October 10, 2018 Edition

Feature Focus

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

Why Am I Hearing So Much About ICD-10 Lately?
ICD-10 should be on everyone’s radar again. As we move into the value-based payment system and the Patient Driven Payment Model (PDPM), ICD-10 will be impacting Skilled Nursing reimbursement.

Value-Based Payment initially removes 2 percent of payments from all SNFs and then returns a percentage of it back – if the SNF earns its return – by meeting or exceeding a specific measure.

Diagnoses are used for risk adjusters in some of these quality measures. It is, therefore, important that all diagnoses impacting the resident are captured and that they are correctly coded, with specificity, in order for them to be used as exclusions or risk adjusters.

Diagnoses specifically impact these measures:

- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay);
- Percent of Patients or Residents with Pressure Ulcers that are New or Worsened; and
- Application of Percent of Long Term Care Hospital Patients with an Admission or Discharge Functional Assessment and a Care Plan that Addresses Function.

The specificity of ICD-10 is the way facilities can communicate the severity of a patient’s medical condition. This is key in determining the level of reimbursement. Diagnosis will impact the therapy components with PDPM. A resident with cognitive impairment is going to increase the SLP reimbursement more than PT or OT. Conversely, a diagnosis of amputation is going to increase the PT and OT components over the SLP.

Now is the time to review ICD-10 coding processes in your facility. Are coding conventions being followed? Are non-specific codes being assigned? It is important that staff are trained and competent in ICD-10. Stay tuned for future IHCA/AHCA trainings in this area.

Kitchen/Dining Observation
The third mandatory LTC Survey Pathway that surveyors must review revolves around Kitchen/Dining Observation. Although these two survey items are combined under one task, the surveyors will review each item individually.
One surveyor will conduct a brief kitchen tour upon arrival at the facility, with observations focused on practices that might indicate potential for foodborne illness. Additional observations will be made throughout the survey process in order to gather all information needed.

Each survey team member will be assigned a dining area. If there are fewer surveyors than dining areas, they will observe the dining areas with the most dependent residents. The team is responsible for observing the first meal upon entrance into the facility. Additional meal observations may be required if the team identifies concerns. The surveyor assigned primary responsibility will answer all Critical Elements (CEs). Any other surveyor assigned a dining location will complete the observations and answer CEs of concern. Potential nutrition or hydration concerns will be investigated.

**Kitchen/Food Service Observation**

On the initial brief tour of the kitchen, an assigned surveyor will review the two following critical elements to ensure the facility has practices in place to prevent foodborne illnesses.

- During the initial brief kitchen tour, are foods stored and/or prepared under sanitary conditions (F812)?
- During the initial brief kitchen tour, does the facility handle, prepare and distribute food in a manner that prevents foodborne illness to the residents (F812)?

If the facility staff are preparing food during the initial brief kitchen tour, the assigned surveyor can proceed with a more in-depth review of the questions noted below. If not, the surveyor will review the following in a future trip to the kitchen:

- Is food stored at the appropriate temperatures (F812)?
- During follow-up visits to the kitchen, are foods stored and prepared under sanitary conditions (F812)?
- Does the facility provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and dietary needs, taking into consideration the preferences of each resident (F800)?
- Does the facility provide food prepared by methods that conserve nutritive value, flavor and appearance and provide food and drink that is palatable, attractive and at a safe and appetizing temperature (F804)?
- Is food prepared in a form to meet individual needs of the residents (F805)?
- Was food procured from approved or satisfactory sources and was food stored, prepared, distributed and served in accordance with professional standards for food service safety (F812)?
- Does the facility have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption (F813)?
- During follow-up visits to the kitchen, does the facility handle, prepare and distribute food in a manner that prevents foodborne illness to the residents (F812)?
- Were dishes and utensils cleaned and stored under sanitary conditions (F812)?
- Is the food preparation equipment clean (F812)?
- Is essential kitchen equipment maintained in safe operating condition (F908)?
- Was garbage and refuse disposed of properly (F814)?
- Was food storage, preparation and service areas free of visible signs of insects and/or rodents (F925)?
- Are snack/nourishment refrigerators on the units maintained with the proper temperature and food items are dated and labeled so as to prevent the potential for foodborne illness (F812)?
- Does the facility follow the menus and does the menu meet the nutritional needs of the residents (F803)?
- Does the facility have a qualified dietician, other clinically qualified nutrition professional, and/or director of food and nutrition services who met the required qualifications in the timeframe allowed (F801)?
- Does the facility have a sufficient number of competent staff to safely and effectively carry out the functions of the food and nutrition services (F802)?
Dining Observation

