New Quality Measures to Five-Star and Nursing Home Compare

The Center for Medicare and Medicaid Services (CMS) announced last week, in their Open Door Forum, that they are adding six new quality measures to Nursing Home Compare and to the Five-Star rating system. Data for the six new quality measures will come from either Medicare claim data or MDS data. The new measures will be added to Nursing Home Compare beginning in April 2016. Skilled nursing centers will get a preview of the changes by accessing the QIES system. Five of the six quality measures will be added to Five-Star in July 2016.

The six new measures are as follows:

- **Short-Stay Measures**
  - Percentage of short-stay (stays of less than or equal to 100 days) residents who were successfully discharged to the community and did not die, or were readmitted to a hospital or skilled nursing facility within 30 days of discharge (comes from Medicare claims-based data).
  - Percentage of short-stay residents who have had an emergency room visit (comes from Medicare claims-based data).
  - Percentage of short-stay residents who were rehospitalized after SNF admission, including observation stays (comes for Medicare claims-based data).
  - Percentage of short-stay residents who have made improvement in physical function and locomotion (comes from MDS based data).

- **Long-Stay Measures**
  - Percentage of long-stay (stays of greater than or equal to 101 days) residents whose ability to move independently worsened (comes from MDS based data).
  - Percentage of long-stay residents who received an anti-anxiety or hypnotic medication (comes from MDS based data).

Five of the six new measures will be phased in to the Five-Star Quality Ratings system over a nine-month period, beginning in July. The measure on anti-anxiety and hypnotic medication use will be left out of the Five-Star system due to concerns about specificity and appropriate thresholds for star ratings. How the quality measures are added or how they will impact your star rating have NOT yet been announced.

**NOTE:** The Rehospitalization, Emergency Room Use and Discharge to Community quality measures posted in April 2016 will reflect care from July 1, 2014 through June 30, 2015. The other MDS-based measures (Improved Function, Mobility and Hypnotics/Anxiolytics) will be from the same time window as other MDS-based quality measures on Nursing Home Compare.
The five measures will be added to the Quality Measure component of Five-Star. **NOTE:** Currently, the Quality Measure component impacts your overall star ratings as follows:

- Add 1 star to QM component = 5 stars
- Lose 1 star in QM component = 1 star
- No change with QM component = 2, 3 or 4 stars

The impact of adding these five measures to the Quality Measure component will depend on how CMS integrates these measures into the scoring system. Nonetheless, skilled nursing center performance on the new measures will likely change a center's ratings for the Quality Measure component.

CMS has **NOT** announced changes to the scoring methodology in the Quality Measure component. For example, the agency has not announced if it has plans to rebase the scoring cut points to achieve five stars. **NOTE:** If and when that is known, we will let you know. We also will continue to advocate for no rebasing.

CMS plans to add additional quality measures to Five-Star in **2017 or 2018**:

- Staffing turnover and retention
- Staffing levels based on data from mandatory staffing data collection from payroll – PBJ
- Other measures from the IMPACT Act

**More information and links to presentation materials can be accessed at:**
http://webinars.ahcancal.org/session-handouts.php?id=17674

Links to CMS site and presentation at https://www.ahcancal.org/facility_operations/survey_reg/Pages/FiveStar.aspx
Measure specifications, instructions to access QIES, and access to webinars at https://educate.ahcancal.org/LearnED

Additional resources will continue to be added to ahcancalED.

Members are urged to begin now to review the new quality measures and start to focus your efforts to improve in these noted areas before the new quality measures are added to Five-Star. Collect data on your current rates for re-hospitalization, Emergency Room use and discharge to community using a free tracking spread sheet by Advancing Excellence at https://www.nhqualitycampaign.org. New information, tools and guidance will be added to Trend Tracker in the very near future.

The Open Door Forum call also included a push for providers to voluntarily submit electronic staffing (PBJ) data ahead of the July 1, 2016 start date of mandatory filing, as well as an update on the government’s research into alternative payment methods for SNFs. The on-going research has been narrowed down to focus on resident characteristics, rather than service use.

**Payroll-Based Journal – Mandated Payroll Submission**

If Paul Revere were alive today, he would be driving around the U.S. in his Ferrari shouting, “PBJ is coming, PBJ is coming!” Are you ready? Have you submitted test data? Will your payroll data be able to be transmitted to CMS without any problems? Do you understand that this data could eventually impact on your LTC funding? Now is the time to make sure you are ready for PBJ, because the mandate begins on **July 1, 2016**.

