May 3, 2016 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!

Centers for Medicare and Medicaid Services (CMS) Updates

The American Health Care Association (AHCA) recently shared some CMS updates/ information on current and future regulatory and program changes that we should all be aware of and make preparations for. The IHCA/CMS summary noted below is broken down into several sections: Regulations; Quality Measure and Reporting; HHS Quality Initiatives; Payments to SNFs; Hospital and Physician Payment Incentive Changes that Will Impact SNF Referral Patterns and Possibly Volume; and OIG Upcoming Reports. This summary will list the current and future changes, some key highlights and estimated dates of implementation. As LTC providers, you need to be aware of future LTC activities as well as current issues.

Regulations

- **MDS Focused Surveys**
  - Focus on MDS accuracy and frequency
  - More numerous and may become part of annual survey
  - Requires posting and archiving of daily staffing
  - CMS will determine how many of these special surveys will be conducted by each state
    - Implemented in February of 2015

- **Dementia Focused Surveys**
  - Staff training and demonstrated competency in dementia care
  - Started as a pilot survey and now will be implemented in every state
  - CMS will determine how many of these special surveys will be conducted by each state
    - To be implemented in early 2016

- **Adverse events focused surveys**
  - These new surveys will focus on medication errors
  - Surveyors will review how facility investigated and handled adverse events
  - CMS will determine how many of these special surveys will be conducted in each state
    - To be implemented in early 2016

- **Requirements of Participation (RoPs)**
  - This is the proposed extensive changes CMS wants to make to the current federal LTC regulations
  - CMS is reviewing the more than 10,000 comments they received and determining what changes they are going to make to the final rulemaking
Once the rulemaking is finalized, CMS will also need to do new Interpretive Guidelines for the new rules
  ▪ CMS is estimating they will have this review completed in the summer of 2016, this timeframe seems suspect due to the large number of comments

• New Life Safety Code
  o Updating the national life safety code from the 2000 edition to the 2012 edition
  o Increases the inspection, testing and maintenance requirements
  o Includes additional sprinklering requirements
    ▪ The final rulemaking is at the Office of Management and Budget (OMB) for final approval before adoption – expected in mid to late 2016

• New Emergency Preparedness requirements for all provider types
  o Extensive rewrite with all hazard approach; includes cost implications to comply
  o Need to have a complete and tested plan for different types of emergencies and must meet the needs of the types of residents served
  o Test generator on load one (1) time each year for four (4) hours
  o Conduct training upon hire and annually
    ▪ The final rulemaking is at the Office of Management and Budget (OMB) for final approval before adoption – expected in mid to late 2016

• Discharge planning for hospitals and home health
  o This proposed rule was issued in November 2015 and does have an impact on SNFs
  o Requires hospitals to give patients information on SNF quality prior to discharge, advice on SNF selection and the SNF’s managed care network
    ▪ Final rule expected in summer 2016

• OSHA electronic reporting of illnesses/injuries
  o Database of electronic reporting info will be available to the public
    ▪ The final rulemaking is at the Office of Management and Budget (OMB) for final approval before adoption – expected in early to mid 2016

• Department of Labor rules on exempt and non-exempt employment
  o Defining and de-limiting the exemption for executive, administrative, professional, outside sales and computer employees
  o Setting minimum salary levels and hourly rates and overtime requirements and annual inflator
  o Changes criteria about exempt compensated employees
    ▪ Expected in early 2016

Quality Measure and Reporting
Changes due to IMPACT Act

• Changes to MDS
  o 2016 SNF PPS rule adds new section GG to MDS and changes to MDS discharge assessment; need to complete when discharged from Part A coverage
    ▪ Estimated to occur in October of 2016

• Three new measures finalized (PU, Falls and Function)
  o 2016 SNF PPS rule finalized three new measures
    ▪ Start to collect data in October 2016

• Four additional measures being considered
Potentially preventable rehospitalizations during and 30 days after SNF discharge
Discharge to community
Drug regimen review
Average cost per beneficiary during and after SNF discharge
  CMS planned to add this to the SNF PPS rule in April 2016 and start collecting data in October 2017

