July 14, 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!


What’s the only thing worse than having a urinary catheter when you’re in the hospital? Having one and getting a urinary tract infection (UTI) – or worse – as a result.

Now, a new detailed guide gives doctors and nurses information to help decide which hospital patients may benefit from a urinary catheter – and which ones don’t.

And that should help spare patients the pain, embarrassment, and potentially serious side effects that can come with having a catheter placed -- which may bring more risk than benefit to the patient.

Called the Ann Arbor Criteria for Urinary Catheter Appropriateness, published in the Annals of Internal Medicine as a special supplement, this guideline provides far more detailed advice than ever before.

Many hospitals currently use a short list of appropriate and inappropriate urinary catheter uses published by the Centers for Disease Control and Prevention in 2009.

Unlike the 2009 guideline, the new guideline includes criteria for choosing between three urinary catheter types: indwelling Foley catheters, which continuously drain the bladder, in-and-out catheters, and external “condom” catheters for men.

It also points to when non-catheter strategies may be better, and addresses common and practical bedside challenges that arise, such as managing incontinence in patients who are very difficult to turn.

“In general, because urinary catheters increase the patient’s risk of infection and other complications such as pain and scarring of the urinary tract, they should only be used when teams have no other way to assess a patient’s urine or his or her fluid status,” says Jennifer Meddings, M.D., M.Sc., lead author of the paper and an assistant professor of internal medicine at the U-M Medical School.

One in five hospital patients receives a Foley catheter -- but the new Ann Arbor Criteria suggest that far fewer should.

For instance, the guide says that Foley catheters should not be placed routinely for all intensive care unit patients. Although many ICU patients need hourly urine volume measurement, which requires an indwelling catheter like a Foley, other patients could be managed with a different strategy. Or they could at least have the catheter removed sooner in their ICU stay, after stabilization.
Each day of catheterization increases the risk of complications. So even one day less of catheter use could make the difference in protecting a patient against infection – especially because many UTIs acquired during hospitalization are resistant to antibiotics.

“Reducing the use of catheters, and the UTIs, bloodstream infections and urological emergencies that can arise from their use, could reduce hospital costs,” says co-author and longtime urinary catheter researcher Sanjay Saint, M.D., M.P.H., Chief of Medicine at the VA Ann Arbor Healthcare System and the George Dock professor of internal medicine at the U-M Medical School.

He points to results from an effort that has involved half of all hospitals in the state of Michigan, run by the Keystone Center for Patient Safety. Through a number of catheter-related tactics, it reduces catheter use and catheter-associated UTIs by 25 percent – during a time when rates in other states decreased far more slowly despite federal-level efforts to drive them down.

Now, that same approach – called the “Bladder Bundle” -- is being used in nearly 1,000 hospitals nationwide as part of the “On the CUSP: Stop CAUTI” initiative sponsored by the Agency for Healthcare Research and Quality. Soon, those hospitals will begin using the Ann Arbor Criteria to guide their catheter use.

Saint and Meddings, and their U-M and VA Ann Arbor Healthcare System colleagues, also run a website called CatheterOut.org that offers free information and resources for hospital teams on all aspects of catheter use. The new criteria will be available there as well.

“Our past research has shown that a third to a half of the days that patients have indwelling catheters are unnecessary.” says Saint. “We would very much like these new criteria to be used nationwide by every care team, to determine when a Foley catheter is appropriate.”

Unlike prior catheter guidelines, this guideline was developed using a rigorous approach called the RAND/UCLA Appropriateness Method. It began with a systematic literature review to tally the evidence of benefits and risks of urinary catheters, which yielded 17 guidelines and 79 studies.

Then 15 experts, including nurses and physicians from multiple specialties and eight institutions, met in Ann Arbor to rate the appropriateness of the three catheter types for more than 100 clinical scenarios for medical (non-surgical) uses. They ‘pressure tested’ each clinical scenario, comparing the risks and benefits of catheterization for specific types of patients. This allowed them to take into account patient-specific characteristics or challenges that previous guidelines did not include, and to identify catheter uses that are appropriate, inappropriate and where more research is needed.

“Although the criteria developed by this method are more complex and will be more challenging to implement and monitor, the complexity mirrors the hard decisions that clinicians are already making each day when deciding to place or remove Foley catheters,” says Meddings.

An editorial being published with the paper by Carolyn V. Gould, M.D., MSCR notes, “Meddings and colleagues should be applauded for their efforts to refine the urinary catheter appropriateness criteria,” especially when evidence is lacking for or against catheter use in many situations. She continues, “Where urinary catheters are concerned, we need to focus on the details — the specifics of patient conditions, needs for monitoring, nursing care processes, available alternatives, and the equipment needed — to make substantial improvements in device use and patient safety.”

