June 9, 2015 Edition

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!

Protection of Quality Assurance (QA) Documents

There is still a lot of confusion regarding surveyor access to facility Quality Assurance (QA) documents. Federal CMS has stated that surveyors need to see records that QA meetings have been held and who from the facility attended/participated. However, surveyors are not entitled to see/review the specific QA meeting minutes. CMS also stated that surveyors are permitted/allowed to see any investigative notes pertaining to a specific facility investigation to determine compliance with state or federal requirements. Surveyors can only make requests for specific investigative notes and cannot ask for all investigative notes in general. Compliance can be shown by a written report of the investigation and the interviews. LTC facilities need to be very careful in these situations as to not be seen as impeding a survey that could result in Medicare/Medicaid termination or state licensure action. If you have a question on this issue during a survey, contact your Regional Supervisor to discuss prior to the situation getting out of hand.

AHCA’s Legal Committee, with valuable input from the Survey & Regulatory Committee, has developed a webinar and guidance document, sharing their collective thoughts regarding confidentiality under the Quality Assessment and Assurance (QAA) privilege. You can register for the webinar and obtain the guidance document at http://webinars.ahcancal.org/session.php?id=16260; I also have a link to the document below for your quick review. Learning objectives for the webinar include:

1. Review the Quality Assessment and Assurance (QAA) privilege law;
2. Understand the practical process for protecting facility documents;
3. Learn how the QAA privilege intersects with Quality Assurance and Performance Improvement (QAPI); and
4. Discuss categorized documents and whether or not the QAA privilege applies in specific instances.

The AHCA Membership Memorandum (click here) discusses the federal law requiring nursing facilities to maintain Quality Assessment and Assurance Committees, the Quality Assurance (QA) Privilege, a Table of Documents commonly found in a nursing facility with general thoughts regarding confidentiality under the QAA Privilege, and a listing of QAA Committee Best Practices.

Practical Advice on Reducing Antipsychotics

Approximately half of all nursing home residents may be given inappropriate prescriptions for antipsychotics, increasing the risk of expensive and unnecessary hospitalization. In March 2012, the Centers for Medicare & Medicaid Services implemented a campaign to help address the problems of antipsychotic misuse in nursing homes. In addition to education and outreach to both providers and consumers, the program addressed oversight and provider accountability for providing appropriate, resident-centered dementia care.
Two of the CMS data tags — F-Tag 329, which addresses unnecessarily using antipsychotic drugs, and F-Tag 309, which addresses taking steps to reduce antipsychotic drug use — are used by nursing home surveyors to identify specific federal nursing home regulations in order to evaluate whether a nursing home is meeting quality of care, quality of life, safety, among other standards.

Despite CMS' campaign to decrease the inappropriate use of antipsychotic drugs in nursing homes, medication management is less than optimal in nursing home residents. In fact, polypharmacy, also known as the excessive or unnecessary use of medications, is often more the rule than the exception. It is not uncommon to find patients on an average number of 15 to 20 medications (if not more) in a given nursing home. Polypharmacy is potentially dangerous because as people take more drugs, their risk for complications increases. Moreover, many of these medications prove to be deleterious or don't have the desired benefit or impact they're designed to have and predispose patients to an adverse drug event. Drug errors, as well as ADRs, can cause complications that can lead to illness, injury, hospitalization and unnecessary re-hospitalization. These adverse drug events can even be fatal.

From a practical standpoint, a good clinical approach to better medication optimization and management is to take a step back, look at the patient, gauge a patient's prognosis, understand a patient's wishes and desires (or Power of Attorney/patient representative) and treat the patient accordingly. It is rare and unusual that anyone living in a nursing home would require 20 or more medications. CMS' regulatory language defines an unnecessary drug as "...any drug used: in excessive dose (including duplicate therapy); for excessive duration; without adequate monitoring; without adequate indications; in the presence of adverse consequences which indicate the drug should be discontinued; any combination of the previous points...".