All of the surveyors will participate in the first full meal dining observation. They will review and determine:

- Does staff distribute and serve food under sanitary conditions (F812)?
- Did the facility provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections (F880)?
- Does the facility promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality (F550)?
- Did the facility provide a homelike dining environment (F584)?
- Does the facility honor the resident’s right to make choices about aspects of his/her life in the facility that are significant to the resident (F561)?
- Does the facility provide assistance with meals, assisting with hydration and nutritional provisions throughout the day (F676/F677)?
- Does the facility provide residents with assistive devices if needed (F810)?
- Is the resident positioned correctly to provide care and services that promote the highest practical well-being (F675)?
- Are residents receiving food that accommodates resident allergies, intolerances and preferences (F806)?
- Are residents selected based on an IDT assessment? Are paid feeding assistants supervised or used in accordance with Illinois law/requirements (F811)?
- Have the paid feeding assistants completed a state-approved training program prior to working in the facility (F948)?
- Does the facility serve meals that conserve nutritive value, flavor, appearance and are palatable, attractive and a safe and appetizing temperature (e.g., provide a variety of textures, colors, seasonings; pureed foods not combined) (F804)?
- Do the residents maintain acceptable parameters of nutritional status unless the resident’s clinical condition demonstrates that this is not possible or resident preferences indicate otherwise (F807)?
- Does the facility offer an appealing option of similar nutritive value to residents who refuse food being served (F806)?
- Are residents receiving therapeutic diets as prescribed (F808)?
- Does the facility provide one or more rooms designated for dining that are well lighted (F920)?
- Does the facility provide adequate and comfortable lighting levels in the dining areas (F584)?
- Does the facility provide one or more rooms designated for dining that is well ventilated (F920)?
- Does the facility provide comfortable sound levels in the dining areas (F584)?
- Does the facility maintain comfortable and safe temperature levels in the dining area (F584)?
- Are the dining areas adequately furnished to meet residents’ physical and social needs (F920)?
- Do the dining areas have sufficient space to accommodate all dining activities (F920)?
- Does the facility provide at least three meals daily at regular times comparable to mealtimes in the community or in accordance with residents’ needs (F809)?
- Does the facility provide sufficient staff to safely and effectively carry out the functions of the food and nutrition services, including preparing and serving meals, in the scheduled time frames (F802)?
- Does the facility provide meals with no greater that a 14 hour lapse between the evening meal and breakfast, or 16 hours with approval of a resident group and provisions for a substantial evening snack (F809)?

Focus F-Tag – F553 Right to Participate in Planning Care

This Regulatory Beat’s Focus F-tag is F553 Right to Participate in Planning Care, which incorporates two F-tags from the pre-November 28 F-tag list, F154 Informed of Health Status, Care & Treatment and F280 Right to Participate in Planning Care – Revise CP.
F553 states that residents have the right to participate in the development/implementation of his or her person-centered plan of care, including:

- Identifying who should be included in the care planning process
- Requesting care plan meetings
- Requesting care plan revisions
- Participating in establishing goals and outcomes of care as well as any other factors related to the effectiveness of the care plan
- Being informed in advance to changes to the care plan
- Seeing the care plan – including the right to sign off on it after a significant change has been made

In addition to the resident’s rights related to care planning, the care plan process itself must be facilitated in a way that maximizes the resident’s participation. This includes resident representative participation especially when the resident is unable to participate. It also requires that an assessment of the resident’s strengths and needs be conducted and that the resident’s personal and cultural preferences are included in developing care plan goals.

