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!

The Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2016 to Fiscal Year 2017 Nursing Home Action Plan
The CMS FY 2016 to 2017 Nursing Home Action Plan lays out five strategies that are to guide the long term care profession in an effort to continue to improve nursing home safety and quality. The most effective approach to ensure quality is one that mobilizes and integrates all available tools and resources — aligning them in a comprehensive, actionable strategy. The Plan outlines five inter-related and coordinated approaches, or principles of action, for nursing home quality, ultimately aligning with CMS’s main goals. The Plan is organized into five actionable strategies:

1. Enhance Consumer Awareness and Assistance,
2. Strengthen Survey Processes, Standards and Training,
3. Improve Enforcement Activities,
4. Promote Quality Improvement, and
5. Create Strategic Approaches through Partnerships.

The Action Plan is located on the CMS website at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html). The effective date is immediately.

1. Enhance Consumer Awareness and Assistance
Consumers are essential participants in ensuring the quality of care in any health care system. The availability of relevant, timely information can significantly assist consumers with actively managing their own care. Additionally, this information can enable individuals to hold the health care system accountable for the quality of services and support that should be provided. To that end, the Division of Nursing Homes (DNH) seeks to provide an increasing array of understandable information that can be readily accessed by the public. The CMS-Medicare website, [https://www.Medicare.gov](https://www.Medicare.gov), features important educational resources such as Nursing Home Compare as well as other information for consumers, families and friends. The top item is enhancing consumer awareness and assistance in navigating nursing home care, through tools like the Five-Star Quality Rating System. Consumers also would benefit from improved staffing data on the CMS website, the plan said, which will be bolstered by the mandatory payroll-based staffing data starting July 1.

2. Strengthen Survey Processes, Standards and Training
The DNH is engaged in several ongoing initiatives to improve the effectiveness of annual nursing home surveys (standard surveys), as well as the investigations that are prompted by complaints (complaint surveys) from consumers or family members about nursing homes. The DNH also has improved the way that data are captured from oversight of state surveys. By strengthening the survey processes, the DNH believes that state agencies will
drive improvement at the population level in nursing homes. This, in turn, is likely to reduce the number of adverse events and preventable healthcare acquired conditions, leading to lower per capita costs. CMS also plans to strengthen guidance and training for surveyors following the finalization of the requirements for nursing homes participating in the Medicare and Medicaid programs, expected to be released in September. The agency expects to streamline its nursing home complaint investigations, and develop a revised survey methodology that combines the “best of both traditional and QIS processes.”

3. Improve Enforcement Activities

The DNH is dedicated to maintaining an enforcement system that is centered on promoting quality resident-centered health and safety to nursing home residents and compliance with federal requirements. To improve our current enforcement efforts, they will continue to work in partnership with Regional Offices, states, consumer advocates, national associations and others. Among those activities is improving monitoring of persistently poor performing “special focus facilities” through pilot programs across various CMS regions.

4. Promote Quality Improvement

The DNH continues to promote comprehensive quality improvement programs in a number of key areas, including reductions in the use of physical restraints, the prevalence of preventable pressure ulcers and reduction in use of unnecessary antipsychotic medication. In an effort to achieve these quality improvement goals, the Agency’s participation in the Advancing Excellence in America’s Nursing Homes Campaign as well as support of the national “culture change” movement continues to grow. The principles behind culture change echo the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) principles of person-centered care – embracing individualized approaches to care. The agency also anticipates taking on several quality improvement areas, including antipsychotic reduction, as well as a reduction of physical and chemical restraints.

5. Create Strategic Approaches through Partnerships

The final strategy in the action plan focuses on partnerships between consumers, providers, professional associations, surveying agencies and other stakeholders in the health care system. No single approach or individual can fully assure better health care. Rather, we must combine, coordinate and mobilize many people and techniques through a partnership approach. State survey agencies and others are committed to such a common endeavor. The differences in their responsibilities remain, but their distinct roles can be coordinated in a number of appropriate ways to achieve better results than can be achieved by any one actor alone. In addition, the DNH plans to strengthen partnerships with non-governmental organizations who are also committed to quality improvement in nursing homes. In May 2006, they began partnering with stakeholders to design and then facilitate the Advancing Excellence in America’s Nursing Homes Campaign. The unprecedented, collaborative campaign seeks to better define quantitative goals in nursing home quality improvement. The DNH also partners with Quality Improvement Organizations (QIOs) to improve care for the millions of nursing home residents across the country and in April 2015, with the QIOs, CMS launched the National Nursing Home Quality Care Collaborative. The Collaborative will strive to instill quality and performance improvement practices, eliminate health care-acquired conditions and improve resident satisfaction by focusing on the systems that impact quality.