Authors: In addition to Meddings and Saint, the authors of the Ann Arbor Criteria paper are Karen E. Fowler, MPH; Elissa Gaies, MD, MPH; Andrew Hickner, MSI; Sarah L. Krein, PhD, RN; and Steven J. Bernstein MD, MPH. Most of the authors are members of the U-M Medical School Division of General Medicine faculty and VA Ann Arbor Healthcare System; Hickner is at the Cushing/Whitney Medical Library, Yale University. Meddings, Saint, Bernstein and Krein are members of the U-M Institute for Healthcare Policy and Innovation.
**Funding:** The study was supported by the Department of Veterans Affairs National Center for Patient Safety, Ann Arbor Patient Safety Center of Inquiry, and a contract with the Agency for Healthcare Research and Quality, as well as AHRQ grant K08HS19767.

**For information and resources on reducing catheter use:** [http://catheterout.org/](http://catheterout.org/)

**For information on the On the CUSP: Stop CAUTI initiative:** [http://www.onthecuspstopcauti.org](http://www.onthecuspstopcauti.org)


**AHCA’s Professional Liability Resources and Tools – 2015 Litigation Strategy**

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, final Focus Group Report and sample ads, a list of state “I’m Sorry” laws and a broad brush litigation strategy.

The fifth product to be available as part of the Professional Liability Toolkit is the **litigation strategy** ([Appendix 1 – Georgia Complaint](#)/[Appendix 2 – Lanham Act Complaint](#)) that provides background and guidance for when nursing and assisted living providers choose to fight negative advertisements in court. Initiating litigation can work to stop ads from being published; but providers must proceed with caution. Before going to court, center staff need to carefully analyze the content of the unfavorable advertisements and determine if there is a strong chance a judge would decide that the advertisement is misleading, inaccurate and should stop. Before implementing any of the guidance suggested in the litigation strategy, be sure to determine with legal counsel if this strategy is in your best interest.

With an ever-increasing volume of negative advertisements against nursing and assisted living centers, providers are starting to fight back in court. Initiating litigation to stop attorneys from publishing negative advertisements can work; but nursing and assisted living centers should proceed with caution. Before going to court, providers need to carefully analyze the content of unfavorable advertisements and determine if there is a strong chance a judge would decide that the advertisement is misleading, inaccurate and must stop. Needless to say, a nursing center that has a good survey record is more likely to be successful in court than one with a troubled history.

For instance, in Georgia, a nursing center challenged a false and misleading advertisement in state court and won. The judge determined that the advertisement did not accurately reflect the center’s survey report and stopped the law firm from publishing any more unfavorable advertisements. Nursing centers in other states are now following similar legal strategies.

AHCA/NCAL is grateful to the law firm of Arnall Golden Gregory (AGG) in Atlanta, Georgia, who helped draft this document, and who routinely do this type of litigation. If you have questions regarding this strategy, please contact staff liaisons Dianne De La Mare at ddelmare@ahca.org or Tom Burke at tburke@ahca.org.
New AHRQ Report: Quality of Care and Patient Safety Are Improving, Particularly for Hospital Care, Although More Work Remains

The overall quality of health care and patient safety are improving, particularly for hospital care and for measures that are publicly reported by CMS, according to AHRQ’s newly released 2014 National Healthcare Quality and Disparities Report. Hospital care was safer in 2013 than in 2010, with 17 percent fewer harms to patients and an estimated 1.3 million fewer hospital-acquired conditions, 50,000 fewer deaths, and $12 billion in cost savings over three years (2011, 2012, 2013). However, quality is still far from optimal, with millions of patients harmed by the care they receive, and only 70 percent of recommended care being delivered across a broad array of quality measures. A few disparities among racial groups for services such as childhood vaccinations have been reduced to zero; however, much additional work remains to address a broad range of other disparities affecting quality of care. This year’s report has been consolidated and now tracks performance measures that align with HHS’ National Quality Strategy. Chartbooks on specific topics such as patient safety and care coordination will be issued in coming months to provide more detailed information and easy-to-understand slides that can be downloaded for presentations. Complimentary copies of the report are available online and also can be ordered via email or phone, 1-800-358-9295.

Key Findings of the 2014 Quality and Disparities Report

The report demonstrates that the nation has made clear progress in improving the health care delivery system to achieve the three aims of better care, smarter spending and healthier people, but there is still more work to do, specifically to address disparities in care.

- **Access improved.**
  - After years without improvement, the rate of uninsurance among adults ages 18-64 decreased substantially during the first half of 2014.
  - Through 2012, improvement was observed across a broad spectrum of access measures among children.

- **Quality improved for most NQS priorities.**
  - *Patient Safety* improved, led by a 17 percent reduction in rates of hospital-acquired conditions between 2010 and 2013, with 1.3 million fewer harms to patients, an estimated 50,000 lives saved, and $12 billion in cost savings.
  - *Person-Centered Care* improved, with large gains in patient-provider communication.
  - *Many Effective Treatment* measures, including several measures of pneumonia care in hospitals publicly reported by CMS, achieved such high levels of performance that continued reporting is unnecessary.
  - *Healthy Living* improved, led by doubling of selected adolescent immunization rates from 2008 to 2012.