The emphasis on person-centered care has been frequently highlighted since the RoPs were updated, and regulations such as this one mandate that the resident’s goals and preferences are identified during the care planning process. Residents and their representatives must be afforded the opportunity to participate to ensure that the plan of care, as per the Interpretive Guidance, “enables the resident to live with dignity and supports the resident’s goals, choices and preferences, including, but not limited to, goals related to their daily routines and goals to potentially return to a community setting.” Some of this information will be identified within 48 hours of admission when the Baseline Care Plan is being developed, but the resident’s inclusion does not stop there.

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**Trending Statistics**

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

**Illinois Ranked 45th in Overall Health Care Quality**

Illinois is near the bottom of the list when it comes to overall health care quality compared to other states and the District of Columbia, according to a new report from the Agency for Healthcare Research and Quality.

The federal agency ranked Illinois 45th. Neighbors Wisconsin and Iowa finished fourth and seventh respectively. Indiana was 21st, Missouri was 22nd and Kentucky finished 35th. Maine took the top spot.

The Agency for Healthcare Research and Quality ranked more than 100 quality measures, and Illinois was “far away from the benchmark” for more than a quarter. That includes Medicare doctors not spending enough time with patients, emergency room visits for opioid-related diagnoses and hospital admissions for asthma.

Illinois providers scored well in, among other things, several measures related to hospice care as well as the number of hospital patients who received the flu vaccine.

Read [more](#).
1) No new federal **CMS Quality, Safety and Oversight Letters** (formerly known as **Survey and Certification (S&C) Letters**) were released since the last issue of **Regulatory Beat**.

2) Federal HHS/CMS released the following notices/announcements:

- **Medicare Cost Report e-Filing System Enhancement.** On May 1, CMS implemented the new Medicare Cost Report e-Filing (MCReF) system; over 2,000 cost reports were submitted through the system in the first month. For FYs ending on or after December 31, 2017, you can electronically submit your cost report package to your Medicare Administrative Contractor through MCReF. After January 2, you must use MCReF to submit your cost report electronically; you may also continue to mail or hand deliver them.

  An enhancement on September 10 allows contractor users to submit MCReF role requests to multiple organizations at the same time without waiting for each request to be approved before submitting another. Users that represent multiple organizations can obtain timely approval.

  For More Information:
  - [Register for the October 15 Medicare Learning Network webcast](#)
  - [MCReF webpage](#), includes how to request a user role?
  - [MCReF User Manual](#)
  - [MCReF MLN Matters Article](#)

  For questions, contact the External User Services helpdesk at [eussupport@cgi.com](mailto:eussupport@cgi.com) or 866-484-8049 (TTY/TDD: 866-523-4759).

- **New Medicare Card: MBI on Remittance Advice October 1.** For Remittance Advices generated after October 1 through the end of the [transition period](#), CMS will return both the new Medicare Beneficiary Identifier (MBI) and Health Insurance Claim Number (HICN) when you submit a claim with a valid and active HICN. They will report the MBI in the same place you get the “changed HICN” today. You can also get the MBI by asking your patients for their new Medicare card or using your Medicare Administrative Contractor’s MBI look up tool through their portal; [sign up](#) if you do not have access. To ensure your Medicare patients continue to get care, you can use either the HICN or MBI for all Medicare transactions through December 31, 2019.

- **New Medicare Card: Replacement Card.** If your patients accidentally threw away their new Medicare card, ask them to call 1-800-MEDICARE and request a replacement. Your patients can also sign into [MyMedicare.gov](http://MyMedicare.gov) to print an official card. They must create an account if they do not already have one.

- **Patients Over Paperwork September Newsletter.** Read the CMS Patients Over Paperwork [September newsletter](#), part of CMS’ ongoing effort to reduce administrative burden and improve the customer experience, while putting patients first. In this edition, they highlight our progress on burden reduction efforts:
  - How they are reducing burden in 2018, including a proposed rule to lift unnecessary regulations and ease burden on providers
  - Requests for information process, including our progress in addressing comments
  - How they are engaging with customers through our customer centered workgroups
  - Proposed and final rules to save money and reduce burden hours
  - Documentation simplification efforts
  - Other initiatives that reduce burden, including the Meaningful Measures initiative and MyHealthEdata

  For More Information:
  - [Patients Over Paperwork](#) website
  - [Past Newsletters](#)
• **Development of a Disability Index.** Toward the Creation of a Patient-Reported Disability Index summarizes the development and initial validation of a Disability Index to assess variability in quality of care and access to care across different population subgroups. Current disability indicators for program eligibility do not provide information on the individual’s level of difficulty or inability to function. The creation of a patient reported Disability Index provides this information in a single summary measure. To learn more, visit the [Office of Minority Health](https://www.minORITYhealth.gov) website.