AHCA Building Prevention Into Every Day Practice:
Framework for Successful Clinical Outcome Series – Part 2 of 13

AHCA’s Clinical Practice Committee designed a framework series that outlines guiding elements such as individualized care approaches, effective transitions of care, QAPI concepts, safety, risk management, team-based care and diagnostic quality. Care providers that use these resources can more effectively apply knowledge through organizational approaches and clinical care that leads to optimal patient outcomes and quality of life.

Over the next several weeks we will feature one element of the Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcomes.

Success in achieving positive resident/patient outcomes is even more critical now than ever before. The link between quality and payment in long term and post-acute care is growing stronger, as evidenced by the SNF Value Based
Purchasing Program (VBP), Improving Post-Acute Care Transformation (IMPACT) Act, SNF Quality Reporting Program (QRP) and more.

In addition, regulatory activity is intensifying through focused surveys on adverse events, dementia care and MDS. The Five-Star Rating system and Nursing Home Compare have been revised and will add items in the future as it broadens public reporting and transparency. Most importantly, consumers expect and deserve high quality care.

The entire framework outlines key elements from both an organizational and clinical nature that are critical to successful clinical and organizational outcomes. Positively, these elements reflect common denominators that cross multiple care situations. Therefore, instead of being yet another initiative or single focused project to achieve just one outcome, it is a way of acting, thinking and being that will benefit multiple areas across an organization. Each element is addressed in detail throughout the framework.

This week we will feature the element of **Organizational Foundation: Right thing in the right way” thinking:**

**Organizational Foundation: “Right thing in the right way” thinking, What does this mean?**

“Right thing in the right way” means focusing everything on running the organization and caring for the residents/patients in a certain way.

Before doing something, we consciously consider whether we are doing the right thing, and how we know that it is the right thing.

As we do something, we consciously consider whether we are doing it correctly, and how we know that it is the right way.

**Why is this important?**

As the saying goes, “an ounce of prevention is worth a pound of cure.” At first, a conscious effort to do the right thing correctly seems like more work and the benefits may be unclear. Ultimately, it saves time and prevents trouble.

Minimizing complications and preventing things from going wrong brings better results, prevents harm to residents / patients, and leaves fewer messes to have to fix later on.

**What are some examples?**

**Examples include:**

- Before assisting a resident with a meal or snack, always check for any limitations on how much time they need to eat and how much to give per bite.
- Before reporting any information to the physician, check to see what others might have already done to address the situation.
- Before assisting a resident with a transfer, double check as to how many individuals are indicated to help with the transfer.
- Before giving a medication, verify it is the right medication, right dose, right resident, right time and right route.
- Before giving a complex or multi-step treatment for the first few times, have the written procedure available, review ahead of time, and read each step as it is done.

**What is my part?**

- Read a short article about how to reduce risk.
- Ask for help in unfamiliar situations.
- Communicate and document clear, accurate and full information in the record about any observations made in caring for residents/patients.
- Resolve to not cut corners.
- Know where to find instructions, and use them.
Report any procedures or instructions that you find unclear, confusing or incomplete and offer suggestions for improvement.

Look it up before doing something the first few times, or have a knowledgeable individual watch you do it.

**What can my organization do?**

- Make sure there are clear, complete, well organized and easily accessible instructions and procedures that are consistent with reliable sources such as medical and geriatrics references.
- Share a good article about how to reduce risk.
- Make it an expectation that staff will ask for help in unfamiliar situations and receive a supportive response when doing so.
- Show examples of documentation about various aspects of care that are considered clear, accurate and complete.
- Remind staff not to cut corners and support them in doing the right thing.
- Give staff an easy way to inform someone about procedures or instructions that are unclear, confusing or incomplete.
- Show staff how to use a computer to search quickly for information needed to do the work.

**Resources/Tools:**


**Key Takeaways: Right Thing in the Right Way Thinking**

- Constant focus on doing the right thing in the right way with an eye on prevention.
- Conscious consideration of whether the right thing is being done and whether it is being done in the right way.

**Probing Questions for Team Reflection and Discussion:**

1. Are we doing the right thing? How do we know?
2. Are we doing it correctly? How do we know?
3. What evidence do we use to support our practices?

---

**Trending Statistics**

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

**General LTC Statistics You Can Use and Share with Potential Admits (LTC Consumer)**

- If an individual set aside and invested the value of the average LTC insurance premium for 22 years, she would accumulate only enough to pay for six months of care. By putting the same amount into premiums, she could own a policy covering more than three years of care.¹
- Compared to those without LTC insurance, insureds reduce their out-of-pocket LTC costs by between $3,000 and $5,000 a month (depending on the service setting).¹
- Individuals with LTC insurance receive on average 35 percent more hours of care than those without, and their care is also somewhat more likely to address their needs than care received by the uninsured.¹
- 4 million Americans are living with Alzheimer’s disease.²
- The financial impact from a long term care event is massive: 88 percent of care-givers said their household income was reduced an average of 34 percent.³
- In 1965 when Medicare became a law, Part A (hospital expenses) was projected to cost $9.1 billion. By 1990, the actual cost was $67 billion.⁴
- 70 percent of seniors will need long term service and support because of physical or cognitive impairment. The average length of time a senior adult will need assistance with activities of daily living is 3 years.⁵
From 2011 to 2029, baby boomers (those born between 1946 and 1964) will turn 65. During this time period, 10,000 people will turn 65 every day.  