Changes to Five-Star

- **Add new measures**
  - Adding rehospitalization, discharge to community, mobility in room, hypnotics, outpatient emergency room visit and change in ADL from admission
    - CMS added these new measures to Nursing Home Compare on April 27, 2016
    - CMS will start phasing these new measures into the 5-Star rating beginning in July 2016 (except antianxiety/hypnotics measure – too be added in future)

- **Rebase ratings**
  - Rebase the Quality Measure (QM) thresholds to achieve each Star level
    - No date was given for the rebasing

Payroll Based Journal (staffing)

- **Mandated Payroll Submission**
  - Requires quarterly submission from facility payroll and all contract and agency use collected and reported by employee name
    - Voluntary since October 2015, mandatory July 1, 2016

HHS Quality Initiatives

- **CDC healthcare acquired infections**
  - Focus on C. Diff and UTI treatment and all antibiotic prescribing
  - Encourages SNFs to use infection reporting to the CDC NHSN website
    - Started November 2015 transitioning into 2016

- **Dementia Care**
  - Focus on antipsychotics and use of medications
    - This is an ongoing initiative

Payment to SNFs

- **SNF Value Based Purchasing (VBP) - (2 percent with-hold linked to rehospitalizations)**
  - Will reduce SNF Part A payments 2 percent based on SNFs’ rehospitalization rates
    - Performance will be based beginning July 2016 to July 2017; Adding first payment adjustment on October 1, 2018

- **SNF PPS 2017 rule**
  - It is possible, but not probable, that CMS would make payment methodology changes in the FY17 rule
    - CMS proposed this new rule on April 21, 2016 ([Fact Sheet](#))

- **IMPACT Act failure to report penalty**
  - Beginning in 2016 for the three formalized IMPACT Act measures (PU, Falls, Function), SNFs that fail to report on quality measures and resource use and other measures will be subject to a two
percentage point reduction in market basket prices in effect under the existing payment methodology in the Social Security Act

- In effect now

**Hospital and Physician Payment Incentive Changes Which Will Impact SNF Referral Patterns and Possibly Volume**

- **Hospital VBP** – 25 percent of hospital payments now tied to some form of VBP. Three are of note to SNFs: Hospital Medicare Spending per Beneficiary Measure; Rehospitalization; and Hospital Acquired Conditions
  
  - Medicare Spending per Beneficiary is part of Hospital Value Based Purchasing, but separately mandated by statute. It is referred to as an “efficiency” measure. First mandated episode of care measure – 3 days before hospitalization and 30 days post-discharge. All Part A and B spending included. Model for resources use measures in other payment systems. Regular reporting to hospitals of their episode cost history – will see exact SNF cost
  
  - Hospitals 3 percent cut Part A payments if high 30 day rehospitalizations
  
  - Hospital payments are adjusted based on infection rates, particularly antibiotic resistant infections so hospitals screening SNF admissions for these types of infections (MRSA, VRE, etc.)
    
    - Began last year but hospitals likely will begin in earnest this year now that hospitals have SNF spending data by facility

- **Physician Payments**
  
  - The Merit Based Incentive Payment System (MIPS) will be the core payment for physicians who don’t qualify for APM bonus and exemption from this system. Begins to impact physician payment in 2019 but physicians will begin to assess downstream care costs and outcomes now, to prepare for 2019. Physicians who meet certain performance criteria will have the opportunity to be exempt from MIPS and participate in an alternative payment method with more opportunity for gainsharing. Again, will result in more physician focus on care transitions, coding and downstream costs than in the past
  
  - Increased attention to codes and valuation, bundling more codes and creating codes for coordination of care
    
    - Physician behavioral changes likely to begin now, to prepare for 2019

- **CJR (Hips and Knees)**
  
  - Holds hospitals in 67 MSAs accountable for 90 day post-hospital discharge costs for hip and knee replacements including SNF costs
  
