July 12, 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!

IMPORTANT ALERT - Federal Civil Monetary Penalties (CMPs) May Double

In accordance with the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, and further amended by the Bipartisan Budget Act of 2015, section 701: Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, this interim federal final rule (click here to view) incorporates the penalty inflation adjustments for the civil money penalties contained in the Social Security Act. What this means is that federal CMS is going to increase CMPs in the near future, due to inflation, in response to this legislative change. The potential amount of increase could be nearly double the current maximum penalty.

The Bipartisan Budget Act of 2015, Section 701: Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (Pub. L. 114-74) (the 2015 Adjustment Act) amends the Federal Civil Penalties Inflation Adjustment Act of 1990 to require federal agencies that impose CMPs subject to inflation adjustments to adjust the penalties for inflation annually instead of at least once every four years. The 2015 Act expanded the categories of penalties that require adjustment for inflation to include CMPs under the Occupational Safety and Health Act of 1970 and the Social Security Act. The 2015 Adjustment Act further requires affected agencies to adjust the level of CMPs with an initial “catch-up” adjustment through the publication of this interim final rule no later than July 1, 2016, to be effective no later than August 1, 2016. We will identify, for each penalty, the year and corresponding amount(s) for which the maximum penalty level or range of minimum and maximum penalties was established or last adjusted in statute or regulation.

This change will affect long term care facilities in two ways, through fines assessed by CMS under Medicare and Medicaid and those assessed by OSHA.

The Occupational Safety and Health Administration (OSHA) is an agency under the U.S. Department of Labor and is the main federal agency charged with the enforcement of safety and health legislation.

- OSHA’s maximum penalties, which were last adjusted in 1990, will increase by 78 percent. Going forward, the agency will continue to adjust penalties for inflation each year based on the Consumer Price Index.
- The new OSHA penalties will take effect on August 1, 2016. Any citations issued by OSHA on or after that date will be subject to the new penalties if the related violations occurred after November 2, 2015.
- The new fine ranges are as follows:
  - Serious/Other-Than Serious/Posting Requirements
    - Current Maximum Penalty = $7,000 per violation
    - New Maximum Penalty = $12,741 per violation
  - Failure to Abate
- **Current** Maximum Penalty = $7,000 per day beyond the abatement date
- **New** Maximum Penalty = $12,741 per day beyond the abatement date

**Willful or Repeated**
- **Current** Maximum Penalty = $70,000 per violation
- **New** Maximum Penalty = $124,709 per violation

To address the impact of these penalty increases on smaller businesses, OSHA will continue to provide penalty reductions based on the size of the employer and other factors.

With regard to the **Centers for Medicare and Medicaid Services (CMS)** and the fine increases related to deficiencies of the Medicare/Medicaid Requirements of Participation, CMS’ Central Office is working on a plan to implement the required inflation adjustments to CMPs, but the date of this change has not yet been announced. As soon as this information is available, we will notify our members. The information will probably be made available through a future Survey and Certification Letter.

The Illinois Health Care Association (IHCA) has also reached out the American Health Care Association (AHCA) to get their take on this and to see if they have any further information or if they are trying to negotiate with CMS on making any increased rates reasonable and to adjust them based on facility size or other related factors.

**HHS Office of Civil Rights Releases Guidance and Resources for Long Term Care Facilities on Using the MDS to Facilitate Opportunities to Live in the Most Integrated Setting**

The U.S. Department of Health and Human Services’ (HHS) Office for Civil Rights (OCR) has issued **new guidance** to assist long term care facilities in complying with their civil rights responsibilities and obligations under regulations by the HHS Centers for Medicare & Medicaid Services that require facilities which are Medicare and/or Medicaid-certified to ensure their residents receive services in the most integrated setting appropriate to their needs.

Long term care facilities are responsible for making referrals to appropriate community assessment agencies in order to help individuals successfully transition into the community.

