October 13, 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!

Proposed CMS Rulemaking – Part 5

My continuing plan over the past several issues of Regulatory Beat is to take 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 will be required to review all comments they received by October 14, 2015, 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. 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.

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 Physician Services (483.30), Nursing Services (483.35), and Behavioral Health Services (483.40)

J. Physician Services (483.30)

CMS retains the current requirements under Physician Services, but does propose to add a few new provisions.
Revises the introductory text to specify that, in addition to a physician’s recommendation that the individual be admitted to a facility, a physician, a physician assistant, a nurse practitioner or clinical nurse specialist must provide orders for the resident’s immediate care and needs.

b) Revises language of (b)(3) to state that the approved above group must sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

e) New requirement requiring that a facility, prior to an unscheduled transfer of a resident to a hospital, provide or arrange for an in-person evaluation of a resident, to be conducted expeditiously, by a physician, a physician assistant, nurse practitioner or clinical nurse specialist prior to transferring the resident to the hospital, unless the transfer is emergent and obtaining the in-person evaluation would endanger the health and safety of the individual or unreasonably delay the transfer.

f) New requirement allowing physicians flexibility to delegate to a qualified dietician or other clinically qualified nutrition professional the task to writing dietary orders (under the physician’s supervision) as allowed by state law. Also, allow the physician flexibility to delegate to a qualified therapist the task of writing therapy orders (under the physician’s supervision) to the extent that the therapist is permitted to do so under state law.

K. Nursing Services (483.35)
CMS retains a lot of the current language but is adding new language to address certain aspects of nursing home staffing related to gaps in a number of areas that address competencies of licensed nurses and the need to take into account resident acuity.

Revises the introductory text to state that a facility must have sufficient nursing staff with appropriate competencies and skills to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at 483.70(e).

a)

- Clarify that nurse aides are included in the term “other nursing personnel.”

- New requirement that facilities must ensure that licensed nurses have the competencies and skill sets necessary to care for residents’ needs, as identified through assessments, and as described in each resident’s individual plan of care.

- New requirement to specify that caring for a resident’s needs would include, but not be limited to, assessing, evaluating, planning and implementing resident care plans and responding to each resident’s needs.

c) Proficiency of Nurse Aides

- Clarify that the facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

d) Requirements for Facility Hiring and Use of Nurse Aides

- CMS proposes to revise the definition of nurse aide.
• Clarify that non-permanent caregivers are expected to meet competency, knowledge and skill requirements to the same extent as permanent employees.

• Add the term “minimum” to clarify the requirements for hiring a nurse aide.

L. Behavioral Health Services (483.40)

This is a new section to include requirements for both behavioral health services and for social workers. CMS believes it is critical that LTC facilities ensure that behavioral health issues are addressed. These new provisions work in conjunction with other provisions in 483, including those related to reducing the inappropriate use of psychotropic medications.

a) New requirement that facilities have sufficient direct care staff with the appropriate competencies and skill sets to provide both nursing and behavioral health interventions as determined by resident assessments and individual plans of care.

b) New requirement explaining that necessary competencies and skills include knowledge and appropriate training and supervisions for caring for residents with the mental illness and psychosocial or adjustment problems as well as residents with a history of trauma and or post-traumatic stress disorder that have been identified in a facility assessment.

c) New requirement that staff must be trained in implementing non-pharmacological interventions.

d) New requirement that based on the comprehensive assessment, the facility must ensure that a resident who displays or is diagnosed with mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental health and psychosocial well-being. In addition, if a resident’s assessment does not reveal or who does not have a diagnosis of a mental illness or psychosocial adjustment difficulty, will not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident’s clinical condition demonstrates that the pattern was unavoidable.

c) If rehabilitative services such as physical therapy, speech-language pathology, occupational therapy and rehabilitative services for mental illness and intellectual disability are required by the resident’s comprehensive plan of care, the facility must provide the required services, including specialized rehabilitation services required in 483.45, or obtain the required services from an appropriate outside provider.

d) The facility must provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident.

The next edition of Regulatory Beat will focus on Pharmacy Services (483.45); Laboratory, Radiology, and Other Diagnostic Services (483.50); and Dental Services (483.55).