- **Few disparities were eliminated.**
  - People in poor households generally experienced less access and poorer quality.
  - Parallel gains in access and quality across groups led to persistence of most disparities.
  - At the same time, several racial and ethnic disparities in rates of childhood immunization and rates of adverse events associated with procedures were eliminated, showing that elimination is possible.

- **Many challenges in improving quality and reducing disparities remain.**

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*
Performance on many measures of quality remains far from optimal. For example, only half of people with high blood pressure have it controlled. On average, across a broad range of measures, recommended care is delivered only 70 percent of the time.

As noted above, disparities in quality and outcomes by income and race and ethnicity are large and persistent, and were not, through 2012, improving substantially.

Some disparities related to hospice care and chronic disease management grew larger.

Data and measures need to be improved to provide more complete assessments of two NQS priorities, Care Coordination and Care Affordability, and of disparities among smaller groups, such as Native Hawaiians, people of multiple races, and people who are lesbian, gay, bisexual, or transgender.

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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 15-42** – This number was skipped for some unknown reason. Will monitor.

- **S&C 15-43 – ASC** - Advanced Copy - Update to Ambulatory Surgical Center (ASC) Infection Control Surveyor Worksheet (ICSW). CMS has made minor revisions to the Infection Control Surveyor Worksheet, Exhibit 351 of the State Operations Manual (SOM) for assessing compliance with the Medicare ASC Infection Control Condition for Coverage (CfC). Revisions were made to bring the worksheet into alignment with current accepted standards of practice; reflect recently released guidance; and improve the clarity of certain questions.

- **S&C 15-44 – ESRD** - Use of Portable Reverse Osmosis (RO) Units and Block Carbon. Portable Reverse Osmosis Units that meet Association for the Advancement of Medical Instrumentation (AAMI) water quality standards, as incorporated by reference in the End Stage Renal Disease (ESRD) Condition for Coverage (CfC) at 42 CFR Section 494.40, may be used in outpatient dialysis facilities. ESRD Surveyors should follow the ESRD Core Survey process in conjunction with this guidance for use of portable RO units and block carbon in outpatient dialysis facilities.

- **S&C 15-45 – CAH** - Clarification of Critical Access Hospital (CAH) Rural Status, Location and Distance Requirements. Update of S&C 11-33-Hospital/CAH/RHC: This memorandum supersedes the portion of the guidance of policy memorandum S&C 11-33, which addresses metropolitan statistical areas (MSAs). That guidance is being updated to reflect the new CAH regulation at 42 CFR 485.610(b)(5). Under the new regulation, a Medicare-participating CAH that previously was located in a rural area, based on adoption by CMS of the Office of Management and Budget’s (OMB) delineations of MSAs, may no longer be located in a rural area when CMS adopts the most recent OMB delineations. Such CAHs are permitted to retain their CAH status up to two years from the effective date of CMS’ latest adoption of the OMB delineations. During this grace period, the CAHs are expected either to reclassify as rural under one of the alternatives permitted at §485.610(b)(2), or to convert to a Medicare-participating hospital. For further detail, view the full memo here.

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

- **Countdown to ICD-10** – CMS resources noted in Medicare Learning Network.
  - CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10
  - MLN Connects National Provider Call: Countdown to ICD-10
  - “ICD-10 Website Wheel” Educational Tool — Released
  - “Medicare FFS Claims Processing Guidance for Implementing ICD-10 — A Re-Issue of MM7492” MLN Matters® Article — Revised
  - Medicare Learning Network ICD-10 Products Available In Electronic Publication Format
In addition, IHCA is sponsoring several seminars around the state to help our members prepare for ICD-10. View seminar brochure, Register online.

- Tuesday, July 21, 2015—Holiday Inn & Suites, East Peoria
- Wednesday, July 22, 2015—Hyatt, Lisle
- Tuesday, July 28, 2015—Hawthorn Suites by Wyndham, Champaign
- Wednesday, July 29, 2015—Rend Lake Resort, Whittington
- Thursday, July 30, 2015—Northfield Inn & Suites, Springfield

We will be expanding on the basics and apply the coding conventions and guidelines to real-life scenarios. There will also be helpful hints on documentation and querying physicians so coders will feel comfortable with their coding abilities, as well as communication with billers and providers. We will also assess where the facility is in the transition process and what steps to take going forward.

**Please Note: Attendees will need to bring a copy of the 2015 ICD-10-CM coding books with them.**

- **FAQ: Home and Community-Based Settings Requirements.** CMS released Frequently Asked Questions (FAQs) related to home and community-based settings. The guidance focuses on the process for states to use in overcoming the presumption that certain settings have the characteristics of an institution, and highlights the heightened scrutiny review that CMS will give such information submitted from states. The guidance also addresses the most common questions asked in topic areas such as state flexibility to exceed federal settings requirements, use of section 1915(b)(3) waiver authority, and application of the settings requirements to visitors and tenancy. More information on home and community-based services and settings is available here.

