Feature Focus

Each edition of the IHCA Regulatory Beat will feature focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

When Nurses Lead
by Alice Bonner, PhD, RN

In Fall 2011, the Centers for Medicare and Medicaid Services (CMS) began a major initiative to improve dementia care in nursing homes. The original goal was to reduce the prevalence of antipsychotic medication use in long-stay nursing home residents with dementia by 15%. Through a new, public-private collaboration, the National Partnership to Improve Dementia Care established coalitions in every state. After 18 months, a 15.1% reduction was achieved nationally. Throughout the initiative, many nurses played key roles in leading the process for change. This article (click here) describes the roles of nurse leaders in this national policy work. (Journal of Gerontological Nursing, 40(6), 17-21).

Although a 15.1% reduction in unnecessary medications use is a first step toward better dementia care, much more remains to be done. The CMS National Partnership demonstrates how a public-private partnership with a broad array of stakeholders, including many nurse leaders, can make an impact in promoting this initiative. Nursing organizations continue to play a major role in promoting peer-to-peer networking. Nurse leaders recognize that the CNA, who is caring for residents 8 to 10 hours per day, is likely to have valuable insights into residents’ behaviors, their needs, and preferences. Thus, effective teamwork between DON’s, nurse managers, charge nurses, and CNA’s is critical to ensuring comprehensive dementia care. Nursing teams that focus on direct care workers, as well as residents and families, and engage them in team decisions are likely to have more success than those who do not.

Nursing and other professional organizations influence policy development in areas such as nursing home staffing and training requirements that affect resident outcomes and staff stability as well. Professional associations of medical directors, geriatricians, psychiatrists, other physicians, psychologists, pharmacists, activities professionals, social workers, and nursing home administrators have provided input and helped shape national and state policy. However, it is only through the active engagement of nurses at the facility, state, and national level that further improvement in resident outcomes for people with dementia will be achieved.

Approval for printing this abstract and attached article was received from Healio and SLACK Incorporated.
**POLST and CPR**
The Illinois Department of Public Health has published a revision of the out-of-hospital emergency treatment form, now called the “IDPH DNR/POLST” form. Old versions of the form will continue to be honored, but clinicians should use the revised form. The Spanish revision has not been released, but will be added when it is available.

POLST Illinois emphasizes that the use of the form is part of an extended conversation regarding advance care planning, and the form is NOT for everybody. It is meant to be discussed with patients for whom death within a year would not be unexpected. These patients are generally those with advanced, serious illness and the frail elderly. The form is a medical order that must be respected at any location, and may be changed by the patient or their appropriate substitute decision-maker at any time if their condition or preferences change. The POLST training materials are currently being updated to reflect the form changes, and should be completed by February 2. Changes to the form include:

1) **Title:** The title of the form has been changed to “IDPH DNR/POLST Form,” where POLST now stands for Practitioner Orders for Life-Sustaining Treatment.

2) **Additional Practitioners:** With the new form, additional practitioners will be able to sign the POLST orders. In addition to attending physicians, additional clinicians who can now sign the form are—Advance Practice Nurses (APNs), Physician Assistants (PAs) and licensed medical residents who are in their second year or above of training.

3) **Form is Voluntary:** Language has been added stressing that this form cannot be required of any patient, and is completely voluntary.

4) **Section A:** The CPR and DNR options are now on a single line to avoid the possibility of checking the wrong box.

5) **Sections B and C:** Language for the titles and description of treatment plans has been changed to allow the form to be more easily understood by both patients and clinicians. The listing order of the options follows the same concept as in Section A, with the most medically invasive treatment plan being listed first, and less invasive following. The following language changes were also made:
   - “Intubation and Mechanical Ventilation” has been changed to “Full Treatment”
   - “Limited Additional Interventions” has been changed to “Selective Treatment”
   - “Comfort Measures Only” has been changed to “Comfort-Focused Treatment”

In addition, federal CMS has revised surveyor guidance in Appendix PP of the State Operations Manual (SOM) ([click here](#)) under F155 to clarify CPR polices for nursing homes, the regulatory language remains unchanged. Pursuant to this revised S&C Letter, it is important to note that:

1) Prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident’s advance directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order.

2) CPR-certified staff must be available at all times.

3) LTC facilities **cannot** establish or implement a facility-wide no CPR policy.

4) Surveyors will ascertain that facility policies related to emergency response require staff initiate CPR as appropriate and that records do not reflect instances where CPR was not initiated by staff even though the resident requested CPR or had not formulated advance directives.