Section 6106, of the Affordable Care Act (ACA), requires electronic submission of direct care staffing (including agency and contract staff) based on payroll and other verifiable and auditable data starting one year from enactment (note: CMS missed this deadline arguing they had no funding. The IMPACT Act of 2014 provided CMS with funding to implement this section.). Also required, is data submission on census. Collection of this data will take place by way of the Payroll-Based Journal (PBJ). CMS has a draft PBJ **policy manual** (updated August, 2015),
which contains information on how staffing and census data should be submitted. It is important to note submission is a Requirement of Participation and subject to all enforcement actions.

REPORTING TIMEFRAME
SNFs, starting on July 1, 2016 will be required to submit direct care staff hours per day quarterly, for all days in the quarter as well as census data on the last day of each month. Currently, providers are able to register for and submit data through the voluntary period (October 1, 2015 to June 30, 2016). This voluntary period, is the only time that providers will be given to test the system. At some point after July 2016, a center’s submitted data will be utilized in the survey process, may result in enforcement actions, and be added to Five-Star. Providers can view a training module on the registration process for the voluntary period at QTSO.

STAFFING DATA
For the purpose of PBJ, direct care staff is defined as those individuals, who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The system will require hire and termination dates (option to leave blank for contract staff), discreet employee IDs and hours submitted per day (salary and other information will NOT be collected). For exempt employees, only hours that they are paid are able to be reported (e.g. in most cases 35 or 40 hours). Corporate staff, when working in a nursing center, can only have their hours reported if they are performing duties directly involving resident care. Any direct care staff members that are directly paid by another payor source (e.g. Medicare, Medicaid, etc.) cannot be counted.

CENSUS AND CASE MIX
CMS will directly source case mix data from the MDS and providers are not required to provide any additional data for case-mix calculations. Providers must submit census data, the count of the number of residents in the center on the last day of each month in the quarter. Census data must specify the primary payer of services for the resident.

DATA SUBMISSION
Staffing and census data must be submitted into PBJ every fiscal quarter. The table below provides the date ranges associated with the fiscal quarters.

<table>
<thead>
<tr>
<th>Fiscal Quarter</th>
<th>Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>October 1- December 31</td>
</tr>
<tr>
<td>2</td>
<td>January 1 – March 31</td>
</tr>
<tr>
<td>3</td>
<td>April 1 – June 30</td>
</tr>
<tr>
<td>4</td>
<td>July 1 – September 30</td>
</tr>
</tbody>
</table>

The staffing and census data from the entire quarter has to be uploaded or manually entered by the end of the 45th calendar day at 11:59 EST after the last day in each fiscal quarter in order to be considered timely. Data can be submitted into PBJ manually, through an XML upload, or a combination of the two. Submitted data can be viewed through CASPER or PBJ.

More Information
More information on PBJ can be found at:

- Electronic Staffing Data Submission Payroll- Based Journal Policy Manual
- Payroll-Based Journal (PBJ) System Policy
- Manual FAQs
- Payroll-Based Journal Technical FAQs
- Voluntary Period Registration
- ahcancalED Electronic Staffing Data Collection and Payroll-Based Journal Webinar
Also, be sure to check out the “Payroll Based Journal Reporting” article submitted by Andrew Cutler from FGMK, LLC in the Spring/Summer 2016 issue of LTC Today magazine (coming your way in May) for more information.

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**Trending Statistics**

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

In the [2014 National Healthcare Quality and Disparities Report, Chartbook on Effective Treatment](#), generated by the Agency for Healthcare Research and Quality (AHRQ), one of the areas noted dealt with conditions causing limited mobility. Severe back/neck conditions affected 7.5 million Americans in 2010, making them the most common chronic conditions limiting mobility. Arthritis/rheumatism, affecting 6.8 million, was the second most common.

**Arthritis**

- Arthritis is the leading cause of disability in the United States, with prevalence projected to double by the year 2020 due largely to an aging population and an increasing prevalence of obesity ([Johnson & Hunter, 2014](#)).
- About one in five adults and 300,000 children have a diagnosed arthritic condition.
- It is estimated that 41 percent of the 50 million U.S. adults living with arthritis report activity limitations caused by arthritis.
- The Centers for Disease Control and Prevention predicts a 25 percent increase to 67 million of U.S adults with some form of arthritis by 2030.

**Effects of Arthritis**

- Arthritis usually affects people who have other chronic conditions.
- For example, arthritis is found among 52 percent of people with diabetes, 57 percent of people with heart disease and 53 percent of people with hypertension.
- Obese people with arthritis are 44 percent more likely not to be physically active compared to those without arthritis ([White & Waterman, 2012](#)).