- **Coverage of Housing Related Activities and Services for Individual with Disabilities.** This Informational Bulletin is intended to assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with disabilities, older adults needing long term services and supports (LTSS), and those experiencing chronic homelessness. Consistent with statute, CMS does not provide Federal Financial Participation (FFP) for room and board in home and community based services, but can assist states with coverage of certain housing-related activities and services. This bulletin underscores CMS’ commitment to help states expand home and community-based living opportunities consistent with the Affordable Care Act, the implementation of the Home and Community Based Services (HCBS) settings final rule governing Medicaid’s 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option and 1915(k) Community First Choice State Plan Option, as well as the Americans with Disabilities Act and the Supreme Court’s decision in Olmstead v. L.C. The information in this bulletin is based on evidence from studies demonstrating that providing housing-related activities and services facilitates community integration and is cost effective. This bulletin is also intended to help states design benefit programs that acknowledge the social determinants of health and contribute to a holistic focus on improvement of individual health and wellness.

- **OIG-HHS conducts study on Skilled Nursing Facility Billing for Changes in Therapy: Improvements are needed.** In fiscal years 2011 and 2012, CMS implemented new policies to address concerns that billing by skilled nursing facilities (SNFs) did not adequately reflect changes in the amount of therapy that a beneficiary receives during a SNF stay. Specifically, CMS introduced new types of assessments that capture changes in a beneficiary’s therapy more quickly. This report provides information about SNF billing for changes in therapy under these new policies.
CMS's new policies are complex and create challenges for effective oversight. To better ensure that beneficiaries are receiving the amount of therapy they need, and that Medicare is paying appropriately, CMS should accelerate its efforts to implement a new method for paying for therapy. A new payment method may eliminate the need for the new assessments by basing payments on beneficiary characteristics rather than on the amount of therapy provided. In the meantime, CMS should mitigate the problems with the new therapy assessments by (1) reducing the financial incentive for SNFs to use assessments differently when decreasing and increasing therapy and (2) strengthening the oversight of SNF billing for changes in therapy. CMS concurred with both of our recommendations. Download the complete report.

- **CMS Proposes Hospital Outpatient and Ambulatory Surgical Center Policy and Payment Changes, Including Proposed Changes to the Two-Midnight Rule and Quality Reporting Changes for 2016.** CMS released the Calendar Year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System policy changes, quality provisions, and payment rates proposed rule [CMS-1633-P] on July 1, 2015. The CY 2016 OPPS/ASC proposed rule proposes updates to Medicare payment policies and rates for hospital outpatient departments (HOPDs), ASCs and partial hospitalization services provided by community mental health centers (CMHCs), and refinements to programs that encourage high-quality care in these outpatient settings. Approximately 3,800 hospitals and 60 CMHCs are paid under the OPPS, while approximately 5,300 ASCs are paid under the ASC payment system. The OPPS provides payment for most HOPD services, including partial hospitalization services furnished by HOPDs and CMHCs. OPPS payment amounts vary according to the Ambulatory Payment Classification (APC) group to which a service or procedure is assigned.

  The proposed rule also includes important proposed changes to the Two Midnight Rule for CY 2016. See related fact sheet for detailed information. The OPPS/ASC proposed rule is one of several rules for CY 2016 that reflect a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people.

- **HHS Education and Training Resources on Multiple Chronic Conditions for the Health Care Workforce.** New training material to help provide health care professionals with education necessary to care for people living with multiple chronic conditions was launched by the U.S. Department of Health and Human Services. The HHS Education and Training Resources on Multiple Chronic Conditions (MCC) for the Healthcare Workforce materials—a first of their kind—were created by the Office of the Assistant Secretary for Health, in collaboration with the Health Resources and Services Administration (HRSA). Through these new resources, HHS seeks to bolster interprofessional education and training materials for health professions students, faculty, practitioners, direct care workers and patients and their families that address the care of persons with multiple chronic conditions. In addition, health professions education focuses on caring for patients with a single disease rather than those with multiple chronic conditions.

- **Accountable Care Organization (ACO) Investment Model.** The ACO Investment Model (click here for the Fact Sheet) is an initiative developed by the CMS Innovation Center for organizations participating as ACOs in the Medicare Shared Savings Program (Shared Savings Program). The ACO Investment Model is a new model of pre-paid shared savings that builds on experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas and current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. *The ACO Investment Model will be available to:*

  1) New Shared Savings Program ACOs that joined in 2015 or are joining in 2016. The ACO Investment Model seeks to encourage uptake of coordinated, accountable care in rural geographies and areas where there has been little ACO activity, by offering pre-payment of shared savings in both upfront and ongoing per beneficiary per month payments. CMS
believes that encouraging participation in areas of low ACO penetration may spur new markets to focus on improving care outcomes for Medicare beneficiaries.