5) Facility staff must maintain current CPR certification for health care providers through CPR training that includes hands-on practice and in-person skills assessment. Online only certification is not acceptable.
Trending Statistics

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

Nearly 1 in 12 Americans Struggles with Depression, Study Finds

But, just a third of severely depressed people have sought help.

Almost 8 percent of Americans aged 12 and older were moderately to severely depressed during 2009 to 2012, U.S. health officials reported Wednesday.

But, only slightly more than one-third of those suffering from severe depression sought help from a mental health professional in the previous year, according to study lead author Laura Pratt.

"Not enough people are getting appropriate treatment for depression," said Pratt, an epidemiologist at the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS).

"People with severe depression should be getting psychotherapy. Some might need complicated medication regimens, which psychiatrists are better equipped to do, which makes it even more concerning that only 35 percent of people with severe depression have seen a mental health professional," she said.

Simon Rego, director of psychology training at Montefiore Medical Center and Albert Einstein College of Medicine in New York City, said the CDC statistics are consistent with previous research findings.

"Much of the information is not new or surprising," he said. "What's disappointing, however, is the fact that the rates of treatment have remained so low."

This is a problem because more severe depression leads to more serious difficulties in work, home and social activities, and people rarely experience remission without treatment, Rego said.

"Even for those who manage to recover naturally, we know that the risk of recurrence is higher if mild symptoms remain during the remission and the last episode was severe," he said.

"Clearly much more work needs to be done to educate the public on the symptoms of depression, the major impact it can have on one's functioning, and the benefits of seeking an appropriately trained mental health professional," Rego added.

The good news is that highly effective treatments are available for depression, including short-term psychological interventions such as cognitive behavioral therapy and interpersonal psychotherapy, as well as medications, such as selective serotonin reuptake inhibitors (SSRIs), Rego said.

According to the U.S. National Institute of Mental Health, symptoms of depression include:

- Being persistently sad or anxious,
- Feeling hopeless,
- Feelings of guilt, worthlessness, helplessness,
- Loss of interest or pleasure in hobbies and activities,
- Lack of energy and fatigue,
- Difficulty concentrating, remembering, making decisions
- Difficulty sleeping or oversleeping,
- Changes in appetite or weight,
- Thoughts of death or suicide or suicide attempts,
• Restlessness, irritability.

According to the report published Wednesday in the NCHS Data Brief, 7.6 percent of Americans reported moderate to severe depression during the last two weeks of the study period.

The researchers found that about 3 percent of Americans aged 12 and over had symptoms of severe depression.

Depression was more common among women aged 40 to 59, with 12 percent of women in this age group suffering from the condition, the findings showed.

There were also racial differences in depression rates. Just over 4 percent of black people reported severe depression compared to 2.6 percent of white people, the researchers found.

When the researchers looked at people who had no symptoms of depression, they found that 78.5 percent of whites said they had no depressive symptoms compared to about 73 percent of black people and 74 percent of Hispanics, according to the report.

The study authors also found that depression was much more common among the poor. People living below the poverty level were nearly 2.5 times more likely to have depression than those at or above the poverty level.

More than 15 percent of people living below the federal poverty level had depression compared with about 6 percent of people living at or above the poverty level, the investigators found.

Depression also took its toll in daily life. Nearly 46 percent of people with symptoms of mild depression reported problems at work, home and social activities. But that number rose to 88 percent for those with severe symptoms of depression.

Sources: Laura Pratt, Ph.D., epidemiologist, National Center for Health Statistics, U.S. Centers for Disease Control and Prevention; Simon Rego, Psy.D., director, psychology training, Montefiore Medical Center/Albert Einstein College of Medicine, New York City; Dec. 3, 2014, NCHS Data Brief, "Depression in the U.S. Household Population, 2009-2012"

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**Important Rules, Regulations & Notices**

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

- **S&C 15-22 – Hospital/ASC/FHC/FQHC** – Revised Guidance Related to New and Revised Regulations for Hospitals, Ambulatory Surgical Centers (ASCs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). CMS has updated its interpretive guidelines in the following State Operations Manual (SOM) Appendices to reflect recent amendments to the applicable Conditions of Participation (CoPs), Conditions for Coverage (CfCs) and Conditions for Certification: Appendix A–Hospitals; Appendix T–Hospital Swing Beds; Appendix L–ASCs; Appendix G–RHCs and FQHCs. View the memo for more information.