**Costs of Arthritis**

- In 2007, the costs attributable to arthritis and other rheumatic conditions were $128 billion:
  - $80.8 billion in direct medical expenditures ($115 billion in 2013 dollars).
  - $47 billion in indirect lost earnings ($59.4 billion in 2013 dollars) ([Ma, et al., 2014](#)).

**Measures**

- Process: Adults with chronic joint symptoms who have ever seen a doctor or health professional for joint symptoms.

**Chronic Joint Symptoms**

- Estimates of arthritis prevalence vary depending on whether the definition includes chronic joint symptoms (pain, aching, joint stiffness).
- People with chronic joint symptoms report similar health outcomes as those with arthritis:
  - Activity limitations.
  - Poor/fair health and mental health.
  - Similar health care use ([Canizares & Badley, 2012](#)).
- These patients need interventions and advice to manage and control the pain and symptoms in order to improve their health and quality of life ([Canizares & Badley, 2012](#)).
Adults Who Have Seen a Doctor for Joint Symptoms

Adults with chronic joint symptoms who have ever seen a doctor or other health professional for joint symptoms, by race/ethnicity and gender, 2009-2012

<table>
<thead>
<tr>
<th>Race / Ethnicity</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>70.5</td>
<td>69.1</td>
<td>72.1</td>
<td>72.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>65.9</td>
<td>64.7</td>
<td>63.2</td>
<td>65.9</td>
</tr>
<tr>
<td>Black</td>
<td>75.2</td>
<td>75.0</td>
<td>73.7</td>
<td>77.6</td>
</tr>
<tr>
<td>White</td>
<td>71.0</td>
<td>69.2</td>
<td>73.5</td>
<td>73.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>66.0</td>
<td>65.5</td>
<td>69.7</td>
<td>69.9</td>
</tr>
<tr>
<td>Female</td>
<td>74.6</td>
<td>72.7</td>
<td>74.4</td>
<td>74.1</td>
</tr>
</tbody>
</table>

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2009-2012.

Note: White and Black are non-Hispanic. Hispanic includes all races.

Overall Rate: In 2012, 72.1% of adults with chronic joint symptoms reported seeing a doctor or other health professional for joint symptoms.

Groups With Disparities:
In all years, Hispanics were less likely than Whites to report seeing a doctor or other health professional for joint symptoms.
In all years, females were more likely than males to report seeing a doctor or other health professional for joint symptoms.
Adults Who Have Seen a Doctor for Joint Symptoms

Adults with chronic joint symptoms who have ever seen a doctor or other health professional for joint symptoms, by insurance and age, 2009-2012

Left Chart:

<table>
<thead>
<tr>
<th>Insurance</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>69.4</td>
<td>67.6</td>
<td>71.1</td>
<td>71.2</td>
</tr>
<tr>
<td>Public</td>
<td>82.4</td>
<td>80.0</td>
<td>82.6</td>
<td>81.4</td>
</tr>
<tr>
<td>Uninsured</td>
<td>52.5</td>
<td>52.3</td>
<td>56.4</td>
<td>54.9</td>
</tr>
</tbody>
</table>

Right Chart:

<table>
<thead>
<tr>
<th>Age</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-44</td>
<td>64.5</td>
<td>62.5</td>
<td>66.4</td>
<td>65.8</td>
</tr>
<tr>
<td>45-64</td>
<td>74.0</td>
<td>73.7</td>
<td>76.6</td>
<td>76.6</td>
</tr>
<tr>
<td>65+</td>
<td>83.2</td>
<td>81.6</td>
<td>81.9</td>
<td>84.0</td>
</tr>
</tbody>
</table>

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2009-2012.

Groups With Disparities:

- In all years, people without insurance were less likely to report seeing a doctor or health professional for joint symptoms compared with people with private insurance.
- In all years, people with public insurance were more likely to report seeing a doctor or health professional for joint symptoms compared with people with private insurance.
- In all years, people ages 45-64 and 65 and over were more likely to report seeing a doctor or health professional for joint symptoms compared with those ages 18-44.
**Important Regulations, Notices & News Items of Interest**

1) **RN Licensing:** or 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 through IDFPR. They recently announced implementation of electronic renewals for professions licensed and regulated by the Divisions of Real Estate and Professional Regulation. License renewals can be completed online via the agency website [click here](#). Proof of licensure can be found at the [License Lookup page](#). And if you want to be reminded electronically, just visit the [online address change site](#) to provide a current email address and contact information.

