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!

Proposed CMS Rulemaking – Part 3
As you know, over the past several issues of Regulatory Beat, I have been taking the various sections of the new CMS proposed rulemaking and explaining the major/significant changes. I have been doing this from the regulatory side, but you as providers, need to determine if the new or modified provisions are workable and can be implemented within your facility. CMS has extended the comment period until October 14, 2015. For those provisions of this proposed rulemaking that are problematic or costly to implement, you need to forward your comments to both IHCA and CMS. CMS will then be required to review all comments they received during the comment period and make any changes they believe are necessary and then do a final rulemaking in the Federal Register. They will also need to do new/revised F-tags and new/revised Interpretive Guidelines. It is believed that CMS will implement these new requirements in stages as opposed to all at one time.

To help with this effort, AHCA has launched a massive grassroots campaign to impress upon CMS just how important this new Proposed Rule on Requirements of Participation (RoP) is to our profession. In addition, they have created a dedicated web page to help you submit comments to CMS regarding RoP. What CMS has developed simply goes too far, demands the changes too quickly and costs too much. There are too many provisions in this 400+ page rule that result in Washington micromanaging even basic functions in our centers.

The new AHCA webpage will make it easy for you to participate in this campaign. It includes suggested topics for commenting, sample comments, instructions for filing a comment, and a link to the filing site. Access the information by clicking here or by logging into the AHCA website and clicking on the "SNF Requirements of Participation" link under the "Facility Resources" tab. Once you’ve submitted your comments, please just let us know you’ve done your part by completing our survey.

This CMS proposed rule would revise the requirements that Long Term Care facilities must meet to participate in the Medicare and Medicaid programs. CMS believes these proposed changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These proposals are also an integral part of CMS’s efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

This segment will focus on Comprehensive Person-Centered Care Planning (483.21) and Quality of Care and Quality of Life (483.25).
**H. Comprehensive Person-Centered Care Planning (483.21)**

This is a new section that retains certain existing provisions of current 483.20 as well as other additions and revisions regarding care planning. CMS believes that relocating the requirements to a new section dedicated solely to care planning will emphasize the importance of care planning as well as provide clarity to the regulations.

a) Baseline Care Plans

1) New requirement that requires facilities complete a baseline interim care plan for each resident upon their admission to the facility. The baseline interim care plan would include the necessary instructions for the proper professional care and services to meet the immediate needs of a new resident. The baseline care plan must be completed with **48 hours** of a resident’s admission.

2) CMS lists the information that would, at a minimum, be necessary for inclusion in a baseline care plan, but would not limit the contents of the care plan to only this information.

3) Facilities are allowed to complete a comprehensive care plan instead of completing both a baseline care plan and then a comprehensive care plan, however, the comprehensive care plan would need to be completed with 48 hours of admission and comply with the requirements of a comprehensive care plan.

b) Comprehensive Care Plans

1) New requirement that would require any specialized services or specialized rehabilitation services that a nursing facility provided pursuant to a PASARR recommendation be included in the resident’s care plan. If the facility disagrees with the findings of the PASARR, it must indicate this disagreement and the reasons for it in the resident’s medical record.

2) New requirement that would require discharge assessment and planning to be a part of developing the comprehensive care plan.

3) New requirement that facilities document whether a resident’s desire for information regarding returning to the community is assessed and any referrals that are made for that purpose. This needs to be an ongoing discussion with the resident or their representatives of the goals of care.

4) CMS is proposing to specify additional mandatory members of the interdisciplinary team (IDT). CMS is proposing to require a nurse aide with responsibility for the resident, an appropriate member of the food and nutrition services staff and a social worker to be part of the IDT. “Other appropriate staff” is also being proposed to be added to the IDT based on the specific needs of the resident or at the request of the resident.

5) Revise to provide to the extent practicable, the IDT must include the participation of the resident and the resident representatives.

6) New requirement that an explanation must be included in a resident’s medical record if the IDT decided not to include the resident and/or their resident representative in the development of the resident’s care plan or if a resident or their representative chooses not to participate.

7) New requirement that services provided or arranged by the facility be culturally-competent (including language, cultural preferences and other cultural concerns) and trauma-informed (minimize triggers and re-traumatization).

