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!

The Scoop on the New Illinois Power of Attorney for Health Care
Written by Attorney Brooke Didier Starks with Nicole Stetzel, seasonal associate

Governor Quinn signed SB 3228 into law on August 26, 2014—effective January 1, 2015—overhauling the Illinois Power of Attorney for Health Care statute.

There were changes to who may act as agent or witness the form, as well as significant changes to the lengthy Notice section and the form itself that broaden its scope and attempt to make it more user-friendly. A quick summary of the highlights follows.

Changes to Definitions
In Sec. 4-4, “Definitions,” the term “health care agent” is now defined as:

an individual at least 18 years old designated by the principal to make health care decisions of any type, including, but not limited to, anatomical gift, autopsy, or disposition of remains for and on behalf of the individual. A health care agent is a personal representative under state and federal law. The health care agent has the authority of a personal representative under both state and federal law unless restricted specifically by the health care agency. 755 ILCS 45/4-4(e-5).

The terms “health care professional” and “health care provider” are now interchangeable.

Gone are definitions of “[i]ncurable or irreversible condition,” “[p]ermanent unconsciousness,” and “[t]erminal condition,” which relate in the current form to points when life support may be withdrawn (formerly 755 ILCS 45/4-4(f)-(h)). The new form no longer calls for such trigger-points.

Changes to Witness Requirements
Sec. 4-5.1, “Limitations on who may witness health care agencies,” now expressly prohibits these enumerated “licensed professionals providing services to the principal” from serving as witnesses (755 ILCS 45/4-5.1(a)):

attending physician;
mental health service provider;
advanced practice nurses;
physician assistant;
dentist;
podiatric physician;
optometrist;
relatives of any such professionals.

Health care facility operators (e.g., directors and executives) may not witness, but that prohibition does not apply to “non-owner chaplains or social workers, nurses and other employees.”

**Changes to the Form Itself**
The new statutory short form presumes that the principal is granting broad-based authority to his or her agent to make decisions in all types of health care scenarios. The choices for life-sustaining treatment have changed significantly and the form now asks the agent to choose between quantity of life and quality of life. There are also check-box options for invoking the start of the authority (upon execution of the form or upon the physician’s determination).

Notably, the new Act entirely rewrites the “Notice to the Individual Signing the Power of Attorney for Health Care,” which appears at the beginning of the health care form, and continues for roughly five pages. It adds a number of sections in Q&A format, illustrating the breadth of a POA and confronting various circumstances that may arise:

- “What Are the Things I Want My Health Care Agent to Know?” warns of the importance of choosing a trustworthy agent, but recommends particular topics and considerations to independently address with the prospective agent.

- “What Kind of Decisions Can My Agent Make?” outlines numerous dilemmas that an agent may face and provides examples as to how the principal may limit or direct these decisions.

- “Whom Should I Choose to be My Health Care Agent?” elaborates considerably upon the prior version’s mere recommendation that the agent be “trustworthy.” For example, a person should choose an agent who “would not be too upset to carry out your wishes if you became very sick” and is “comfortable talking with and questioning physicians.”

- “What if My Agent is Not Available or is Not Willing to Make Decisions for Me?” explains the role of successor agents and their importance.

- “What Will Happen if I Do Not Choose a Health Care Agent?” describes the surrogacy statute and the potential benefits of appointing an agent over relying on the default authority provided for by statute.

- “What if I Change My Mind?” addresses how to destroy the documents or fill out a new form.

Other sections, addressing practical steps in finalizing the appointment of a health care agent, include, “What Do I Do With This Form Once I Complete It?” and “What if I Do Not Want to Use This Form?”

Under the prior act and as amended, Sec. 4–10(c)(4) describes the agent’s authority to examine, copy and consent to disclosure of principal’s medical records. The section now clarifies that the POA is HIPAA compliant and that “[t]he agent serves as the principal’s personal representative, as that term is defined under HIPAA and regulations thereunder.”
Saving Clause
Under the Saving Clause, all powers of attorney for health care that were validly created prior to January 1, 2015 will be grandfathered in under the new statute, so unless a client’s personal preferences have changed or a client simply prefers the updated format, a revision to the estate plan is not necessitated by this statutory rewrite. Nevertheless, we always encourage our clients to review plans periodically to ensure that they still adequately address needs and now is as good a time as ever.