2) There were no federal Survey and Certification (S&C) Letters released since the last issue of *Regulatory Beat*.

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

   - CMS released the [Next Steps Toolkit](#) to help providers track and improve ICD-10 progress with information and resources on how to:
     - Assess ICD-10 progress using key performance indicators to identify potential productivity or cash flow issues
     - Address opportunities for improvement
     - Maintain progress and keep up-to-date on ICD-10

     Visit the [ICD-10](#) website and [Roadto10.org](#) for the latest news and official resources, including the [ICD-10 Quick Start Guide](#), and a contact list for provider Medicare and Medicaid questions.

   - **Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21**
   
     All Quality Improvement and Evaluation System (QIES) systems will be unavailable from Wednesday, March 16 after 8 pm ET through Monday, March 21, 2016. This downtime will affect all QIES connectivity and systems. The national database, Certification and Survey Provider Enhanced Reporting (CASPER) reports, and quick reference (QW) will not be available during this time. In addition, the following submission systems will be unavailable:
   
     - Hospice Item Set
     - Inpatient Rehabilitation Facility (IRF) - Patient Assessment Instrument (PAI)
     - Long-term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set
     - Minimum Data Set (MDS) and Payroll-Based Journal
     - Outcome and Assessment Information Set (OASIS)

     Affected providers should make contingency plans to accommodate for this downtime.

   - On February 16, CMS and America’s Health Insurance Plans (AHIP), as part of a broad Core Quality Measures Collaborative of health care system participants, released seven sets of clinical quality measures. These measures support multi-payer alignment, for the first time, on core measures primarily for physician quality programs. Partners in the Collaborative recognize that physicians and other clinicians must currently report multiple quality measures to different entities. Measure requirements are often not aligned among payers, which has resulted in confusion and complexity for reporting providers. To address this problem, CMS, commercial plans, Medicare and Medicaid managed care plans, purchasers, physician and other care provider organizations, and consumers worked together through the Collaborative to identify core sets of quality measures that payers have committed to using for reporting as soon as feasible.

     The core measures are in the following seven sets:

     - Accountable Care Organizations, Patient Centered Medical Homes, and Primary Care
     - Cardiology
The Final Annual Report Project Year 3: Evaluation of Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents can be found at: https://innovation.cms.gov/Files/reports/irahnfr-finalythreeevalrpt.pdf.

An audio recording and transcript are available for the February 4 call on IMPACT Act: Connecting Post-Acute Care across the Care Continuum.

4) The federal Agency for Healthcare Research and Quality (AHRQ) posted a reminder regarding the Data Submission for AHRQ Nursing Home Survey.

- Nursing homes that have administered AHRQ’s Nursing Home Survey on Patient Safety Culture can submit their data to the Comparative Database April 1-21. The results of this database will be compiled into the Nursing Home Comparative Database Report. Average scores and percentiles on the survey items and composites will be included to help nursing homes assess their own results in order to identify strengths and opportunities for improvement.

Nursing homes who have not previously administered the survey may still do so. The survey, toolkit materials, and general data submission information are available here.

If you have any questions, call 888-324-9790 or email: DatabasesOnSafetyCulture@westat.com.

5) The Illinois Department of Healthcare and Family Services (HFS) released the following two Provider Notices:

- HFS has posted a new Ambulance Transportation Fee Schedule to the Medicaid Reimbursement page. You may view the new Ambulance Transportation Fee Schedule here.

- HFS has posted a new Dental Fee Schedule to the Medicaid Reimbursement page. You may view the new Dental Fee Schedule here.

6) The Illinois Department of Public Health (IDPH) notified IHCA of an upcoming National Partnership to Improve Dementia Care and QAPI Provider Call on Thursday April 28, 2016 from 12:30-2:00pm (CST).

- To Register: Visit MLN Connects Event Registration. Space may be limited, register early. This call will focus on infection control, highlighting Antibiotic Stewardship and community-wide efforts, including a presentation from a nursing home administrator. Common concerns related to the clash between individualized, person-centered care and the medical model of controlling infections will also be addressed. This is critical for residents with dementia, who often struggle to complete complex tasks and may have issues with continence. Additionally, CMS subject matter experts will share information about the upcoming Infection Control Pilot Project, as well as updates on the progress of the National Partnership and Quality Assurance and Performance Improvement (QAPI). A question and answer session
will follow the presentations. The National Partnership to Improve Dementia Care in Nursing Homes and QAPI are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care, and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to ensure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.