People who need long term care will more than double by the year 2050 (from 12 million in 2010 to 27 million in 2050).  

48 percent of people age 40 or older say they will need long term care as they age, but only 35 percent say they’ve set aside funds to pay for their long term care needs.  

American women live longer than men (81 years on average versus 76 for men), according to data released in 2013 by the Institute for Health Metrics and Evaluation.  

70 percent of people over age 65 will require some care at some point in their lives.  

$750,000 is the projected average cost for 3 years of long term care 30 years from now.  

“Long term care is a blind spot in many clients’ portfolios. In fact, 85 percent of people don’t have a plan for covering the costs of long term care.”  

Using a conservative definition, 62.1 percent of all bankruptcies in 2007 were caused by the cost of medical care. Most medical debtors were well educated, home-owners, in white-collar occupations and 3/4 were covered by health insurance.  

In 2030, 54 percent of the 78 million baby boomers will be women, according to the National Association of Baby Boomers.  

A healthy female, age 65, has a 67 percent chance she will live to age 90 and a 38 percent chance she will live to age 95.  

Approximately 72 percent of baby boomers whose parents had long-term care insurance said it was a “good value” for reasons such as increasing quality of life, preserving their parents’ nest egg, and lessening the family’s financial contribution to care. Of those baby boomers whose parents did not have coverage, 71 percent said that long term care coverage would have benefited their families.  

47 percent of early baby boomers (now 56 to 62 and nearing retirement age) are likely to exhaust their retirement savings, according to the Employee Benefit Research Institute.  

A recent AALTCI survey of 151,500 people enrolled in group LTC plans found:  

- 36 percent chose daily benefit levels of $100 – $149  
- 34.4 percent chose daily benefit levels of $150-$199  
- 22.5 percent chose benefit levels of $200 or more per day  

In 2011:  

- 5 percent of LTCI policies were purchased by people age 55 to 64  
- 8 percent had a three-year benefit period  
- 0 percent had daily benefit amounts between $100 and $149  
- 0 percent had an elimination period of 90 days  
- 8 percent had 5 percent compound inflation protection  

$92,378 is the average annual cost for a private room at a nursing home according to the 2016 cost of care study by Genworth Financial.  

The average annual cost for LTCI is equal to half the amount of one month in a nursing home or one month of professional in-home care.  

The top four reasons individuals purchase of long term care insurance:  

- To protect assets  
- For financial security/peace of mind  
- To cover the cost of LTC services in the future  
- They don’t want to be a financial burden on family  

Employer provided long term care insurance plan information:  

- 12,000: Approximate number of employers offering long term care insurance  
- 2 million: Approximate number of employees covered by employer-sponsored long term care insurance plans  

Research estimates about 15 percent of Americans over age 70 suffer from dementia, a condition that includes Alzheimer’s disease. The number of seniors with Alzheimer’s disease is projected to triple by 2050, afflicting as many as 14 million in the United States.
Important Regulations, Notices & News Items of Interest

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


- **S&C 16-23 – AO/ASCs** - Approval of The Institute for Medical Quality’s (IMQ’s) Ambulatory Surgical Center (ASC) Accreditation Program. Announcement: CMS announces its decision to recognize and approve IMQ’s accreditation program for ASCs seeking to participate in the Medicare program via deemed status.

- **S&C 16-24 – Hospitals** - Solid Transplant Programs - Outcome Thresholds - Revised Guidelines. We expect that this revised policy, by lessening such concerns and augmenting the policy with other efforts, will promote more effective use of available organs and help more waitlisted individuals to benefit from a transplant, while continuing to promote high rates of patient and graft survival.


2) Federal HHS/CMS released the following notices/announcements since the last issue of Regulatory Beat:

- **Updated Information on the Special Focus Facility Initiative and List.** This webpage offers a list of nursing homes that (a) have had a history of serious quality issues and (b) are included in a special program to stimulate improvements in their quality of care. Please take a minute to review this background information on our “Special Focus Facility” initiative. The background here will help you be as informed as possible about what special focus facilities are, how a facility gets designated as a special focus facility and how a facility can get off this listing.

- **Dementia and Antipsychotic Use.** CMS reports that the American Psychiatric Association just published *The American Psychiatric Association Practice Guidelines on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*. There are 15 Guideline Statements. This link will take you to an option for downloading a pdf of the report.