  - Opportunity for SNFs to serve as collaborators with hospitals and share risk bearing
  
  - Waives three (3) day stay for SNFs rated 3-stars or better
    
    - Started January 2015

- **Bundle Payment models (BIPA)**
  
  - Creates incentive to decrease SNF utilization and SNF LOS
    
    - Ongoing demonstration project

- **ACOs**
  
  - Creates financial incentives for hospitals and others to the lower rehospitalizations, improve outcomes and lower SNF utilization and create post-acute care networks. The most recent iterations of ACOs are now active and carry double sided risks. This could be an opportunity to engage in risk sharing
    
    - Ongoing demonstration program

**OIG Upcoming Reports**

- **Adverse Events in Inpatient Rehabilitation Facilities (IFF) and Long Term Care Hospitals (LTCH)**
Report on the estimate of the national incidence of adverse and temporary harm events for those in IRFs. The report will identify factors contributing to these events, determine the extent to which these events are preventable and show the associated cost

- Report due sometime in 2016

- National Background Check Program for Long Term Care Employees
  - Report on the implementation status and early results from the National Background Check Program for long term care employees from the first four (4) years of the program
    - OIG released their interim report in January 2016 (click here)

- Skilled Nursing Facility PPS Requirements
  - Review compliance with various aspects of the SNF PPS, including the documentation requirement in support of the claims paid by Medicare
    - Report due sometime in 2016

As these various rules, program changes and reports are implemented, IHCA will keep our members informed and provide as much information as we can put our hands on. Please contact us with any questions.

**Pneumococcal Immunizations – Revised Recommendations**

In late 2015, the Centers for Disease Control’s (CDC) Advisory Committee on Immunization Practices (ACIP) revised the pneumococcal immunization recommendations as follows:

**What is currently recommended?**
The Advisory Committee on Immunization Practices (ACIP) currently recommends that both 13-valent pneumococcal conjugate vaccine (PCV13) and 23-valent pneumococcal polysaccharide vaccine (PPSV23) be given to all immunocompetent adults aged ≥65 years. ACIP recommends that PCV13 be given first followed by PPSV23 6-12 months later. ACIP also recommends that adults aged ≥65 years who already received a dose of PPSV23, should also receive a dose of PCV13 ≥1 year after the dose of PPSV23. Among persons aged ≥2 years with medical indications to receive both PCV13 and PPSV23 in a series, including adults aged ≥65 years with immunocompromising conditions, functional or anatomic asplenia, cochlear implants, or cerebrospinal fluid leaks, a dose of PPSV23 should be given ≥8 weeks after a dose of PCV13.

**Why are the recommendations being modified now?**
To simplify the recommendations for PCV13 and PPSV23 use among immunocompetent adults aged ≥65 years, ACIP recommended harmonization of recommended intervals between PCV13 and PPSV23 regardless of the order in which the two vaccines are given.

**What are the new recommendations?**
ACIP recommends that both PCV13 and PPSV23 be given in series to adults aged ≥65 years. A dose of PCV13 should be given first followed by a dose of PPSV23 at least 1 year later to immunocompetent adults aged ≥65 years. The two vaccines should not be co-administered. If a dose of PPSV23 is inadvertently given earlier than the recommended interval, the dose need not be repeated.

The full report can be found here (pg. 944).

Also, the Agency for Healthcare Research and Quality (AHRQ) recently released a ‘Measure Summary’ entitled “Pneumococcal Vaccination Status for Older Adults: Percentage of Medicare Members 65 Years of Age and Older Who Have ever Received a Pneumococcal Vaccination.”
**Trending Statistics**

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

**Central Complaint Registry (CCR)- 210 ILCS 30-13,14**

The CCR is a 24-hour toll-free nationwide complaint hotline mandated under the Illinois Nursing Home Care Act. The CCR reviews/logs and sends complaints to the appropriate region for scheduling and subsequent investigation. Complaints are assigned a timeframe of 24-hours, seven-days or 30-days. Complaints can be received through the toll free hotline (800-252-4343), email ([DPH.CCR@ILLINOIS.GOV](mailto:DPH.CCR@ILLINOIS.GOV)), fax (217-524-8885) or mail (IDPH-CCR, 525 W. Jefferson St., Ground Floor, Springfield, IL 62761).

