.gov). Using new methodology, scientists calculate that approximately 6 million American adults have Alzheimer’s disease or mild cognitive impairment, which can sometimes be a precursor to the disease. The estimate, funded by the National Institutes of Health, also forecasts that these numbers will more than double to 15 million by 2060, as the population ages.

12) MedlinePlus reports that [Flu Can Have Dangerous Domino Effect on Older Adults](https://www.medlineplus.gov). Even months after recovering from the flu, older people remain at increased risk for a heart attack, stroke or disability, a doctor who specializes in infectious diseases warn.

13) The [Washington Post](https://www.washingtonpost.com) reports that [Drugs Intended to Calm People with Alzheimer’s May Lead to Early Death](https://www.washingtonpost.com). Benzodiazepines, also known as benzos, are drugs sometimes prescribed to ease the agitation, anxiety and insomnia often experienced by people with Alzheimer’s disease. Might these powerful medications have an effect beyond their sleep-inducing or calming properties?

14) Medical News Today reports on [What to Know About Double Pneumonia](https://www.medicalnewstoday.com). Double pneumonia is an infection of both lungs. A virus, bacteria or fungus causes the tiny sacs of the lungs, called alveoli, to become inflamed and fill with fluid or pus, causing a range of symptoms, including breathing difficulties. Doctors sometimes refer to double pneumonia as bilateral pneumonia.
15) **Healio** reports that *Clostridium Difficile Persists Most Often in Floor Corners, Bathroom Floors After Cleaning of Rooms*. *Healio* recently reported that research indicates "Clostridium difficile persists most frequently in floor corners and on bathroom floors after routine and terminal cleaning of hospital rooms." Investigators also "identified nurse call buttons as the most highly contaminated surface after both routine and terminal cleaning." The findings were published in *Infection Control & Hospital Epidemiology*.

16) **U.S. News and World Report** reports that *Medicare Patients Expected to Receive More End-Of-Life Counseling From Physicians*. **U.S. News & World Report** reported that in 2016, the first year that the government allowed health care providers to bill for advanced planning conversations, 575,000 Medicare beneficiaries had end-of-life counseling with their physicians. This figure was "a little more than 1 percent of the 56 million Medicare beneficiaries" in the nation, but was above the American Medical Association’s estimate of 300,000. The article discussed the reasons behind the adoption rate and experts’ expectations that the figure will continue to rise as providers make arrangements to bill for the counseling.

17) **Politico** reports that *Some Physicians Avoiding Sickest Patients for Fear of Grades on Health Quality Measures*. The *Politico* "Morning eHealth" blog reports that some physicians "areavoiding some of the nation’s sickest patients for fear that they’ll get dinged by Medicare or graded poorly on health quality measures." Even though there is no "hard data" on the subject, "anecdotes abound of physicians avoiding patients who might make them look bad or cost them money." Colleagues often tell David Barbe, MD, president of the American Medical Association, "they are avoiding a complex patient because it will hurt their ‘scores,’ he says. ‘It breaks my heart because it’s undermining engagement of physicians with their patients,’” he added.

18) **CNBC** reports, *Many May Find Complete Long Term Care Coverage Out of Reach*. **CNBC** reports complete long term care coverage "may be out of reach for most people." Scott J. Witt, fee-only insurance advisor with Witt Actuarial Services, said, "In my experience, the vast majority of consumers come away from this process with a false sense of satisfaction and confidence that they have adequately covered this risk, when in reality they could still be wiped out by a catastrophic long term care episode." He said to achieve an affordable premium most clients cut back in various areas, such as "inflation protection, shortened the benefit period, lengthened the elimination period or lowered the monthly benefit." Meanwhile, the industry is responding with ever more options, such as fife insurance hybrid plans, long term care annuities, short-term care policies and long-term partnership programs.

19) **ModernHealthcare** reports, *Providers Express Concerns That CMS’ Meaningful Measures Will Not Reduce Reporting Burden*. **ModernHealthcare** recently reported that providers who attended a webinar presented by CMS on the agency's "Meaningful Measures" quality reporting framework "remained confused about the initiative’s goals." The article says "clinicians who called into the agency’s webinar expressed concern that the framework wouldn’t actually reduce their reporting burden, especially as some struggle to figure out which quality measures they should report on in the first place." Dr. Theodore Long, senior medical officer for CMS’ quality measurement and value-based incentives group, said, "We get that there is a burden in terms of what we ask clinicians to do in terms of reporting measures. ... Our goal with the meaningful measures framework is to land at a place where we have measures that have the absolutely lowest level of burden for clinicians but that are still meaningful for patients and clinician."