- **Open Door Forums.** CMS reminds us that you can access the Open Door Forum calls sponsored by CMS. You can sign up to get updates based on the forums you are interested in. Currently, there are 13 regular calls covering various providers or topics and there is a category for Special Open Door Forums. For information on the calls, click here.

- **How to Use ICD-10 and Maintain Your Progress.** CMS developed two infographics to help you continue to use ICD-10 successfully:
  - Use ICD-10 Now: Offers useful information about coding in ICD-10 and gives a quick reference to helpful ICD-10 resources.
  - Next Steps: Based on the Next Steps Toolkit, it can help you analyze ICD-10 progress. Track and compare key performance indicators to assess progress, address findings, and maintain progress.

  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.

- **Talk to Your Patients/Residents About Mental Health.** Mental Health Month raises awareness about mental health conditions and the importance of good mental health for everyone. Medicare covers several preventive services to help monitor your patients’ mental health, including the Initial Preventive Physical Examination, Annual Wellness Visit, and depression screening.

  For More Information:
  - Medicare Preventive Services Educational Tool
  - Initial Preventive Physical Examination Educational Tool
  - Annual Wellness Visit Educational Tool
  - Centers for Disease Control and Prevention Mental Health and Aging website
  - Mental Health America website

  Visit the Preventive Services website to learn more about Medicare-covered services.

3) The Agency for Healthcare Research and Quality (AHRQ) released a couple of items that are geared towards hospitals, but are interesting and might be of interest/use to you:

- **Patient Safety Primer Discusses How Trigger Tools Can Screen for Patient Safety Events.** Hospitals and health systems can use targeted injury detection systems, commonly known as triggers, to screen for patient safety events, according to a new patient safety primer. Triggers have become a widely used way to analyze medical records in order to identify patient safety events, measure how often such events occur and track the progress of safety initiatives over time. Triggers alert patient safety professionals to possible events so they can review the medical record to determine if an actual or potential patient safety event has occurred. The main value of triggers is efficiency, since a complete review of every medical record to find adverse events is time intensive. When a trigger correctly identifies an adverse event, analysis can uncover causes or
contributing factors, and interventions can be developed to prevent such events. When reviewers are properly trained to interpret alerts, triggers are a practical tool for routine improvement efforts. Access the patient safety primer on the AHRQ Patient Safety Network (PSNet).

- **AHRQ Toolkit Helps Health Care Organizations and Providers Communicate With Patients and Families When Harm Occurs.** A new online toolkit from AHRQ is designed to help hospital and health system leaders and clinicians communicate accurately and openly with patients and their families when something goes wrong with their care. The toolkit will help expand use of an AHRQ-developed communication and resolution process called Communication and Optimal Resolution, or CANDOR, which gives hospitals and health systems the tools to respond immediately when a patient is harmed and to promote candid, empathetic communication and timely resolution for patients and caregivers. The toolkit, which includes facilitator notes, slides and online videos, enables health care organizations to make care safer by implementing the CANDOR process to encourage proactive, open communication with patients and their families when harm occurs. For more information, read the press release and the blog post by AHRQ Director Andy Bindman, M.D.

4) The National Fire Protection Association (NFPA) recently released a free download on Medical Gas Cylinder Storage (click here). There are two types of hazards associated with medical gas equipment: general fire and explosions, and mechanical issues such as physical damage to compressed gas cylinders. This document is provided to help identify the requirements of NFPA 99 that addresses the storage and handling of medical gas cylinders in a health care facility.

5) The United States Department of Labor (DOL) announced a Non-Enforcement policy for providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds (click here). On May 17, 2016, President Obama and Secretary Perez announced the publication of the Department of Labor’s final rule updating the overtime regulations. At the same time, the Department of Labor announced that it will publish in the Federal Register a time-limited non-enforcement policy for providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds. From December 1, 2016 to March 17, 2019, the Department will not enforce the updated salary threshold of $913 per week for the subset of employers covered by this non-enforcement policy. Throughout the duration of this non-enforcement policy, the Department will engage in outreach and technical assistance efforts, including to providers of services in settings covered by this policy. This non-enforcement policy does not apply to providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential care facilities with 16 or more beds.

6) The Illinois Department of Healthcare and Family Services (HFS) posted three announcements:

   - The Illinois Department of Healthcare and Family Services has posted a new Nursing Facility Participation in the Managed Long Term Services and Supports (MLTSS) Program Provider Notice available here: [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx) (LTC).

   - The Illinois Department of Healthcare and Family Services has posted a new Participation in the Managed Long Term Services and Supports (MLTSS) Program Provider Notice available here: [http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx](http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx) (LTC and Supportive Living).

   - The Illinois Department of Healthcare and Family Services has posted the May 18, 2016 Webinar - “Long Term Care Service Billing Requirements and Coding.” You may view the webinar here: [http://www.illinois.gov/hfs/MedicalProviders/Ltss/Pages/LongTermCareDirectBilling.aspx](http://www.illinois.gov/hfs/MedicalProviders/Ltss/Pages/LongTermCareDirectBilling.aspx).