Meeting Notes from CMS/Stakeholder Meetings on September 15, 2015

On September 15, 2015 AHCA had a meeting with CMS and participated in a stakeholder meeting convened by CMS. The first meeting included AHCA, LeadingAge and CMS. The second was a larger, invitation only Stakeholder Meeting on Future Changes to Five-Star and Nursing Home Compare.

AHCA and CMS Meeting

Attendees:  Karen Tritz, Evan Schulman, Ed Mortimore from CMS
David Gifford, Holly Harmon, Lyn Bentley from AHCA
Cheryl Phillips from LeadingAge

Purpose of meeting: Discuss focused surveys and CMS’s Payroll Based Journal (PBJ)

1) AHCA requested the training materials used to prepare surveyors to conduct MDS-focused surveys.
   - CMS refused to share the training materials. The reason is they believe that the materials will enable providers to “manipulate the system” and identify the patients/residents that surveyors will review and prior to the survey the center will “fix” the MDS/care plans.
   - CMS states the most common deficiency is related to inconsistency between the MDS and the care plan.

2) CMS gave us a Surveyor Worksheet that is used during Dementia-Focused Surveys, which CMS will be releasing to all providers later this fall. CMS requested we keep this embargoed because they may make changes to it, based on any feedback we provide.

3) CMS expressed concern about a slowdown in the reduction of off-label use of antipsychotics. They asked AHCA and LeadingAge for ideas about why this slowdown may be occurring.
   - Ed confirmed the biggest driver for high use of antipsychotics is geography.
   - AHCA and LeadingAge indicated part of the problem could be the language used in CMS’s initiative that suggests there is a “fix” to the problem or another “treatment” that will result in not requiring the use of antipsychotics. Rather, there should be an emphasis that individuals with dementia are attempting to communicate and no longer have use of clear expression through conversation. A drug will sedate someone but not get to the root cause and enable a better quality of life for the resident/patient.

4) Following repeated requests by AHCA, CMS will no longer identify the “focus surveys” as “complaint surveys” on Nursing Home Compare/Five-Star. Rather, they will be listed as “focus surveys.” Deficiency citations will continue to be calculated in the Survey domain score for Five-Star.

5) AHCA and LeadingAge requested CMS clearly differentiate complaint surveys that are the result of a self-reported incident as opposed to a complaint by an actual patient/resident/family member. Without clearly distinguishing the difference, the general public perception is that all complaint surveys are the result of actual complaints by consumers. CMS seemed to understand the issue and will consider altering how complaint surveys versus self-reported incident surveys are identified on Nursing Home Compare/Five-Star.

Stakeholder Meeting on Future Changes to Five-Star and Nursing Home Compare
Attendees: Representatives from the following organizations:
- AMDA
- National Association of Long Term Care Ombudsmen
- Advancing Excellence in Long Term Care
- AHCA/NCAL
- Coalition of Geriatric Nursing Organizations
- Consumer Voice Leadership Council Member
- Voices for Quality Care
- Center for Medicare Advocacy
- Alzheimer’s Association
- NADONA
- National Consumer Voice for Quality Long-Term Care
- Families for Better Care
- Kansas Advocates for Better Care
- Paraprofessional Healthcare Institute
- Long Term Care Community Coalition
- Leading Age
- AARP
- SEIU
- California Advocates for Nursing Home Reform
Purpose of meeting: Discuss and solicit input from stakeholders about future changes to Nursing Home Compare and Five-Star

1) CMS confirmed that in 2016, two new measures will be added to Nursing Home Compare – readmission to hospital and discharge to community. There was discussion about the data CMS will use for calculating each measure and based on the responses to recommendations, it appears that CMS will use claims-based data.

2) Other quality measures are under development, consistent with the requirements for such measures across post-acute care providers specified in the IMPACT Act.

3) In 2016, there will be a rebasing of Quality Measures in an effort by CMS to continue to “raise the bar” of quality for nursing centers.

4) There was discussion about the need for additional short-stay measures and Abt (contractor working with Five-Star project) and CMS are considering including additional short-stay measures.

