Active Shooter Planning

While many emergencies are caused by natural disasters, staff and facilities should also be prepared for other types of emergencies. One emergency for which facilities should have plans and a policy in place is an active shooter. Understandably, this is a sensitive topic. No single answer exists for what to do, but a survival mindset can increase the odds of saving a life. As appropriate for your health care facility or campus, it may be valuable to schedule a time for an open conversation regarding this topic. Though some health care staff may find the conversation uncomfortable, they also may find it reassuring to know, as a whole, their facility is thinking about how best to deal with this situation. This article is primarily designed to encourage facilities to consider how to better prepare for an active shooter incident by providing information and model policies to consider. The policies noted in this article are models only and should be modified and tailored to meet the needs of individual long term care facilities.

Our nation’s health care facilities (HCFs), including long term care facilities, are entrusted with providing expert medical care in safe and secure environments for residents, staff and visitors. HCFs include hospitals, health clinics, hospices, long term care facilities, academic medical centers, group medical care facilities and physicians’ and other health care providers’ offices. HCFs are faced with planning for emergencies of all kinds, ranging from active shooters, hostage situations and other similar security challenges, as well as threats from fires, tornadoes, floods, hurricanes, earthquakes and pandemics of infectious diseases. Many of these emergencies occur with little to no warning; therefore, it is critical for HCFs to plan in advance to help ensure the safety, security and general welfare of all members of the health care community.

Active shooter events in a health care setting present unique challenges: a potentially large vulnerable patient population, hazardous materials (including infectious disease), locked units, special care units, as well as caregivers who can respond to treat victims. There is no single method to respond to an incident, but prior planning will allow you and your staff to choose the best option during an active shooter situation, with the goal of maximizing lives saved. The best way to save lives is to remove potential targets from the shooter’s vicinity. We address some difficult choices that will need to be made in this article.

During an active shooter situation, the natural human reaction is to be startled, feel fear and anxiety, and even experience initial disbelief. You can expect to hear noise from alarms, gunfire and explosions, and people shouting and screaming. Training provides the means to regain your composure, recall at least some of what you have learned and commit to action. We know a trained individual will more likely respond according to the training received and will not descend into denial, while the untrained will more likely not respond appropriately, descend into denial and helplessness and will usually become part of the problem.
Health care professionals have a duty to care for the patients for which they are responsible. Since incidents such as an active shooter scenario are highly dynamic, some ethical decisions may need to be made to ensure the least loss of life possible. Every reasonable attempt to continue caring for patients must be made, but in the event this becomes impossible without putting others at risk for loss of life, certain decisions must be made. The following guidelines are meant to provide issues to consider when making difficult decisions, prompt meaningful discussions and prepare those who might be involved in such an incident before it ever happens.

- Allocate resources fairly with special consideration given to those most vulnerable
- Limit harm to the extent possible. With limited resources, health care professionals may not be able to meet the needs of all involved
- Treat all patients with respect and dignity, regardless of the level of care that can continue to be provided them
- Prepare to decide to discontinue care to those who may not be able to be brought to safety in consideration of those who can
- Realize some individuals who are able to avoid the incident will choose to remain in dangerous areas; consider how to react to those situations
- To the extent possible, think about the needs of others as well as yourself; consider the greater good as well as your own interests

There is no single method to respond to an incident, but prior planning will allow you and your staff to choose the best option during an active shooter situation, with the goal of maximizing lives saved. Noted below are some active shooter resources that can be used/modified to develop your own unique active shooter policy for your facility.

- Example Lockdown Policy
- Active Shooter Poster
- Sample Active Shooter Policy
- Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans

Summary of the LTC Advisory Board Meeting
The Illinois Department of Public Health’s Long-Term Care Advisory Board Meeting was held on February 18, 2016. A quorum was present and the following issues/items were discussed:

- **Subpart S Rulemaking** – The Subpart S rulemaking, which deals with the certification of long term care facilities that provide services to persons with serious mental illness, has been drafted and is currently sitting in the Governor’s Office for review and approval prior to them being proposed in the Illinois Register. The Governor’s Office returned the draft rulemaking to IDPH and asked them to break the rulemaking down into smaller pieces and resubmit one piece at a time. IDPH is in the process of breaking the rulemaking down into workable pieces and will resubmit to the Governor’s Office. The entire rule, once approved, will be then sent to the LTC Advisory Board for review prior to publishing in the Illinois Register as proposed rulemaking. Timeline for publication in the Illinois Register will probably be late 2016.