Discussion Topics:
- Antibiotic Stewardship, involving urinary tract and respiratory infections
- Infection Control Pilot Project
- QAPI
- National Partnership

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

6) The American Health Care Association (AHCA) released several guidance items for their members:

- CMS Releases 2017 Advance Notice and Draft Call Letter for MA Plans (click here for the AHCA summary). CMS released the 2017 Advance Notice and Draft Call Letter for the Medicare Advantage (MA) and Part D programs. The Notice includes updated payment rate information and guidance to plan sponsors as they prepare bids for the upcoming plan year.

- New Interactive Map Profiling State Dementia Training Requirements and CARES Training Courses - www.hcinteractive.com/StateRequirements. Below is a link of a U.S. map that was developed by Health Care Interactive (HCI) – the folks behind the CARES Alzheimer’s training program that is supported by AHCA/NCAL and CMS and can come with the Alzheimer’s Association’s essentiALZ® certification. To use the interactive map, click on your state and if your state has dementia care training requirements, a list of CARES training modules that meets those training requirements appears. If your state does not have any training requirements, HCI make recommendations various training modules for different care settings. Currently 15 state affiliates have partnership agreements with AHCA/NCAL for the CARES program. To refresh everyone’s memory, those states are: CT, DC, IN, IA, IL, KY, MD, MN, NV, NC, ND, OK, TN, WA, and WI. Regardless of whether you have a partnership agreement, all AHCA/NCAL members receive a 10 percent discount on the CARES program by using the code AHCA10 when ordering.

- Overpayment Rule Summary and Suggested Member Action Steps - On February 11, 2016, the 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." The rule becomes effective 30 days after publication in the Federal Register. Thus the effective date is March 14, 2016. A separate final rule was published on May 23, 2014 that addresses Medicare Parts C and D overpayments. AHCA/NCAL has prepared a short summary of the final rule and a possible set of member action steps in preparation for complying with the rule. The action steps list is in no way exhaustive and should not be considered legal advice. Rather, the points included are intended to serve as an outline for discussions with AHCA/NCAL members' legal counsel and accounting experts. In other words, this document is not intended as legal advice and should not be used as or relied upon as legal advice. It is for general informational purposes only and may not be substituted for legal advice.
AHCA Updates in Medicaid Managed Care. As you may know, CMS has sent the final Medicaid Managed Care rule to the Office of Management and Budget (OMB) for final approval. One of the key provisions in the proposed rule that we expect will be finalized is CMS’s proposal to add a new standard that payment incentive arrangements be designed to support program initiatives tied to targets, performance measures, and quality-based outcomes. While the final rule still is in process, it has come to our attention that CMS is incorporating this requirement, and other provisions in the Medicaid managed care rule, as conditions for approval of a waiver amendment or renewal in states with existing 1115 waivers and other Medicaid managed care implementation authorities. Click here to view Medicaid managed care program authorities. States now must comply with state and federal level comment periods on Section 1115 waiver submissions (see below); however, other Medicaid managed care program options are not subject to the same level of rigor. We understand that this may have significant implications for providers in Medicaid managed care states that include payment provisions targeted to providers under which the State has directed that a portion of the capitation payment paid to a managed care plan be distributed to a certain category of provider. AHCA/NCAL’s summary and comments on the proposed rule are available on the AHCA/NCAL website. To view the proposed rule in its entirety, click here.

AHCA 2015 Annual Report – Strengthening Our Commitment – Click here to view.

IT Funding from CMS - Although there are no details, we need to watch out for this because it now includes funding for LTC. Long-term care providers can receive additional technology funding under a new initiative announced by CMS. The initiative seeks to make interoperable technology attainable for a “broader universe” of Medicaid-certified healthcare providers, CMS Acting Administrator Andy Slavitt and National Coordinator for Health Information Karen DeSalvo said in a blog post. States will be able to request 90 percent enhanced matching funds from CMS to allow a greater variety of healthcare providers — including long term care facilities, behavioral health providers and substance abuse treatment centers — to purchase technology to connect them to the “complete circuit” of health information sharing. The funding will also help improve the sustainability of health information exchanges, CMS said. “Adding long-term care providers, behavioral health providers, and substance abuse treatment providers, for example, to statewide health information exchange systems will enable seamless sharing of a patients' health information between doctors or other clinicians when it's needed,” the blog post reads. “This sharing helps create a more complete care team to collaborate on the best treatment plans and goals for Medicaid patients.”

TelligenQINQIO had two items of interest:

The latest Telligen events/announcements can be found here.