A practical approach to starting to reduce the number of antipsychotic medications in patients would be to look at a patient cohort in a given nursing home and choose anyone who's on more than 15 medications and start there. Tailoring and optimizing these medications more appropriately and following the patient's clinical course as a result of changing medications leads to the very best outcomes for these frail elderly institutionalized seniors.

A case study from IPC Healthcare shows how it is possible to limit antipsychotic drug use and instead use non-pharmacologic interventions in a skilled nursing facility. The project was undertaken as part of the Fellowship for Hospital Leaders leadership program, an exclusive partnership formed by IPC Healthcare with the University of California, San Francisco Division of Hospital Medicine in 2010. As part of the year-long program, IPC physician participants work closely with the facility administration in which they practice to define, design and lead an improvement project relevant to the strategic goals of the facility. The IPC-UCSF partnership has the goal of improving the quality of care and the efficiencies of the inpatient care delivery system. Graduates of the Fellowship program complete an intensive one-year training and education program designed to provide leadership skills to the facilities they serve.

At the beginning of this case study, approximately 65% of the residents in the SNF were taking antipsychotic medications. The goal of the project was to reduce antipsychotic use for three consecutive months by 3% per month.

As a first step, an antipsychotic committee was formed, which met twice weekly to discuss patient behavioral changes and assess them for possible recurrences of behavioral and psychological symptoms of dementia. The goal of the committee was to identify those patients who would be a candidate for gradual dose reduction of their medications. Ultimately, 20 patients were identified; 10 were receiving doses of 2 mg twice daily of risperidone and 10 were receiving daily 20 mg doses of olanzapine. The patients on risperidone were ultimately reduced to 1 mg twice daily and those on olanzapine were reduced to 15 mg daily.

At the end of the three-month test period, those patients were taking fewer unnecessary dosages of antipsychotic medications leading to fewer side effects, such as increased risk of falls, as well as fewer behavioral disturbances. The facility saw an 18% reduction of antipsychotic drug doses for those patients, 6% per month.
Additionally, there were measurable results in cost savings for the facility—and ultimately the healthcare system. Within the three month period, there was a total savings of $17,100, approximately $300 per month per patient for those taking olanzapine and $270 per month per patient for those taking risperidone.

The program goal is to continue the dose reduction until patients can, if feasible and with continued monitoring and reassessment, be taken off their medications completely.

As post-acute care facilities grapple with the complexities revolving around providing quality, clinically appropriate patient care and meeting new patient safety criteria, as well as financial challenges that include dwindling reimbursement, a focus on polypharmacy can provide significant benefits. As our observation project proves, not only can patients be the beneficiary of reduced medications leading to better health outcomes, but the facility can see significant cost reductions in the medication spend that it is currently absorbing.

This article was reprinted out of McKnight’s and was authored by Jerome Wilborn, M.D., who is the national medical director of post-acute services for IPC Healthcare.

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**Trending Statistics**

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

Among the five costliest health conditions in both 2002 and 2012—heart conditions, cancer, trauma-related disorders, mental disorders and chronic obstructive pulmonary disease and asthma—mental health conditions showed the biggest increase in the number of patients treated. About 45 million Americans received mental health care services totaling $84 billion in 2012, an increase from 2002, when 31 million Americans received services for mental health care totaling $59 billion. Those receiving mental health care paid the highest out-of-pocket share of expenses (roughly 20 percent) while those treated for cancer paid the lowest out-of-pocket share (about 6 percent) in 2002 and 2012. (Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Statistical Brief #470, *Trends in the Five Most Costly Conditions among the U.S. Civilian Noninstitutionalized Population, 2002 and 2012.*)