- **S&C 15-23 – ICF/IID** – Use of Audio Surveillance Devices in Common Areas in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). To ensure that client’s rights are protected, the use of audio surveillance devices in the ICF/IID must be reviewed, approved and monitored by the Specially
Constituted Committee (SCC) of the facility as constituted per 42 CFR 483.440(f)(3)(i-iii). If approved by the SCC, written informed consent must be obtained from every affected client or designated guardian prior to the implementation of audio surveillance devices. Audio surveillance devices may be used in common areas within the ICF/IID. Audio surveillance devices may never be used for any reason in areas where there are the highest expectations of privacy such as bathrooms, areas for private visitation or areas for private phone calls. Audio surveillance devices may not be used as a substitute for or supplement to adequate staffing or supervision protocols. The cost of the audio surveillance devices must be incurred by the facility and not the clients.

2) The federal Centers for Medicare and Medicaid Services (CMS) released several notices of interest since the last issue of Regulatory Beat. They include:

- The next CMS Skilled Nursing Facility/Long Term Care Open Door Forum is scheduled for Thursday, February 12, 2015 at 1:00 PM Central Time (CST). Click here for the conference call instructions. This call will focus on the changes to the Five Star Rating changes, Nursing Home Compare and Errata Document clarifying A1900: Admission/Entry and Reentry in the RAI User’s Manual – posted to the Nursing Home Quality Initiative’s Webpage.

- Click here for the CMS News Release regarding the launching of the Dialysis Facility Compare Star Ratings. CMS has added star ratings (similar to the LTC Five Star) for dialysis facilities. The purpose of these new ratings is to spotlight excellence in health care quality with respect to dialysis facilities.

- CMS recently released the Medicaid enrollment data (click here) that all states have been reporting to CMS through the Medicaid Budget and Expenditure System (MBES). The enrollment information is a state-reported count of unduplicated individuals enrolled in the state’s Medicaid program at any time during each month in the quarterly reporting period.

- As part of the state-federal partnership in administering the Medicaid program, CMS issues guidance in the form of letters to State Medicaid Directors, State Health Officials and stakeholders. Recently, CMS has issued to following:

- CMS has updated their resources with respect to ICD-10. Click here for the ICD-10 Resources webpage.

3) Federal Health and Human Services (HHS) Secretary Sylvia M. Burwell announced (click here) measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care given their patients/residents. HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.

4) The Illinois Department of Healthcare and Family Services (HFS) released a couple of Informational Notices since the last issue of Regulatory Beat. They include:

- New Federal Rule Regulations for the Home and Community Based Waiver Programs. CMS published Federal Regulations on January 16, 2014, that require all federally approved 1915c waivers to comply with new regulations for Home and Community Based Services (HCBS) settings. Each state operating a 1915c waiver is required to develop a Statewide Transition Plan, which will describe Illinois’ assessment of its current waiver programs and discuss proposed remediation strategies to ensure full compliance with new
regulations. Additional information and updates are available on the HFS Home and Community Based Services (HCBS) Waivers website (click here). This informational notice informs Supportive Living Program (SLP) facilities of the requirement to provide notice to the public for input on the new CMS regulations. Providers are encouraged to share this information with their residents, representatives, and other interested parties. There is a webinar entitled: New Medicaid Waiver Rules Draft Statewide Transition Plan Listening Webinar to be presented on Wednesday, February 11, 2015, 9:00 - 10:00 am. Register here.

- HFS posted a new Non-Ambulance Transportation Fee Schedule to the Transportation Fee Schedule page (click here).

5) The American Health Care Association (AHCA) released several email updates that include:

- Summary of Key Provisions in President’s Proposed FY 2016 Budget (click here).
- AHCA Member Webinar on Five Star on Friday, February 13, 2015 at 12:30 pm Central (CST). Click here to register. For AHCA/IHCA members that are unable to join this Webinar live, the event will be recorded and a link to the recording will be made available.

6) CMS’s Medicare Learning Network (MLN) had several news items of interest released since the last issue of Regulatory Beat. They include:

- CMS is offering ICD-10 acknowledgement testing and end-to-end testing to help the Medicare Fee-For-Service (FFS) provider community get ready for the October 1, 2015, implementation date. During this MLN Connects™ National Provider Call, CMS subject matter experts will discuss opportunities for testing and results from previous testing weeks, along with implementation issues and resources for providers. A question and answer session will follow the presentations. The National Provider Call is scheduled for Thursday, February 26; 12:30 – 2:00pm Central (CST). To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

- The National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement (QAPI) are partnering on future MLN Connects™ National Provider Calls to broaden discussions related to quality of life, quality of care, and safety issues. Register (click here) for the first call on March 10. Save the dates for upcoming calls in 2015: Tuesday, March 10, 1:30-3pm ET; Tuesday, June 16, 1:30-3pm ET; Thursday, September 3, 1:30-3pm ET; Tuesday, December 1, 1:30-3pm ET.

