March 6, 2018 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat features focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

Health Care Worker Background Check Updates

The Illinois Department of Public Health (IDPH) has made some recent changes to the Health Care Worker Background Check Program. One change has to do with background checks for licensed staff and the other change has to do with how the actual background check appears on the website.

1) IDPH Change With Regard to Initiating Livescan Fingerprinting for Licensed Staff.

The following is a summary of the reason why IDPH is no longer allowing health care facilities to initiate livescan fingerprinting through their vendors for licensed staff, such as RNs and LPNs, or adding information on licensed staff to the registry:

If an employee is currently working as a licensed nurse, he or she is not under the jurisdiction of the Health Care Worker Registry. The Health Care Worker Registry (HCWR) is governed by the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code [77 Ill. Adm. Code 955]. The Act and the Code mandate which employees fall under the jurisdiction of the HCWR.

This Act and the Code apply only to “unlicensed” individuals employed or retained by a health care employer as home health care aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel, or an individual working in any similar health-related occupation where he or she provides direct care . . . or has access to long-term care residents or the living quarters or financial, medical, or personal records of long-term care residents. This Part also applies to all unlicensed employees of licensed or certified long-term care facilities who have or may have contact with residents or access to the living quarters or the financial, medical, or personal records of residents.” [77 Ill. Adm. Code 955.100]

Therefore, the only employees who fall under the jurisdiction of the HCWR are unlicensed staff providing direct care or unlicensed staff in long term care facilities who have access to residents’ living quarters or records. Licensed staff (such as nurses) and staff not providing direct care (except in long term care facilities) do not fall under the jurisdiction of the HCWR and should not be added to the registry.

IDPH cannot process waiver applications from employees who do not fall under the jurisdiction of the HCWR. The Illinois Department of Financial and Professional Regulations (IDFPR) handles work eligibility of licensed staff, such as nurses. So we cannot tell an RN that he or she is ineligible to work or provide a waiver to an RN, because that would be beyond our authority. The authority to discipline staff licensed by IDFPR would rest with IDFPR.
IDPH is working with the Illinois Health and Hospital Association on developing a webinar that would better explain all of this and that could be made available to IHCA and the other LTC health care associations once it’s rolled out. It’s not done yet, but IDPH hopes to have it done in the very near future.

Of course, there is nothing in the Act or the Code that would prevent a health care employer from doing a fingerprint background check on its licensed staff. It’s just that background checks for licensed staff can’t be done through the process provided in the HCWBC Act and Code that is administered by the Department, since that background check process can only be used for unlicensed individuals.

2) Health Care Worker Registry Screen Changes

Under the “Background Checks” section of an employee’s registry profile, employers will no longer see whether a background check was a “Hit” or a “No Hit,” and they will no longer see the red or green flags. These changes are the result of recently enacted legislation (HB 4515), which requires the registry to clearly show an employee’s eligibility to work in the health care field. Before these changes, employers often became confused trying to determine an employee’s eligibility for work. Instead of the “Hit/No Hit” designation and the flags, they have added a “Work Eligibility,” which appears just below the employee’s name near the top of the profile. The Work Eligibility will be one of the following: “Eligible” (highlighted in green), “Ineligible” (highlighted in red), or “Not Yet Determined” (highlighted in orange/yellow). Descriptions of each type appear below:

“Eligible” (with green highlighting) means an employee is eligible to work in the health care field. That employee has had a FEE_APP (or a CAAPP). “Eligible” means either he/she had no disqualifying convictions, or he/she has been granted a waiver for any disqualifying convictions. (Employers are still able to see disqualifying criminal convictions, and they are still able to see any waivers and the status of those waivers.)

“Ineligible” (with red highlighting) means an employee is not eligible to work in the health care field. There are two potential situations that would result in an “Ineligible” determination. The first situation resulting in “Ineligible” is an employee with an Administrative Finding of Abuse, Neglect and/or Theft (ANT Finding). An employee with an ANT Finding is ineligible for work, and ANT Findings are not waiverable. An employee with an ANT Finding is prohibited from working in a direct patient care role. The second situation resulting in “Ineligible” is an employee with one or more disqualifying criminal convictions who has not been granted a waiver(s). Employers are still able to see disqualifying criminal convictions and waivers with the status of those waivers. If there is no waiver, or if a waiver is listed with a status of “Denied,” “Revoked,” or “Returned,” that employee is not eligible to work. An employee listed as “Ineligible” can submit a waiver application if he/she meets certain waiver eligibility requirements.

“Not Yet Determined” (with orange/yellow highlighting) means an employee has not had a FEE_APP or CAAPP. It might mean the employee has never had a background check, or it might mean he/she had only a UCIA background check. An employer wishing to hire such an employee must initiate a Livescan request and send the employee to have his/her fingerprints scanned for a FEE_APP background check. Once the Registry receives the background check results, that employee’s “Work Eligibility” will change to either “Eligible” or “Ineligible,” based on those results.