5) There was a presentation by Evan Schulman about the Payroll-Based Journal (PBJ). Consumer advocates requested CMS to show hours worked by exempt employees, not hours paid (presumably no more than 40 hours per week). The argument focused on the importance of transparency and the need for consumers to have a clear understanding of how many direct-care staff members are available. (NOTE: This is the same argument providers have used.) CMS responded they are willing to show hours worked by exempt staff, providing the information is auditable and verifiable. Several suggestions were made about submissions that attendees thought would be auditable and verifiable. CMS refused to consider using the required posting of nurse staffing data stating they do not believe it is verifiable and auditable. Also, CMS refused to consider nursing centers utilizing “swipe cards” in order to reflect hours worked by exempt staff. No resolution was reached during this meeting.

Evan provided a few of the goals of the PBJ, including “determining the staffing level needed for providing better care.”

The data from the PBJ will not be used for the Five-Star staffing domain until late calendar year 2017 or early calendar year 2018. Until then, nursing centers will need to submit CMS Forms 671 & 672 in addition to submitting data electronically. Additionally, he stated CMS expects there will be “an increase in the role of staffing” in calculating the overall Five-Star rating due to the relationship with outcomes.

More than 500 nursing centers have registered to submit data during the voluntary submission period (October 2015 – June 2016).

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**Trending Statistics**

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

**At Least 81 Percent of Major Health Care or Health Insurance Companies Had a Data Breach in the Past Two Years.**

A recent report by auditing service KPMG confirms what most Americans probably suspected already: personal data held by hospitals and health insurance companies is extremely insecure. Indeed, KPMG says that 81 percent of hospitals and health insurance companies suffered a data breach in the past two years.

"Extremely hackable" health care system
The hackability of American health care won't surprise anyone who's paid attention. Consider this partial sampling of hacks dating back only to summer 2014: that August, the for-profit hospital network Community Health Systems admitted that Chinese hackers had breached their network and stolen confidential data on more than 4.5 million patients. The following February, the Anthem health-insurance network admitted that hackers had stolen up to 80 million medical records dating back to 2004.

In March, Premera Blue Cross admitted to a breach compromising 11 million medical and financial records dating back to 2002. CareFirst Blue Cross/Blue Shield admitted to a hacking in May: “only” 1.1 million records were compromised that time. In mid-July, the UCLA Health System admitted that 4.5 million patient records were at risk from a hacking UCLA had discovered two months earlier.

In May – around the same time that the UCLA hacking occurred, though two months before any affected patients were notified of it, Larry Ponemon, of the Ponemon Institute, and Rick Kam, of ID Experts, co-wrote an article for the Dark Reading security blog suggesting outright that “escalating cyberattacks threaten U.S. health care systems…. Imagine a hostile nation-state with your psychiatric records. Or an organized crime ring with your child’s medical file. Or a disgruntled employee with your medical insurance information.”

And stealing medical or financial records isn’t the worst thing hackers might do to hospital patients, either. Early last month, the Food and Drug Administration issued an alert advising hospitals and medical centers to stop using a certain model of wireless-connected intravenous pump because hackers could exploit a security vulnerability to remotely seize control of a patient’s IV; it would allow hackers to make potentially fatal alterations to the amount or type of drugs administered.

**Matter of national security**

Such anecdotes arguably painted a bleak-enough picture of American medical cybersecurity, even before KPMG released its report with that dismal 81-percent statistic.

Greg Bell, KPMG’s Cyber US Leader, said “These are all incidents where they have determined they lost data. This wasn't just a malware or a virus infection – it actually went to exfiltration.”

To produce the report, which is available as a .pdf file here, KPMG analyzed a survey of 223 senior security or technology executives from health care organizations with more than $500 million in annual revenues. “Apart from typical financial fraud, there is also the possibility of medical insurance fraud, or, in the case of providers, attacks on computer-controlled medical devices. As this is the largest part of the U.S. economy and a safeguard of peoples' well-being, health care is a matter of national security,” KPMG explained in the report's executive summary.

Yet despite such high stakes, “the health care sector lags in terms of its preparedness for cyber threats…. In terms of technical capabilities, the health care industry is behind other industries in protecting its infrastructure and electronic protected health information.”

And even that 81-percent statistic might be understating the threat. KPMG’s Michael Ebert suspects that many healthcare and health insurance organizations might actually be understating or underreporting various cybersecurity threats – not through deliberate dishonesty, but because they genuinely don’t know the truth. “They are probably compromised and don’t even know it,” Ebert said.