The CCR was established in May 1984, as a result of a legislative mandate to create a central clearinghouse for reports on the quality of care provided to residents of long term care facilities. In 1994, the registry hotline began accepting calls for other health care facilities. The CCR acts as a repository for concerns or complaints concerning more than 29 different programs monitored by the Department.

The CCR receives complaints from a variety of entities: Illinois Department on Aging, Illinois Department of Healthcare and Family Services, Illinois Department of Human Services, Illinois Guardianship and Advocacy, Illinois Department of Financial and Professional Regulation, Office of the Attorney General, Illinois Citizens for Better Care, states' attorneys, relatives, patients, staff, friends, visitors and residents. Many persons contacting the CCR do not file a complaint, but request information or solutions to problems. These persons are often referred to the Illinois Department on Aging or to a local area sub-state ombudsman. The CCR received more than 22,000 calls, faxes and emails in 2014, which generated 5,909 complaints, with 2,922 of those alleging abuse and/or neglect. Of the 5,909 complaints taken, 4,906 of these were for long term care facilities (including ICF/IIDs). Of the ICF/IID complaints, 1,063 were anonymous, leaving 3,842 as actual trackable complaints. There were 4,758 complaints filed against certified facilities, which resulted in 1,790 complaints being substantiated and 2,940 being unsubstantiated. There are an additional 28 complaints from the original 4,758 that are still in the investigative process at the time of this report and have yet to be identified as substantiated or unsubstantiated. Table 8 shows the number of complaints and percentage of complaints received by provider type.

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<td><strong>Complaints and Percentage of complaints received by Provider Type-2014</strong></td>
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<tr>
<td><strong>Long Term Care</strong></td>
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<td>o Skilled Nursing Facilities</td>
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<td>o Intermediate Care Nursing Facilities</td>
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<td>o Shelter Care Facilities</td>
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<td>o Community Living Facilities</td>
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<td><strong>Hospitals</strong></td>
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<td><strong>ICF-IID/Under 22/State Owned Mental Health Facilities</strong></td>
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<td><strong>Assisted Living Facilities</strong></td>
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<td><strong>Home Health Agencies</strong></td>
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<td><strong>Ambulatory Surgical Treatment Centers</strong></td>
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<td><strong>Hospice</strong></td>
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<td><strong>Portable X-rays</strong></td>
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<td><strong>Home Services</strong></td>
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<td><strong>Ambulance Companies/EMS/EMT</strong></td>
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<td><strong>Laboratories</strong></td>
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<td><strong>Unlicensed Facilities</strong></td>
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<td><strong>Total</strong></td>
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Long term care received the greatest amount of complaints, 80 percent (4,740), in 2014 with hospitals receiving the second greatest amount at 10.6 percent (630). CCR received a total of 5909 complaints in 2014.

The CCR is also the central reporting location for the Abuse and Neglect Long Term Care Facility Residents Reporting Act. In addition to long term care facilities licensed under the Nursing Home Care Act, intellectual centers operated by IDHS are required to report suspected resident abuse and neglect incidents.

**Important Regulations, Notices & News Items of Interest**

1) **National Nursing Home Week** is May 8-14, 2016. Access a PDF version of the AHCA 2016 Planning Guide and Product Catalog [here](#).

2) **May 6-12 is National Nurses Week:** Nurses play a huge role in our long term care centers every day. Take the opportunity during Nurses Week to show your nursing staff how much their dedication and hard work means to you, your staff and your residents! [Click here](#) for more information.

3) **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 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.

4) No new federal Survey and Certification (S&C) Letters were released since the last issue of *Regulatory Beat*.