• **Medicare Appeals Council: New Decision Format.** Beginning in October, the Medicare Appeals Council at the HHS Departmental Appeals Board is changing the look and format of its decisions, including a different font style and simplified layout. Email questions about the new format to DABStakeholders@hhs.gov.

• **LTCH Compare Refresh.** The September 2018 quarterly Long-term Care Hospital (LTCH) Compare refresh is available, including:
  - Quality measure results based on data from the fourth quarter of 2016 to the third quarter of 2017
  - Five new quality measures

Visit [LTCH Compare](https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/LTCFeeForServicePayment/LTCCompare) to view the data. For more information, visit the [LTCH Quality Public Reporting](https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/LTCFeeForServicePayment/LTCCompare) webpage.

• **ABNs and Dual Eligible Beneficiaries: Special Guidelines.** When Advance Beneficiary Notices (ABNs) are issued to dual eligible beneficiaries, including Qualified Medicare Beneficiaries (QMBs), distinct billing limitations apply. See [QMB Billing Requirements FAQs](https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/LTCFeeForServicePayment/LTCCompare) pages 6 and 7 for special instructions and guidelines. For More Information:
  - [QMB Program](https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/LTCFeeForServicePayment/LTCCompare) webpage
  - [ABN](https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/LTCFeeForServicePayment/LTCCompare) webpage

• **Enteral Device Connectors that Reduce Patient Injury.** As indicated in a [CMS Memo](https://www.cms.gov/medicare-coverage-database/search/Enteral-Device-Connectors-Reduction-Patient-Injury-Chronic-Discharge-Acute-Care), Luer misconnections continue to result in serious injuries and deaths. The creation of industry standards and new products provides an opportunity to reduce patient harm. For example, the Food and Drug Administration (FDA) recommends that hospitals and clinicians use enteral devices with connectors that meet the [International Organization for Standardization (ISO) 80369-1 or ISO 80369-3](https://www.iso.org/standard/46538.html) standard or are designed to reduce the risk of misconnections. Many connectors that meet the 80369-3 standards use the trade name ENFit.

Protect your patients by learning how to prevent misconnections with a variety of devices or delivery systems, including syringes, catheters, and tubing sets that connect to each other:
  - [FDA Medical Device Connectors](https://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/DeviceApproval/default.htm) website – view webpages on the left for what you can do, tips, and resources

• **Submitting Your Medicare Part A Cost Report Electronically Webcast — Monday, October 15, 12:30 - 2 pm CST.** Register for Medicare Learning Network events. Medicare Part A providers: Learn how to use the new Medicare Cost Report e-Filing (MCreF) system. Use MCreF to submit cost reports with fiscal years ending on or after December 31, 2017. You have the option to electronically transmit your cost report through MCreF or mail or hand deliver it to your Medicare Administrative Contractor. You must use MCreF if you choose electronic submission of your cost report. For more information, see the [MCreF MLN Matters Article](https://www.cms.gov/mediotecare-cost-report-electronically-filing-system/mcref-mln-matters) and [MCreF](https://www.cms.gov/medicare-coverage-database/search/Enteral-Device-Connectors-Reduction-Patient-Injury-Chronic-Discharge-Acute-Care) webpage.

During this webinar, CMS discusses:
  - Changes based on user feedback
  - How to access the system
  - Detailed overview
  - Frequently asked questions

A question and answer session follows the presentation; however, attendees may email questions in advance to OFMDPAOQuestions@cms.hhs.gov with “Medicare Cost Report e-Filing System Webcast” in the subject line. These questions may be addressed during the webcast or used for other materials following the webcast.
CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio, phone lines are available.