Indeed, among the health care executives KPMG interviewed, 25 percent said that “based on their organization’s current protection systems, they don’t have or don’t know their capabilities, in real time, to detect if their organization’s systems are being compromised.” (And a cynic might suggest the other 75 percent suffer from overconfidence.)

This article was taken out of *ConsumerAffairs* and written by Jennifer Abel.
**Important Rules, Regulations & Notices**

1) There were no federal Survey and Certification (S&C) Letters released since the September 29, 2015 edition of *Regulatory Beat*.

2) CMS/HHS released several notices/announcements since the last issue of *Regulatory Beat*. They include:
   - **ICD-10**
     - Get ICD-10 Answers in One Place
     - 5 Ways to Check Your Claim Status
   - CMS’s Center for Medicare and Medicaid Innovation (CMMI) announced a model to test strategies to improve medication use among Medicare beneficiaries enrolled in Part D. Medication therapy management, when implemented effectively, can improve health care and outcomes for patients and has the potential to lower overall health care costs.
   - **Fact Sheet: Electronic Health Record Incentive Program and Health IT Certification Program Final Rules**. Patients, providers, businesses, health plans, and taxpayers all have a common interest in building a health care system that delivers better care, spends health care dollars more wisely, and makes our communities healthier – all with the patient at the center of their care. Electronic health records are critical to this effort. We want actionable electronic health information available when and where it matters most and for health care providers and consumers to be able to readily, safely, and securely exchange information. Electronic health records offer providers easy access to patient information; a series of tools, such as clinical alerts and reminders to support clinical decisions; enhanced communication with other clinicians, labs, and health plans; documentation that facilitates accurate coding and billing; and safer, more reliable prescribing. Patients benefit from less paperwork, reminders of important health interventions, convenience of e-prescriptions, and an avenue for communication with their providers. Moreover, electronic health records (EHRs) can expose potential safety problems when they occur, leading to better patient outcomes.
   - **CMS launches new ACO dialysis model**. Affordable Care Act model designed to improve care for beneficiaries with kidney failure while reducing costs. More than 600,000 Americans have end-stage renal disease (ESRD), also known as kidney failure, and require life sustaining dialysis treatments several times per week. These individuals typically have many health problems, are at higher risk of hospital readmissions, and suffer from fragmented care. In 2012, ESRD beneficiaries comprised 1.1 percent of the Medicare population and accounted for an estimated 5.6 percent of total Medicare spending.
   - **This site** contains the current MDS 3.0 RAI Manual v1.13, effective October 1, 2015. This version of the MDS 3.0 RAI Manual incorporates clarifications to existing coding and transmission policy, integrates previously published Questions and Answers (Q & As) into the appropriate sections and addresses requested clarifications and scenarios concerning complex areas.

3) The Illinois Department of Healthcare and Family Services issued one Informational Notice since the last issue of *Regulatory Beat*. It was:
   - **ICD-10 Implementation Reminder**. This notice informs providers that the federally-mandated conversion from ICD-9 to ICD-10 codes was implemented on October 1, 2015.

4) AHCA announced an exciting new member benefit from AHCA/NCAL – a comprehensive online Learning Management System (LMS) to support the training needs of your members and augment the training resources you provide. AHCA/NCAL formally launched ahcancalED on Sunday, October 4, during the Association's Annual Convention in San Antonio. They created this resource to support their members who do not have time to develop the newest in-service training.
The objective also was to provide the best and latest educational tools, especially as CMS increases its regulatory requirements about staff training and competency in a number of areas. Please note that ahcancalED does not provide Continuing Education Units (CEUs), so it will not compete with the training programs you offer. ahcancalED contains a wealth of information including educational programs, webinars, instructional videos, training courses and other tools. It also includes opportunities to discuss topics, learn best practices and grow the competency of staff. It is designed to help individuals in our profession do a better job of caring for patients and residents and advance in their careers.

Teams of member experts from around the country working with AHCA/NCAL staff have helped to create the content. They will constantly be adding new programs and materials so that they can keep the site fresh and dynamic.

AhcancalED will be a great value-added benefit and a tangible example of AHCA/NCAL’s commitment to enhancing quality. They heard from many state affiliates and members who recognized an education gap due to the fast-paced nature of our profession and they responded by creating a solution to bridge the education gap. Best of all, the information on ahcancalED is available free to members.