**Highlights**

- The same five medical conditions—heart conditions, cancer, trauma-related disorders, mental disorders, and chronic obstructive pulmonary disease (COPD) and asthma—were ranked highest for medical spending in both 2002 and 2012.
- Heart conditions accounted for the highest total spending in both 2002 and 2012.
- The number of people with expenses for mental disorders increased from 31 million in 2002 to 45 million in 2012.
- Among these five medical conditions, mean expenditures per person were highest for cancer and heart conditions in both 2002 and 2012.
- The percentage of out-of-pocket expenses was highest for the treatment of mental disorders in both 2002 and 2012 among the top five most expensive conditions.
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 15-38 – Hospitals** - Revised Hospital Radiologic and Nuclear Medicine Services Interpretive Guidelines—State Operations Manual (SOM) Appendix A. Updated Guidance for Hospital Services: The CMS updated the interpretive guidelines for the hospital Conditions of Participation (CoPs) for Radiologic Services at 42 CFR 482.26 and Nuclear Medicine Services at 42 CFR 482.53. to reflect current accepted standards of practice.


- **S&C 15-40 – Nursing Homes** - Information Only - Review and Status of Nursing Home Survey: Summary of Traditional and Quality Indicator Survey (QIS) Findings and Issues. For the past 10 years, the CMS and the states have used two standard survey processes that assess the quality of care and quality of life for nursing home residents. This memo includes a review of both the traditional survey and QIS processes. CMS is continuing to make improvements to QIS to address the challenges, concerns and feedback they have received to optimize the effectiveness and efficiency of the survey process.

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

- CMS’s Medicare Learning Network’s [MLN Connects Provider eNews](https://www.cms.gov/Medicare/Medicare-Facts-and-Statistics/MLNConnects.html) had several items of interest. They include the following National Provider Calls:
  - National Partnership to Improve Dementia Care and QAPI Provider Call – June 16, 12:30-2 p.m. CST. During this provider call, CMS subject matter experts will provide updates for the National Partnership and Quality Assurance and Performance Improvement (QAPI). Additionally, a nursing home will discuss steps taken to achieve antipsychotic medication reduction in their facility, and
Indiana University will present information about evidence-based dementia care training. A question and answer session will follow the presentations.

- Hospice Quality and Hospice Item Set Manual V1.02 Provider Call – June 17, 12:30-2 p.m. CST. During this provider call, CMS subject matter experts will discuss the new Hospice Item Set (HIS) Manual (V1.02). This call will focus on updates that were made to the HIS Manual from V1.01 to V1.02 and provide clarifications of HIS definitions and expectations for use. Providers should review V1.02, which will be available on the HIS web page prior to the call.

- ICD-10: Preparing for Implementation and New ICD-10PCS Section X Provider Call – June 18, 12:30-2 p.m. CST. It’s not too late to get ready for ICD-10 implementation on October 1, 2015. During this provider call, CMS subject matter experts will present strategies and resources to help you prepare. Also, learn about ICD-10-PCS Section X for new technologies, which will be used by hospitals. A question and answer session will follow the presentations.

- Hospital Compare Overall Star Ratings Methodology Provider Call – June 24, 12:30-2 p.m. CST. The Hospital Compare Overall Star Rating encompasses a wide range of publicly reported quality measures publicly reported on Hospital Compare. This provider call will help you understand the proposed methodology for determining your Hospital Compare Overall Star Rating. A question and answer session will follow the presentation.

- CMS ICD-10 News:
  - CMS Conducts Second Successful Medicare FFS ICD-10 End-To-End Testing Week in April (click here). This second end-to-end testing week demonstrated that CMS systems are ready to accept ICD-10 claims. Approximately 875 providers and billing companies participated, and testers submitted over 23,000 test claims. View the results.

- CMS proposes rule to strengthen managed care for Medicaid and CHIP Enrollees (click here). CMS proposed to modernize Medicaid and Children’s Health Insurance Program (CHIP) managed care regulations to update the programs’ rules and strengthen the delivery of quality care for beneficiaries. This proposed rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. It would improve beneficiary communications and access, provide new program integrity tools, support state efforts to deliver higher quality care in a cost-effective way, and better align Medicaid and CHIP managed care rules and practices with other sources of health insurance coverage. Overall, this proposed rule supports the agency’s mission of better care, smarter spending, and healthier people.