Regardless of the “Work Eligibility” status, employers must be performing the Registry Checks (the six registries that are checked when initiating a Livescan request) on all new employees. In addition, when hiring an employee for a CNA position (or other position that requires certification), employers must check the “Certifications” section and the “Training and Work History” section. For CNAs, if the employee has not worked in a direct patient care role for more than 24 months, this employee would need to recertify to reactivate his/her CNA certification—even if the “Training and Work History” shows “Active.”

Preventative Oral Care in Older Adults

People of all ages can keep their teeth for a lifetime—and enjoy the benefits of a healthy mouth—through two simple steps: regular professional check-ups and cleanings combined with good daily oral hygiene. One of the most important
actions health professionals of all types can take is making sure patients understand the importance of keeping their mouths healthy.

Older adults and their families need to know that good dental care does not have to be complicated or expensive. Those without dental coverage can seek reduced-cost or free professional care at federally qualified health centers, dental schools, or providers who accept Medicaid. For daily hygiene, the only requirements are manual dexterity (or assistance from a family member or aide) and a toothbrush, toothpaste, dental floss, mouth rinse and, if needed, cleansers and brushes for dentures.

Manual toothbrushes are inexpensive and effective when used properly two or more times daily. The older person or a caregiver helping with oral hygiene should select a toothbrush with a handle, head, and bristles of appropriate shape and size.

Older people often have limited dexterity. For them, powered toothbrushes can greatly assist with oral hygiene. The longer handles are easier to grasp, and greater effectiveness of the rapidly rotating head enables older people to keep their teeth, tongue, and gums cleaner and healthier.

A basic fluoride toothpaste is all most people need. Older adults whose teeth are sensitive because of gum recession, caries (cavities), or other factors or with xerostomia (dry mouth) can select one of several specially formulated toothpastes.

Dental floss and/or other interdental cleaning devices should be used daily to remove plaque between the teeth and thereby prevent inflammation and caries. Patient preference is generally the most important consideration in choosing a dental floss (waxed/unwaxed, flavors, thickness of strands), and other interdental cleaning devices (e.g., floss handles, interdental brushes) can make things easier for those who cannot floss with their fingers. Older people, especially those who have sensitive teeth and/or xerostomia, generally prefer mouth rinses that are fluoridated and alcohol-free. Rinses with higher fluoride concentrations are available by prescription.

Removable dentures need the same cleaning regularity as natural teeth but with different products. Minimally abrasive denture cleaners or mild soap and water should be applied with a denture brush twice daily, after which the dentures can be soaked in an appropriate marketed solution. The wearer should rinse the dentures using water or a nonalcoholic antimicrobial mouth rinse and also rinse the mouth with that type of product before reinserting the dentures.

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Trending Statistics

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

**SNF Deficiencies Declining, but Staffing Still Lower Than Recommended: Report**

The average number of deficiencies per nursing home has dropped in recent years, but staffing levels are still falling short of what some experts recommend, according to a new report from the Kaiser Family Foundation.

Kaiser’s “Nursing Facilities, Staffing, Residents and Facility Deficiencies” report outlines recent trends in skilled nursing facilities across the United States using data from the On-line Survey, Certification and Reporting (OSCAR) system and Survey Provider Enhanced Reports.
Among the findings: Data show that deficiencies, for the most part, declined in the 2009-2015 time frame. Between 2009 and 2013 the average number of citations per facility fell from 9.33 to 7.28. That average jumped back up slightly between 2013 and 2015, reaching 8.6 that year.

The percentage of nursing facilities that received no deficiencies followed a similar pattern, rising from 7 percent in 2011 to 8 percent in 2013, before dropping again to 7 percent in 2015. In 2015 more than one-fifth of facilities had a deficiency for actual harm or Immediate Jeopardy, Kaiser found.

The most commonly cited deficiencies were reported in the areas of infection control, accident environment, food sanitation, quality of care and pharmacy consultation.

The report also showed total nursing hours averaged 4.1 hours per resident day in 2015, a slight bump from 3.9 hours in 2009. But despite the increase, the level still falls short of recommendations from some experts, Kaiser noted. That includes a panel of University of California researchers that suggested levels of 4.55 hours per resident day in an article in *The Gerontologist*.

The Kaiser report also found:

- Nursing staff training may not be adequate to properly care for high-need residents or those with behavioral conditions, the report’s authors said, citing limited training on conditions such as dementia
- Nursing home capacity has stayed relatively flat, but occupancy rates have declined from 83.7% in 2009 to 81.7% in 2015
- The percentage of facilities owned by for-profit or chain companies grew slightly between 2009 and 2015, from 67% to 68%

The report’s authors said that future research into facility and resident characteristics should focus on “whether and how new requirements are affecting care and outcomes and to identify additional areas of concern for future policy changes.”