7) The Illinois Department of Public Health (IDPH) conducted a Long-Term Care Advisory Board meeting on May 19, 2016. The following items were discussed:
• There are four vacancies on the Board. One advocate, two public members and one resident advisory council member. If you have any suggestions/nominations for these vacancies, please contact Bill Bell at IHCA.
• IDPH Legal is still evaluating the electronic monitoring and medical marijuana statutes to determine what rulemaking is needed.
• Subpart S regulations – still in IDPH/Governor’s Office review – unknown timetable for proposed rulemaking.
• Special Mental Health Rehabilitation Facilities (SMHRF) – former IMD facilities – Applications being accepted – received applications being reviewed for initial licensure.
• Distressed Facility regulations – Still in development within IDPH – no timetable for proposed rulemaking.
• Informed Consent regulations – still in development within IDPH – no timetable for proposed rulemaking.
• Behavioral Unit regulations – no action on this.
• There was a question raised with respect to some sex offenses being too old to appear on certain sex registries. It was decided that any sex offense (no matter how old) should be treated as a sex offense and proper action taken to protect that resident and other residents within the facility.

Next meeting of the LTC Advisory Board is set for June 29, 2016 – PLEASE let me know if you have any issues you would like raised/discussed in this meeting.

8) The Department of Public Health has scheduled the following Town Hall Meetings through June 30. Individual notices will no longer be sent to each facility. We are requesting that reservations be made in advance for ALL town hall meetings. This is due to limited space available in some locations, as well as respectfully considering time and resources of all parties involved. Reservations should be at least two days prior to the date of the Town Hall Meeting. All reservations should be made via email to Lisa.Reynolds@illinois.gov. Please include the words Town Hall Reservation in the subject line. They are regional meetings, very informal and an excellent opportunity to ask questions.

   6/7 - Brookens Building – 500 South Art Bartell Drive - Champaign – 1-3 p.m.
   6/29 – Norridge HC and Rehab – 7001 West Collum – Norridge - 2-4 p.m.

9) The American Health Care Association (AHCA) released several items of interest:

• CMS Using Big Data To Deter Fraud, Detect More Than $1.5B In Inappropriate Payments. CMS’s Dr. Shantanu Agrawal, deputy administrator and director of the Center for Program Integrity; Raymond Wedgeworth, director of the Data Analytics and Systems Group; and Kelly D. Bowman, senior adviser at the Center for Program Integrity, write in a Modern Healthcare (5/24, Subscription Publication, 231K) commentary that in the last “five years, the CMS has successfully implemented a Fraud Prevention System using ‘big data’ and predictive analytics approaches to fight fraud, waste and abuse in the Medicare fee-for-service program.” This move has allowed CMS “to better connect with public and private predictive analytics experts and data scientists,” and also to work more closely with the authorities. Since the program was launched, “over $1.5 billion in inappropriate payments has been identified by the system through new leads or contributions to existing investigations.”

• Department of Labor Publishes Final Overtime Rule (AHCA Brief Summary)

• AHCA is working with vendors to add the CoreQ Questions to their existing questionnaires or to administer it. The LTC profession lacks a national data source that would allow the measurement of satisfaction across all long term and post-acute care providers. AHCA/NCAL has developed a core set of customer satisfaction questions to address that challenge. The CoreQ—consisting of three questions for long-stay residents/family members and four for short-stay—has been independently tested as a valid and reliable measure of customer satisfaction.

   CoreQ: Short-Stay Discharge
   o In recommending this facility to your friends and family, how would you rate it overall?
   o Overall, how would you rate the staff?
   o How would you rate the care you receive?
   o How would you rate how well your discharge needs were met?
CoreQ: Long-Stay Residents & Family Members

- In recommending this facility to your friends and family, how would you rate it overall?
- Overall, how would you rate the staff?
- How would you rate the care you receive?

**HHS Final Rule; Nondiscrimination in Health Programs and Activities.** On May 13, 2016, the US Department of Health and Human Services (HHS), Office for Civil Rights (OCR) published the [Nondiscrimination in Health Programs and Activities; Final Rule](https://www.hhs.gov/ocr/privacy/lawsregs/index.html), implementing §1557 of the Affordable Care Act (ACA), and prohibiting discrimination on the basis of race, color, national origin, sex, age or disability in certain health care programs (including the Medicare and Medicaid programs), effective July 18, 2016. Section 1557 extends nondiscrimination protections to individuals participating in: 1) any health program receiving HHS funding; 2) any health program administered by HHS; or 3) health insurance marketplaces and all plans offered by issuers that participate in those marketplaces. Section 1557 builds on long-standing federal civil rights laws including Title VI of the Civil Rights Act (prohibits race, color or national origin discrimination), Title IX of the Education Amendments (prohibits sex discrimination), the Rehabilitation Act, § 504 (prohibits disability discrimination) and the Age Discrimination Act (prohibits age discrimination). Further, since the passage of the ACA in 2010, §1557 has been in effect and OCR has been enforcing this provision. In light of this final rule, AHCA/NCAL encourages its membership to review the summary below, along with the HHS press release, summary and fact sheets, to determine any areas for strengthened compliance.