2) ACOs that joined the Shared Savings Program starting in 2012, 2013 or 2014. Here, the ACO Investment Model will help ACOs succeed in the Shared Savings Program and encourage progression to higher levels of financial risk, ultimately improving care for beneficiaries and generating Medicare savings.

• CMS Begins Implementation of Key Payment Legislation. Proposed Update to Physician Fee Schedule is First Since Repeal of SGR. On July 8, CMS released the first proposed update (click here) to the physician payment schedule since the repeal of the Sustainable Growth Rate through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The proposal includes a number of provisions focused on person-centered care, and continues the Administration’s commitment to transform the Medicare program to a system based on quality and healthy outcomes.

• Comprehensive Care for Joint Replacement Model Announced. The U.S. Department of Health and Human Services (HHS), CMS Innovation Center has announced a proposal (click here), through the notice and comment rulemaking process of a new model to support better and more efficient care for beneficiaries undergoing the most common inpatient surgery for Medicare beneficiaries: hip and knee replacements. This model, called the Comprehensive Care for Joint Replacement (CCJR) Model, would test bundled payment and quality measurement for hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve quality and coordination of care throughout an entire episode of care, from the initial hospitalization through recovery. With publication of a proposed rule, CMS is seeking input and comments from the public, including beneficiaries, health care providers, and other stakeholders.


• State Fiscal Year 2016. Illinois begins FY 2016 (July 1, 2015 – June 30, 2016) without a state budget and appropriation. While payments from the department will be impacted, beneficiaries remain eligible and the department will be obligated to pay once appropriations are available. Click here to get the full details.

• Conversion from International Classifications of Disease (ICD)-9 to ICD-10 - Electronic Data Interchange (EDI) Vendor Programming Delay. HFS released a provider notice that updates information provided in a recent Notice dated 06/17/2015 regarding the requirement that the federally-mandated conversion from ICD-9 to ICD-10 codes be implemented no later than 10/01/2015.

Facilities must update current resident’s ICD-9 codes to ICD-10 codes during the three month time period 07/01/2015 through 09/30/2015 using the Medicaid Electronic Data Interchange (MEDI). MEDI must be used for this update of current residents even if the facility normally uses one of the EDI vendors (formerly referred to as REV). Although providers were previously informed they could continue to use EDI vendors for new admissions once the current resident’s ICD-9 codes were updated to ICD-10 codes, the EDI vendors may not complete all programming required to allow new admissions to be processed with both the ICD-9 and ICD-10 code during this three month period.

Providers can determine if their EDI vendor has completed this programming by completing an inquiry on the “Admissions” screen for two fields labeled as ICD-9 and ICD-10. If those two fields are not present in EDI, the provider should use MEDI to submit the admissions during the three month time period 07/01/2015 through 09/30/2015. Submission of a new admission through EDI prior to the programming not being completed may result in an unsuccessful transaction.

Since providers must already register with MEDI to update the codes for current residents and MEDI is a free service this should not cause any undue hardship.
Questions regarding this notice may be directed to the HFS Bureau of Long Term Care at 217-782-0545.

- **Requirements for Enrollment and Revalidation in the New Enrollment System - Illinois Medicaid Program Advanced Cloud Technology (IMPACT).** [This notice](#) outlines the requirements for enrolling in or revalidating existing information in the new computer-based provider enrollment system, called Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

- **ICD-10-CM Implementation- 837P Electronic Transactions.** The purpose of [this notice](#) is to advise all transportation providers of billing changes required by the implementation of the ICD-10-CM code set beginning on October 1, 2015.

4) The American Health Care Association (AHCA) had one summary of the Supreme Court ruling regarding *King v. Burwell* and what it means to AHCA-NCAL members. [Click here](#) for the summary.

5) **News from the Illinois Health Care Association (IHCA) with regard to the MDS Focused Surveys.** IHCA has heard from one of our members that they have had the newly revised MDS Focused Survey. We are in the process of getting more specific information concerning this survey and the process, but early information is that the survey was done by federal surveyors rather than state surveyors. Not sure if this is the overall, ongoing plan or if the surveys will also be done by state surveyors. [Click here](#) for the Entrance Conference form that the federal surveyors gave the facility upon their entrance and before beginning the MDS Focused survey. As we gather more information, we will pass it on to our members. Please contact Debbie Jackson at IHCA if you have one of these surveys.