- **Patient Relationship Categories and Codes Webcast — Wednesday, October 17, 12:30-2 pm CST.** Register for Medicare Learning Network events. Receive guidance for classifying patient relationships during the voluntary reporting period that CMS implemented on January 1, 2018. This webcast presents real-world clinical scenarios to illustrate how Patient Relationship Categories and Codes work and reviews the statutory context and policy principles used in their development. A question and answer session follows the presentation.

  For inquiries about the Patient Relationship Categories and Codes, contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222).

CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio, phone lines are available.

- **Influenza Resources for Health Care Professionals: 2018-2019 MLN Matters Article — New.** A new MLN Matters Article SE18015 on **2018-2019 Influenza (Flu) Resources for Health Care Professionals** is available. Learn about influenza resources, including payment rates.

- **AWV, IPPE and Routine Physical – Know the Differences Educational Tool — New.** A new **AWV, IPPE and Routine Physical – Know the Differences** Educational Tool is available. Learn about:
  - Differences between these services
  - What is covered

- **Dementia Care Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the September 18 call on Dementia Care: Opioid Use & Impact for Persons Living with Dementia. Gain insight on opioid use in the post-acute and long-term care setting. Also, learn about the impact of opioid use on persons living with dementia.

- **Looking for Educational Materials?** Visit the [Medicare Learning Network](https://www.medicare.gov/) and see how they can support your educational needs. Learn about publications; calls and webcasts; continuing education credits; Web-Based Training; newsletters; and other resources.

- **New Waived Tests MLN Matters Article — New.** A new MLN Matters Article MM10958 on **New Waived Tests** is available. Learn about the latest tests approved by the Food and Drug Administration under the Clinical Laboratory Improvement Amendments.

- **HCPCS Drug/Biological Code Changes: October Update MLN Matters Article — Revised.** A revised MLN Matters Article MM10834 on **Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – October 2018 Update** is available. Learn about the new HCPCS codes Q5108 and Q5110.

3) The federal [Centers for Disease Control and Prevention (CDC)](https://www.cdc.gov/) provides updates on the 2018-2019 Flu Season:

- **Vaccination Remains Your Best Flu Protection.** Fall brings cooler temperatures, colorful leaves and football games. It also means another flu season is upon us. Last year’s season was rough. The best way to prevent flu and its potentially serious complications is getting a flu vaccine. To find flu vaccine in your area use the [Health Map Vaccine Finder](https://www.healthmap.org/).

- **Flu Vaccination Coverage Among HCP.** Annual influenza vaccination is recommended for health care personnel to reduce influenza-related morbidity and mortality. An opt-in Internet panel survey assessed flu vaccine coverage among health care professionals during the 2017-18 flu season. Results found vaccination coverage to be 78.4 percent, similar to previous flu seasons.
• **CDC’s 2018-2019 Flu Campaign Toolkit.** As you gear up for the 2018-2019 influenza season, be sure to check out [CDC’s campaign toolkit website](https://www.cdc.gov/fluarange/fluactivity.html). The toolkit includes social media content, posters, website assets, and important events.

4) The U.S. General Accountability Office (GAO) released a report on [Medicaid Home and Community Based Services: Selected States’ Program Structures and Challenges Providing Services](https://www.gao.gov/products/GAO-18-730). People who need long term services to help with routine daily activities, such as bathing and eating, often prefer to remain in their homes and communities rather than receive care in nursing homes or other institutions. State Medicaid programs must cover nursing home care, but can choose to cover most home- and community-based care—and they’re increasingly opting to do so. States have faced challenges in providing these services, however, including finding and keeping home care workers, due to the low wages for these services. We found that states have made efforts to respond to these challenges.

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

• HFS posted a new provider notice regarding **Webinar on the Application for Benefits Eligibility (ABE) Partner Portal – Requirements for the Data Sharing Agreement and Security and Privacy Controls.** You may view the notice [here](https://illinoismedicaid.com/ProviderInformation/ProviderNews/Webinar-on-ABE-Partner-Portal).  