Permission to use this article was given by the author, Brooke Didier Starks, who is an attorney in Champaign, IL working for the Meyer Capel Law Firm. Her phone number is 217-352-1800 and her email address is www.meyercapel.com.

Tube Feeding Information
No matter how often we train our nurses on tube feedings, we still are seeing increases of aspiration pneumonia. Is there something we may be missing during training?

We agree updated training of the staff is needed if you are having aspiration pneumonia. Consider making this a QAPI project.

To start, drill home raising the head of the bed. Lower the head for a nap, but if it is a continuous feed, it should be a continuous elevation.

Percutaneous gastrostomy tube feedings are the best choice for a resident with a feeding tube for a length of time. It is more comfortable for the resident needing a prolonged use of the tube. The incidence of pneumonia is no different between nasogastric tubes and percutaneous tubes, according to researchers (Gomes et al., 2010).

With the tube feedings, measure the gastric residual volume every four to six hours during continuous feedings and immediately before each intermittent feeding. This is especially important if the resident can’t communicate signs of gastrointestinal intolerance.

There is evidence brushing a resident’s teeth and mouth after each meal lowers the risk of aspiration pneumonia. Missing teeth or poorly fitted dentures hinder chewing and swallowing. Infected teeth and poor hygiene contaminate oral secretions and predispose the resident to aspiration pneumonia.

The closed system of feeding, using what resembles IV bags, also can help. Some of the bags for the “open” system, in which individual cans are added by a nurse to the feeding bags, can grow bacteria in less than 20 minutes. A nurse with unwashed hands or who opens a can with a pen is accidently adding bacteria to the bag, increasing the chances of aspiration pneumonia.

This article appeared in the February McKnight’s Long-Term Care News. It was authored by Sherrie Dornberger, RNC, CDONA, FACDONA. Ms. Dornberger is the Executive Director of NADONA.

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

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), established the National Quality Strategy for Quality
Improvement in Health Care (National Quality Strategy), which serves as the national blueprint to improve the health care delivery system and health outcomes by pursuing three goals: better care, healthy people/healthy communities and affordable care. These three goals are reflected in the activities undertaken by the CMS and other agencies of the U.S. Department of Health and Human Services (HHS) to improve care for adults enrolled in Medicaid.

The Affordable Care Act also required the Secretary of HHS to establish a comprehensive adult health care quality measurement program to standardize the measurement of health care quality across state Medicaid programs and facilitate the use of the measures for quality improvement. As required by section 1139B of the Social Security Act (as added by section 2701 of the Affordable Care Act), this report (click here) summarizes the status of state annual reporting on:

- a core set of health care quality measures for adults enrolled in Medicaid, and
- the quality of health care furnished to adults covered by Medicaid, including information collected through external quality reviews of managed care organizations (MCOs).

The HHS Secretary is required to “collect, analyze, and make publicly available the information reported by States” by September 30, 2014, and annually thereafter. This is the Secretary’s first annual report on the quality of health care for adults enrolled in Medicaid, and complements the Secretary’s report on the quality of care for children in Medicaid and the Children’s Health Insurance Program (CHIP), which has been published annually since 2010.

---

**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 15-28 – CMHC** - Community Mental Health Center (CMHC) FAQs. In response to the numerous questions received during the recent CMHC basic surveyor training courses, CMS has compiled a list of FAQs and responses. The FAQs are provided to promote greater surveyor consistency nationally and will be incorporated into Interpretive Guidance as indicated.

- **S&C 15-29 – ESRD** - Contacting End Stage Renal Disease (ESRD) Networks for survey related facility information. Reinforcement of CMS policy regarding contacting providers/suppliers prior to survey entry.