- Over the last year, CMS has listened to your feedback about Internet-based Provider Enrollment, Chain & Ownership System (PECOS) and made improvements to increase access to more information. PECOS is easier than ever to use now that the following report upgrades are available:
  - The HTML Report, which is a provider’s online view of their Medicare enrollment application, has been updated to identify information that was added, updated, or deleted. Providers suppliers are able to view the HTML Report before they submit their Medicare application. The HTML Report is available in the Topic View tab as well as the Fast Track View tab in the “Reports” section.
  - Note: The View Medicare ID Report hyperlink is not available for initial Medicare enrollment applications. Multiple sections of the Medicare Enrollment Report are known to occasionally contain more than 50 individual records. When there are more than 50 records for an enrollment, a “Show All” button displays directly under the section to enable display of the remaining data.
  - Important Note: For enrollments with large volumes (4,000 records or more) of data in one or more of the sections listed above, it may take up to ten minutes for all data to return after the
“Show All” button is selected. HTML Report response times will vary depending on the amount of memory available on your PC/laptop and the internet browser you are using.

- For additional information regarding the updated HTML Report, please review the PECOS Medicare Enrollment Report Help available in the top right corner of the HTML Report. Please consider printing your HTML Report to help facilitate potential application development questions from your Medicare Administrative Contractor. To access internet-based PECOS, go to the PECOS website: https://pecos.cms.hhs.gov/pecos/login.do.

7) The federal Agency for Healthcare Research and Quality (AHRQ) released information that should be of interest, including:

- AHRQ offers Web-based continuing education for nurses, nurse practitioners, case managers, staff educators and nurse practitioner faculty. Eligible professionals can view recorded webinars that highlight resources such as the National Guidelines Clearinghouse, the Electronic Preventive Services Selector and the Improving Patient Safety in Long Term Care Facilities training modules. The webinars offer practical insights on how these resources can be integrated into education and practice. Registration is open.

- AHRQ’s Safety Program for Nursing Homes: On-Time Prevention is designed to improve long term care by turning daily documentation into useful information that enhances clinical care planning. On-Time Prevention (click here) provides a strategy for preventing adverse events in nursing homes. It uses electronic medical records to develop weekly reports that identify residents at risk of common adverse events in nursing homes to help clinical staff intervene early. On-Time uses a facilitator to help the nursing home's change team integrate these reports into clinical decision making to improve care planning. It also provides implementation tools to help the team use the reports on a weekly basis.

  AHRQ is developing four sets of reports and materials for the following adverse events:
  - Pressure ulcer prevention.
  - Pressure ulcers with delayed healing.
  - Falls prevention.
  - Avoidable hospitalizations.

  For each adverse event the Web site provides a description of the reports and suggested meetings and huddles where the reports may be used, the functional specifications for programming the reports, description of implementation tools and a 2-day training curriculum for facilitators.

8) The Centers for Disease Control and Prevention recently revised their publication entitled, 10 Reasons to Get Vaccinated (click here). Many adults in the U.S. are not aware of vaccines recommended for them – and that means they are not taking advantage of the best protection available against a number of serious diseases. According to the 2013 National Health Interview Survey (NHIS):

- Only about 1 out of 5 (21 percent) adults 19-64 years old with certain high-risk medical conditions had received a pneumococcal vaccination.
- Only about 1 out of 4 (24 percent) adults 60 years and older, had received a shingles vaccination.
- Only about 1 out of 6 (17 percent) adults 19 years and older, had received a Tdap vaccine in the last 8 years to provide protection from tetanus, diphtheria and pertussis (whooping cough).

9) McKnight’s had several recent articles that might be of interest to you. They include:

- Practical tips for improving frontline staff morale (click here)
- Study to examine Medicaid-centric nursing homes that excel (click here)
- Tele-health in three steps (click here)
• What the National Labor Relations Board (NLRB) new ambush election rules mean for you (click here)
• Non-drug interventions reduce delirium: study (click here)

10) Interesting Fact: People who laugh a lot are much healthier than those who don't. Dr. Lee Berk at the Loma Linda School of Public Health in California found that laughing lowers levels of stress hormones and strengthens the immune system. Six-year-olds have it best - they laugh an average of 300 times a day. Adults only laugh 15 to 100 times a day. What is that old saying...laughter is the best medicine!!!