OCR is responsible for enforcing Section 504 of the Rehabilitation Act (Section 504) and Title II of the Americans with Disabilities Act (ADA), as interpreted by the U.S. Supreme Court in *Olmstead v. L.C.* Under Section 504 and the ADA, long term care facilities that receive Federal financial assistance cannot discriminate against individuals based on disability. The **U.S. Supreme Court** further clarified in its *Olmstead v. L.C.* decision that discrimination includes unnecessary segregation of persons with disabilities and continued placement in an inpatient facility when the resident could live in a more integrated setting.

OCR's announcement states that in order to assess placement needs among residents, CMS regulations mandate that long term care facilities routinely administer the **Minimum Data Set** (MDS) for all residents in a Medicare and/or Medicaid-certified long term care facility. Section Q of the MDS has questions designed to help assess residents’ interests in returning to the community and in turn to help facilities and staff better identify and assist residents in exploring those opportunities, with the support of Local Contact Agencies and other community-based organizations. As such, Section Q also assists the state in meeting its non-discrimination requirements.

Through analysis of MDS data and collecting information from a large sample of facilities, OCR found many long term care facilities are misinterpreting the requirements of the MDS or inadequately administering the MDS because they are not referring residents who are interested in living in the community to appropriate referral sources.

This new guidance provides a series of recommendations for steps that long term care facilities can take to ensure the MDS is properly used to facilitate compliance with Section 504 and to avoid discriminatory practices towards residents. These steps include:
- Establish strong relationships with the Local Contact Agency, a local community organization responsible for providing counseling to nursing center residents on community support options;
- Properly administer Section Q of the MDS "to ensure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible";
- Update facility policies and procedures to comply with OCR guidance and provide periodic training to all staff involved in the MDS assessment on Section Q; and
- Review available resources on administration of the MDS.


**AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 5 of 13**

This is part of a series featuring 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: Principles of Person-Centered Care*

**Key Takeaways: Principles of Person-Centered Care**

- Primary purpose of care is to support individuals in living as satisfactory and fulfilling a life as possible, in the face of their illnesses and impairments.
- Be aware of each individual’s preferences, issues and risks and tailor recommendations and actions accordingly.
- Residents make choices and actively participate in their care planning, which is used as a foundation for everyday person-centered care.
- Competent clinical reasoning and effective diagnosis facilitate truly individualized care by enabling interventions tailored to underlying causes.
Visit the AHCA Clinical Practice [website](#) to learn more about the element of “Organizational Foundation: Principles of Person-Centered Care” and answers to these key questions:

**What does this mean? Why is this important? What are some examples? What is my part (as an individual employee, manager or practitioner)? What can my organization do?**

Start somewhere, pick one element and work through it with your team.

Enjoy the journey through the framework!

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**Trending Statistics**

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

**Illinois - State Dashboard**

In this comparison, the NHQR quality measures for Illinois for the most recent data year and the baseline year are compared to the average of all states. Compared to all states, for the most recent data year, the performance for all Illinois measures is in the Average range. For the baseline year, performance is in the Average range.

The meter represents Illinois's balance of below average, average, and above average measures compared to all States. The performance meter has five categories: very weak, weak, average, strong and very strong. An arrow pointing to "very weak" means all or nearly all included measures for a state are below average within a given data year.

An arrow pointing to "very strong" indicates that all or nearly all available measures for a state are above average within a given data year.

A solid blue arrow ( ) describes results for the most recent data year; a dashed black arrow ( ) describes results for the baseline year. A missing arrow means there were insufficient data to create the summary measure for this state.

- Illinois's Score for the Recent Data Year: 47.66
- Illinois's Score for the Baseline Year: 42.54
Review underlying data

For the specific measures in the bars below, an arrow pointing to "very weak" means all or nearly all included measures for a State are below average within a given data year. An arrow pointing to "very strong" indicates that all or nearly all available measures for a State are above average within a given data year.

A solid blue triangle (▼) describes results for the most recent data year; an open white triangle (▲) describes results for the baseline year. A missing triangle means there were insufficient data to create the summary measure for this state.

### NQS Priority

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### Access to Care

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### Diseases & Conditions

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Important Regulations, Notices & News Items of Interest

1) There were no new federal Survey and Certification (S&C) Letters issued since the last issue of Regulatory Beat.