20) **NPR** reports, *Severe Shortage of Inpatient Care for People With Mental Illness Resulting in Public Health Crisis*. In a special series in its "Here & Now Compass" column, **NPR** reports, "A severe shortage of inpatient care for people with mental illness is mounting to a public health crisis, as the number of individuals struggling with a range of psychiatric problems" steadily increases. What’s more, "The disappearance of long term care facilities and psychiatric beds has escalated over the past decade, sparked by a trend toward deinstitutionalization of psychiatric patients in the 1950s and ’60s, says Dominic Sisti, director of the Scattergood Program for Applied Ethics of Behavioral Health Care at the University of Pennsylvania." Due to the lack of community care in many places in the US, more people with mental illness are finding themselves homeless or incarcerated. Others end up in emergency departments.

21) **STAT** reports, *Flu Season Begins Early, Could Peak by Christmas, CDC Says*. **STAT** reports that the flu season "is off to an early start this year" and could "peak over the holidays," a new CDC analysis indicates. The piece says the "wildly unpredictable" flu viruses leave experts uncertain of precisely how extensive the season will be, but the CDC’s weekly flu
reports offer updated predictions and data, with the most recent report showing "that Louisiana and Oklahoma already have widespread flu activity and some nearby states are heating up too." According to CDC influenza epidemiologist Lynnette Brammer, who leads flu reporting, "If it continues to go up like it has the last couple of weeks, yeah, we could have a fair amount of activity right at Christmas."

22) **HealthDay** reports:

- **Getting Surgery Within 24 Hours of a Fractured Hip Improves Survival, Reduces Complications.** HealthDay reports on a study published in the *Journal of the American Medical Association* that found that "seniors with a fractured hip need surgery as soon as possible or they could suffer life-threatening complications." The researchers, led by Daniel Pincus, a doctoral student with the University of Toronto, found that undergoing "surgery within 24 hours decreases the risk of hip fracture-related death," and "lowers odds of problems such as pneumonia, heart attack and blocked arteries." The survey included "data on over 42,000 people treated for hip fracture at 72 hospitals in Ontario between April 2009 and March 2014."

- **Interest in Nursing Home Care Among Health Care Professionals Rising.** HealthDay recently posted about a study by the University of Pennsylvania School of Medicine that found "that the number of doctors, nurse practitioners and physician assistants who were nursing home specialists rose from about 5,100 in 2012 to more than 6,800 in 2015 — about 34 percent." Investigators suggested the trend is propelled by a growing older population and additional federal government oversight of nursing homes. Researchers published the study in the *Journal of the American Medical Association*.

23) **Provider Magazine** reports:

- **Providers Should be Prepared for ‘Aggressive’ Reporting Policies Following HHS OIG Alert.** Winston Chan, partner at Gibson, Dunn & Crutcher, and Ian Long, associate at Gibson Dunn, write in the December issue of *Provider Magazine* that HHS’ Office of Inspector General’s early alert on elder abuse reporting found "that 28 percent of the emergency room visits" assessed "involved potential elder abuse or neglect incidents...that likely should have been reported to state authorities but were not." The authors warn that such findings could lead to legal overreach by authorities who now may engage in "aggressive interpretation of state reporting requirements," and advise providers to "re-examine whether their policies and approaches to elder abuse reporting, and reliance on intervening internal investigations and legal advice, would pass muster."

- **American College of Cardiology and American Heart Association Publish New Guideline for High Blood Pressure Threshold.** Provider Magazine reported the new American College of Cardiology and the American Heart Association guideline, published in the *Journal of the American Medical Association*, for managing high blood pressure (BP) "lowers the threshold for a diagnosis of stage one hypertension, expanding the number of people who now fall under that classification." The piece said that under the new guideline, stage one hypertension is defined "as any systolic BP measurement of 130 mm Hg or higher, or any diastolic BP measurement of 80 mm Hg or higher (130/80 mm Hg)," compared to the previous definition of a BP reading "140/90 mm Hg or higher."