8) CMS urging, but not requiring, that care plans be done electronically so that they can be easily shared with other providers across the continuum of care.
c) **Discharge Planning**

**Discharge Planning Process**

1) The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113-185) amended Title XVIII of the Social Security Act by, among other things, adding Section 1899B to the Social Security Act. Section 1899B(i) requires that certain providers, including long term care facilities, take into account, quality, resource use, and other measures to inform and assist with the discharge planning process, while also accounting for the treatment preferences and goals of care of residents. This section implements the discharge planning requirements mandated by the IMPACT Act by revising, or adding where appropriate, discharge planning requirements for LTC facilities.

2) New requirement that facilities must develop and implement an effective discharge planning process, ensuring that the discharge goals and needs (including returning to the community) of each resident are identified.

3) New requirement that the facility’s discharge planning process require the regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan is to be updated, as needed, to reflect these changes.

4) New requirement that the IDT responsible for developing a resident’s comprehensive care plan be involved in the ongoing process of developing the discharge plan.

5) New requirement that the facility consider caregiver/support person availability, and the resident’s or caregiver’s support person’s capacity and capability to perform the required care, as part of the identification of discharge needs.

6) New requirement that the discharge plan address the resident’s goals of care and treatment preferences documenting their interest in returning to the community, any referrals made to local contact agencies and if the return to community was determined to not be feasible, the facility would document who made the determination and why.

7) New requirement requiring facilities to assist residents and their resident representatives in selecting a post-acute care provider by using data. CMS expects the facility would compile the relevant data and present it to the resident and their representative in an accessible and understandable format and with useful content.

8) New requirement that facilities must document in the discharge plan whether a determination is made by the resident, resident representative, or IDT that discharge to the community is not feasible. This decision must be discussed with the resident and resident representative.

9) New requirement that all relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident’s discharge or transfer.

**Discharge Summary**

1) Revise the requirement that the post-discharge plan of care specify that a recapitulation of a resident’s stay would include, but not be limited to, diagnosis, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.

2) New requirement that facilities include what arrangements have been made with other providers for the resident’s follow-up care and any post-discharge medical and non-medical services as needed.
3) New requirement that facilities must reconcile all pre-discharge medications both prescribed and non-prescription, with the resident’s post-discharge medications.

4) New requirement that the post-discharge plan be developed along with the participation of the resident, and with their consent, their resident representative.

I. Quality of Care and Quality of Life (483.25)
Retitle of section. Overarching Principles: Clarifies that quality of care and quality of life are overarching principles in the delivery of care to residents of nursing homes and should be applied to every service provided. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care.

a) General Concepts

1) Clarification that the facility must provide the necessary care and services to maintain or improve, as practicable, the resident’s abilities to perform their activities of daily living (ADLs) and to ensure that those abilities do not diminish unless the diminution is unavoidable as a result of the individual’s clinical condition.

2) New requirement that the facility must ensure that appropriate personnel provide basic life support, including cardiopulmonary resuscitation (CPR) to a resident requiring this emergency care prior to the arrival of emergency medical personnel and subject to accepted professional guidelines and the resident’s advance directives.

b) Activities of Daily Living

1) Revised list of what CMS considers to be ADLs, which include: hygiene – bathing, dressing grooming and oral care; mobility – transfer and ambulation; elimination – toileting; dining – eating, including meals and snacks; communication – including speech, language and other functional communication systems.

c) Activities

1) Revised language to include a required consideration of the comprehensive assessment, care plan and the preferences of the resident as well as potential for independence and ability to interact with the community.

2) CMS is soliciting comment with regard to the possible revision of the educational and professional requirements for the director of a facility activities program.

d) Special Care Issues

Revised, re-located and new provisions for specific special concerns. Each of these special concerns is related to an ADL but has a significant medical component or is an issue that could significantly impact a resident’s ability to perform or engage in ADLs.

1) Restraints

- Revised language that ensures residents are free from physical or chemical restraints imposed for the purposes of discipline or convenience not required to treat a resident’s medical symptoms.
Revised language that when use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

2) Bed Rails

- New requirement requiring the facility to ensure correct installation, use and maintenance of bed rails, including attempting to use alternatives prior to installing a side or bed rail, assessing the resident for risk of entrapment form bed rails prior to installation, reviewing the risks and benefits of bed rails with the resident and obtaining informed consent prior to installation, ensuring that the resident's size and weight are appropriate for the bed’s dimensions, and following the manufacturers’ recommendations for installing and maintaining bed rails.

3) Vision and Hearing

- No revisions – ensure residents receive proper treatment and assistive devices to maintain visions and hearing abilities by making appointments and providing transportation.