2) Federal HHS/CMS released the following notices/announcements since the last issue of Regulatory Beat:
   - CMS implemented the mandatory Payroll Based Journal (PBJ) system on July 1, 2016. Are you in compliance? For more information click here.
   - The CMS Midwest Division recently released their inaugural installment of Provider Update Newsletter (click here). CMS states that they are very excited about implementing this new way of communicating
and hope that this effort helps to achieve two important goals. One goal is to share information in a more interactive manner and create a product that is more engaging and will reach a wider audience. Creating effective forums for communication also serves a second, larger goal. The more their communications promote interaction and foster an environment of information sharing, the stronger the partnership between CMS, State Agencies, Advocates and the Providers becomes. Strong partnerships are essential for us to continue to meet shared goals.

- **Rule Gives Providers/Employers Improved Access to Information for Better Patient Care.** MACRA provides expanded opportunity for the use of Medicare and private sector claims data to drive higher quality, lower cost care. On July 1, CMS finalized new rules that will enrich the Qualified Entity Program by expanding access to analyses and data that will help providers, employers and others make more informed decisions about care delivery and quality improvement. The new rules, as required by the Medicare Access and CHIP Reauthorization Act (MACRA), allow organizations approved as qualified entities to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers and other groups who can use the data to support improved care. The rule also includes strict privacy and security requirements for all entities receiving patient identifiable and beneficiary de-identified analyses or data. Qualified entities must combine Medicare data with other claims data (e.g., private payer data) to produce quality reports that are representative of how providers and suppliers are performing across multiple payers. Currently, 15 organizations have applied and received approval to be a qualified entity. For More Information:
  - Final rule
  - Qualified Entity Program

See the full text of this excerpted CMS press release (issued July 1).

- **CMS has proposed a $180 million pay cut for home health next year.** The Affordable Care Act “mandated the reduction to address Medicare overpayments for home health services dating back to 2000.” Since 2002, nearly “500 home health agencies a year have signed up for Medicare, according to a December 2014 Medicare Payment Advisory Commission report.” However the pays cuts “appear to have weeded out some providers.”

- **CMS Skilled Nursing Facilities and Long Term Care Open Door Forum:** The next CMS Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum scheduled for Thursday, July 14, 2016 at 2:00 PM Eastern Time. Please dial-in at least 15 minutes before call start time. The Conference Leaders are Todd Smith & Jill Darling.

**This Agenda is Subject to Change**

I. Opening Remarks..... Acting Chair – Todd Smith (Center for Medicare)/ Moderator – Jill Darling (Office of Communications)
II. Announcements & Updates
   a. PBJ Update Announcement
   b. SNF Waiver for CJR
   c. Nursing Home Compare QM updates
   d. SNF Value Based Purchasing
III. Question and Answer

**Open Door Participation Instructions:**
This call will be Conference Call Only.

**To participate by phone:**
Dial: 1-800-837-1935 & Reference Conference ID: 41652346
Persons participating by phone do not need to RSVP.
Encore: 1-855-859-2056; Conference ID: 41652346

Encore is an audio recording of this call that can be accessed by dialing 1-855-859-2056 and entering the Conference ID. Encores for ODFs held on Thursdays can be accessed the following Monday. The recording is available for 3 business days. For ODF schedule updates and Emailing List registration, visit their website.

- CMS proposed changes (click here) to the Physician Fee Schedule to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. It includes significant aspects for care transition management and the skilled nursing 3-day stay waiver. Health care providers are not currently required to use a specific tool to exchange patients' medical records, as long as they are sent electronically. Under the CMS proposal issued last Thursday, the agency would no longer standardize the content of the records or how providers must exchange patient documents — as long as it is done in a timely manner. Those changes would help improve care transitions and communication between skilled nursing facilities, hospitals, clinicians and other settings, according to CMS.

3) The Illinois Department of Healthcare and Family Services (HFS) posted the following notices:

- HFS posted a new provider notice regarding Nursing Home Participation in the Medicare Medicaid Alignment Initiative (MMAI) and Medicaid Managed Long Term Services and Supports (MLTSS) Program. You may view the notice here.