Please take a minute to check out ahcancalED at https://educate.ahcancal.org/. If you have suggestions for content or other site enhancements, please contact a member of the ahcancalED team at educate@ahca.org.

5) The Annals of Long-Term Care recently published two articles of interest. They were:
- Second-generation antipsychotics (SGAs) may treat delirium better than placebo, usual care, or haloperidol, according to new research. "Our results suggested that antipsychotic medications were superior to PLA/UC (placebo or usual care) in efficacy outcomes. Moreover, SGAs are more beneficial for the treatment of delirium regarding efficacy and safety outcomes compared with haloperidol," the authors wrote online September 4 in the Journal of Neurology, Neurosurgery & Psychiatry.
- A biomarker that declines as Alzheimer’s disease progresses was stabilized in patients who took resveratrol in a phase II trial. In people with mild to moderate AD who took purified synthetic resveratrol for one year, the cerebrospinal fluid and plasma biomarker amyloid beta40 (Abeta40) declined significantly less than in the placebo group, the study authors reported online September 11 in Neurology.

6) Medical News Today recently reported on a couple of issues of interest. They were:
- A new clinical trial has demonstrated that combining an antidepressant with an antipsychotic drug could improve clinical depression in older adults who do not respond to regular treatment. The study, published in The Lancet, could bring hope to the millions of people with depression whose symptoms are not improved with taking an antidepressant.
- New study shows a further benefit: reducing the risk of flu-associated pneumonia. In this latest study, researchers set out to determine whether flu vaccines can lower the risk of flu-associated hospitalizations for community-acquired pneumonia, a question that - until now - has remained unclear.

7) MedicalXpress had a recent article entitled, “Antipsychotics Increase Risk of Death in People with Parkinson's disease Psychosis.” Antipsychotic drugs may increase the risk of death in people with Parkinson's disease psychosis (PDP), according to a new study led by researchers from the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) at King’s College London. The study, published in JAMDA, found that people with PDP who were treated with antipsychotics were four times more likely to have died following three to six months of treatment than those who did not receive any antipsychotic medication. They were also more likely to experience serious health issues including cognitive decline, worsening of Parkinson's symptoms, stroke, infections and falls. Parkinson's disease affects approximately 7-10 million people worldwide and is characterized by progressive loss of motor function, psychiatric symptoms and cognitive impairment. Psychosis is a common and distressing group of psychiatric symptoms affecting people with Parkinson's, usually manifesting as hallucinations and delusions.
8) Telligen recently announced (click here) that a complete list of Telligen events will be sent out every Monday. This will allow for interested parties to plan ahead and register for webinars, conference calls and events that fit your schedule in your areas of interest. Telligen convenes healthcare providers, practitioners, and patients/residents in quality improvement collaboratives to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvements in patient care, population health, and healthcare costs for all Americans.

9) The New York Times recently published a couple articles of interest. They were:
   - Nursing Homes Bill for More Therapy Than Patients Need, U.S. Says. Nursing homes receive far more in Medicare payments than it costs them to provide care, exploiting the billing system in some cases by giving patients more therapy services than they need, federal investigators said in a new report. The report, to be issued on Wednesday by the inspector general of the Department of Health and Human Services, said that nursing homes regularly filed claims for the highest, most expensive level of therapy, regardless of what patients required.
   - An Aging Population, Without the Doctors to Match. Most health care professionals have had little to no training in the care of older adults. Currently, 97 percent of all medical students in the United States do not take a single course in geriatrics. Recent studies show that good geriatric care can make an enormous difference. Older adults whose health is monitored by a geriatrician enjoy more years of independent living, greater social and physical functioning and lower presence of disease. In addition, these patients show increased satisfaction, spend less time in the hospital, exhibit markedly decreased rates of depression and spend less time in nursing homes.

10) News Medical recently published an article entitled, “Study: Bright Light Therapy Reduces Depression and Agitation in Dementia Patients.” Dementia is most often associated with memory loss, but seniors who suffer from the condition also experience depression and agitation. These symptoms are often treated with medication. But results of a new study, a collaboration between Radford University and CCR (Commonwealth Care of Roanoke), indicate bright light therapy reduces depression and agitation in dementia sufferers.