4) Skin Integrity

- Relocated language on the prevention and treatment of pressure ulcers.
- Revised language to include a statement that care must be consistent with professional standards of practice and to clarify that foot care includes care to prevent complications from the resident’s medical conditions such as diabetes, peripheral vascular disease, or immobility and also include assistance in making and keeping necessary appointments with qualified healthcare providers such as podiatrists.

5) Mobility

- CMS proposes to retain, unchanged, the provisions related to range of motion, but to add a new provision to require that residents with limited mobility receive appropriate services and equipment to maintain or improve mobility unless reduced mobility is unavoidable based on the resident’s clinical condition.

6) Incontinence

- CMS proposes to retain existing provisions on urinary incontinence, add new requirements to address residents who are admitted with or who subsequently receive an indwelling urinary catheter and add a new requirement that residents with fecal incontinence receive the appropriate treatment and services to restore as much normal bowel functions as possible.

7) Colostomy, Ureterostomy, or Ileostomy Care

- CMS retains, unchanged, colostomy, ureterostomy and ileostomy care.

8) Assisted Nutrition and Hydration

- Modify existing provisions on nasogastric tubes to reflect current clinical practice and to include enteral fluids. CMS is proposing to include gastrostomy tubes with nasogastric tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy.
• New requirements regarding both assisted nutrition and hydration and specify that the facility must ensure that the resident maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and protein levels, unless the resident’s medical condition demonstrates that this is not possible and that the resident receives sufficient fluid intake to maintain proper hydration and health.

• Modify the requirement for a therapeutic diet to require that the resident if offered a therapeutic diet when appropriate, recognizing that the resident has a right to choose to eat a therapeutic diet or not.

• New requirement that specifies that based on the comprehensive assessment of a resident, the facility must ensure that a resident who has been able to eat enough on their own or with assistance is not fed by enteral methods unless the resident’s clinical condition demonstrates that enteral feeding is clinically indicated and consented to by the resident; and a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding.

9) Parenteral Fluids

• This section will now only address parenteral fluids and not enteral fluids.

10) Accidents

• Revised to ensure that the resident’s environment remains free of accident hazards and each resident receives adequate supervision and assistance devices to prevent accidents.

11) Respiratory Care, Including Tracheostomy Care and Tracheal Suctioning

• See Section 483.65 regarding specialized rehabilitative services.

12) Prostheses

• No change

13) Pain Management

• New requirement to ensure that residents receive necessary and appropriate pain management.

14) Dialysis

• New requirement to ensure that residents who require dialysis receive those services in accordance with professional standards of practice and the resident choices.

15) Trauma-Informed Care

• New requirement to ensure trauma survivors receive care that addresses the special needs of trauma survivors. Specifically, CMS proposes to require that facilities ensure that residents who are trauma survivors receive care and treatment that is trauma-informed, takes into consideration the resident’s experiences and preferences in order to avoid triggers that may cause re-traumatization, and meet the professional standards of practice.
The next edition of *Regulatory Beat* will focus on **Physician Services (483.30)**, **Nursing Services (483.35)** and **Behavioral Health Services (483.40).**

**Per CMS, Nursing Homes Can Start Submitting Staffing Data on October 1, 2015**

Skilled nursing facilities should start submitting electronic staffing data October 1 for the best results, federal officials said during a recent SNF Open Door Forum conference call. Currently, the submission of staffing and census data through the Payroll-Based Journal (PBJ) system is voluntary starting October 1, 2015.

Lorelei Chapman, a health insurance specialist with the Division of Nursing Homes, Survey & Certification Group, encouraged providers to use the voluntary submission period to test their data submission processes as soon as possible. The mandatory filing period begins July 1, 2016.

She clarified that it's acceptable if facilities submit only partial data to CMS, or cannot begin by October 1.

“The data will not be used for survey or enforcement purposes and not used in the Five-Star Quality Rating system. There is no risk to submitting data,” Chapman said. “We've received feedback that providers need assistance to meet the mandatory submission deadline, and this is the best way to prepare.”

CMS also held a one-hour conference call with selected stakeholders to respond to questions posed by providers related to information included in the draft policy manual for the Payroll-Based Journal (PBJ). [Click here](#) for the questions and CMS’s responses.

The [CMS website](#) contains additional policy and technical information, along with downloads that should be helpful for providers.

To begin submitting data, providers should first obtain a [CMSNet user ID](#) for the individual corporate and third party PBJ users. CMS noted that many users may already have an idea for other Quality Improvement and Evaluation Systems applications or MDS submissions.