- HFS posted a new provider notice regarding the Clarification of the Requirements for the Nursing Facility Enhanced Care Rate for Ventilator Services. You may view the notice here.

- HFS posted a new provider notice regarding IMPACT New Rendering/Servicing Providers. You may view the provider notice here.

4) The Illinois Department of Public Health (IDPH) Town Hall regional meetings dates are below. They are 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.

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<th>Date</th>
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<td>7/20</td>
<td>Pine Crest Manor – Mt. Morris</td>
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<td>8/11</td>
<td>Hamilton Memorial Rehab – McLeansboro</td>
<td>1-3 p.m.</td>
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<td>8/31</td>
<td>Memorial Education Building – O’Fallon</td>
<td>1-3 p.m.</td>
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<td>9/14</td>
<td>Alden Estates of Shorewood – Shorewood</td>
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<td>10/19</td>
<td>Brookens Building – Champaign</td>
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<td>Friendship Village – Schaumburg</td>
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5) The Illinois Department of Financial and Professional Regulation, in accordance with the provisions of Public Act 98-990, has announced that the facilities below have been approved to participate in the Licensed Medication Aide Pilot Program:

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<tr>
<td>St. James Wellness Rehab and Villas</td>
<td>DuPage Convalescent Center</td>
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<td>Crete, IL 60417</td>
<td>400 North County Farm Road</td>
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<td>1251 E Richton Road</td>
<td>Wheaton, IL 60187</td>
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<tr>
<td>Norridge Gardens</td>
<td>Alpine Fireside Health Center</td>
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<tr>
<td>7001 W Cullom Avenue</td>
<td>3650 N Alpine Road</td>
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<tr>
<td>Norridge, IL 60706</td>
<td>Rockford, IL 61114</td>
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The Medication Aide Pilot Program begins July 1, 2016, and will end on June 30, 2019. The approved facilities listed above are authorized to provide training and employ individuals who receive licenses as medication aids under the provisions of the Nurse Practice Act (225 ILCS 65/80). The facilities were approved following submission of an application and review by a committee that included two members of the Board of Nursing and one member of the Nursing Home Administrators Licensing and Disciplinary Board.

6) The American Health Care Association (AHCA) recently released the following notices/informational items:

- **2016 AHCA Mid-Year Report** – Success on Reimbursement Issues, but Concern Over Regulatory Burdens (click here to read the full report). The year has started well, but there is still plenty to worry about. We have won our battles to-date on the reimbursement front, but the relentless onslaught of regulatory burdens continues to keep many of us up at night. The purpose of this memo is to outline what has occurred so far this year, discuss our additional challenges and opportunities, and explain what the Association is doing about all of this.

- **AON 2016 Long Term Care General Liability and Professional Liability Benchmark Call.** With the support of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL), Aon is again soliciting your help to assemble the facility-specific data necessary to conduct the annual Aon Study on General Liability (GL)/Professional Liability (PL) Costs in the Long Term Care (LTC) profession.

  Last year we were able to split liability costs for Cook County, Illinois from the rest of Illinois. We hope to build on that model in Pennsylvania and Florida.

  The purpose of the Aon study is to:

  - Identify the overall trends in the cost of GL/PL claims for long term care;
  - Identify state specific trends in the cost of GL/PL claims for long term care;
  - Identify trends in frequency and severity overall and on a state by state basis, including detail on Cook County, Illinois; Philadelphia, Pennsylvania; and Miami-Dade County, Florida.
  - Explore the impact of Alternative Dispute Resolution (ADR) on GL/PL claims; and
  - Examine differences in claims costs segregated by payer type.

  Over the years, many AHCA/NCAL members have participated in this effort. We are requesting your help again. There is no cost to participate and you will receive an advance free electronic copy of the report as soon as it is available in mid-November 2016. Your participation is essential to ensure that the Aon analysis is representative of the profession, and that the states where you operate are profiled. Note: Aon holds all data in confidence and no individual participant is identifiable in the study.

  Please click here for additional information on how you can participate. Click here for the survey form. The deadline for participation in the Aon Study is Tuesday, August 16, 2016.