Over the past decade, on average 3,500 Illinoisans died each year from flu or pneumonia; a majority of these deaths occurring among seniors. In the United States, adults over the age of 65 accounted for approximately 61 percent of hospitalizations due to influenza from October 2014 – May 2015. As the CMS Illinois Quality Innovation Network – Quality Improvement Organization (QIN-QIO), Telligen wants to work with your organization to improve immunization rates in Illinois and save lives from avoidable deaths and hospitalizations. By partnering with Telligen, you will receive guidance on assessment, administration/referring, documenting and reporting of influenza, pneumonia and shingles immunizations and assistance with interpretation of immunization data reports to identify opportunities for improvement. In addition, you will have access to educational programs and opportunities to collaborate with local pharmacies to increase your immunization rates. Please contact Kateri Nelis at kateri.nelis@area-d.hcgis.org or 630-928-5811 to become a collaborative partner or for more information about this life-saving initiative.

AARP recently reported on “RX Price Watch Report: Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans; 2006 to 2013 (click here). The latest Rx Price Watch report by Leigh Purvis and Dr. Stephen W. Schondelmeyer finds that retail prices for widely used prescription drugs increased, on average, between 2006
and 2013. In 2013, retail prices for 622 brand name, generic, and specialty prescription drugs widely used by Medicare beneficiaries increased by an average of 9.4 percent. In contrast, the general inflation rate was 1.5 percent over the same period.

9) **Medical News Today** had several articles of interest:

- **New Definitions Created for Sepsis and Septic Shock.** Updated definitions and clinical criteria for sepsis should facilitate earlier recognition and more timely management of patients with or at risk of developing sepsis. The report, which appears in *JAMA*, is being released to coincide with its presentation at the Society of Critical Care Medicine's 45th Critical Care Congress.

- **Copper Destroys MRSA at a Touch.** New research from the University of Southampton shows that copper can destroy *MRSA* spread by touching and fingertip contamination of surfaces. Frequently-touched surfaces in busy areas - such as hospitals, transport hubs and public buildings - are at high risk of community-acquired and healthcare-associated infections (HCAIs) caused by methicillin-resistant Staphylococcus aureus (MRSA) and methicillin-sensitive Staphylococcus aureus (MSSA). Bacteria deposited on a surface by one person touching it, or via contaminated body fluids, can be picked up by subsequent users and spread to other surfaces, potentially causing thousands of infections worldwide.

- **Chocolate May Boost Cognitive Function.** If you're looking for an excuse to chomp that bar of chocolate calling your name, then look no further; a new study suggests eating chocolate at least once weekly may boost cognitive function. While chocolate is still perceived as an indulgent treat, studies have increasingly documented the potential health benefits of habitual consumption.

10) **MedlinePlus** also posted several articles of interest:

- **New TB Test May Help Simplify Diagnosis.** A simple new blood test for tuberculosis may one day help improve diagnosis and treatment of the deadly disease in developing countries, researchers report. The inexpensive test identifies a gene expression "signature" that distinguishes people with active TB from those with either latent TB or other diseases, according to the research team from the Stanford University School of Medicine, in Palo Alto, Calif.

- **Flu Season Continues to Be Mild: CDC.** WEDNESDAY, Feb. 24, 2016 (HealthDay News) -- This flu season continues to be mild, and the flu vaccine is working better than the one used last season, U.S. health officials reported recently. But that doesn't mean everyone can rest easy yet, because flu activity is picking up a bit and the season isn't expected to peak for several weeks, probably some time in March, officials from the U.S. Centers for Disease Control and Prevention said.

- **Decline in Senses Affects Nearly All Seniors, Study Finds.** Nearly all older U.S. adults have an age-related decline in at least one of their senses, a new study finds. Researchers checked more than 3,000 people between the ages of 57 and 85. The investigators found that 94 percent had a problem with at least one of their five senses: taste, smell, hearing, sight or touch. Almost 40 percent had problems with two senses, and 28 percent had problems with three or more of their senses, the study found.

- **“Mindfulness” Might Help Older Adults With Back Pain.** Mindful meditation may offer a measure of pain relief to seniors suffering from chronic lower back pain, new research suggests. The study involved nearly 300 older adults with long-term lower back pain, half of whom were assigned to a two-month mindful meditation course. "Mindfulness meditation is a method to learn how to be fully engaged in the present moment and not let the mind get so easily distracted," explained study lead author Dr. Natalia Morone. She is an associate professor of medicine at the University of Pittsburgh. As patients practiced mindful meditation and tried to stay more focused on the present moment, "participants found they experienced less pain," Morone said. They also saw short-term benefits in physical function, the study found.
11) **MedicalXpress** reports that “*Chronic Conditions Rise in Older People.*” The number of older people in England living with more than one chronic condition could have risen by ten per cent in the last decade putting increasing pressure on the NHS, new research has suggested. NIHR-funded researchers have found more older people now have at least one chronic disease, adding further strain on health budgets amid a rise in long-term conditions and people living longer.