Those registering will also have to obtain a [PBJ QIES provider ID](#) for CASPER Reporting and PBJ system access. PBJ training modules, an introduction to the PBJ system and more detailed registration instructions are available on [QTSO e-University](#).

Questions regarding the PBJ Data Specifications should be directed to NursingHomePBJTechIssues@cms.hhs.gov. Software developers or vendors that provide services such as automated payroll or time and attendance systems that will support electronic submissions should use this address. In an effort to serve you better, we are offering voluntary vendor registration at [https://www.qtso.com/vendor/post.php](https://www.qtso.com/vendor/post.php). This information will be used to contact you with important PBJ news, updates and conference call information.

Please note that CMS may not provide an individualized response to each inquiry; however, CMS will address all applicable issues and comments through Open Door Forums, training sessions, vendor calls, or updates to the information provided on this page.

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*
JAMA Study Finds Half of U.S. Adults Have Diabetes or Prediabetes
There’s no question that diabetes is a major cause of morbidity and mortality in the United States; in 2012, the disease cost the nation an estimated $245 billion in increased use of health resources and lost productivity.

Recently, researchers set out to quantify just how prevalent the disease and its precursor are among American adults. In a large population-based study (jama.jamanetwork.com) published September 8 in JAMA: the Journal of the American Medical Association, authors examined the prevalence of diabetes and prediabetes and related disease trends in U.S. adults from 1988-2012.

One of the most startling findings in this study was that in 2012, more than half of American adults had either diabetes or prediabetes. Also of interest was the fact that more than one-third of those who met the study’s criteria for diabetes were unaware they had the disease.

Key Study Findings
One of the most startling findings was that using the hemoglobin A1c, FPG or 2-hour PG definition, more than half of Americans age 20 or older in 2012 had either diabetes (14.3 percent of total population) or prediabetes (38.0 percent). Also of interest was the fact that more than 36 percent of those who met the study’s criteria for diabetes, or an estimated 5 percent of the overall population, were unaware they had the disease.

Researchers found diabetes was more prevalent among Hispanics (22.6 percent of all Hispanic participants), blacks (21.8 percent) and Asians (20.6 percent) compared with whites (11.3 percent). Asian-Americans also had the highest percentage of undiagnosed cases (50.9 percent of total diabetes cases in this group).

Overall, the study found that diabetes rates increased from 9.8 percent of the total U.S. population in 1988-94 to 12.4 percent in 2011-12 across all age and racial/ethnic groups, in both genders, and by all education and income levels.

Family Physicians Critical in Diabetes Fight
Gary Levine, M.D., and Jonathon Firthaber, M.D., both from the Department of Family Medicine at the Brody School of Medicine at East Carolina University in Greenville, N.C., will lead an AAFP self-assessment module (SAM) working group on diabetes Sept. 19 in Rosemont, Ill. The course fulfills the knowledge assessment portion of the Maintenance of Certification for Family Physicians SAM process, and the Academy will report answers directly to the American Board of Family Medicine on behalf of workshop participants.

Levine told AAFP News that the results of this JAMA study reflect what he sees in his practice: about 50 percent of his adult patients have diabetes.

"It does seem like we are in the midst of a diabetic epidemic, although according to this study, the increase in prevalence over the past 20 years is less than 5 percent," he said. "It's not clear how many patients with prediabetes go on to become diabetic. In my experience, not many do."

Levine said the surge in diabetes appears to be directly tied to the current obesity epidemic in the United States, and he noted that a shift in U.S. demographics attributed to a growing minority population has probably contributed, as well.

So why does adding more minorities to the population lead to a higher overall diabetes rate? Levine said the greater prevalence of diabetes in minority populations could be due to a combination of genetic and social factors specific to each group.

This means family physicians have a serious battle ahead of them, said Levine, and fighting diabetes starts with offering patients some common-sense information. Patients need to stop overeating and start exercising regularly, if they aren't currently. Dietary recommendations should include a call for healthier foods, and physicians need to recommend at least 150 minutes of aerobic exercise per week to their patients.
For patients with a new diagnosis of diabetes, pharmacologic therapy is indicated and should generally include metformin and other oral agents or insulin as indicated by the individual’s hemoglobin A1c or level of hyperglycemia, said Levine.

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**Important Rules, Regulations & Notices**

1) There were no federal Survey and Certification (S&C) Letters released since the September 8, 2015 edition of *Regulatory Beat*.