11) HealthDay recently reported on a CDC research project dealing with a new antibiotic-resistant “superbug” that is an emerging threat. A relatively new antibiotic-resistant bacteria called CRE is making inroads in some major American cities, U.S. health officials report. About 9 percent of people died due to their infection from CRE, the researchers found. But some estimates have held that as many as 50 percent of CRE infections contribute to death if they lead to a bloodstream infection, Kallen said. CRE, or Carbapenem-resistant Enterobacteriaceae, are a class of common bacteria that have developed resistance to some of the most widely used antibiotics, Kallen said. CRE were first reported in 2001. The best-known enterobacteriaceae are E. coli, a common cause of food poisoning, and Klebsiella pneumoniae, which can cause pneumonia and potentially fatal bloodstream infections, Kallen said. CRE bacteria are able to produce an enzyme that breaks down antibiotics, forcing doctors to resort to older and more toxic antibiotics to stave off infections, he said. Most CRE infections occur at a hospital. In fact, hospitalization was the most common potential exposure to CRE, the study found. Patients’ median (midpoint) age was 66.

12) MedlinePlus recently reported on a study of a drug combination that may calm agitation in Alzheimer’s patients. A drug that combines a cough suppressant with a heart medication might offer a safer option for calming the agitation that commonly affects people with Alzheimer’s disease, an early clinical trial suggests. The study, of 220 Alzheimer’s patients, found that the drug -- called Nuedexta -- generally eased agitation symptoms over 10 weeks. And it did not worsen patients’ problems with memory, thinking and judgment, researchers reported in the Sept. 22/29 issue of the Journal of the American Medical Association.

13) HealthData Management recently reported on a couple issues of interest. They were:
   - After October 1, ICD-10 Work Isn’t Over. Once the actual ICD-10 transition date has passed, the detective work begins. Healthcare organizations will need to identify what’s going well with the new coding system, what needs to be tweaked and what requires rapid intervention. Unlike Y2K, ICD-10 will remain a key
concern of organizations for weeks to come.

- **Facing a HIPAA Audit? Here is What Auditors Want.** The HHS Office for Civil Rights, once again, is promising that its expanded HIPAA privacy/security/breach notification audit program will soon start. There are a lot of issues OCR looks for during an audit and its protocols are available here. But, as the cyber threat continues to intensify, the feds are taking a closer look at the security posture of healthcare organizations’ business associates and subcontractors.

14) **McKnight's** had several recent articles of interest. They include:

- **Behavioral Health Care – Not Drugs - for Dementia.** Antipsychotic medications have proved ineffective at reducing the symptoms associated with dementia. They also have serious side effects in older adults, including restlessness, dizziness, higher likelihood of falls and other problems that can contribute to an increased risk of death. Behavioral health interventions, on the other hand, have no such side effects and have been found effective in reducing behaviors such as aggression, care refusal and wandering. Employing behavioral health techniques with people with dementia becomes increasingly valuable as facilities in this country endeavor to follow CMS guidelines and reduce the use of antipsychotic medications.

- **Study: Fall Prevention Programs Cut Costs.** Fall prevention programs may help Medicare beneficiaries save money on hospitalizations and skilled nursing facility care, a new study has found. The study analyzed data from more than 6,000 Medicare beneficiaries enrolled in the fall prevention program A Matter of Balance, an eight-week group program that helps reduce the fear of falling and help seniors change their environments to reduce fall risks. Results showed that Matter of Balance participation led to average cost savings of $938 per person over the course of a year. Broken down by service, the program was associated with saving beneficiaries around $517 for unplanned hospitalizations, followed by an average of $234 for skilled nursing facility care and $81 for home health care.

- **False Claims Act Liability for Poor Quality of Care.** At the most basic level, there will always be significant disagreement among providers over the proper course of care for a particular patient and when to deviate from standard clinical protocols. Without clear consensus on how to quantify the quality of care in each instance, the fact that reasonable minds can differ should not automatically lead to FCA liability. In addition, defense attorneys routinely raise questions about whether whistleblowers and government enforcement attorneys are in the best position to make professional determinations about the quality of care provided to a particular beneficiary. These questions are even more difficult in an industry where clinical guidelines are constantly evolving and changing with the underlying science.

15) **Interesting Fact:** 90 percent of pumpkins grown in the U.S. come from a 90 mile radius of Peoria, IL.