• HFS posted a new provider notice regarding **Federal Fiscal Year 2019 Safety Net Determination.** You may view the notice [here](https://illinoismedicaid.com/ProviderInformation/ProviderNews/2018-FY-Safety-Net-Determination-Notice).  

• HFS posted a new provider notice regarding **Distribution of Fiscal Year 2019 Disproportionate Share Hospital (DSH) Determination.** You may view the notice [here](https://illinoismedicaid.com/ProviderInformation/ProviderNews/DSH-Determination).  

• HFS posted updated **Nursing Facilities Rates.** You may view the new rates [here](https://illinoismedicaid.com/ProviderInformation/ProviderNews/Nursing-Facilities-Rates).  

• HFS posted a new provider notice regarding **Improper Submission of the CMS 1500, Health Insurance Claim Form.** You may view the notice [here](https://illinoismedicaid.com/ProviderInformation/ProviderNews/Improper-CMS-1500-Submission).  

• HFS posted an updated **270/271 Health Care Eligibility Benefit Inquiry and Response.** You may view the updated version [here](https://illinoismedicaid.com/ProviderInformation/ProviderNews/270-271-Health-Care-Eligibility).  

6) The Illinois Department of Public Health (IDPH) continues with its Town Hall Meetings for 2018. Notices are being sent to the individual providers prior to the meeting in their location. Reservation information is included in that letter. The dates and locations are:

• October 16, 2018 – Pekin Manor  1-3pm  
• November 14, 2018 – Oak Trace in Downers Grove  1-3pm

7) The American Health Care Association (AHCA) and the Illinois Health Care Association (IHCA) recently reported on:

• **CMS Issues Proposed Rule to Reduce Burden, Improve Efficiency and Transparency** ([click here](https://www.cms.gov/Regulations-and-Guidance/Guidance/Proposed-Rules-and-Final-Rules)). CMS issued a proposed rule on September 20, 2018, entitled: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency and Burden Reduction. CMS aims to reduce regulatory burden with this proposed rule, which includes two main issues of importance to skilled nursing centers and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): Emergency Preparedness and Hospice.

• **The Quality Initiative Quarterly Update** ([click here](https://www.aha.org/quality-care/quality-initiative)). In this edition:
  - Progress: The Quality Initiative  
  - Video: Reducing Hospital Readmissions  
  - Quality Sessions at Convention  
  - Quality Award ITA
• **AHCA Members Have Decreased Antipsychotic Use By More Than 37 Percent.** Skilled nursing facilities have achieved sizable decreases in the use of antipsychotics in the past seven years, the American Health Care Association announced recently. AHCA noted that its skilled-nursing members have been able to drop use of the drugs to a greater degree that non-SNF members between 2011 and 2018. During that time span, AHCA members decreased antipsychotic use by 37.2 percent, compared to 34.4 percent for non-members, the association said, citing new information from the CMS. “There is no question that the data released by CMS shows that nursing homes are reducing unnecessary medication use,” AHCA Senior Vice President of Quality and Regulatory Affairs David Gifford, M.D., said in a [statement](https://www.ahca.org/newsroom/press-releases/2019/ahca-skilled-nursing-members-have-decreased-antipsychotic-use-by-more-than-37-percent). “Nearly seven years ago, AHCA members set a goal to reduce unnecessary antipsychotic medication use. We’ve achieved that and more.” AHCA is now working to reduce antipsychotic use by another 10 percent by 2021. The association tied the already-made gains to its quality initiative, launched in 2012, and linking up with the [National Partnership to Improve Dementia Care in Nursing Homes](https://www.ahca.org/national-partnership-to-improve-dementia-care-in-nursing-homes) to raise awareness to about safe alternatives to using tranquilizers. There’s been a 36.2 percent decline, nationwide, in antipsychotic use, since the initiative started, AHCA noted.

• **The latest Your AL Top-Line publications for assisted living communities in your state are now available!** Your AL Top-Line is a LTC Trend Tracker℠ publication that includes metrics and charts outlining progress of individual assisted living communities on AL Quality Measures, the Quality Initiative for Assisted Living and other necessary data to help them achieve their desired goals. Distributed each quarter, the report also highlights member resources that may help providers. Log into Trend Tracker.