6) The Agency for Healthcare Research and Quality (AHRQ) had a couple of articles on recent studies that may be of interest to you. They were:

- **Measuring Patient-Reported Outcomes Can Help Identify Patients at Higher Risk for Hospital Readmission, AHRQ Study Finds.** Despite widespread efforts to accurately predict which patients are at greatest risk for being readmitted to the hospital within 30 days of discharge, patient-reported outcome measures are infrequently used in predictive models. To find out whether patients’ self-reported views of their health services can accurately predict readmission, a research team at Cook County Health and Hospital System in Chicago administered the Memorial Symptom Assessment Scale and the Patient Reported Outcomes Measurement Information System (PROMIS) Global Health short form to 196 patients at discharge. Patients also took the health assessment surveys at 30, 90 and 180 days after discharge. Patients who scored poorly on the PROMIS measures of general self-rated health and mental health were at greater risk of rehospitalization within 14 days of discharge, researchers found. However, low scores by patients on the Memorial Symptom Assessment Scale and the PROMIS measures of global physical health were better able to predict readmission. Because the sample size of the population was relatively small, researchers acknowledged that the findings may be limited. They recommended that systems to obtain patient-reported outcomes be developed as a routine part of clinical care. The study, “When Do Patient-Reported Outcome Measures Inform Readmission Risk?” and [abstract](#) were published online on April 9 in *Journal of Hospital Medicine*.

- **AHRQ Study Examines Nursing Homes With Pay-for-Performance Programs.** Creating a reimbursement context that facilitates the collection and use of reliable local evidence is an important consideration for nursing home leaders contemplating pay-for-performance policies, AHRQ-funded researchers concluded in a study in *BMJ*. Pay-for-performance programs are used in organizations aiming to improve the quality of care. This study explored ways in which data were collected and used as a result of participation in a pay-for-performance program. Interviews were conducted with 232 employees from 70 nursing homes that participated in pay-for-performance-sponsored quality improvement projects. Interviewees included supervisors, nurses and nursing assistants, therapists, other patient care staff and administrators. Researchers found that data and evidence played an important role in quality improvement project implementation. Nursing home staff discussed using data to identify problems, track progress, motivate
employees and increase the marketability of the organization. The study and abstract, “Pay-for-Performance Policy and Data-Driven Decision making Within Nursing Homes,” appeared online March 6.

7) MedlinePlus published several article of interest. They include:

- **Many Doctors Underestimate Risks of Prescription Painkillers: Survey** - Nearly half questioned were misinformed about potential for abuse. Doctors who are ill-informed about narcotic painkillers are unintentionally contributing to their misuse, new research suggests. Almost half of 1,000 primary care doctors surveyed in the United States mistakenly believed that abuse-deterrent pills -- those that can't be crushed and snorted or injected -- are less addictive than standard narcotic painkillers (opioids). "Physicians and patients may mistakenly view these medicines as safe in one form and dangerous in another, but these products are addictive no matter how you take them," wrote study leader Dr. G. Caleb Alexander, co-director of the Center for Drug Safety and Effectiveness at Johns Hopkins Bloomberg School of Public Health in Baltimore. "If doctors and patients fail to understand this, they may believe opioids are safer than is actually the case and prescribe them more readily than they should," he said in a Hopkins news release.

- **Common Antidepressants Linked to Higher Fracture Odds in Menopausal Women** - Drugs like Celexa, Prozac could undermine bone, research suggests. Women prescribed a common class of antidepressants to ease menopausal symptoms may face a long-term rise in their risk for bone fracture, a new study suggests. The antidepressants in question are selective serotonin reuptake inhibitors (SSRI) medications such as Celexa, Paxil, Prozac and Zoloft. Besides being used to treat depression, these drugs are often prescribed as an alternative to hormone replacement therapy (HRT) to tackle hot flashes, night sweats and other problems that can accompany menopause. However, "SSRIs appear to increase fracture risk among middle aged women without psychiatric disorders," wrote a team led by Dr. Matthew Miller of Northeastern University in Boston.

- **Exercise Benefits People With Parkinson's Disease: Study** - The sooner you start regular physical activity, the better, researchers say. Parkinson's disease patients who begin regular exercise earlier have a much slower decline in quality of life than those who start exercising later, a new study finds. National Parkinson Foundation (NPF) researchers looked at information from nearly 3,000 patients. More than 1,300 reported doing little regular exercise before taking part in the study. Over two years, 500 of the inactive patients began to exercise more than 2.5 hours a week. The researchers compared patients who exercised regularly for the entire two years to people who were inactive at the start of the study, but then began a regular exercise routine. The study didn't note the type of workouts, just the total amount of exercise.

- **Many Hospital Patients Not Asked About Supplements: Study** - This raises risk of harmful drug interactions. Most hospitalized Americans aren't asked if they take dietary supplements, such as multivitamins, a new study suggests. "If clinicians are unaware of possible drug-[dietary supplement] reactions, they may unknowingly provide a treatment plan or prescribe medications that could have an adverse reaction or interactions with the dietary supplement," said study author Dr. Paula Gardiner.