- **AHCA/NCAL Webinar - Payroll-Based Journal Reporting: Staffing Strategies for Success.** July 13, 2016, 1:00 p.m. CDT. Presented by Peter Corless, EVP of Enterprise Development, OnShift, Inc. Join this webinar,
exclusive to AHCA members, to learn the ins and outs of the PBJ requirements and walk away with staffing best practices to collect, review and submit the required information to CMS.

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

8) Provider Magazine reports a new antibiotic TXA709, which was developed by scientists at Rutgers University, “has been shown to successfully treat methicillin-resistant Staphylococcus aureus (MRSA) infections and simultaneously restore the efficacy of a commonly prescribed antibiotic that has become ineffective against this dangerous infection.” The article points out that research has suggested that “MRSA remains a serious problem in skilled nursing care centers, where community-associated strains of MRSA may cause invasive diseases, including bloodstream infections, abscesses, and pneumonia.”

9) The Newburyport (MA) Daily News reports that understanding “the Medicare system can be one of the most difficult tasks in the complex universe of modern financial paperwork.” Fortunately, there is a program called the State Health Assistance Program (SHIP), which helps seniors navigate Medicare, but a Senate panel recently voted to defund it starting in 2017. Advocates for seniors are urging beneficiaries to tell lawmakers that the funding should be preserved.

10) Healthcare IT News reports CMS is providing more access to claims data and analyses in order “to help care providers, employers and others boost the quality of care across the country.” The objective is to assist groups and individuals in making “better informed decisions about care delivery and quality improvement.” CMS Chief Data Officer Niall Brennan stated, “Medicare data will make it easier for stakeholders throughout the healthcare system to make smarter and more informed healthcare decisions.” Healthcare Finance News reports the rule change was “required under the Medicare Access and CHIP Reauthorization Act of 2015,” or MACRA, and it “essentially enhances the Affordable Care Act’s Qualified Entity Program.” It allows “the confidential sharing or selling of private sector claims data to groups that can then use the information to support better care.”

11) The Associated Press (AP) reports that US Medical Schools Expand Training to Curb Painkiller Abuse. Medical schools nationwide are rethinking their training on opioids amid rising overdose deaths. Schools are taking action after critics said they had inadvertently contributed to addiction problems. Federal health experts say that physicians have been prescribing addictive opioid painkillers too often, and that poor training is frequently to blame.

12) CaringKind, the Heart of Alzheimer’s Caregiving with the assistance of Comfort Matters, recently developed a new project/guideline entitled, “Palliative Care for People With Dementia: Why Comfort Matters in Long-Term Care (click here). For the reasons mentioned in these guidelines, there can be no more important role for long term care providers than that of bringing comfort to people with advanced dementia, and by extension, to their families and friends. Palliative care means taking active steps to discover what comforts someone and even gives them pleasure, and taking active steps to prevent or avoid unnecessary pain and suffering before they take hold. It is not about giving up. The more advanced the dementia, the more palliation has to offer. Nursing homes have much to gain from adopting a palliative approach to care for people with dementia.

13) Reuters reported on two items of interest:

- Reuters reports that the Medicines Company announced that “its experimental antibiotic met the main goals of a late-stage trial on patients with complicated urinary tract infections.” The drug, called Carabance (meropenem-vaborbactam), “also demonstrated statistical superiority over piperacillin-tazobactam, a combination of existing antibiotic treatments.” The company expects to file a submission with the FDA in early 2017.

- Many Patients at Risk for Stroke Get Wrong Medicine. More than a third of patients with a heart rhythm problem that can cause a stroke are incorrectly given aspirin instead of the blood-thinning medications
they need to make this complication less likely, a U.S. study suggests. Most strokes occur when an artery that carries blood to the brain gets blocked by a clot. While aspirin can prevent clots, it doesn’t work well as blood thinners to prevent stroke in these patients, guidelines say.

14) **HealthDay** reports:

- **FDA Asks How Safe is That Hand Sanitizer?** Millions of Americans use hand sanitizers every day, believing they safely kill bacteria. Now, the U.S. Food and Drug Administration wants to find out if that’s really true. The agency Wednesday requested makers of antibacterial hand sanitizers and related products to provide data showing the products' active ingredients actually reduce bacteria and are harmless over time.