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

- **CMS announced** an extension of its proposed rule on conditions of participation for long term care facilities in Medicare and Medicaid. The initial deadline was September 14, and has been extended to October 14.

- **The Medicare Payment Advisory Commission**, during its September meeting, reviewed a **staff presentation** on drug costs in the Medicare Part D program and discussed options for controlling drug prices. Even though program costs are lower than initial estimates, drug spending now comprises 19 percent of all Medicare spending.

- **The Centers for Disease Control** has published an **extensive guide** to establishing antibiotic stewardship programs in the nursing home setting. This appears as CMS has proposed a mandatory program of antibiotic stewardship in its recent proposed rule on conditions of participation for LTC facilities in Medicare and Medicaid.

- **AHRQ Issue Brief:** [Harnessing the Power of Data](#) - The Agency for Healthcare Research and Quality published a helpful discussion of the new emphasis on aggregating data for use in medical decision making. This is among the hottest topics in healthcare and this backgrounder is a good place to get started.

- **The AHRQ State Snapshot tool has been updated:** The [State Snapshots](#) provide state-specific health care quality information, including strengths, weaknesses, and opportunities for improvement. The goal is to help state officials and their public- and private-sector partners better understand health care quality and disparities in their state.

- **CMS published** [final payment information and policy changes](#) for SNFs for fiscal year 2016. Payments will increase 1.2 percent, or $430 million. Beginning July 1, 2016 SNFs will be required to submit staffing data to CMS. See [fact sheet](#).

- **Countdown to ICD-10** (October 1, 2015)
  - Updated Results for ICD-10 End-to-End Testing Week in July
  - ICD-10 Coding and Clinical Documentation Resources
  - New Webcasts Cover Dental, Lab, Pharmacy, and Radiology Services
  - Audio Recording and Written Transcript from August 27 MLN Connects Call Available
  - Finding ICD-10 Information Online Just Got Easier
  - Revised ICD-10 Products Now Available in Hard Copy Format
  - Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
  - Use of Unspecified Codes in ICD-10-CM
  - Get ICD-10 Answers in One Place
  - Use ICD-10 to Successfully Bill for Your Services
Clarifying Questions and Answers Related to the CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities — Update

Access the ICD-10 Code Set

List of Valid ICD-10-CM Codes

Claims that Span the ICD-10 Implementation Date

MLN Learning Network (MLN) Educational Products

“Skilled Nursing Facility (SNF) Consolidated Billing (CB)” Web-Based Training Course — Revised

“HIPAA EDI Standards” Web-Based Training Course — Revised

“Medicare-Required SNF PPS Assessments” Educational Tool — Released

3) The United States Environmental Protection Agency (EPA) has released its long-awaited proposed rule on hazardous waste pharmaceuticals. The proposal has been in the works for several years and comes on the heels of a DEA rule that regulates the destruction of controlled substances. The EPA proposal defines pharmaceutical hazardous waste, proposes standards for handling this waste (no more flushing) and describes acceptable methods for storage and transport. EPA has studied this issue extensively and has worked with long-term care pharmacies to better understand how the industry handles and distributes drugs. The proposed rule has sections dedicated to the discussion of the management of hazardous pharmaceutical waste in the LTC environment. The proposed rule has not yet been published, but when it is published there will be a 60-day comment period.

4) The Illinois Department of Healthcare and Family Services (HFS) released several notices. They include:

- HFS has posted a new Preferred Drug List (PDL) for Medicaid.

- This HFS Notice informs providers that Healthcare and Family Services (HFS) Bureau of Collections (BOC) has replaced the Small Estates Affidavit form previously used to collect the resident account/room and board account when a resident dies and the facility manages their funds. A new form titled, “Notice of Claim for Funds in Personal, Trust and Room and Board Accounts on Death of Resident,” has been developed for this purpose. This form will be sent to a facility when a resident’s death is reported to the Department of Human Services by the facility. This form will be directed to “Bookkeeper” as the facility contact.

- This HFS Notice reminds providers that less than one month remains for the ICD-9 to ICD-10 codes conversion to be completed for current residents. This federally-mandated conversion must be implemented before 10/01/2015. A Notice dated 6/17/2015 explained the need and process for facilities to update the ICD-9 code to ICD-10 code during the three month time period ending with the 10/01/2015 deadline. A follow-up Notice dated 6/24/2015 instructed providers to use the Medicaid Electronic Data Interchange (MEDI) for both updating the ICD-9 code of current residents and submitting new admissions (which require both ICD-9 and ICD-10 codes) due to EDI vendor programming not completed. These two Notices should be reviewed for guidance.