- **Even Light Activity Can Boost Seniors' Health** - Researchers suggest 300 minutes weekly of activities such as walking or gardening. Regular light exercise can be as good for seniors as moderate or vigorous exercise, according to a new study. Moderate-intensity physical activity has been shown to be good for your health. But, this study suggests that seniors should also be encouraged to engage in lower-intensity activity whenever they can, study lead author Paul Loprinzi, an assistant professor of exercise science and health promotion at the University of Mississippi, suggested in a news release from Oregon State University. Loprinzi was at Oregon State University at the time of the study.
8) Medpage Today published several articles that might be of interest to you. They include:

- **Overused Antibiotics Cause Havoc Among Nursing Home Patients** - Residents suffered adverse reactions even when they didn't take the meds. One in eight nursing home residents experienced an adverse event related to antibiotic prescribing, regardless of whether they personally took the antibiotics, researchers reported. During a 2-year period, residents living in Ontario nursing homes that were in the highest one-third of antibiotic use facilities had a 24% higher risk for having an antibiotic-related adverse event, when compared with those living in the lower two-thirds of the 607 facilities housing over 110,000 residents (adjusted odds ratio 1.24, 95 percent CI 1.07-1.42, P=0.003), Nick Daneman, MD, MSc, of the University of Toronto, and colleagues reported in JAMA Internal Medicine. "Antibiotics are one of the most frequently prescribed medications in [nursing homes] where 6 percent to 10 percent of residents are taking antibiotics at any given time and more than half receive at least one antibiotic prescription in a single year," Lona Mody, MBBS, MSc, of the University of Michigan Medical School, and Christopher Crnich, MD, of the University of Wisconsin School of Medicine and Public Health, wrote in an editorial in JAMA Internal Medicine. "Much of this use is inappropriate."

- **Pneumo Vaccine Rules Clarified** - Immunization committee harmonizes guidance on vaccines against pneumococcus in people 65 or older. For adults 65 or older, the two recommended vaccines against pneumococcus should be given at least a year apart, regardless of their order, according to the CDC's Advisory Committee on Immunization Practices (ACIP). The recommendation will eliminate confusion among healthcare providers and close a loophole in Medicare payment policies, the committee was told. The two approved drugs are a 13-valent pneumococcal conjugate vaccine (PCV13 or Prevnar-13) and a 23-valent polysaccharide vaccine (PPSV23 or Pneumovax). The current guidance recommends that adults 65 or older get PCV13 first followed by PPSV23 between 6 and 12 months later, with a minimum interval between the doses of 8 weeks.

- **OK to Lower Antipsychotics in Older Schizophrenia Patients** - Dose reduction can lessen side effects while maintaining symptom control. Physicians can safely reduce the dose of antipsychotics in patients with late-life schizophrenia, diminishing the potential adverse effects of these medications, researchers found. In a single-center trial of 35 schizophrenia patients, 80 percent achieved dose reductions without signs of clinical deterioration, Ariel Graff-Guerrero, MD, PhD, of the Center for Addiction and Mental Health in Toronto, and colleagues reported online in JAMA Psychiatry. Their findings also suggested a lower therapeutic window for dopamine receptor occupancy than seen in younger schizophrenia patients, they said. While those patients achieve optimal therapy around 65 percent occupancy, late-life patients may do better at 50 percent and up. "Antipsychotic dose reduction is feasible in most patients with stable late-onset schizophrenia," they wrote. "Antipsychotic dose reduction can improve extrapyramidal symptoms, hyperprolactinemia, and some symptoms through decreases in D2/3 receptor occupancy."

- **CMS, AMA Unveil Steps to Ease ICD-10 Transition** - CMS will set up ombudsman and be flexible about accepting claims. CMS and the American Medical Association (AMA) are trying to make things easier for physicians transitioning to the new ICD-10 diagnosis codes set to take effect on October 1. On Monday, the AMA and CMS jointly announced that CMS "is releasing additional guidance that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set." In addition, the agency will appoint an ICD-10 ombudsman "to triage and answer questions about the submission of claims." The ombudsman will be located in a new ICD-10 communications and coordination center that CMS is setting up. The center will be "learning from best practices of other large technology implementations that will be in place to identify and resolve issues arising from the ICD-10 transition," the announcement said.

9) The National Institute on Aging released a document entitled “Advice for Older People on Staying Safe in Hot Weather.” Summer weather can pose special health risks to older adults and people with chronic medical conditions. It is critically important that adults particularly susceptible to hyperthermia and other heat-related
illnesses know how to safeguard against problems. The National Institute on Aging (NIA), part of the National Institutes of Health, has some tips to help avoid the hazards of hot weather.