24) **MedicalXpress** reports:

- **Resistance Training Improves Quality of Life and Psychological Functioning for Older Adults.** Resistance training can promote environmental quality of life and sense of coherence in older adults. This was observed in a study carried out at the University of Jyväskylä, Faculty of Sport and Health Sciences, Finland, in co-operation with the Gerontology Research Center and the Neuromuscular Research Center. "The importance of resistance training for the muscular strength and physical functioning in older adults is well known, but the links to psychological functioning have been studied less," says doctoral student Tiia Kekäläinen from the University of Jyväskylä.

- **Older Men Need More Protein to Maintain Muscles.** The amount of protein recommended by international guidelines is not sufficient to maintain muscle size and strength in older men, according to a new study. Researchers say their findings mean older men should aim to have high quality protein at every meal. The size of
our skeletal muscles – the muscles we use to move our body – and our ability to perform everyday tasks naturally decline with age from the around the fifth decade. Severe muscle loss can lead to frailty, loss of independence and a greater risk of dying. Regularly eating enough protein is known to help maintain muscles.

- **Shingles Vaccine Important for Older Adults.** Shingles, also referred to as herpes zoster, is a painful rash that develops as the result of reactivation of the varicella-zoster virus (VZV). VZV is responsible for varicella infection, more commonly known as chickenpox. Even after chickenpox resolves, the virus remains in the body and presents again later in life as shingles. An estimated 99.5 percent of adults over the age of 40 were infected with the virus at some point during childhood, and there are roughly 1 million cases of shingles each year in the U.S. The shingles rash can be extremely painful and result in postherpetic neuralgia, which is pain that lasts even after the rash has resolved. Your risk for shingles increases significantly after the age of 50 and the Centers for Disease Control and Prevention (CDC) estimates that 1 in 3 people in the United States will develop shingles in their lifetime. The most effective way to treat herpes zoster infection is prevention through vaccination. The pain associated with the rash can be difficult to treat, and the vaccine is an effective way to prevent recurrence of the inactive virus.

25) **Skilled Nursing News** reports:

- **Humana Study Suggests Value-Based Care Could Improve SNF Care, Lower Costs.** *Skilled Nursing News* reports that a Humana *study* concluded that "[v]alue-based programs can lead to lower costs of care and better quality of care for seniors enrolled in Medicare Advantage (MA) plans." Humana examined "quality metrics and prevention measures in calendar year 2016 for about 1.65 million Humana MA members in value-based reimbursement model agreements, then compared those numbers with those for 191,000 Humana members linked to standard MA providers." The article adds, "the Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP) from the Center for Medicare and Medicaid Services (CMS) is set to take effect in fiscal 2019, putting increased pressure on SNFs to plan for the entire process of care: Under the new SNFVBP rules set to go into effect next October, skilled nursing operators will automatically lose 2 percent of their Medicare reimbursements, which they can earn back by reducing readmissions."

- **SNF Residency for Nurses in Long Term Care Benefits Residents.** *Skilled Nursing News* reported on the University of Wisconsin’s formation of a Geri-Res long term care nurse residency program that started in 2014 to develop the specialization. The piece profiled Attic Angel Place in Middleton, Wisconsin, which is one of the 18 organizations that have piloted or are currently piloting the program. The article explained that "nurses are the front line in the long term care setting." Betsy Gerhardt, the PM shift supervisor at Attic Angel Place Health Center, said, "The residents are benefitting a lot, because the nurses are taking the extra step to make sure that they’re getting the best care."

- **Collaborative Programs to Reduce SNF Infections Improves Outcomes Although Issues Remain.** *Skilled Nursing News* reports a *study* published in the *American Journal of Infection Control* indicates the Agency for Health care Research and Quality’s (AHRQ) "collaborative" initiative "to reduce catheter-associated urinary tract infections (CAUTI) received high marks from participants across the country" although "some structural barriers to success remain." Nearly one-fourth of nursing home residents face hospital readmissions – a "key cornerstone of new quality metrics from the Centers for Medicare & Medicaid Services" – due to infections, researchers found, leading to as much as $4 billion in yearly health care costs.