8) The latest [Telligen](https://www.telligen.com) report can be found [here](https://www.telligen.com/trend-tracker).

9) **JAMDA** reports on [Study Suggests Approaches to Creating Antibiograms for Long Term Care Facilities](https://jamanetwork.com/journals/jamda/fullarticle/1177156). Antibiograms are important clinical tools to help guide antimicrobial therapy and support antibiotic stewardship. However, it is challenging for long term care facilities (LTCFs) to create antibiograms due to the low number of bacterial isolates they are able to collect annually. An article in the September issue of *JAMDA* proposed some ways LTCFs can overcome this barrier and improve stewardship. In “Antimicrobial Stewardship in Long-Term Care Facilities: Approaches to Creating an Antibiogram When Few Bacterial Isolates Are Cultured Annually,” the authors suggested some possible approaches to creating clinically useful antibiograms in this setting. These include extending the isolate data beyond one year, combining isolate data from other facilities in the same geographic region, using a nearby acute-care facility’s antibiogram as a proxy, and/or collapsing isolate data.

10) **Health News Illinois** reports [Illinois Hospitals Penalized for Readmissions](https://www.illinoishealthnews.org/2019/09/18/illinois-hospitals- penalized-for-readmissions). Nearly 91 percent of eligible Illinois hospitals under a Medicare program will face penalties for having more discharged patients readmitted than expected within a month, according to a recent [analysis](https://www.illinoishealthnews.org/2019/09/18/illinois-hospitals- penalized-for-readmissions). Kaiser Health News found that 114 out of 125 Illinois hospitals in the program will face penalties during the 2019 federal fiscal year. The program exempts cancer hospitals, critical access hospitals and facilities dedicated to psychiatry, long term care, rehabilitation and veterans. It doesn’t penalize hospitals that had too few cases to be evaluated fairly. CMS changed its methodology this year to calculate the penalties relative to other hospitals treating a similar proportion of patients who are dual eligible for Medicare and Medicaid.

11) **Today’s Geriatric Medicine** reports, [Prevent Survey Citations With a Survey Readiness Toolkit](https://www.todaysgeriatricmedicine.com/2019/09/25/prevent-survey-citations-with-a-survey-readiness-toolkit). If you work in a skilled nursing facility, you know the impact a bad survey can have, particularly financially, and how hard it can be on your staff and reputation. Don’t get caught unprepared when the surveyors come knocking. The American Association of Directors of Nursing Services (AADNS) has developed the Survey Readiness 24/7 Toolkit. This comprehensive preparation kit walks nurse leaders and facility managers through the new standard survey process before surveyors arrive.

12) **Skilled Nursing News** reports, [Experts Caution Providers About Navigating Payment Success under PDPM](https://www.skillednursingnews.com/articles/experts-caution-providers-about-navigating-payment-success-under-pdpm). Skilled Nursing News reports that experts are cautioning that skilled nursing providers must be prepared for the Patient-Driven
Payment Model, and an analysis from KeyBanc Capital Markets indicates they should minimize the number of errors or omissions when shifting residents into different case-mix groups by conducting an Interim Payment Assessment (IPA). KeyBanc VP Erika Haanpaa said, "A change based on the IPA would not reset the variable per diem adjustment schedule, which underscores the importance of ensuring the patient’s condition is accurately reflected on the initial assessment."

Others reminded providers that they “need to keep an eye out for certain treatments or services that are now ‘reimbursement-sensitive’ in PDPM,” among other considerations.

13) **CBS Evening News** reports that CDC Data Revealing Severity of Last Year’s Flu Sparks Concern for This Year. The CBS Evening News reported new data that "show last winter’s flu season was the worst in decades," during which "80,000 Americans died, including 180 children" and "900,000 were admitted to hospitals, double the usual number." CBS added that the CDC "recommends a flu shot for everyone six months and older," noting, "Less than half the population was vaccinated last season."