**Payroll Based Journal (PBJ)** The Payroll Based Journal (PBJ) deadline of July 1 is fast approaching. To see what percentage of facilities in your state are registered for the PBJ, please see this spreadsheet. As members are working on complying with this mandatory requirement, we'd like to highlight some of tools available to your members. Please review a template email and e-newsletter article that includes these links as a toolkit. The template is designed for you to communicate with your members about the resources available to them as they prepare for this.

**AHCA Reaches 30 Percent Antipsychotic Reduction Goal.** McKnight’s Long Term Care News reports that AHCA announced recently that it had reduced antipsychotics use among members by 30 percent, and that it had reached that goal six months ahead of schedule. AHCA’s next goal is to reduce rehospitalizations by 15 percent, as well as to improve employee turnover, resident satisfaction survey use and discharge practices.

10) The latest Telligen events/announcements can be found at [https://www.telligenqingio.com/](https://www.telligenqingio.com/).

11) The Patient Safety Network (PSNet) recently published an article on the Mismanagement of Delirium. This is a case study which highlights the challenges and pitfalls of managing delirium in patients with dementia. The article also provides some guidance and action steps with regard to treatment of delirium.

12) Medscape published two article of interest:

- **Education, Reminders Reduce Risky Prescriptions for Elders.** About 60 percent of older patients receive at least one new drug when they are discharged from an emergency department, Dr. Stevens reported. And they are not always appropriate.

- **Real-Time Tool Assesses Violence Risk in Psych Patients.** Canadian researchers have incorporated real-time analytics to better determine the risk for violence in psychiatric patients. The tool assists in predicting, assessing, and managing risk for violence. "We think it's the best tool for this," Dr. Chaimowitz told Medscape Medical News. "This is the first time in psychiatry, as far as I know, that we have been able to use analytics in our clinical activity."
13) The Associated Press reports on Elderly Book End-Of-Life Talks Once Labeled ‘Death Panels’. The Centers for Medicare and Medicaid Services quietly tucked the change allowing for payment for end-of-life counseling into a massive package of regulations last summer, with billing permissible as of January 1. To date, CMS has not released any data on how many people have taken part in the sessions, but a survey released last month suggests it may be off to a slow start.

14) HealthDay published an article Blood Pressure Swings Linked to Faster Decline in Mental Skills. Fluctuations in blood pressure may be linked to faster declines in thinking skills among seniors, a new study suggests. Among older patients, those whose systolic blood pressure -- the top number in a blood pressure reading -- varied between doctor’s visits showed more rapid mental deterioration and loss of verbal memory than those whose blood pressure stayed within normal ranges, researchers found. Variability in the bottom number -- diastolic blood pressure -- was also associated with faster decline of mental ability among those aged 55 to 64, but not among people aged 65 and older, the study authors added.

15) The Washington Post reports The Days of Freely Prescribed Painkillers Are Ending. Here’s What’s Next. For more than a decade, doctors, dentists and nurse practitioners liberally prescribed opioid painkillers even as evidence mounted that people were becoming addicted and overdosing on the powerful and addictive pain medications. Now, in the face of a prescription drug overdose epidemic that killed more than 14,000 people in 2014, a handful of states are insisting that health professionals do a little research before they write prescriptions for such highly addictive drugs as Percocet, Vicodin and OxyContin.

16) Infection Control Today reports Flu Shots Associated With Fewer Hospitalizations in Patients With Heart Failure. The flu shot is associated with a reduced risk of hospitalization in patients with heart failure, according to research presented in a late-breaking trial session at Heart Failure 2016 and the 3rd World Congress on Acute Heart Failure. The study in about 60,000 patients ended the controversy over influenza vaccination in heart failure patients and provides more robust evidence for current recommendations. Professor Kazem Rahimi, deputy director of the George Institute for Global Health, University of Oxford, UK, said, "Many guidelines recommend that elderly patients and those with co-morbidities including heart failure should have annual flu vaccinations to reduce the risk of adverse events." "Uptake of the flu vaccination in heart failure patients is relatively low, ranging from less than 20 percent in low and middle income countries to 50 percent to 70 percent in high income countries like the UK," he continued. "This may partly be because there is no strong evidence to support the recommendation in these patients. In fact, there is limited evidence to suggest that vaccination may be less effective in heart failure patients than in the general population because of their blunted immune response."