- State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals. CMS put on display at the Federal Register an annual notice that sets forth the states’ final allotments available to pay the Medicare Part B premiums for Qualifying Individuals (QIs) for the federal fiscal year (FY) 2013 and the preliminary QI allotments for FY 2014. For more information, please click here.

- New Medicare Data Available to Increase Transparency on Hospital and Physician Utilization. As part of the Administration’s efforts to promote better care, smarter spending, and healthier people, CMS is posting the third annual release of the Medicare hospital utilization and payment data (both inpatient and outpatient) and the second annual release of the physician and other supplier utilization and payment data. The announcement was made at the annual Health Datapalooza conference in Washington, DC.
CMS Announces Entrepreneurs and Innovators to Access Medicare Data. At Health Datapalooza, the acting CMS Administrator, Andy Slavitt, announced a new policy that for the first time will allow innovators and entrepreneurs to access CMS data, such as Medicare claims. As part of the Administration’s commitment to use of data and information to drive transformation of the health care delivery system, CMS will allow innovators and entrepreneurs to conduct approved research that will ultimately improve care and provide better tools that should benefit health care consumers through a greater understanding of what the data says works best in health care. The data will not allow the patient’s identity to be determined, but will provide the identity of the providers of care. CMS will begin accepting innovator research requests in September 2015.

CMS Issues Guidance to States on Provider Fingerprint-Based Criminal Background Checks for Medicaid and Children’s Health Insurance Program (CHIP). CMS issued guidance to states on Provider Fingerprint-Based Criminal Background Checks for Medicaid and the Children’s Health Insurance Program (CHIP). This guidance is part of a series relating to the implementation of Section 6401 of the Affordable Care Act, Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP. The letter is available on Medicaid.gov at http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

CMS Finalizes Rules for Medicare Shared Savings Program (click here). CMS released a final rule updating the Medicare Shared Savings Program to encourage the delivery of high-quality care for Medicare beneficiaries and build on the early successes of the program and of the Pioneer Accountable Care Organization (ACO) Model. This final rule is an effort to provide support for the care provider community in creating a delivery system with better care, smarter spending, and healthier people.


After many years of dedicated service to the Office of Health Care Regulation/Division of Quality Assurance, Ted Zelinski and Lesley Stevens have retired. Until their positions are filled permanently, Allison Retzer will be assuming Ted’s duties and Celia Weatherford will be assuming Lesley’s duties.

The Office of Health Care Regulation (OHCRR) wanted us to notify our members regarding identifying the relocation location on the “Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents” Form. 42 CFR §483.12(a)(2) indicates circumstances under which a facility may involuntarily transfer/discharge a resident. While the §483.12(a)(6) requirements for contents of the notice must be met for involuntary discharges, if a specific location is not identified when the notice is provided but the facility is diligently working on providing options for the location to which the resident will be transferred/discharged, documentation of the information available would be reasonable. However, whenever possible, the specific location should be provided. More information documented in the clinical record may assist the surveyors in determining whether requirements are met.

The IDPH Bureau of Long term Care has announced the next round of Town Hall Meetings. These regional meetings are very informative and well worth your time to attend. They provide current survey information and allow time for questions and discussion. The actual agenda will be released/announced closer to the dates. Meeting notifications/registration information will be sent to the Administrators of the homes in the region where meeting will be held. This will be done approximately two weeks prior to the meeting date.