- **Complaint Issues** –
  - The required/mandated consent decree questions that are to be asked of persons filing a complaint via the Hotline (Central Complaint Registry) are now posted on the IDPH website and can be found here.
Pursuant to an earlier IHCA request, IDPH provided a breakdown of complaint information with regard to anonymous versus non-anonymous complaints. We asked for the total number of substantiated and unsubstantiated complaints and the percent valid in each category. Upon review of this information, we further asked for a breakdown as to deficiencies cited and whether or not the deficiency was related to the complaint. This information will be helpful and we work with all interested parties with respect to the anonymous complaint problem. We will provide that information to our members upon receipt from IDPH.

- **LTC Facility Serious Injury Incident Report Form** – At a previous LTC Advisory Board Meeting, IDPH proposed an electronic incident reporting form for use by all LTC facilities. IHCA submitted several comments and suggested changes to the draft form. IDPH has been reviewing the comments/suggested changes and was not prepared to discuss at this meeting. They hope to have the new draft for review at the next LTC Advisory Board Meeting in May.

- **Status of Specialized Mental Health Rehabilitation Facilities (SMHRF)** – The rules to implement this new category of care were adopted last year. IDPH is now in the process of implementing the program. Eligible facilities (former Institutions for Mental Diseases – IMDs) have between March 1, 2016 and March 31, 2016 to send in an application. IDPH will review the applications, and if acceptable, will issue a provisional license to the facility. The facility is also required to forward a letter to HFS to remove them from the Medicaid Program and evaluate each of their residents to determine if they meet the criteria to be in this type of facility.

- **Status of Distressed Facility Regulation** – This draft set of regulations was in the Governor’s Office for final review but was sent back to IDPH for further justification. IDPH will review and resubmit to the Governor’s Office in the near future. Once approved by the Governor’s Office, this rule will be sent to the LTC Advisory Board for review and comment.

- **Status of Informed Consent Regulation** – This rulemaking is currently being drafted within IDPH. Once program is finished, it will be sent to IDPH Legal for review and approval before being sent to the Governor’s Office for review.

- **Status of Behavioral Unit Regulation** – This rulemaking is also being developed within IDPH. Several of the LTC Advisory Board members requested that IDPH form a work group to discuss the intent of a behavioral unit and discuss how to proceed. DHS also needs to be involved in the process. IDPH took this under advisement and will report back.

- **Does IDPH Plan to Proposed Rules for the Use of Medical Marijuana in LTC Facilities?** IDPH understands the concerns of LTC providers with regard to this issue. They are currently looking to see if any of the states that permit the use of medical marijuana have addressed this issue in health care facilities. With all the concerns with liability, diversion, storage, use, etc., IDPH is moving slowly and offered no timetable on resolving this issue. The other fact that this is still federally prohibited (although the current Obama Administration is currently looking the other way) and not sure the future federal stance on this.

- **Status of IDPH Regulations with Regard to the Authorized Electronic Monitoring in Long-Term Care Facilities Act (Granny-Cams)** – IDPH is taking their time with respect to drafting regulations to implement the authorized electronic monitoring legislation. At the current time, IDPH Legal feels the statute is clear enough and no regulations are needed. Many members of the LTC Advisory Board and others in the meeting totally disagreed with that conclusion. There are many unanswered questions with the implementation, including: the roommate’s rights regarding dissemination of the audio/visual; who can turn the electronic monitoring device on and off; where do the on/off controls need to be located; what if the roommate wants the device turned off for a visit/phone call/treatment and the resident who owns the device refuses; how moving a resident to another room affects the moving of the device and who is
responsible; etc. IDPH asked attendees of the LTC Advisory Board Meeting to send in any areas or suggestions for rulemaking on this and they will evaluate and report at the next Board Meeting.