- **Video May Aid End-Of-Life Decision-Making.** Watching a video about end-of-life care options may help patients with advanced heart failure choose the approach best for them, a new study finds. The choices include comfort-focused care versus more invasive care that could extend their days.

15) **Medscape** reports:

- **Medscape** reports, “A gradual increase in depressive symptoms, as opposed to more stable symptoms, is linked to an increased risk of developing dementia,” research suggests. The findings of the 3,325-participant study were published in the July issue of Lancet Psychiatry. An accompanying commentary observed, “Evidence exists for a bidirectional relationship between vascular disease and late-life depression; findings from some studies support an association between depression and subsequent vascular disease, and others provide evidence that vascular disease promotes the development of depression.”

- **Top Ten Causes of Death in the US.** The death rate in the United States hit an all-time low in 2014. For the age-adjusted death rate of 724.6 deaths per 100,000, down 1 percent from 2013, heart disease and cancer were still the top two causes of death in the United States in 2014, according to new data from the National Center for Health Statistics published June 30 in *National Vital Statistics Reports*.

- **Many Physicians Predict Mass Exodus From Medicare Over MACRA.** Almost four in 10 physicians in solo and small group practices predict an exodus from Medicare within their ranks on account of the program's new payment plan and its punishing penalties, a Medscape Medical News survey reveals. Fifty-nine percent of physicians in practices with fewer than 25 clinicians also said they expect to receive a performance penalty as high as 4 percent under proposed regulations that implement the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Only 9 percent of physicians in under-25 groups expect a bonus, with another 12 percent counting on no change in compensation. Roughly one third of physicians in small practices said merger into larger groups promises to be the most likely fallout from MACRA.

16) **MedlinePlus** reports:

- **Elderly Patients Get Unnecessary End-Of-Life Treatments.** People dying naturally of old age often receive unnecessary end-of-life medical treatments in hospitals, a new global study finds. The Australian-based research found that one-third of patients with advanced, irreversible chronic conditions were given treatments that didn’t necessarily benefit them -- including admission to intensive care or chemotherapy - - in the last two weeks of their life. The study also revealed that one-quarter of older patients who had Do-Not-Resuscitate orders were still given cardiopulmonary resuscitation (CPR). People with serious conditions were subjected to invasive procedures, unnecessary scans and blood tests, intensive heart monitoring and other treatments that did little to alter their outcomes, sometimes against their wishes, the researchers found.
**Fiber: The Rx for Disease-Free Aging.** Foods rich in fiber not only keep you "regular," they may help you live longer without disease, new research suggests. Among more than 1,600 Australian adults, the top fiber consumers were 80 percent more likely to remain fully functional and disease-free as they aged, the study found. Fiber-rich foods include fruits and whole grains.

**Memory Loss: Normal or a Sign of Trouble?** Mild memory lapses such as forgetting where you put your keys or reading glasses, though worrisome, are normal, experts say. But certain memory problems -- such as putting your car keys in the fridge -- may indicate a more serious issue. So, what kind of memory issue suggests the need for a medical assessment? Some examples include: memory loss that disrupts daily activities such as balancing a checkbook, maintaining personal hygiene and driving; or frequent memory lapses such as regularly forgetting appointments or where you parked your car, the U.S. Food and Drug Administration (FDA) said in a news release. Other warning signs include forgetting whole conversations, forgetting the names of relatives or close friends, frequently repeating yourself, or asking the same questions in the same conversation. Another red flag is memory loss that's getting worse over time.

**Donated Blood Won’t Transmit Alzheimer’s, Parkinson’s Disease.** People who've received a blood transfusion can breathe a bit easier: A new study finds no evidence that degenerative brain disorders can be transmitted via donated blood. "This study provides reassurance to individuals who have received blood transfusions from patients with Alzheimer's or Parkinson's disease," said Dr. Irving Gomolin, a geriatrician who reviewed the Swedish study findings. "It demonstrates that the transmission of these diseases via blood either is not biologically possible or, at worst, must be exceedingly rare," said Gomolin. He is chief of geriatric medicine at Winthrop-University Hospital in Mineola, N.Y.