- June 30—Brookens Building, Champaign, 1 p.m. - 3 p.m.
- July 16—Friendship Senior Options Friendship Village, Schaumburg, 10 a.m. - 12 noon
- July 23—DeKalb County Rehab and Nursing Center, 1 p.m. - 3 p.m.
- August 24—Memorial Education Building, O’Fallon, 1 p.m. - 3 p.m.
- October 15—Norridge Healthcare and Rehab, 10 a.m. - 12 noon
- October 23—Pekin Manor, 1 p.m. - 3 p.m.
4) The Illinois Health Care Association (IHCA) has two items of interest. They include:

- **The 2015 IHCA Regular Legislative Session Report.** The 2015 regular legislative session came to a relatively quiet close for a session that had up to that point been marked by mudslinging and name calling.

  This session was no different from others in that the state budget was the primary focus. The FY16 budget was a daunting one to tackle, as it contained a deficit of over $6 billion. To compound that problem further, Governor Bruce Rauner, as the first Republican to hold the office in a dozen years, also insisted that numerous other reforms be wrapped into the budget negotiation, including workers compensation reform, tort reform, right to work zones, and property tax freezes. With the majority Democrat controlled legislature unwilling to make the massive cuts called for by the Governor, and the administration unwilling to move forward on revenue solutions to the budget hole without reform concessions, the legislative process quickly turned into a quagmire. Ultimately the battle between Governor Rauner and the Democrat legislative leaders resulted in the scheduled May 31 adjournment date passing with no final agreement on a FY16 budget package, and announcements that the legislature will work through the summer to reach an agreement.

  As far as IHCA’s legislative agenda, we were able to see more success. In addition to the broad issues we continue to work towards solving, such as Medicaid eligibility determinations and meaningful managed care reforms and clarifications, we put forward a small but meaningful package of legislative reforms. Most of these initiatives passed and are poised to become law, with the remainder well positioned to be moved in the coming months. Please click here to read the full **2015 IHCA Regular Legislative Report**.

- **The 2015 IHCA Educational Calendar Update.** Click here to see the IHCA Educational Calendar to view the remaining educational sessions for 2015.

5) The American Health Care Association (AHCA) released several notices of interest. They include:

- **Medicaid Managed Care Proposed Regulation.** CMS issued a proposed rule addressing managed care regulations; this is the first update to the regulations governing Medicaid managed care organizations (MCOs) since 2002. The impact of this regulation is significant given the size and scope of Medicaid managed care programs nationwide. According to CMS, 39 states have contracts with comprehensive managed care organizations, and 20 states have implemented managed care programs that incorporate long term services and supports.

- **Summary of CMS Memorandum to Long Term Care Facilities on Disenrollment Issues.** Click here for the AHCA Summary. On May 26, 2015, CMS issued a memorandum (click here) on beneficiary disenrollment from Medicare Advantage (MA) Plans and dual demos. Specifically, CMS alleges that long term care (LTC) facilities, including nursing centers and skilled nursing facilities, are inappropriately encouraging Medicare beneficiaries to disenroll from MA plans and dual demonstrations. In the transmittal, CMS indicates that the agency has received reports that LTC facilities are disenrolling beneficiaries from Medicare Advantage prescription drug plans (MA-PDs) and enrolling them into stand-alone drug plans (PDPs), and that this practice has occurred without the beneficiary or their representative’s knowledge and/or complete understanding. CMS states that these practices have also been seen among facilities serving dual eligible enrollees participating in or who could participate in a Medicare-Medicaid plan (MMP) as part of the CMS Financial Alignment Initiative. Such practices are noncompliant with current CMS regulatory requirements.
• **AHCA/NCAL Taking Steps to Ensure the Responsible Use of Antibiotics.** AHCA/NCAL recently reinforced its commitment to the responsible use of antibiotics in assisted living, long term and post-acute care settings. AHCA/NCAL joined key federal agencies and private sector organizations at the White House Forum on Antibiotic Stewardship in pledging support for the development, promotion and implementation of antibiotic stewardship activities. [Click here](#) for the full press release.

• **Provider stakeholders had a conference call with CMS on June 1, 2015.** [Click here](#) for the summary of the meeting.