17) MedlinePlus recently published three articles of interest:

- More Support For Aggressive Blood Pressure Treatment For Elderly. People who get their high blood pressure down to normal levels may substantially cut their risk of heart disease -- even if they're elderly or have already had heart problems, new research suggests. The study results, from a major clinical trial called SPRINT (Systolic Blood Pressure Intervention Trial), add to evidence that aggressively treating high blood pressure in older adults can pay off. Specifically, experts said, the benefits appear to extend to elderly and less-healthy patients.

- Why Pleasant Mealtimes Could Be Key To Alzheimer’s Care. Making meals more enjoyable for people with dementia might reduce their risk of malnutrition and dehydration, researchers report. Family-style meals and music, in particular, showed promise for improving eating and drinking habits, British researchers found. "It is probably not just what people with dementia eat and drink that is important for their nutritional well-being and quality of life -- but a holistic mix of where they eat and drink, the atmosphere, physical and social support offered, the understanding of formal caregivers, and levels of physical activity enjoyed," said lead researcher Lee Hooper, of the University of East Anglia.

- Antidepressants Not Just For Depression Any More. Doctors prescribe antidepressants for a wide range of medical problems other than depression, apparently fuelling the boom in sales of these medications, researchers report. Depression accounts for only a little more than half the antidepressant prescriptions
issued by Quebec physicians during the past decade, the Canadian study found. Doctors also issued antidepressants to treat anxiety, insomnia, chronic pain, panic disorders, fibromyalgia, migraine, obsessive-compulsive disorders, and a host of other "off-label" conditions for which the drugs are not approved, according to the report. Two out of every three non-depression prescriptions for antidepressants were handed out under an off-label purpose, the findings showed.

18) The New York Times reports Opioid Prescriptions Drop For First Time In Two Decades. After years of relentless growth, the number of opioid prescriptions in the United States is finally falling, the first sustained drop since OxyContin hit the market in 1996. For much of the past two decades, doctors were writing so many prescriptions for the powerful opioid painkillers that, in recent years, there have been enough for every American adult to have a bottle. But for each of the past three years — 2013, 2014 and 2015 — prescriptions have declined, a review of several sources of data shows. Experts say the drop is an important early signal that the long-running prescription opioid epidemic may be peaking, that doctors have begun heeding a drumbeat of warnings about the highly addictive nature of the drugs and that federal and state efforts to curb them are having an effect. “The culture is changing,” said Dr. Bruce Psaty, a researcher at the University of Washington in Seattle who studies drug safety. “We are on the downside of a curve with opioid prescribing now.”

19) McKnight’s reported on several items of interest:

- Improper Payments Often About Inaccuracy. (Recent editorial by Elizabeth Leis Newman, Senior Editor) One of the common aphorisms uttered in the Newman house is Hanlon's razor. It has various iterations, but it is basically “never assume malice what can be explained by stupidity.” It’s often cited when we are discussing local or national politics, or in the context of other people’s business decisions. I thought of it again this week during a conversation with Kristen Walter, spokeswoman for every long-term care provider's favorite pro-RAC group, the Council for Medicare Integrity. We were discussing the latest HHS Office of Inspector General report, which found that the error rate for Medicare Fee-for-Service in fiscal year 2015 was 12.09 percent. The threshold is 10 percent. As related in the McKnight’s story, the report noted SNFs improper payment rate increased 4.1 percent. To be fair to long-term care and Hanlon’s razor, “stupidity” is a little harsh when dealing with billing mistakes. But carelessness is sadly common in many areas of documentation. It’s easy to start the OIG report and think the federal government wants to nail those committing fraud. It does, of course, but it’s likely more concerned with those making mistakes. The report focuses on accuracy, noting the OIG was asked to review verifying payment reduction goals and efforts to recapture improper payments. HHS knows the primary causes of improper payments are related to insufficient documentation and medical necessity errors.

- Report: SNFs' Failure To Accept Transgender Residents A 'National Problem'. Skilled nursing facilities' reluctance to admit transgender residents is poised to become a “national problem,” according to a report published Thursday. The story, published in the Des Moines Register, highlights 52-year-old LeQuan Edwards, a transgender woman who claims to have been denied admission to all but one of the 90 nursing homes and rehabilitation facilities contacted by hospital staff. Edwards was placed in a rehabilitation facility after a stroke and sent to a hospital in March with leg wounds, in addition to other health problems. The main issue, the Register reports, is that many of the facilities contacted to admit Edwards say both male and female residents don’t want to share a room with someone who is biologically male but identifies as a woman. The report cites a survey attempted last year by Iowa-based LGBT advocacy group One Iowa that asked 50 facilities if they accepted transgender residents, and if they would be willing to train staff to be more welcoming to transgender residents. Only three facilities responded, said Donna Red Wing, executive director of One Iowa.