The next meeting of the Long-Term Care Advisory Board Meeting is scheduled for May 19, 2016. If you have any questions on the above or have items you would like added to the agenda for the next LTC Advisory Board Meeting, please let us know.

Trending Statistics

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

National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Trend Update
The following information is from a CMS update received from the National Partnership to Improve Dementia Care in Nursing Homes. This reflects updates through 2015Q3.

In 2011Q4, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication. Since then, there has been a decrease of 27 percent to a national prevalence of 17.4 percent in 2015Q3. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 25 percent. Unfortunately, Illinois is ranked 50th with an overall prevalence of antipsychotic use of 21.71 (click here to view breakdown by state). We need to do better.

Additionally, the MLN Connects® National Provider Call schedule for 2016 will be as follows:
Thursday, April 28, 1:30pm-3:00pm EST
Thursday, September 15, 1:30pm-3:00pm EST
Tuesday, December 6, 1:30pm-3:00pm EST
Important Regulations, Notices & News Items of Interest

1) RN Licensing: For those RNs out there, remember that your licenses are due for renewal by May 31, 2016. The state is not sending notices anymore, so you’ll need to renew on your own. The state’s website isn’t taking renewals yet, but we’ll let you know when we see it up and running.

2) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 16-08 – CAH** – CAH Recertification Checklist: In order to routinely re-evaluate the compliance of currently certified CAHs with the status and location requirements at 42 CFR 485.610, CMS has revised the CAH Recertification Checklist: Rural and Distance or Necessary Provider Verification for use by the CMS Regional Office (RO) staff when processing CAH recertifications. The revised checklist includes procedures on determining whether a CAH that was certified by CMS prior to January 1, 2006...
had been designated by the state as a necessary provider and examples of documentary evidence to demonstrate necessary provider designation prior to January 1, 2006.

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

- **CMS hosts webinar on new Medicaid drug rule.** On February 11, CMS hosted a pharmacy webinar to review the provisions of the recently-finalized Medicaid drug benefit rule. Hosted by Medicaid Pharmacy Director John Coster, the webinar reviewed the replacement of Estimated Acquisition Cost with the new Actual Acquisition Cost (AAC) as the new basis for drug reimbursement, along with the newly-defined professional dispensing fee and the now-final federal upper limits (FUL) formula. See webinar slides and CMS State Medicaid Director Letter for more information.

- **CMS hosts IMPACT Act webinar.** CMS hosted a webinar on its implementation of the IMPACT Act, entitled Connecting Post-Acute Care across the Care Continuum the presentation slides are here.

- **AHRQ Study: Joint Replacement to Become the Most Common Elective Surgical Procedure in the Next Decades.** By 2030, about 11 million Americans will have either a hip or knee replacement, making it one of the nation’s most common elective surgical procedures, according to an AHRQ-funded study. Using data from AHRQ’s Healthcare Cost and Utilization Project State Inpatient Database, researchers analyzed general population trends by year, state, gender and age group from 1990 to 2010. In 2010, researchers estimate that approximately 7 million Americans had had a total hip or knee replacement, including 620,000 individuals who had both procedures, according to the study. Researchers attributed the increase in joint replacement surgeries to several factors: the aging of the baby boomer population, high rates of diagnosis and treatment of arthritis and demands for improved mobility and high quality of life. Also contributing to the trend are younger individuals undergoing these procedures, coupled with improvements in life expectancy. In some cases, researchers said, younger patients will outlive their implants and require expensive revision surgeries with substantial cost implications. The majority of the individuals (70 percent) who have undergone total hip and/or knee replacement surgery are alive today. The study and abstract were published in The Journal of Bone and Joint Surgery.