6) **MedlinePlus** had several articles of interest since the last issue of *Regulatory Beat*. They included:

• **Even in Later Life, Exercise Seems to Pay Dividends.** A little exercise late in life may help men live longer, new research from Norway suggests. "Even in the elderly, there is a lot to gain by being moderately active as compared to being sedentary," said study lead author Ingar Holme, professor emeritus at the Norwegian School of Sport Sciences in Oslo. The study ([click here](#)) of older men found that increasing physical activity benefited life span as much as quitting smoking.

• **Most Americans Still Not Using Sunscreen.** Most Americans still don't regularly use sunscreen to help prevent exposure to the sun's cancer-causing rays, a new study reveals. When used as recommended, sunscreen has been shown to reduce risk for all types of skin cancer and prevent or delay signs of aging, the researchers explained. But their 2013 survey ([click here](#)) found only 14 percent of men and 30 percent of women regularly use sunscreen both on their face and other exposed skin.

• **Cholesterol Drugs May Lower Stroke Risk for Healthy Adults.** Healthy older adults who take cholesterol-lowering drugs may be cutting their risk of stroke, a new French study suggests. The study ([click here](#)) found that when people took medications called statins or fibrates, their risk of stroke over almost a decade went down by about one-third.

7) The federal Agency for Healthcare Research and Quality (AHRQ) had several articles of interest in their recent newsletter. They include:

• **AHRQ Case Study Analysis Pinpoints Success Factors for Reducing Central Line-Associated Bloodstream Infections.** An analysis of case studies of health care organizations that participated in AHRQ’s Comprehensive Unit-based Safety Program (CUSP) national implementation project has identified management practices and “success factors” in reducing and eliminating central line-associated bloodstream infections (CLABSI) in health care facilities. AHRQ has funded numerous projects to prevent and reduce healthcare-associated infections as part of its patient safety mission, including CUSP, which intensive care units across the country used to reduce CLABSI by 41 percent. In this analysis, “High-Performance Work Practices in CLABSI Prevention Interventions,” AHRQ-funded researchers conducted in-depth case studies of health care organizations and intensive care units that participated in a CUSP implementation project to study whether and how high-performance work practices facilitate successful reduction of healthcare-associated infections, focusing particularly on CLABSI. Researchers concluded that the following management practices lead to the reduction of CLABSI in health care settings: engaging staff, acquiring and developing talented employees, empowering frontline providers and aligning leaders. Researchers also identified six factors widely evident in health care facilities that reduce CLABSI and missing or inconsistently applied in lower-performing facilities. Included were frontline accountability, strong leadership and use of data.

• **Problematic Medication Use Still High Among Seniors, but Dropping.** The use of potentially inappropriate medications among older people declined between 2006–2007 and 2009–2010, an AHRQ-funded study found. However, there is still an overall high use of such medications, which contributes to poor outcomes and adverse events. Nonsteroidal anti-inflammatory drugs (NSAIDs) are the most prevalent of the
potentially problematic medications. The article and abstract, “Prevalence of Potentially Inappropriate Medication Use in Older Adults Using the 2012 Beers Criteria,” appeared online March 6 in the Journal of the American Geriatrics Society. Coauthors included AHRQ’s G. Edward Miller, Ph.D., and Eric M. Sarpong, Ph.D. The study reported that use of potentially inappropriate medications among older people declined from 45.5 percent in 2006–2007 to 40.8 percent in 2009–2010. Researchers used AHRQ’s 2006–2010 Medical Expenditure Panel Survey data and updated the Beers criteria in the study. The Beers list is a guideline for health care professionals to help improve the safety of prescribing medications for older adults.