- **S&C 15-30 – All** - Administrative Changes for Two CMS-Approved Accrediting Organizations (AOs).
  - AO Name and Domain Changes – Det Norske Veritas Healthcare, Inc. (DNVHC’s) new legal name is DNV Healthcare USA, Inc. DNVHC’s new trade name is DNV GL - Healthcare. The new acronym is DNV GL. Please use the trade name and acronym on all official documents and correspondence. The domain name for all email addresses is @dnvgl.com and was effective January 5, 2015.
  - AO Name Change – The Community Health Accreditation Program (CHAP) continues to use the legal name Community Health Accreditation Program, but began to do business as the Community Health Accreditation Partner, effective January 1, 2015. Please use this name on
all official documents and correspondence. The organization continues to use the acronym CHAP with a new logo and trade name.

2) CMS released several notices/announcements since the last issue of Regulatory Beat. They include:

- HHS is establishing a Health Care Payment Learning and Action Network to work with private payers, employers, consumer groups, individual consumers, providers, states and state Medicaid programs and other partners to expand alternative payment models into their programs. On January 26, 2015, the HHS set a goal of tying 30 percent of 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. Changes within Medicare alone, however, are insufficient to transform the U.S. health care system. Achieving system wide improvement will require a strong partnership across the private, public, and nonprofit sectors. Click here for the CMS Fact Sheet on the Health Care Payment Learning and Action Network.

- CMS announces the successful completion of the first week of end-to-end testing of the new ICD-10 coding. Approximately 660 providers and billing companies submitted nearly 15,000 test claims. This successful week of testing continues to put us on course for successful implementation of this important initiative that better reflects modern practice of medicine by Oct. 1, 2015. Click here for the full News Update on the successful ICD-10 testing.

- Click here for the CMS Fact Sheet on Transitioning to ICD-10.

- CMS released proposed changes for the coming year for the Medicare Advantage (MA) and Part D Prescription Drug Programs that will advance Health and Human Services Secretary Sylvia M. Burwell’s vision of building a better, smarter health care system and moving the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. Click here for the News Release and Fact Sheet.

- CMS announces release of the 2015 Impact Assessment of Quality Measures Report (click here). This report is a comprehensive assessment of quality measures used by CMS. It examines the effectiveness and impact of measurement and demonstrates our commitment to achieving optimal results from our quality measurement programs. The report summarizes key findings from CMS quality measurement efforts and recommended next steps to improve on these efforts.

3) The Illinois Health Facilities and Services Review Board recently sent out the Long-Term Care Facility Questionnaire for 2014. The questionnaire is mandatory and is to be completed and returned by April 17, 2015. There are no exceptions or extensions. There is the possibility of sanctions/fines if the facility fails to respond in the required timeframe. Click here for a copy of the LTC Questionnaire.

4) AHCA recently released the third product of the Professional Liability Toolkit (click here for the AHCA Memo and here for the attachments). Mark Parkinson created the Professional Responsibility Work Group to develop ways for providers to prepare for or respond to plaintiffs’ attorneys’ aggressive strategies, including paid media campaigns, to target individual nursing and assisted living centers for litigation. With AHCA Board approval, the Work Group has been working with AHCA staff to create resources and tools to help the members prevent or prevail in litigation. The Work Group plans to complete and distribute a comprehensive toolkit by the end of 2015. However, the Work Group believes it’s important to share materials as soon as they became available and not wait until a final toolkit is ready later this year. Material distributed to date includes the 2014 Aon Report, revised arbitration agreement and final Focus Group Report and sample ads.
5) CMS’s Medicare Learning Network (MLN) had a couple news items of interest since the last issue of *Regulatory Beat*. They include:

- The CMS MLN Connects® National Provider Call Program has hosted many educational conference calls for the health care community on a variety of topics, including ICD-10, PQRS, chronic care management, Open Payments (the Sunshine Act), 2-Midnight Rule, Medicare Shared Saving Program, ESRD QIP, and dementia care in nursing homes — just to name a few. Check out their Calls and Events web page for links to slide presentations, audio recordings, written transcripts and a list of upcoming calls, or view one of our videos on the Medicare Learning Network® Playlist on the CMS YouTube Channel. Become more informed about the Medicare Program by reading, listening or viewing these information packed programs at your convenience. Visit [www.cms.gov/npc](http://www.cms.gov/npc) for more information on the MLN Connects National Provider Call Program.