5) Federal HHS/CMS released several noteworthy notices/announcements since the last issue of *Regulatory Beat*:

- **PEPPER Reports Available:** The Q4FY15 release of the SNF Program for Evaluating Payment Patterns Electronic Report (PEPPER) with statistics through September 2015 is now available! [Click here](#) for directions or read below.

**Free-standing SNFs:** Download PEPPER through the [PEPPER Resources Portal](#). The SNF’s Chief Executive Officer, President, Administrator or Compliance Officer should:

1. Review the [Secure PEPPER Access Guide](#).
2. Review the instructions and obtain the information required to authenticate access. *Note: A new validation code will be required. A patient control number or medical record number from a claim for a traditional Medicare FFS beneficiary with a “from” or “through” date in September 1-30, 2015 will be required.*
3. Visit the [PEPPER Resources Portal](#).
4. Complete all the fields.
5. Download the PEPPER.

**Hospital-based SNFs:** PEPPER was uploaded to the AutoRoute_inbox of QualityNet account administrators and those with user accounts with the PEPPER recipient roles. The PEPPER file will be available for download in QualityNet for 60 days from the date it was uploaded. [View instructions](#) for downloading your PEPPER.

- **CMS/Five-Star:** SNFs may now access their new Five-Star Ratings through the [CMS QIES system](#). This report includes a preview of data for each center on the new quality measures that will be added to Nursing Home Compare on April 27, 2016 and incorporated into the Five-Star Ratings in July 2016.
CMS Proposes 2017 SNF Payment Rule and Policy Changes: On April 21, CMS issued a proposed rule (CMS-1645-P) outlining proposed FY 2017 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). CMS will accept comments on the proposed rule until June 20, 2016. Based on proposed changes, CMS projects that aggregate payments to SNFs will increase in FY 2017 by $800 million, or 2.1 percent, from payments in FY 2016. This estimated increase is attributable to a 2.6 percent market basket increase reduced by 0.5 percentage points, in accordance with the multifactor productivity adjustment required by law. The proposed rule also includes:
- SNF Quality Reporting Program (QRP)
- SNF Value-Based Purchasing (VBP) Program

For More Information:
- SNF PPS website
- SNF QRP Measures and Technical Information webpage
- SNF VBP Program webpage
- IMPACT Act Downloads and Videos webpage

See the full text of this excerpted CMS fact sheet (issued April 21).

Hospice Benefit: Proposed FY 2017 Updates to the Wage Index and Payment Rates: On April 21, CMS issued a proposed rule (CMS-1652-P) that would update the hospice wage index, payment rates and cap amount for FY 2017. CMS will accept comments on the proposed rule until June 20, 2016. As proposed, hospices would see a 2.0 percent ($330 million) increase in their payments for FY 2017. The proposed 2.0 percent hospice payment update percentage for FY 2017 is based on an estimated 2.8 percent inpatient hospital market basket update, reduced by a 0.5 percentage point productivity adjustment and by a 0.3 percentage point adjustment set by the Affordable Care Act. The proposed rule also includes:
- Hospice CAHPS® Experience of Care Survey
- New hospice quality measures
- Enhanced data collection
- Public reporting

See the full text of this excerpted CMS fact sheet (issued April 21)

CMS Finalizes 2017 Payment and Policy Updates for Medicare Health and Drug Plans: CMS released the final Medicare Advantage and Part D Prescription Drug Program changes for 2017 that seek to provide stable payments to plans, and make improvements to the program for plans that provide high quality care to the most vulnerable enrollees.

The final policies are similar to those proposed in February but incorporate several changes in response to feedback received during the public comment period. On average, the expected revenue change is 0.85 percent without accounting for the expected growth in coding acuity that has typically added another 2.2 percent. The final revenue increase is somewhat smaller than the increase estimated in the February Advance Notice due primarily to technical updates in the risk adjustment normalization factor. See CMS press release. See Final Rule.