14) **U.S. News & World Report** notes that Half of Women, One-Third of Men Likely to Develop Dementia, Parkinson’s or Stroke. **U.S. News & World Report** reports, a study published in the *Journal of Neurology, Neurosurgery & Psychiatry* found that nearly half of women and one-third of men will develop Parkinson’s disease, dementia or suffer a stroke after age 45. The researchers wrote that their findings "strengthen the call for prioritizing the focus on preventive interventions," which could reduce the "burden of common neurological diseases in the aging population."

15) **McKnight’s** reports:

- **Congress Passes Disaster Preparedness Bill for Nursing Homes.** *McKnight’s Long Term Care News* reports that a new bill passed by Congress titled the "Worst-Case Scenario Hospital Preparedness Act" would fortify nursing home preparation plans for natural disasters following a series of "deadly hurricanes hitting Florida and Puerto Rico." The bill, which "tasks the National Academy of Medicine with analyzing how future natural disasters may affect emergency preparation," aims to also improve Congress’ understanding of preparation policies.

- **U.S. News Incorporates Short-Stay Rehab Component Into Nursing Home Ratings System.** *McKnight’s Long Term Care News* provided coverage of a change to how U.S. News and World Report publishes its nursing home ratings, saying the company "announced Wednesday that it is adding a new short-stay rehab rating." The company "also said it will put much greater emphasis on staffing levels and quality, a move that coincides with the CMS’ recent change from self-reported staffing data to payroll-based staffing data."

- **Nursing Homes Able to Treat Higher-Acuteness Patients Without Raising Mortality Risk.** *McKnight’s Long Term Care News* reports that according to a new study, SNFs "can safely take on higher levels of care for their residents to avoid the hospital" without increasing residents' risk of death. Researchers analyzed seven Enhanced Care and Coordination Providers (ECCPs) involved in the Initiative to Reduce Avoidable Hospitalizations, finding "that not only did the effort reduce hospitalizations by treating residents at the SNF, but they also did so without greatly risking seniors’ lives." The findings, published in Health Affairs, showed mortality rate changes "ranging from an 0.8 percentage-point reduction to a 1.5 percentage-point increase."

- **Provider Groups Applaud Passage of Expansive Opioid Legislation.** *McKnight’s Long Term Care News* reports that LeadingAge and other long term care advocates are welcoming new legislation passed by Congress this week which "creates, expands and authorizes programs within almost every federal agency, and aims to address prevention, treatment and recovery" for opioid addiction. LeadingAge said Thursday "it was pleased to see several provisions in the bill to help address opioid dependence among the elderly population," calling "the use of telehealth to detect and treat opioid dependence…especially promising." The piece adds that the Medicare Payment Advisory Commission will meet this week to examine "opioid use among the senior population."

- **Study Reveals Long-Term Care Indicators for Predicting Hospital Readmissions.** Nursing homes looking to gauge whether a resident is at risk for readmission may have a new tea leaf to read. Pouring over data from more than 700,000 patients, at a mean age of 78, Canadian researchers found that care setting, before and after the hospital episode, is a key predictor of rehospitalization within 30 days. Most notably, those returning to long
term care had a greater risk of readmission, while those newly admitted to long term care had a lower risk. “The information from this study will contribute to a better understanding of the extent to which complicated transitions to and from hospital influence readmission among older adults, which is essential for system planning,” wrote Andrea Gruneir, Department of Family Medicine, University of Alberta and ICES in a summary of the study.

- **Provider Advocates Applaud ‘Monumental Step’ on CNS Training at Skilled Nursing Facilities.** Skilled nursing advocates are applauding the “long-overdue” introduction of a bill Friday, which could kill “rigid provisions” they say are keeping the field from meeting its own dire staffing needs. Rep. Sean Duffy (R-WI) introduced legislation that would modify what’s called the certified nursing training lockout, which has been in place since 1987. Existing laws state that nursing homes assessed civil monetary penalties above $10,000 on their annual survey lose their ability to train CNAs for two years. Industry trade groups have long advocated for abolishment of the provision.

16) **Interesting Fact:** October was the name of the eighth month of the year in the ancient Roman calendar. In Latin, *octo* means eight. When the Romans converted to a 12-month calendar, the name October stuck, even though it’s now the 10th month.