4) The Illinois Department of Healthcare and Family Services released the following Provider Notice:

- **Requirement for Providers to Submit Monthly Billing for Reimbursement Purposes - Effective July 1, 2016.** A March 18, 2015 notice entitled Monthly Billing Requirement provided introductory information regarding the provisions of P.A. 98-0104 which requires certain long term care providers to submit monthly billings for reimbursement purposes. Healthcare and Family Services (HFS) will be implementing this process, following national billing standards, for all Nursing Facilities and Supportive Living Program providers beginning July 1, 2016. This billing process will follow the UB04 and 837I Implementation guidelines. Providers or their billing agents will be required to electronically submit monthly claims for dates of service beginning July 1, 2016, using Health Insurance Portability and Accountability Act (HIPAA)-compliant 837I Institutional Health Care Claim. The monthly claim will be submitted via an X12 file transfer or direct data entry following the UB-04 format. Paper claims will not be accepted. Providers will be able to submit claims for consideration through the HFS Internet Electronic Claim (IEC) system which is accessible through the Medical Electronic Data Interchange (MEDI). HFS currently supports HIPAA version 005010XX223A2 for 837I claims in X12 format.

5) The American Health Care Association (AHCA) released two memos of interest. They were:

- **CMS Posts New Targeted Therapy Manual Medical Review (MMR) Process.** As you are aware, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) enacted last April contained provisions to replace the problematic Part B therapy Manual Medical Review (MMR) process, which required 100 percent review of all claims above a $3,700 annual per-beneficiary threshold with a targeted review program for claims over the $3,700 threshold. CMS was instructed to implement the targeted approach no later than 90 days of enactment, and that deadline expired last July. Since then, as we have informed
you previously, there have been limited reviews of MMR eligible therapy claims from 2014 that were in the review pipeline prior to the enactment of MACRA. However, no targeted reviews of MMR eligible claims from 2015 to present have been conducted as we were waiting for CMS to develop a new review process that complied with MACRA. Soon after the enactment of MACRA, a coalition including AHCA and other therapy professional and provider organizations contacted CMS and met with agency staff in June 2015 to clarify the intent of the legislation, ask questions, and provide verbal and written recommendations regarding implementation. At that time CMS assured the coalition they would interact with us prior to implementation so that we could prepare our members regarding the new process. However, despite frequent repeated requests to meet again, the agency staff has not agreed to meet with us. CMS posted the following on their Therapy Cap Webpage.

- **CMS Releases Final ’60-Day Rule’.** CMS released the final version of a 2012 proposed rule that requires Medicare Parts A and B health care providers and suppliers to report and return overpayments by the later of the date that is "60 days after the date an overpayment was identified, or the due date of any corresponding cost report if applicable." A separate final rule was published on May 23, 2014 that addresses Medicare Parts C and D overpayments.

6) IHCA has drafted two documents, one explaining Medicare (click here) and one explaining Medicaid (click here) that you are welcome to use in your admissions packets or however you’d like. Just click on the links to view, print and use as necessary.

7) The latest Telligen events/announcements can be found at https://www.telligenqingio.com/.

8) ScienceDaily recently published an article entitled, “C.Diff study Provides Insight Into Antibiotic Resistance and Risks for Infection.” Exposure to specific antibiotics is linked to the development of certain strains of antibiotic-resistant *C. difficile*, one of the fastest growing bacteria superbugs, according to a new study published by Stuart Johnson, MD, of Loyola University Health System (LUHS), Loyola University Chicago Stritch School of Medicine (SSOM) and the Hines VA Medical Hospital.

9) The New York Times reported that under pressure from Congress, the Food and Drug Administration took action by announcing several measures aimed at dealing with the abuse of opioids. Dr. Robert Califf, the acting commissioner and nominee to run the agency, announced the measures in a phone conference with reporters. He said the steps were an attempt by the agency to toughen its response to the crisis, in which tens of thousands of Americans were addicted to the prescription painkillers and were dying of overdoses. He said the actions were part of a broader government effort: Earlier this week, the Obama administration said it would ask Congress to spend an additional $1.1 billion next year on the problem, which would help increase badly needed treatment facilities.