12) **Medscape** reported on several articles of interest:

- **CDC Guidelines for Opioid Use.** On December 14, 2015, the CDC posted the draft guidelines. The number of invited public comments through January 15, 2016, totaled more than 4000. The process has been elaborate, based on exhaustively referenced literature review and involving all of the major professional stakeholders. This draft is a really big deal, and if you have the time, you could plow through all of it. But here is the "skinny"—read it, apply it. It may be boring but it really matters to your daily practice. The recommendations are grouped into three areas for consideration.

- **FDA Unveils Sweeping Changes to Opioid Policies.** In response to the ongoing opioid abuse epidemic, top officials at the US Food and Drug Administration (FDA) today announced plans to reassess the agency's approach to opioid medications. "We are determined to help defeat this epidemic through a science-based and continuously evolving approach," Robert Califf, MD, the FDA's Deputy Commissioner for Medical Products and Tobacco, said in a news release. "This plan contains real measures this agency can take to make a difference in the lives of so many people who are struggling under the weight of this terrible crisis." The plan is further outlined in an article published online today in the *New England Journal of Medicine.*

- **High CAC Scores Associated with Increased Dementia, Mortality Risk in ‘Oldest’ Old.** Measures of subclinical CVD may help predict risk of cardiac events, mortality, and dementia in the "very elderly," new research suggests. Analysis of more than 500 patients older than 80 years from the *Cardiovascular Health Study–Cognition Study* showed that a high coronary artery calcium (CAC) score was significantly associated with adjusted mortality, CHD, and MI rates. In addition, there was a significantly decreased incidence of dementia in the white female participants with low CAC scores.

- **Quality Indicator, Physicians Differ on Preventable Admissions.** The majority of hospital admissions deemed preventable using the standardized Prevention Quality Indicator (PQI) were not rated preventable by physicians at the hospital, a new study finds. Instead, the physicians found a larger, mostly distinct group of admissions were preventable, researchers report in a study published online February 18 in the *Journal of General Internal Medicine.* In fact, physicians and the PQI agreed on the preventability of only 10 percent of overall admissions, a concordance no different than what would be expected by chance.

- **Psychiatric Symptoms Speed Conversion to Dementia.** Neuropsychiatric symptoms (NPS) are associated with more rapid progression from mild cognitive impairment (MCI) to Alzheimer's disease (AD), two new studies confirm. The first study, led by Sarah Forrester, a doctoral candidate at Johns Hopkins University, in Baltimore, Maryland, pinpoints clusters of NPS associated with faster progression. The second study, led by R. Scott Mackin, PhD, University of California, San Francisco, suggests that chronic depressive symptoms are associated with structural brain changes that may contribute to more rapid conversion.

- **New APS Guideline on Postoperative Pain.** A new evidence-based clinical practice guideline that includes 32 recommendations related to postoperative pain management in children and adults has been released by the American Pain Society (APS). The guideline is based on the findings of an interdisciplinary expert panel. The APS commissioned the panel with input from the American Society of Anesthesiologists, and the document was subsequently approved also by the American Society of Regional Anesthesia and Pain Management. Research shows that most surgical patients receive inadequate pain relief, which can
increase the risk for prolonged postoperative pain, mood disorders, and physical impairment, said lead author of the guideline, said Roger Chou, MD.

13) McKnight's reports:

- **Number of Seniors Who Need Personal Care Help Increasing, CDC Says.** A “significantly” increasing number of adults over age 65 need help with personal care, according to new data from the Centers for Disease Control and Prevention. The data, released last Tuesday by the CDC's National Center for Health Statistics, shows 7.2 percent of seniors required help with activities of daily living in 2015, compared to 6.6 percent in 1997. The report included eating, bathing, dressing and getting around as personal care needs. Seniors over age 85 were twice as likely as adults between age 75 and 84 to require personal care help, and were five times as likely as adults age 65 to 74. The report also found 6.4 percent of white seniors required personal care help, compared to 9.6 percent of black and 11.3 percent of Hispanic seniors.