- **Register Now: June 24 AHRQ Webinar on Improving Informed Consent and End-of-Life Communication.** AHRQ will host a webinar June 24, 1 - 2 p.m. ET to share results from recent reviews of interventions to improve informed consent processes and documentation of patients’ preferences for end-of-life care. Research shows the informed consent process is often incomplete and patient recall and comprehension of the discussion is usually low. Additionally, care patients receive at the end of life is often not consistent with their preferences. Effective patient-provider communication can make a difference. The webinar will describe the seven elements of the informed consent process. The webinar also will address strategies to improve advance health care directive completion for end-of-life care. Continuing education is available. [Registration is open.](#)

- **Featured Impact Case Study: Memorial Hospital Uses AHRQ Resources To Cut Readmissions, Promote Patient Self-Management.** The [readmissions rate](#) at Memorial Hospital declined to single-digit percentages after the 97-bed community hospital in Marysville, Ohio, implemented AHRQ’s [Re-Engineered Discharge (RED) toolkit](#) to help discharged patients follow their treatment plans.

8) **MedPage Today** had several articles of interest since the last issue of *Regulatory Beat*. They include:

- **Overactive Bladder (OAB) Diagnosis Associated with Higher Odds of Falls in Medicare Population.** A diagnosis of overactive bladder (OAB) significantly increased the risk of falls among a Medicare population, researchers said [here](#).

- **“Less is More” Deepens Focus on Informed Consent.** There is a fair amount of uncertainty about the potential benefits and risks of the [vast majority of medical procedures](#). In an ideal world, patients would learn about all the risks and benefits of a treatment and its alternatives, including doing nothing, through the process of informed consent and shared decision-making [click here](#).

- **Calming Dementia Patients Without Powerful Drugs.** Nursing homes are trying non-drug methods to improve patient behavior [click here](#).

9) **HealthData Management** recently published an article entitled, “[Security Survival Guide: 10 Steps for Protecting Patient Data](#).”

10) **McKnight’s** has published several articles of interest since the last issue of *Regulatory Beat*. They include:

- **Healthy Diets Link to Enhanced Cognitive Flexibility Study.** Adults at risk of late-onset Alzheimer’s disease who ingest more omega-3 fatty acids perform better in cognitive flexibility tests and have bigger anterior cingulate cortices, according to a new [study](#) conducted at the University of Illinois-Champaign.

- **Depression Leaves Permanent, Higher Stroke Risk Study.** Depression can cause irreversible damage leading to stroke even after depressive symptoms have subsided, according to new research.

- **CVS to Acquire Omnicare for $10.4 Billion.** Retail pharmacy giant CVS announced that it will acquire Omnicare, marking the third major recent consolidation among pharmacies and allied companies providing specialty services and pharmacy benefit programs.
- **OIG to Investigate Part A Billing, ED Transfer Practices by Nursing Homes.** The Office of Inspector General released its [Fiscal Year 2015 Mid-Year Update](#), and it includes several initiatives important to long term care operators.

- **Nursing Home Caregivers Often MRSA Conduits: Study.** Nursing home caregivers are often unwittingly conduits that spread an infection that could lead to a potentially lethal flesh-eating disease, according to a new study in a leading infection control journal. In many cases, it's happening simply because workers avoid or are unaware of simple precautions such as personal protective equipment and hand washing, researchers said.

- **Risk of Sepsis Higher for Those Recently Discharged From a Hospital: Study.** Routine hospital stays may disrupt the balance of microbes in the bodies of some older adults enough to increase the risk of sepsis after they've been released, a new study finds.

- **OIG Recovers $1.8 Billion From Providers.** The federal government recovered $1.8 billion from healthcare providers and programs in the first six months of fiscal 2015, a federal watchdog has revealed.

11) **Interesting Fact:** There are up to 1,000 different types of good [bacteria](#) living in our skin. They help with our skin cell turnover and immunity, and we leave remnants of them wherever we go. No two people have the same combination, so scientists are investigating using samples of bacteria from our palms to get a reading that could one day replace or be used alongside DNA in criminal profiling. They’re talking about using a bacterial footprint instead of fingerprints.

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*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](mailto:). 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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