10) The United States Pharmacopeial Convention (USP) published an important new standard as part of a suite of healthcare quality standards included in the United States Pharmacopeia-National Formulary (USP-NF). The new general chapter, Hazardous Drugs – Handling in Healthcare Settings, has been developed to help protect personnel and patients, and reduce the risk of residual exposure in health care settings. The standard applies to all health care personnel (i.e., physicians, nurses, veterinarians, pharmacists and technicians) and all health care facilities where hazardous drugs are handled or manipulated, including their storage and distribution — with a goal of preventing and/or limiting exposure. The USP Compounding Expert Committee recognized that it may take healthcare facilities additional time to comply with the new standard and therefore approved an extended official implementation date of July 1, 2018. With the extended date, health care facilities have more than two years to conform to the new requirements. For more information on the chapter and training, visit http://www.usp.org/FAQ-Hazardous-Drugs and http://bit.ly/1Pa2m6u. General Chapter will be available in both the First Supplement to USP 39–NF 34 and the USP Compounding Compendium.

11) HealthDay recently reported on a study that noted that anxiety drugs like Valium and Xanax won’t raise seniors’ dementia risk. However, experts note that these drugs -- collectively called benzodiazepines -- can have
other side effects and should still be used with caution. As the study authors explained, some prior research has suggested that use of the medicines may be associated with increased risk of dementia. However, other findings have contradicted that finding.

12) Medical News Today recently published several articles of interest. They include:

- **GW Researcher Tests New Method for Rapid Detection of Infection in Wounds.** A new method for detection of infection in wounds could take physicians less than a minute to complete, rather than the current 24 hours it takes to plate bacteria and leave it to incubate overnight, according to research by the George Washington University's (GW) Victoria Shanmugam, M.D.

- **Sepsis: Causes, Symptoms and Treatment.** Sepsis is the result of a massive immune response to bacterial infection that gets into the blood. It often leads to organ failure or injury, and the critical condition often leads to death. The key point with sepsis, however, is that the starting point is an infection. Estimates for the number of people hospitalized in the US for sepsis each year top a million, and sepsis is in the top 10 of all the diseases leading to mortality in America.

- **Oral Capsule with Bacterial Spores May be Effective Treatment for Recurrent C. difficile.** Microbiome drug containing spores from beneficial species appears to prevent recurrent infection, restore normal bacterial population. Results from a Phase 1b/2 trial suggest that an investigational microbiome-based, oral therapeutic drug is effective for the treatment of recurrent C. difficile infection. In a paper published online in the *Journal of Infectious Diseases*, a multi-institutional research team reports that treatment with the preparation, containing the spores of approximately 50 species of beneficial bacteria, successfully prevented recurrence of C. difficile infection (CDI) in patients with a history of multiple recurrent disease. This therapeutic drug also restored the participants' gut microbiome - the microbial community within the gastrointestinal system - to a state similar to that observed in healthy individuals.

- **Eating Fish Helps Stave Off Dementia.** Eating at least one portion of fish per week may help to reduce a person's risk of developing Alzheimer's disease and dementia-related illnesses. This was the conclusion reached following international research conducted at the Rush University Medical Center in Chicago and published in the *Journal of American Medical Association (JAMA)*. Ondine van de Rest, a researcher at Wageningen University, collaborated on the study. Starting in 1997, the study monitored elderly people living in Chicago and the surrounding areas. The researchers recorded participants' eating habits and other lifestyle factors. Upon death, the brains of 286 elderly were examined for dementia and Alzheimer's disease.

13) MedlinePlus recently reported on a couple of studies of interest:

- **New Mental Challenges Can Sharpen Aging Brain.** New mental challenges might help your mind stay sharp as you age, according to a small study. The research, from the University of Texas at Dallas, included 39 older adults who were randomly assigned to high- or low-mental challenge groups or to a control group.

- **Weakened Knees a Big Cause of Falls for Older People.** A new study supports what many American seniors may already know: that knee "instability" boosts their odds for a dangerous fall. "Falls, injury from falls and poor balance confidence are extremely common and debilitating problems in older people," said study author Michael Nevitt, a professor of epidemiology and biostatistics at the University of California, San Francisco. "The present study has demonstrated for the first time that knee instability and knee buckling are important causes of these problems in the very large segment of the older population suffering from knee pain," Nevitt added. Therefore, doctors should make treating knee instability a priority among older patients, the researchers said.
14) Medscape had several articles of interest including:

- **Vaccinate to Prevent AF? Risk in Seniors Falls after Flu Shot.** Getting hit by the flu sometime within the past year, among those not vaccinated against it, raises the risk of developing atrial fibrillation (AF) by a significant 18 percent, while the risk drops a significant 12 percent for those who are vaccinated against and don't contract the flu, suggests a large observational study based on 10 years of health insurance records in Taiwan. The analysis also suggested that persons who develop influenza despite having been vaccinated had a risk of developing AF similar to the reference group, those without flu or vaccination. The findings support the view that “influenza infection may increase the risk of AF, and the risk could be reduced through vaccination,” write Dr. Ting-Young Chan (Taipei Veterans General Hospital, Taiwan) and colleagues in their report published February 1 in *Heart Rhythm*. "High-risk patients should be encouraged to receive influenza vaccination annually."

- **CMS: Physicians Obliged to Look for Medicare Overpayments.** Physicians must not only return Medicare overpayments within 60 days of identifying them but also actively look for overpayment through self-audits and other forms of research, according to final regulations released yesterday by the Centers for Medicare & Medicaid Services (CMS). If a physician fails to hand back overpayments within 60 days, he or she risks getting sued by the government under the False Claims Act (FCA). The new regulations implement a provision of the Affordable Care Act that requires physicians, hospitals, and other healthcare providers to return overpayments they identify on their own. When CMS issued a draft of the regulations in February 2012, medical societies objected to language that suggested to them that physicians had a "perpetual duty" to research whether Medicare overpaid them.

- **Therapy, Antidepressants Similarly Effective for Depression.** Cognitive behavioral therapy (CBT) is as effective for treating depression as antidepressants, and given its relative lack of potential harms, should be strongly considered as the first-line treatment, according to a new guideline issued by the American College of Physicians (ACP). The guideline is based on a systematic review of randomized controlled trials from 1990 through September 2015 comparing the benefits of second-generation antidepressants (SGAs) and non-pharmacologic interventions such as psychotherapies, complementary and alternative medicines (including acupuncture and St John's wort [Hypericum perforatum], and exercise. The guideline was published online February 9 in the *Annals of Internal Medicine*.

- **Proton Pump Inhibitors Linked to Dementia.** A new study has confirmed an association between proton pump inhibitors (PPIs) — drugs that treat heartburn, peptic ulcers, and other acid-related disorders of the upper gastrointestinal tract — and increased risk for dementia in older patients. An earlier study by the same researchers found the same connection between PPI use and dementia risk, although the current study is larger and based on information from a pharmaceutical database rather than on medical records, as the previous one was.

15) McKnight’s also published several articles of interest:

- **What Providers Need to Know About Joint Bundles.** As many more new orthopedic bundles will soon be coming on the market under CMS value-based payments this April, post-acute care providers need to be talking with the hospitals — or bundle initiators or leads — in the planning stage, and not wait to be the downstream vendors with lots of imposed expectations but no part in the planning (or participation in the risk).

- **CMS Urges Providers to Look at “Big Picture“ of IMPACT Act, Health Data.** Although providers are rightfully preoccupied with the requirements of the Improving Post-Acute Care Transformation Act of 2014, they should also be paying attention to widespread changes in data standardization and exchange, CMS officials emphasized recently. The IMPACT Act marks the first time CMS has attempted to unite different providers with a shared data vocabulary, said Terrence O'Malley, M.D., of Massachusetts General Hospital during an MLN Connects provider conference call. Skilled nursing facilities will be
required to submit standardized patient data for some quality measure domains starting on October 1, 2016.

- **American Diabetes Association Releases First-Ever Guidelines for Managing Diabetes in LTC.** Hypoglycemia and care transitions are among the topics in the first-ever guidelines relating to diabetes management in long term care facilities. “Management of Diabetes in Long-term Care and Skilled Nursing Facilities,” released by the American Diabetes Association, highlights the differences in diabetes management for younger and older people. The guidelines primarily focus on type 2 diabetes, since the majority of diabetic long term care residents have that type, according to the ADA. For older diabetes patients, especially those needing long term care, hypoglycemia risk, commonly known as low blood sugar, is the most important factor in determining glycemic goals, the guidelines warn. Long term care residents need plans that strike a balance in maintaining glycemic levels, the guidelines suggest. Long term care facilities should also avoid sole use of sliding scale insulin, as it leads to wide variations in blood glucose levels, is a burden for patients and uses up more nursing time and resources, the ADA notes. Liberal diet plans are also preferable for diabetic residents, compared to therapeutic diets, as more food choices benefits nutritional needs and glycemic control.