- This HFS notice informs providers that the federally-mandated conversion from ICD-9 to ICD-10 codes will be implemented on October 1, 2015. Federal Centers for Medicare and Medicaid Services (CMS) had previously delayed the deadline for implementation from 10/1/2014 to 10/1/2015.

5) The University of Iowa recently published in their IowaNow an article entitled, “Keeping Older Muscles Strong.” University of Iowa scientists have discovered the cause of and potential treatment for muscle weakness and loss due to aging. As we grow older, we lose strength and muscle mass. However, the cause of age-related muscle weakness and atrophy has remained a mystery. Scientists at the University of Iowa have discovered the first example of a protein that causes muscle weakness and loss during aging. The protein, ATF4, is a transcription factor that alters gene expression in skeletal muscle, causing reduction of muscle protein synthesis, strength, and mass. The UI study also identifies two natural compounds, one found in apples and one found in green tomatoes, which reduce ATF4 activity in aged skeletal muscle. The findings, which were published online September 3 in the Journal of Biological Chemistry, could lead to new therapies for age-related muscle weakness and atrophy.
MedlinePlus published several articles of interest. They include:

- **Early Treatment With Flu Antivirals May Shorten Seniors’ Hospital Stay.** Early antiviral treatment for seniors with severe cases of the flu may shorten their hospital stay and reduce the need for extended care after discharge, a new government study finds. "Flu can be extremely serious in older people, leading to hospitalization and, in some cases, long-term disability. This important study shows that people 65 and older should seek medical care early when they develop flu symptoms," Dr. Dan Jernigan, director of the U.S. Centers for Disease Control and Prevention's influenza division, said in an agency news release on the study. People aged 65 and older are at high risk for serious flu complications and should be treated with antiviral drugs as early as possible, according to the CDC.

- **New Guidelines Call For Kids, Health Care Workers To Get Flu Shots.** All eligible children and health care workers should get flu shots, according to new policy statements from the American Academy of Pediatrics (AAP). The AAP also noted that many people at high risk for flu and related complications require regular medical care, meaning they have frequent, close contact with health care workers. By getting flu shots, health care workers reduce the risk they pose to these vulnerable patients. "Employees of health care institutions have an ethical and professional obligation to act in the best interest of their patients' health," Bernstein said. "For the prevention and control of influenza, we must continue to put the health and safety of the patient first." In the 2013-14 flu season, 75 percent of U.S. health care workers received flu vaccinations, well below the Healthy People 2020 target of 90 percent. Voluntary programs are less effective than mandatory programs, which can achieve health care worker vaccination rates higher than 94 percent, according to the AAP, which repeated its call for mandatory vaccination for health workers nationwide.

- **Delirium In Older Surgical Patients Threatens Recovery.** Preventing postsurgical delirium in older patients can help ensure a successful recovery, a new study says. Patients with delirium following major surgery are more likely to have worse outcomes, including lower quality of life, disability or even death, the researchers found.

- **Other People’s Flu Vaccines Help Shield Seniors, Too.** Getting a flu vaccine doesn't just protect you -- it may also help older folks in your community avoid the miserable illness, new research says. Higher flu vaccination rates for young and middle-aged adults seem to lower the risk of flu among older people. That's important because seniors have a greater risk for serious flu-related complications, the researchers said. "Our findings suggest that flu vaccination should be encouraged among low-risk adults not just for their own benefit, but also for the benefit of higher-risk adults in their community, such as the elderly," study author Glen Taksler, a Cleveland Clinic researcher, said in a news release from the Infectious Diseases Society of America.

- **Antibacterial Soaps Fail To Beat Plain Soap.** When it comes to ridding your hands of bacteria, plain old soap is just as good as many "antibacterial" soaps, new research contends. Lab tests conducted by a team of Korean researchers revealed that when bacteria are exposed to the standard over-the-counter antibacterial ingredient known as triclosan for hours at a time, the antiseptic formulation is a more potent killer than plain soap. The problem: People wash their hands for a matter of seconds, not hours. And in real-world tests, the research team found no evidence to suggest that normal hand-washing with antibacterial soap does any more to clean the hands than plain soap.