26) **McKnight’s** reports:

- **CDC Requests Public Comment on Expansion to Program Examining Workplace Violence in Nursing Homes.** *McKnight’s Long Term Care News* reports the US CDC is seeking public comment on the expansion of its research program called the Workplace Violence Prevention Programs in NJ Health care Facilities, it said in a *notice*. The augmented program would allow the CDC to "study how facilities comply with a New Jersey law to prevent violence in health care prevention, and if their compliance translates into lower employee violence-related injury rates."
• CMS Initiative Reduced Nursing Home Hospital Readmissions by 33 Percent. *McKnight’s Long Term Care News* reports a recent analysis by Indiana University researchers found CMS' "Optimizing Patient Transfers, Improving Medical Quality and Improving Symptoms: Transforming Institutional Care" program – termed the OPTIMISTIC project – reduced avoidable hospitalizations among nursing home residents by 33 percent. Researchers "revealed that in addition to the one-third reduction in hospitalizations, the program," initiated in 2013, "eliminated nearly one-fifth of both avoidable and unavoidable nursing home resident hospitalizations."

• Verma Vows CMS Will Prioritize Efforts to Reduce Provider Burden, Update Policies. *McKnight’s Long Term Care News* reports CMS Administrator Seema Verma spoke at the Office of the National Coordinator for Health Information Technology’s annual meeting, calling for deregulation in the health care sector to allow providers to focus on health care outcomes. Verma also said CMS will work to reduce provider burden while adapting the agency’s policies to include a greater focus on technological operations, including electronic health records, telehealth, and connections with "digital seniors."

• Federal Office to Release Proposed Health Care Data Exchange Requirements. *McKnight’s Long Term Care News* reports the proposed Trusted Exchange Framework and Common Agreement plan, focused on developing requirements for how health care organizations exchange data, is anticipated to be released prior to the end of the month, according to Office of the National Coordinator for Health Information Technology. The plan was first outlined in the 21st Century Cures Act, and according to the office, will be "an integral component of the nationwide network-to-network exchange of health data and a critical part of ONC’s charge to support nationwide interoperability."

• Reductions in Long-Stay Antipsychotic Use May be Offset by Exclusion of New Mental Health Condition Diagnoses from Audits. *McKnight’s Long Term Care News* reports a recent study published in *Clinical Gerontologist* found reductions in antipsychotic use among long-stay SNF residents "may reflect more residents being diagnosed with mental health conditions excluded from quality measurement audits." The piece says CMS’ National Partnership to Improve Dementia Care program "recently reported that it met its goal of cutting the national rate of antipsychotic use among long-stay residents by 20 percent by the end of 2016," adding that the "American Health Care Association has also touted meeting its reduction goals." However, researchers found "combined rates of schizophrenia, Tourette’s and Huntington’s diagnoses increased 12 percent in long-stay residents in the two years since the Partnership was introduced."

• National Long-Term Care Spending Hits All-Time High at $163 Billion. Americans spent nearly $163 billion on nursing care facilities and continuing care retirement communities in 2016, according to a new federal report. CMS' National Health Care Spending report for 2016, published in *Health Affairs*, found that total health care spending in the United States increased 4.3 percent in 2016, reaching $3.3 trillion. When it comes to long term care, $162.7 billion was spent last calendar year. That marks the highest point in total nursing care and CCRC spending to date, compared to $140.5 billion in 2010. The annual growth rate for nursing care facilities and CCRCs hit 2.9 percent for 2016, down from 3.7 percent the prior year.

• Fire Safety Advice from the Pros. Two recent news stories may have you re-examining your emergency preparedness plans, especially as they pertain to fires. "When we have these fires, they are unusual, they are unexpected," he said. "At NFPA, we want to know what the circumstances were, what the scenarios were, because what we do with that information is go back and evaluate our code. ...These codes do not remain static. The Life Safety Code, for instance, is updated every three years.” Compliance with the Life Safety Code, also known as NFPA 101, is mandated by CMS for nursing homes, hospitals and other facilities that receive Medicare and Medicaid reimbursement. State and local jurisdictions — licensing authorities, health departments, fire marshals, building commissioners, etc. — also can decide to mandate compliance with the NFPA’s codes and standards, in part or in whole, for buildings under their purview, including assisted living communities.

27) *Interesting Fact*: There is a village in Peru where people settle the previous year's grudges by fist fighting. They then start the new year off on a clean slate.
If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don’t hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!

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