- **Results of Rehospitalization Reduction Efforts “Promising,” CMS Say.** Early results of the CMS initiative to reduce hospitalizations among nursing home residents indicates a promising start to the program, CMS officials say. The results of CMS’s “Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents” for calendar year 2014, recently released, showed that Medicare expenditures were generally reduced at all seven testing sites, relative to a comparison group. Two sites showed “statistically significant” reductions in expenditures.

- **Dementia: First Diversity Study Shows Incidence Highest in African-Americans, American Indians; Rates Falling Overall.** A first-of-its kind study of dementia risk among different populations in the United States has found African-Americans to have the highest incidence, while another shows U.S. dementia rates to be dropping as a whole. The population study looked at data from 274,000 California residents divided into six racial and ethnic groups: Whites, Asian-Americans, Latinos, African-Americans, American Indians/Alaskan Natives and Pacific Islanders. Results of the 14-year study showed an annual average rate of 26.6 cases of dementia per 1,000 people for African-Americans, followed by 22.2 cases per 1,000 people for American Indians/Alaskan Natives. Asian-Americans had the lowest incidence of dementia, with 15.2 annual cases per 1,000 people.

- **GAO: Changes to Medicaid Formula Could Improve State Funding.** Changing the current formula used to allocate Medicaid funding to states would improve the way the government provides Medicaid funds during economic downturns, according to a new report from the U.S. Government Accountability Office. CMS currently uses Federal Medical Assistance Percentage Formula to determine the amount of state Medicaid expenditures that the federal government will match. The FMAP is based on per-capita income, which is a “poor proxy” for the size of a state's population that need Medicaid services and the ability of the state to fund Medicaid, GAO said in its February 10 report.

- **Data, Culture Change Crucial to New Payment Models, Experts Say.** Providers will need to undertake a drastic culture change and refocus on data to prepare for upcoming post-acute payment changes, an expert shared during a McKnight’s Super Tuesday webinar. “This transition from fee-for-service payments to advanced payment models (APMs) is not going to be for the faint of heart,” said Chris Murphy, CPA, a partner at BKD Consulting. Data will be critical as new APMs, including bundled payments and accountable care organizations, are tested out by CMS. Facilities that know their Nursing Home Compare data, as well as the public data for their competitors and even home health agencies, will have a leg up on landing care coordination partnerships with hospitals.
High-Risk Prescriptions, Preventable Hospitalizations Among Seniors Are Down. The number of preventable hospital admissions and high-risk drug prescriptions among Medicare beneficiaries have substantially decreased in recent years, a new report shows. The percentage of Medicare beneficiaries hospitalized for a preventable condition, or a condition that could be treated through outpatient care, declined 23 percent between 2003 and 2012. That's according to a “report card” for senior healthcare released Wednesday by the Dartmouth Atlas Project. The report also found a slight decrease in 30-day readmission rates, from 16.2 percent of beneficiaries in 2008 to 15.5 percent in 2012. Progress was also seen in the use of high-risk medications among Medicare beneficiaries. The percentage who received at least one prescription for a high-risk medication decreased almost 43 percent between 2006 and 2012, which the study's authors largely attribute to the 2010 removal from propoxyphene from the U.S. market.

Interesting Fact: We have between two and four million sweat glands that help keep our body temperature regulated, GP and author Dr. Ginni Mansberg says. Women tend to have more than men, but men’s sweat glands are more active. Associate professor David Ranson, of the Victorian Institute of Forensic Medicine, says that until recently the only real marker sweat seemed to leave was in the armpits of our gym gear, but research suggests it could hold a forensic key: “A study found they could get DNA out of a fingerprint because there were cells shed that stuck to the surface of the fingerprint with sweat.”