**Competency Testing Crucial to Preventing Hospitalizations, Mitigating Risk, LTC Expert Says.** Improving employee competency testing in long term care facilities can help reduce rehospitalizations, cut down on workplace injuries and boost overall resident care, an expert told a national gathering of nursing directors late last month. Linda Shubert, MSN, RN, CHSE, director of clinical education at River Garden Hebrew Home Senior Services, also urged facilities to review their competency testing methods to improve their hiring efforts and increase scores on resident satisfaction surveys. Shubert spoke at the National Association of Directors of Nursing Administration in Long Term Care 2016 National Conference.

**Providers Urged to Use Claims Data to Help Drive LTC Business Plans.** Skilled nursing providers should examine health care claims data to find regional or state trends that may change their business plan, an expert said last month. “In a general sense, we’re seeing tremendous changes that are happening in the way people are seeking their care,” said Robin Gelburd, JD, of FAIR Health, a nonprofit focused on health care claims and insurance transparency. Her presentation at the LTPAC conference, titled “Precursors to LTPAC: How Healthcare Claims Data Can Help Drive Strategic Decision Making” examined diagnosis and other demographics related to how people seek care.

**Survey Shows How Much Long-Term Care Costs Continue to Climb.** Five out of six senior-care settings became notably more expensive over the past year, with national average costs for homemaker services and a semi-private nursing home room rising the most (2.56 percent and 2.27 percent, respectively). Private nursing home rooms rose 1.24 percent. The cost of a private nursing home room became $92,376 annually ($7,698 per month), while a semi-private room climbed to $82,128 annually ($6,844 per month), according to Genworth's 13th annual Cost of Care Study.

**Preventive Care Lacking For SNF Residents, Analysis Finds.** Nursing home residents, specifically those with diabetes, are not receiving the recommended amount of preventive care procedures, according to a new analysis. Researchers for the Jagiellonian University Medical College in Kraków, Poland, assessed the care needs of nursing home patients with diabetes and without diabetes in 59 facilities throughout seven
European countries and Israel. More than 4,000 residents were included in the cohort study. The results, published in the *Journal of Post-Acute and Long-Term Care Medicine*, found that the only preventative services residents received frequently were flu vaccinations and yearly blood pressure checkups. The comparison also showed residents with diabetes required a greater amount of clinically complex care and were hospitalized more frequently than the non-diabetes group. Despite the increased amount of care for residents with diabetes, researchers concluded that neither group was receiving the proper amount of preventative care based on their assessed care needs.

- **False Claims Act Penalties to Double, Feds Say.** Penalties for False Claims Act violations will nearly double over the next month in response to a rule from an obscure federal agency, the U.S. Department of Justice announced recently. The penalty spike has been on the horizon since May, when the U.S. Railroad Retirement Board — a government body that administers retirement, unemployment and sickness benefits for railroad workers and their families — published a rule increasing FCA penalties. Various healthcare providers — including several notable long-term care-related groups — have been targets of FCA complaints recently. It would not be unreasonable to expect more to follow. In the rule published in the *Federal Register* at the end of last month, the DOJ confirmed that the penalties will increase. Minimum penalties will jump from $5,500 to $10,781 per claim, while maximum penalties will go from $11,000 per claim to $21,563.

- **Survey: Cameras Cause Providers Privacy, Litigation Concerns.** Privacy violations and litigation risks are among the top worries of providers considering installing cameras in resident rooms, new survey results show. Preliminary results of the provider survey, conducted by Brown University researchers, found skilled nursing and assisted living providers are concerned that placing cameras in rooms will violate the privacy of residents, their roommates, facility staff and visitors. Many providers also stated concerns that the cameras could open them up to potential litigation if activity caught on film were misinterpreted. The survey also captured less common camera concerns, including undermining resident and staff trust, demoralizing staff, and fear over ensuring that the video feed is secure.

18) **Interesting Fact:** CMS estimates that by 2018, 90 percent of Medicare claims will be tied to quality or value as opposed to 25 percent today, as evidence of a broader push by the federal government and ACOs towards value-based payment models.