- Nearly 9,000 SNFs Expected To Train On New Healthcare Non-Discrimination Rule, Feds Say. An estimated 8,600 skilled nursing facilities will participate in training for a non-discrimination rule finalized by the Department of Health and Human Services last week. The HHS’ Nondiscrimination in Health Programs and Activities rule, published in the Federal Register, prohibits discrimination based on race, color, national origin, age or disability in federally funded health programs. The rule also expands Title IX protections to include discrimination of sex, gender identity, pregnancy and sex stereotyping, making it the first federal law to
prohibit such discrimination. People with disabilities or limited English proficiency are also protected by the rule. The HHS expects 8,623 skilled nursing facilities to train on the new regulations. The training is expected to cost nearly $327 million for the more than 7.2 million healthcare workers affected by the rule.

- **EEOC Issues Final Rules On Workplace Wellness Programs.** Employers may offer employees and their spouses incentives for joining workplace wellness programs up to 30 percent of their individual “self-only” health coverage, the Equal Employment Opportunity Commission said in final rules released Monday (5/16/16). Many health care entities have started wellness programs as ways to motivate employees and keep health insurance costs down. The incentive caps aim to clear up a question of whether offering incentives for employees to join a wellness program and submit their and their families’ health information would make the programs involuntary — and in violation of the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act. The rules’ financial incentives for participation should be a “welcome development” for employers seeking to spur participation in their wellness programs, Christine Lyon, a partner at San Francisco-based law firm Morrison & Foerster, told McKnight’s via email. But employers should still be wary about requesting health-related information, Lyon said.

- **CMS Temporarily Stops Two-Midnight Audits.** CMS has temporarily halted audits of short-term hospital admissions under the controversial two-midnight rule. The rule, which was finalized as part of the 2016 physician fee schedule last November, requires patients to be in a hospital for at least two midnights before they qualify as an inpatient. Organizations that review the “appropriateness” of hospital stays shorter than two midnights were instructed by CMS to temporarily stop their audits earlier this month, Bloomberg BNA reported on Friday. An unnamed CMS official confirmed to Bloomberg that the agency has told Medicare Quality Improvement Organizations to halt their reviews in order to “improve standardization across the QIO program.” While the length of the audit freeze isn’t known, the CMS official added that more details will be forthcoming.

- **Obscure Rule Could Double Fraud Penalties For Healthcare Providers, Experts Say.** A rule recently released by a little-known federal agency could set the stage for fraud penalties against healthcare providers to rise dramatically, according to some law experts. The U.S. Railroad Retirement Board’s rule, published last week in the Federal Register, raises the minimum fraud penalty from $5,500 to $10,781 for each false claims submitted to a government program. The maximum penalties were also increased, from $11,000 per claim to $21,563. The board’s adjustments were mandated for all federal agencies, according to the National Law Review, so providers can expect rules for the healthcare industry to follow suit by August 2016 — the date by which the Bipartisan Budget Act of 2015 requires all agencies to raise their penalty levels to account for inflation. That includes penalties under the False Claims Act, which haven’t seen an increase in 20 years, according to Modern Healthcare.

- **OIG: Most States Not Screening Medicaid Providers Properly.** A majority of states have failed to implement risk-based screenings for Medicaid providers, according to a recent report by the Office of Inspector General. Thirty-seven of the 47 states included in the report stated that they had not implemented fingerprint-based criminal background checks required for new and existing providers to be enrolled in the federal healthcare program. Medicaid funding pays for roughly 65 percent of all nursing home care in the U.S., though the report did not break out findings specifically for skilled nursing in its conclusions. Between March 2011 and August 2014, a total of 27,000 high-risk providers were allowed to enroll without completing the background checks, OIG researchers found. Almost two-thirds of the providers had been newly enrolled without any knowledge of the state Medicaid programs. The majority of the states that had not begun conducting the screenings claimed they needed guidance on challenges they encountered during implementation process. However, the report says the states did not provide any explanation of the issues they faced. Several states also failed to meet other requirements to enroll in Medicaid, which are regulated by the Center’s for Medicare and Medicaid Services.

- **CMS Wants 12 Percent Decrease In Hospital Readmissions By 2019.** CMS is seeking to cut the number of 30-day hospital readmissions by 12 percent over the next three years under a hospital improvement plan.
announced recently. The agency released its request for proposals for new Hospital Improvement and Innovation Networks, organizations that will work with hospitals, patients and other caregivers to “spread well-tested, evidence-based best practices,” said Patrick Conway M.D., CMS acting principal deputy administrator and chief medical officer, in a blog post. The new initiative seeks to decrease 30-day hospital readmissions by 12 percent, and achieve a 20 percent reduction in overall patient harm by 2019. Those reductions will “bolster the impact” of the QIO program and the Hospital Improvement and Innovation Networks’ parent organization, the Partnership for Patients, Conway said.

20) **Interesting Fact:** The nation's rate of uninsured hit a historic low of 9.1 percent last year, according to CDC survey data.