- The “Diagnosis Coding: Using the ICD-10-CM” Web-Based Training Course (WBT) was released and is now available. This WBT is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes ICD-10-CM/PCS implementation guidance, information on the new ICD-10-CM classification system, and coding examples. Continuing education credits are available to learners who successfully complete this course. See course description for more information. To access the WBT, go to [Medicare Learning Network® Products](http://medicarelearningnetwork.org), scroll to “Related Links” at the bottom of the web page, and click on “Web-Based Training Courses.”

6) A new federal General Accounting Office report to Congress casts significant doubts on the integrity and effectiveness of information systems many state Medicaid programs use to process claims, and CMS has agreed with it its recommendation that they verify those systems when applying for Medicaid funds. State Medicaid agencies should be required to measure and report to the federal government how well their electronic payment-integrity tools work, the Government Accountability Office concluded in its March 2 report. The report concluded that CMS and the states cannot be assured of the systems' effectiveness in helping to prevent and detect improper payments unless they are able to identify and measure such benefits (i.e., money saved or recovered) that result from using MMISs and other systems.

7) *MedlinePlus* recently reported that a small, early study hints that a skin test may someday be able to help diagnose people with Alzheimer's and Parkinson's diseases. Researchers found that skin biopsies can reveal elevated levels of abnormal proteins associated with the two disorders. According to the American Academy of Neurology (AAN), about 5.4 million Americans have Alzheimer's disease and 1 million have Parkinson's disease.

8) The Gupta Guide on Medpage Today recently published an article entitled, “Don't Like ICD-10? Don't Worry—ICD-11 is on the Horizon.” According to the World Health Organization (WHO), which coordinates implementation of the coding system, “ICD is currently under revision, through an ongoing Revision Process, and the release date for ICD-11 is 2017.” How different ICD-11 will be from ICD-10 is hard to say, since it’s still in development.

9) *Health Data Management* recently reported on Lessons on Healthcare Breaches Learned in 2014. They were:

- Red Flags – the healthcare industry accounted for 49 percent of Kroll’s “client events” in 2014.

- Causing Harm – about 45 percent of data breaches that Kroll responded to in 2014 were caused by an individual or organization attempting to cause harm, a 10 percent increase from 2013. Despite the
increase, only 18 percent of these breaches were attributed specifically to hacking. Healthcare, however, counted for 30 percent of the hacks, compared with 18 percent for retail. Non-malicious cases in the remaining 55 percent of breaches were caused by lost laptops, negligence, accidents and improper disposal among other reasons.

- In the News – Kroll sees healthcare as a big target for malicious activity. Healthcare has massive amounts of information in their systems. Healthcare is a treasure trove of diverse and valuable information for someone looking to sell data on the black market.

10) The **Annals of Long-Term Care** recently reported that the American Academy of Physicians (ACP) released new clinical practice guidelines on risk assessment, prevention, and treatment of pressure ulcers. The objective of the ACP’s systematic review of the literature was to compare the available evidence of various risk assessment tools as well as the benefits and potential harms of strategies that prevent pressure ulcers. The report issues three general recommendations and three treatment recommendations.

11) The CDC recently released a report that *Clostridium difficile* — *C-diff* infections are on the rise. The findings, the CDC says, also underscore the need for hospitals, nursing homes and other health care facilities to do a better job of preventing the spread of *C-diff* spores from one patient to the next (paying careful attention to frequent hand-washing and other hygiene protocols, for example, and offering infected patients a private room where possible). Many of these difficult infections emerge in a patient who is being treated for some other condition.

12) **McKnight's** had several articles of interest, They include:

- **Quality Measurement Efforts Positive in Nursing Homes: CMS Review**
- **Solutions for Dehydration in Seniors Stump Researchers**
- **Quick Tips for Adapting QAPI**
- **Assisted Living Residents With Dementia Receiving too Many Antipsychotics, GAO says**

13) Interesting Fact: The human body has more bacterial cells than "human" cells.