CMS Adds New Quality Measures to Nursing Home Compare: CMS announced that it has added six new quality indicators to the Medicare Compare website, three of which relate to the short-stay experience. Three new quality measures use data provided by hospitals, rather than that provided by nursing homes. The agency is also reporting on the percentage of long-stay residents who received an antianxiety or hypnotic medication (MDS-based). See press release and Fact sheet.
• CMS Created a PowerPoint on the Payroll Based Journal Initiative (click here). Also, Mr. Andrew Cutler, the Managing Director, Healthcare, FGMK, LLC did a fantastic article on Payroll Based Journal Reporting in the Spring/Summer edition of LTC Today magazine (click here).

• Track and Improve Your ICD-10 Progress: CMS released the Next Steps Toolkit and companion infographic to help you analyze and improve your ICD-10 progress:
  o Assess your progress: Establish a point of comparison for each Key Performance Indicator
  o Address your findings: Once you have identified opportunities for improvement, you can develop a feedback system
  o Maintain your progress: Be sure to keep all your systems and coding tools updated.

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

6) The Illinois Department of Healthcare and Family Services (HFS) released three Provider Notices since the last issue of Regulatory Beat:

• New Monthly Billing Process for Long Term Care Services - Effective July 1, 2016. This Informational Notice provides detailed information to Long Term Care (LTC) Providers regarding monthly fee-for-service billing processing that will be implemented July 1, 2016. The information contained in this notice will be the basis for an upcoming webinar presented by the Department. As this notice contains detailed billing instructions, it may be helpful for providers to utilize a copy of the UB-04 Data Specifications Manual for reference. The UB-04 Data Specifications Manual identifies and defines institutional claim elements. To become a UB-04 Subscriber, refer to the National Uniform Billing Committee (NUBC) website.

• Webinar on the New Monthly Billing Process for Long Term Care Services - April 27, 2016. The Illinois Department of Healthcare and Family Services (HFS) will offer a series of webinars through GoToWebinar relating to the new monthly billing process for long term care services that will be implemented July 1, 2016. It is recommended that you test your computer settings to make sure you will not encounter any problems with the transmission on the day of the webinar.

• Correction in the Crosswalk for the New Electronic Claims Processing of Long Term Care and Introduction to the New Electronic Claims Processing of Long Term Care. Caring for those with long term challenges is a vital societal goal. This section contains information and resources for long term care and services.

• Upcoming HFS LTC Webinar Information. HFS is changing how providers access information for the next two webinars on the LTC Direct Billing process. In order to avoid the technical issues experienced last week, and not waste providers’ time, the narrative to the webinar will be recorded ahead of time and the slides with the voice recording will be posted to the HFS LTSS website page. This will allow providers to access the webinar at their convenience, rather than forcing their participation at one specific time. Since the live chat function is not being utilized, the product to the providers will be exactly the same. For each webinar, HFS will post both the slide deck by itself and also the slides with the voice recording. The next two webinars should be available to access at the following times:

  o May 4 after 4 pm for the presentation on Direct Data Entry and File Uploading
  o May 18 after 4 pm for the presentation on Coding Requirements for Claim Submittal

Please submit questions to the HFS LTC inbox HFS.LTC@illinois.gov and they will be included in the FAQ document on the website.
7) There are three items of interest regarding the Illinois Department of Public Health:

- **Food Handler Training Requirements**: Effective July 1, 2016, all non-restaurant food handlers in Illinois, other than someone holding a food service sanitation manager certificate, must receive or obtain training in basic food handling principles within 30 days of employment. Only people who handle, prepare and dish up the food are considered food handlers and will need the required training. All Illinois food handlers employed in nursing homes and long-term care facilities must renew their training every three years. Click here for more information concerning the Illinois Food Handler requirements.

- The next round of IDPH Town Hall Meetings has been scheduled. They are regional meetings, very informal and an excellent opportunity to ask questions. Please have staff from each facility attend one of these Town Hall Meetings. Contact the IDPH Regional Office to RSVP due to limited space in some locations.