- **This Year’s Flu Vaccine Should Be Better Match: CDC.** This year's flu vaccine should be a better match than last year's for circulating flu strains, U.S. health officials said Thursday. Dr. Tom Frieden, director of the U.S. Centers for Disease Control and Prevention, said that in most years, the vaccine is 50 to 60 percent effective, meaning that your odds of getting the flu are reduced by as much as 60 percent if you get a flu shot.
7) *HealthData Management* recently published several articles of interest. They include:

- **What You Need To Do Now To Avoid Cyber Attack.** Whether Excellus BlueCross BlueShield learned that it had suffered a cyber attack because the organization or a contractor was looking for signs of hacking, or learned from a law enforcement agency is not clear, as the company isn’t saying much about the incident outside of formal announcements. But Mac McMillan, CEO at the privacy, security and compliance consultancy CynergisTek, believes there is a good chance that the company was being proactive. Since Blues plans started getting hacked, word has gotten out that plans need to get their act together and do forensic analysis, he says. But he wonders the degree to which other health insurers are being proactive. What really bothers McMillan is the industry obsession, forced upon by the federal government to make sure that the I’s are being dotted and the T’s are being crossed on all the compliance requirements of HIPAA. “We’re focusing on HIPAA at the expense of just improving security,” he laments.

- **Healthcare Pros Share-Last-Minute ICD-10 Checks.** There are only days to go before the transition to ICD-10. In preparing for this big change, what types of things should an organization or HIT professional be checking as the clock winds down?

- **Need To Address Diagnostic Errors Is Urgent, IOM Says.** Diagnostic errors in healthcare are at epidemic proportions and causing serious safety concerns, yet the problem has received limited attention from the medical community, according to a core finding in an Institute of Medicine report on diagnostic errors released on Tuesday.

8) The *New York Times* published an article entitled, “**Lower Blood Pressure Guidelines Could Be Lifesaving, Federal Study Says.**” Declaring they had “potentially lifesaving information,” federal health officials said on Friday that they were ending a major study more than a year early because it has already conclusively answered a question cardiologists have puzzled over for decades: How low should blood pressure go? The answer: way lower than the current guidelines.

9) *Medical News Today* recently published a couple of articles of interest. They include:

- **New Antibody Offers Hope In Fight Against C. Difficile Infection.** An important new treatment aimed at fighting a recurrent type of infection frequently affecting older people in community health care and nursing home settings - *Clostridium difficile* - has passed a milestone in clinical studies and is due to be submitted for approval. Bezlotoxumab is not an antibiotic but a "selective, fully-human, monoclonal antibody designed to neutralize C. difficile toxin B," according to Merck, the international pharmaceutical company with the license to develop it.

- **Existing Arthritis Drug Bodes Well For Alzheimer’s.** An existing prescription drug may be able to help in the fight against Alzheimer’s, according to research published in *Nature Medicine*. A study at the Gladstone Institutes in San Francisco, CA, has found that salsalate, already established as a treatment for *rheumatoid arthritis*, is able to prevent the accumulation of the protein tau - known to cause toxicity and contribute to cognitive degeneration. The discovery has implications for frontotemporal dementia (FTD) and Alzheimer’s disease.

10) *McKnight’s* reported on several issues of interest. They include:

- **Medicare Advantage Enrollment to Rise, Premiums Stay Steady.** Medicare Advantage enrollment is expected to increase next year for the sixth straight year, and grow to cover 32 percent of Medicare beneficiaries, CMS announced. The Medicare Advantage program enrollment is expected to increase to 17.4 million by next year. That would be up from 16.5 million in 2015, and would constitute a 50 percent increase in total enrollment since 2010. MA plans also will begin offering additional benefits to enrollees,
including dental, hearing and vision coverage, according to CMS. Premiums are projected to decrease slightly next year. CMS estimates the average MA premium will drop $0.31, from $32.91 in 2015 to $32.60. A majority of MA enrollees (59 percent) will see no increase in premiums.

- **Long Term Care Workers, Providers Most Lax About Vaccinations: CDC.** Health care personnel working in long term care settings have the lowest rate of influenza vaccine coverage, the Centers for Disease Control and Prevention has found. The CDC estimates that 64 percent of LTC workers received a flu vaccine during the 2014-2015 flu season, despite its urging that all health care workers receive a vaccine. An estimated 77 percent of all health care personnel, including medical and nonmedical staff, reported receiving a vaccine. Hospital workers reported the highest amount of vaccine coverage at 90 percent. Long term care workers were also the least likely to report that their employer required vaccination, or made vaccinations available to employees on site.