10) *McKnight’s* published several articles of interest. They include:

- **New OIG litigation team will tackle Medicare, Medicaid fraud cases.** The U.S. Department of Health and Human Services Office of Inspector General has created a new team of attorneys focused solely on litigation involving Medicare and Medicaid fraud (click here). The new team was announced at the American Health Lawyers Association’s annual meeting, and aims to help fill an enforcement gap among attorneys handling civil penalty and exclusion cases, OIG officials said. Previously, attorneys worked on OIG-initiated litigation in addition to other cases. “Lawyers used to have to wear multiple hats, and their attentions could get diverted,” Tony Maida, an attorney at McDermott Will & Emery LLP and a former deputy chief of the OIG’s administrative and civil remedies branch, told Bloomberg News. The new attorney team will focus heavily on owners and executives of healthcare organizations, physicians involved in kickback schemes and top billers of high-risk procedures, Maida said. He advised smaller, independent healthcare providers to especially take note of the new litigation team and the overall crackdown of Medicare and Medicaid fraud by the federal government, since they lack the compliance resources of large organizations.

- **Providers should use technology to reduce antipsychotic drug use, experts say.** New technology can help reduce the use of antipsychotics for nursing home residents with dementia, experts said during a McKnight’s Super Tuesday webinar. In a case study, Western Home Communities found adding computers at Martin Health Center that focused on person-centered recreation helped reduce PRN antipsychotic drugs among residents by 50 percent. The number of doses given to residents went down 20 percent, according to Josh Hansen, Western Home Communities’ technology director.

- **EHRs and predictive analytics could predict nursing home fall risks: study.** Using electronic health records with predictive analytics algorithms could help identify long term care residents who are at a high risk of harmful falls, a new study has found. The study, conducted at 13 California nursing homes, analyzed data from the CMS Minimum Data Set and EHRs for more than 5,000 residents. On its own, the CMS Minimum Data Set collected data infrequently and didn’t account for all the factors that can contribute to falls. Researchers found that adding clinical data from EHRs to the CMS assessment data helped create more thorough and up-to-date predictions for residents at risk for falls. Adding EHR data with the CMS data improved the fall prediction algorithm’s accuracy by 13 percent, and confirmed 32.2 percent of observed falls among residents in the highest 10 percent of risk. Prior analysis using only the CMS data confirmed 28.6 percent of falls.

- **Healthcare inspections for nursing homes to be tougher under new OSHA rules.** Nursing homes will face more scrutiny based on a new key hazard list from the Occupational Safety and Health Administration. The new hazards, specified in an OSHA memorandum, include musculoskeletal disorders related to resident handling, workplace violence, bloodborne pathogens, tuberculosis and slips, trips and falls. The hazards were addressed in OSHA’s recent National Emphasis Program – Nursing and Residential Care Facilities, which involved collecting specific injury and illness data from 80,000 healthcare facilities. “The goal of this policy is to significantly reduce overexposures to these hazards through a combination of enforcement, compliance assistance and outreach,” the OSHA memo reads. Nursing homes must make sure there are an adequate number of lifts, assistive devices and accessories for each resident requiring a lift, and enough charged batteries to power the assistive devices needed during a shift to avoid unnecessary manual handling, OHSA said.

- **LTC will face more pressure to lessen antipsychotics, government officials say.** The push for long-term care facilities to abandon the use of off-label use of antipsychotic medications for residents with dementia will intensify over the next two years, CMS officials said recently. The National Partnership to Improve Dementia Care is pushing forward with a 25 percent reduction of the medications by the end of 2015,
which it wants to hit 30 percent by the end of next year, according to CMS coordinator Michelle Laughman, speaking during a CMS Open Door Forum call. Nursing homes reached the national goal of a 15.1 percent reduction in 2013. “We’re working towards that 25 percent goal,” Laughman said. “But there’s still many homes across the country that continue to have higher rates than the national average, and we’re looking at that.” The cornerstones for antipsychotic medication reduction include person-centered care, training of facility management and staff, and embracing culture change, Laughman said.

- **Assessment finds Medicare quality measurements lacking.** Many chronic conditions seen in long term care settings are under-represented in Medicare pay-for-quality programs, an Avalere survey has found. This shortcoming limits the program’s ability to pay for value, investigators noted. Among the top 20 high impact conditions listed in Avalere’s assessment, osteoporosis, hip/pelvic fracture, lung cancer and prostate cancer have only three Medicare quality measures, while Alzheimer’s and endometrial cancer have zero. “Quality measures are increasingly driving the economics of Medicare Advantage and other coordinated care programs,” said Avalere CEO Dan Mendelson in the assessment. “As Medicare and other payers move towards value based payments for services and pharmaceuticals, we need more meaningful quality measures.

11) Interesting Fact: A recent study reported that more than two-thirds of U.S. adults are now overweight or obese. About 35 percent of men and 37 percent of women are obese. Another 40 percent of men and 30 percent of women are overweight. (OUCH – I’m in this category...won’t tell you which one.) The report went on to state that obesity is not getting better – it is getting worse. Obesity has been linked to a number of chronic health conditions, including type 2 diabetes, heart disease, certain cancers and arthritis.

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