  - 5/12 – Marion Regional Office Building – 1-3 p.m.
  - 5/26 – Oak Trace – Downers Grove – 1-3 p.m.
  - 6/7 - Brookens Building – Champaign – 1-3 p.m.
  - 6/29 – Norridge HC and Rehab – 2-4 p.m.
  - 7/6 – Washington County Hospital – Nashville – 1-3 p.m.
  - 7/20 – Pine Crest Manor – Mt. Morris – 1-3 p.m.
  - 8/11 – Hamilton Memorial Rehab – McLeansboro – 1-3 p.m.
  - 8/31 – Memorial Education Building – O’Fallon – 1-3 p.m.
  - 9/14 – Alden Estates of Shorewood – 1-3 p.m.
  - 10/19 – Brookens Building – Champaign – 1-3 p.m.
  - 11/15 - Friendship Village – Schaumburg – 10 a.m.-12 noon

- IDPH has agreed to provide more detailed information as to why Informal Dispute Resolution (IDR) requests are denied. The revised format responses to the IDR requests started on April 1, 2016.

8) The American Health Care Association (AHCA) and the Illinois Health Care Association (IHCA) released several items of interest:

- Update on New Nursing Home Compare Quality Measures
- Anonymous Survey About Camera Use in LTC Resident Rooms
- CMS Issues Final Medicaid Managed Care Regulations
- 2015 Medicaid Underfunding for Nursing Center Care/Medicaid Shortfall Report
- IDPH Licensure Fine Summary/Update
- CMS Issues Proposed Rule for SNF PPS FY 2017 Update
- CMS Issues Clarification Letter on Medicaid’s “Any Willing Provider” Provision

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

10) *Infection Control Today* recently published an article entitled, “Vaccinations are More Effective When Administered in the Morning.” New research from the University of Birmingham has shown that flu vaccinations are more effective when administered in the morning. The findings, published in the journal *Vaccine*, suggest administering vaccinations in the morning, rather than the afternoon, could induce greater, and thus more protective, antibody responses.

11) The *Annuls of Long-Term Care* reports that “Hearing Aid Use Associated with Improved Cognitive Function in Hearing-Impaired Elderly.” Hearing aids may lessen the forgetfulness and mental confusion tied to moderate to severe hearing loss, suggests a new study.

12) *HealthDay* reports that “Palliative Care Gets a Bad Rap.” The term "palliative care" triggers negative feelings among many cancer patients, and needs "rebranding," researchers say. The stigma surrounding palliative care can
mean patients wait too long to receive supportive care that improves their quality of life, said researchers at the Princess Margaret Cancer Center in Toronto. This new study shows there's a "branding issue," said principal investigator Dr. Camilla Zimmermann, head of palliative care for the hospital and the University Health Network. Palliative care "is not something to be afraid of or that is stigmatizing, but is helpful even while patients are receiving life-prolonging therapies," Zimmermann said in a network news release.

13) **Medscape** recently reported that “Early Alzheimer’s Pathology May Trigger Diabetes.” Individuals with Alzheimer's disease (AD) may be at increased risk of developing type 2 diabetes because of impairments in insulin signaling in the hypothalamus, say U.S. investigators in findings that turn on its head the presumed association between diabetes and AD.

14) **Medical News Today** reported on several articles of interest:

- [Rosemary Aroma Can Help Older Adults to Remember to do Things](#). The aroma of rosemary essential oil may improve ability of people over 65 to remember events and to remember to complete tasks at particular times in the future.

- [Half of Long-Stay Nursing Home Residents Go to Hospital ED Regardless of Cognitive Status](#). A new study from the Indiana University Center for Aging Research and the Regenstrief Institute has found that almost half of all long-stay nursing home residents experience at least one transfer to an Emergency Department over the course of a year regardless of their cognitive status. While a high percentage of long-stay nursing home residents were sent to the ED, only about a third of these individuals were subsequently admitted to the hospital. The study determined that while dementia severity was not associated either with likelihood of transfer to the ED or with having that transfer result in a hospitalization; age, race, two or more chronic diseases, number of hospitalizations in the year prior to study entry, and "Do Not Resuscitate" status all influenced the time to first ED visit.