- **45 Percent Of ACOs Cost More Than Estimated.** Almost half of all Medicare accountable care organizations are costing the government more than originally estimated, according to a new report from Kaiser Health News. While some ACOs have proven successful in creating more efficient care, 45 percent of the groups' patients are costing more money than the government originally predicted based on historic patient costs, federal records show. Kaiser also reported that 196 ACOs saved money last year, while 157 cost more than expected.

- **FDA Panel Approves New Flu Vaccine For Seniors.** Food and Drug Administration advisory panel has recommended the agency approve a new flu vaccine specifically designed to be more effective in patients over age 65. Fludad, made by Novartis, contains a substance designed to stimulate a greater immune system response that isn't found in the 12 currently available flu vaccines designed for seniors. Experts advocating for better flu vaccines for seniors say Fludad is “superior” to other similar vaccines and may “fit the bill,” Medscape reported.

- **Three Drug Combo Kills MRSA.** Three antibiotics previously thought to be useless against MRSA infections may be able to kill the pathogen when used together in humans, according to new research. Investigators from Washington University in St. Louis say the drugs — meropenem, piperacillin and tazobactam — belong to a class of antibiotics that hasn't been effective against the staph infection for decades. But when used together, the three proved effective at killing MRSA in cultures and in mice.

- **Regulators Call For ACA Small Group Revision.** A changing definition of a “small group” of employees under the Affordable Care Act could lead to higher health insurance premiums for small companies, including nursing homes, experts said recently. The ACA defines a small group as a company with up to 100 employees; prior to that a small group included up to 50 employees. That change could push mid-sized companies with young, healthy employees to self-insure, Monica Lindeen, the Montana commissioner of securities and insurance and the president of the National Association of Insurance Commissions, told Bloomberg BNA. As a result, employee premiums for those companies left in the small group market could increase 18 percent. Lindeen urged “immediate passage” of a revision to the small group definition to the House Energy and Commerce Committee’s health subcommittee on September 9. The revision, known as the Protecting Affordable Coverage for Employees Act, would allow states to set limits for the small group market that reflect the “unique characteristics and dynamics” at play in each state, and maintain stability in market, Lindeen said.

- **CMS Prioritizes Areas For Reducing Healthcare Disparities.** A new action plan from CMS will aim to reduce healthcare disparities among Medicare beneficiaries in four years. The “CMS Equity Plan for Improving Quality in Medicare,” released recently, focuses on populations of Medicare beneficiaries that experience high burdens of disease, lower qualities of care and difficulties accessing care. Those populations include racial and ethnic minorities, sexual and gender minorities, people with disabilities and people living in rural areas. The plan is broken up into six priority areas for reducing healthcare disparities, including increasing physical access to healthcare facilities, improving communications for people with disabilities
or limited English proficiency and improving healthcare workers’ abilities to meet the needs of underserved populations.

- **Workplace Violence, Patient Handling Key Concerns Facing Healthcare Workers.** The Association of Occupational Health Professionals in Healthcare (AOHP) has released its 2015-2017 Public Policy Statement, which specifically targets health and safety concerns in healthcare. These key areas of focus for AOHP for the next two years were identified by the 2015 AOHP membership survey and needs assessment, and through the partnerships that AOHP has developed with other stakeholders. Highlights of the AOHP 2015-2017 Public Policy Statement include: Overall Healthcare Worker Safety and Health Healthcare workers experience some of the highest rates of non-fatal occupational injuries and illnesses. Therefore, AOHP supports efforts to reduce and eliminate occupational hazards in the healthcare setting. AOHP will work to improve awareness of potential synergies between patient and worker health and safety activities, using as its foundation a landmark 2012 document published by the Joint Commission, Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation.

- **Capitalize On QAPI Now, Experts say.** There’s no better time for providers to tackle Quality Assurance and Performance Improvement, one of the hottest topics in long-term care, experts said during a McKnight's webcast on Wednesday. CMS’s recently proposed rules for LTC reform offer the perfect opportunity to dive in, said Andrew Kramer, M.D., chief executive officer of Providigm. “I would argue that QAPI is underlying the entire evolution of the regulations because it is really the means by which providers will be able to accomplish the changes in care that are included in these revisions,” Kramer said. Integrating QAPI requires a four-step process, where facilities collect data, analyze and investigate the data, identify issues, make improvements and monitor performance. But the process isn’t over once QAPI has been implemented, Kramer said.

11) Interesting Fact: **66 percent of individuals 75 or older are in good health.** Only 34 percent report fair or poor health at 75 or older.