- **Providers With Problematic Partners Will Face More Medicare Scrutiny Under CMS Proposal.** Providers would have to report affiliations with individuals or groups who “pose risks” to the Medicare program under a proposed rule released by CMS. The rule, which implements provisions included in the Affordable Care Act, aims to cut down on Medicare fraud by adding scrutiny to provider enrollment and weeding out individuals who pose a risk of waste, fraud or abuse. One major provision of the rule would require providers and suppliers to report affiliations with individuals or entities that either have uncollected debt to Medicare or Medicaid, have had their reimbursements suspended, or have had their enrollment in either program denied or revoked. Medicare enrollment may be denied or revoked if CMS determines the affiliation poses a fraud risk, the agency said.

- **Readmissions Decline Not Connected to Observation Status, Researchers Find.** The recent decline in hospital readmissions isn’t due to hospitals increasing the number of patients kept on observation status, a new study asserts. The study, conducted by the U.S. Department of Health and Human Services, says the 3.7 percent drop in readmission rates seen between 2007 and 2015 is likely due to hospitals' responses to provisions in the Affordable Care Act that impose penalties for readmissions — not the use of observation stays.

- **Medicare Costs Rise as Hospice Stays Lengthen, WSJ Report Finds.** Increasingly long hospice stays have nearly doubled the amount Medicare is spending on patients in recent years, according to a new report from the Wall Street Journal. Medicare's hospice coverage program was designed for patients who doctors deemed likely to die within six months, or 180 days. More than 106,000 beneficiaries received care averaging 1,000 days or more between 2005 and 2013, the report found. By that year, hospice spending climbed to $15 billion, almost double the amount eight years earlier. Those beneficiaries with extended lengths of hospice care cost Medicare 14 percent of its hospice spending, although they accounted for slightly above 1 percent of hospice patients. Fifteen years ago, the average length of stay for Medicare beneficiaries in hospice was 54 days, which climbed to an average of 88 days by 2013. At that time, more than a third of Medicare hospice payments were going to patients with at least a year of total hospice care.

- **Nursing Home Capacity Down Across Country, CDC Report Finds.** While nursing homes remain the top long term care providers in most regions of the United States, residential care communities are steadily gaining ground, according to a new report from the Centers for Disease Control and Prevention. To read the full CDC report, click here.

- **CMS Ramps Up Site Visits, Data Monitoring To Combat Medicare Fraud.** CMS is beefing up its efforts against Medicare fraud with increased provider site visits, the agency announced recently. The increased site visits will initially target providers located in “high risk” areas that receive high Medicare reimbursements, Shantanu Agrawal, M.D., deputy administrator and director for CMS's Center for
Program Integrity, wrote in a blog post. The post did not include specific high risk areas for long-term care providers. The visits will ensure that provider enrollment and location information is accurate, Agrawal said.

- **False Billing Tops Healthcare Fraud Cases, GAO Says.** Fraudulent billing is the most common health care fraud scheme, making up about 68 percent of all resolved cases, per the Government Accountability Office. In a report released last month, the GAO reviewed 739 healthcare fraud cases resolved in 2010. Of those cases, about 43 percent were related to billing for services that were not provided. Another 25 percent of cases involved providers billing for services that were not medically necessary. Other common schemes include falsifying records at 25 percent of resolved cases, paying kickbacks at 21 percent and fraudulently obtaining controlled substances or misbranding prescription drugs also at 21 percent.

- **Mandatory Flu Vaccinations For Health Care Workers Pay Off, Researchers Say.** State laws that mandate flu vaccinations for health care workers help increase the overall vaccination rate, a new study reports. The study, led by researchers at the University of Pittsburgh School of Medicine, analyzed immunization records from 2000 to 2011. During that period, the number of states with mandatory vaccination laws for healthcare workers jumped from two to 19. Between 2000 and 2005, when only Maine and New Hampshire required healthcare workers to get vaccinated, the average immunization rate for those in the healthcare industry was 22.5 percent. From 2006 to 2011 — a span when 17 other states joined in creating vaccination laws — that rate jumped to 50.9 percent.

- **Bundled Payment Models Showing Mixed Results For Post-Acute Care, Report Finds.** Medicare beneficiaries being sent home after a hospital visit saved post-acute care bundled payment networks more money than if they were moved to a skilled nursing facility, according to a model analyzed in a new report. An analysis of Bundled Payment Care Improvement models, released last week by the Kaiser Family Foundation, showed mixed cost-savings results among the four BPCI models currently being tested.

14) **Interesting Fact:** An adult has fewer bones than a baby. We start off life with 350 bones, but because bones fuse together during growth, we end up with only 206 as adults.