- [New Antibiotic Stewardship Guidelines Focus on Practical Advice; Emphasize Customized Interventions](#). Preauthorization of broad-spectrum antibiotics and prospective review after two or three days of treatment should form the cornerstone of antibiotic stewardship programs to ensure the right drug is prescribed at the right time for the right diagnosis. These are among the numerous recommendations included in new guidelines released by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA) and published in the journal *Clinical Infectious Diseases*.

- [Antipsychotic Medications May be Ineffective for Treating or Preventing Delirium](#). In a study published in the *Journal of the American Geriatrics Society*, researchers examined whether or not antipsychotic drugs, which are sometimes used to prevent or treat delirium, are effective. Delirium, a psychiatric syndrome that is the direct result of a medical problem, is a sudden change in ability to think and pay attention. It can cause people to become confused, potentially aggressive, agitated, sleepy, and/or inactive. Delirium also is a psychiatric syndrome that is a direct result of a medical problem.

15) There were several articles of interest in *McKnight’s*:

- [Aggressive Advance Care Planning Shown to Cut SNF Costs, Hospitalizations](#). Nursing homes that implement advance care planning programs and train staff in palliative care may see lower costs and fewer hospitalizations, according to [new research](#) published recently. The study, conducted by researchers at Ireland's University College Cork, found that on average hospitalizations in nursing homes that implemented end-of-life or advance care planning programs dropped by almost half from 27.8 percent. The percentage of residents who died in a hospital also decreased, from almost 30 percent to 8.4 percent.

- [Average Cost of Nursing Home Care Rises 2 Percent Annually, Lincoln Report Shows](#). The average national cost of both private and semi-private skilled nursing rooms increased a total of 2 percent over 2014, according to a new report from Lincoln Financial Group. Lincoln's new “[What Care Costs](#)” data report shows the average cost of a semi-private room is nearing $87,000 annually, while a private room runs close to
$99,600 annually, representing a 2 percent increase over the span of 2014. The report, which also breaks down skilled nursing costs by state and metro area, shows Connecticut, Massachusetts and New York to be the most expensive states for semi-private rooms with annual averages of $151,110, $138,335 and $135,780, respectively.

- **CMS Drops Payment Cut Related to Two-Midnight Rule.** Faced with a legal challenge, CMS has killed a two-midnight inpatient payment cut to hospitals. The agency will not move forward with a 0.2 percent inpatient payment cut to hospitals under the “two-midnight” rule, giving a partial victory to the hospital industry. CMS had said inpatient admissions that spanned shorter than two midnights could be payable under Medicare Part A, based on the ruling of an admitting physician. As part of that policy, CMS cut inpatient payments to hospitals by 0.2 percent because it said the rule would boost Part A reimbursements.

- **Accuracy Key to Staying Ahead of Changes to MDS 3.0, Quality Measures, Experts Say.** Providers should conduct accuracy reviews of their facility’s databases in order to prepare for changes to the MDS 3.0 and the Five-Star Quality Measures slated for this year, experts emphasized. With MDS 3.0 updates scheduled to hit October 1, and new quality measures expected to be added to the CMS’s Nursing Home Five-Star Ratings system even earlier in July, providers “have to make sure [their] MDS' are one thing — accurate,” said Leah Klusch, RN, RN, BSN, FACHCA, during a session at the American College of Health Care Administrators Annual Convocation and Exposition.

- **Feds Increase Push to Keep Seniors Out of Nursing Homes.** The federal government is upping its efforts to keep more seniors out of nursing homes, and in home and community-based long term care programs, according to a recently published report. Data published by the Associated Press shows that in 2013, 51 percent of the $146 billion spent on long term care benefits for seniors and those with disabilities was spent on home and community-based services, compared to 49 percent on institutional LTC services. That year marked the first time where more federal money was spent on home and community-based LTC services than institutional care.

16) **Interesting Fact:** Cartilage is one of the few tissues that grows throughout life. Between ages 30 and 70, a nose might grow half an inch, and the ears grow about a quarter of an inch.