Click [here](#) to read the full Kaiser report.

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

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

2) Federal [HHS/CMS](#) released the following notices/announcements:

- **Low Volume Appeals Settlement Process.** On February 5, CMS started accepting Expressions of Interest for the Low Volume Appeals (LVA) settlement process. The LVA settlement option is for providers, physicians and
suppliers (appellants) with: Fewer than 500 appeals pending at the Office of Medicare Hearing and Appeals and the Medicare Appeals Council at the Departmental Appeals Board, combined, as of November 3, 2017. A total billed amount of $9,000 or less per appeal. If you are interested in participating in LVA to address your pending appeals:
  o Visit the Low Volume Appeals Initiative web page
  o Register for the Medicare Learning Network call on March 13

- **Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20.** National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement - Tuesday, March 20, 12:30 – 2 p.m. CST. Register for Medicare Learning Network events. During this call, gain insight on the phase two changes for person-centered care planning and discharge planning. Also, learn about the new Alzheimer’s Association Dementia Care Practice Recommendations. Additionally, CMS shares updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes. A question and answer session follows the presentations.
  
  Speakers:
  o Debra Lyons, CMS
  o Douglas Pace, Alzheimer’s Association
  o Michele Laughman, CMS

- **CMS Provider Minute Video: Utilizing Your MAC to Prepare for CERT Review — New.** Discover how your Medicare Administrative Contractor (MAC) can help you with a Comprehensive Error Rate Testing (CERT) review. Learn the review process and how to be prepared. The CMS Provider Minute: Utilizing Your MAC video gives you the tools necessary to be successful in navigating CERT review. Learn about:
  o Your MAC’s role
  o CERT process
  o Your role

- **Low Volume Appeals Settlement Call: Audio Recording and Transcript — New.** An audio recording, transcript, and clarification are available for the February 13 call on the Low Volume Appeals Settlement Option. CMS speakers discuss how to identify whether you are eligible and which of your pending appeals may be settled.

- **Provider Compliance Tips for Infusion Pumps and Related Drugs Fact Sheet — New.** A new Provider Compliance Tips for Infusion Pumps and Related Drugs Fact Sheet is available. Learn about:
  o Requirements for Infusion pumps
  o How to prevent claim denials
  o Documentation needed to submit a claim

- **Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet — New.** A new Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet is available. Learn about:
  o Coverage Requirements for Nebulizers
  o How to prevent claim denials
  o Documentation needed to submit a claim

- **Provider Compliance Tips for Laboratory Tests – Blood Counts Fact Sheet — New.** A new Provider Compliance Tips for Laboratory Tests – Blood Counts Fact Sheet is available. Learn about:
  o Different types of blood counts
  o How to prevent claim denials
  o Type of order needed to submit a claim

- **Provider Compliance Tips for Diabetic Test Strips Fact Sheet — Revised.** A revised Provider Compliance Tips for Diabetic Test Strips Fact Sheet is available. Learn about:
  o How to prevent claim denials
Documentation needed to submit a claim


- **Telehealth Services Booklet — Revised.** A revised [Telehealth Services](https://www.cms.gov) Booklet is available. Learn about:
  - Originating sites
  - Distant site practitioners
  - Billing and payment for professional services and the originating site facility fee

- **Medicare Enrollment for Institutional Providers Booklet — Revised.** A revised [Medicare Enrollment for Institutional Providers](https://www.cms.gov) Booklet is available. Learn about:
  - Quick start guide
  - Resources

- **2018 CMS Guidelines for Physician Documentation and E&M Codes — Live Webinar on Thursday, April 26, 2018, 12 p.m. – 1 p.m. CST. CLICK HERE TO REGISTER.** As physicians, coders, auditors and billers, you must ensure that the documentation supports the encounter. How is your EMR set up for documentation? Because if all the notes look the same or all examinations are the same for every patient, you run a high audit risk. And many other documentation pitfalls will set you up for a potential scrutiny, too.

  It’s time for an upgrade to ensure compliance with 2018 physician documentation requirements. This is especially important in light of the possible changes to documentation CMS is proposing for evaluation and management (E&M) codes.

  In this session, coding expert **Melody Irvine** will discuss the CMS Proposed Policy, Payment and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2018 factsheet. She will also discuss CMS’ proposed E&M code changes. She will outline the specific areas CMS is looking at for documentation and how the new focus will affect future provider documentation.

  E&M codes are always on the OIG Workplan, and you want to be able to protect your institution from unnecessary audits. After attending this session, you’ll be equipped to educate your team on possible trouble areas: spots where there is or could be over-coding of encounters. And you’ll be an expert at spotting cloned-looking documentation that could send up a red flag with the feds. [Read more](https://www.cms.gov).

- **CMS Launches Public Reporting of CAHPS Hospice Survey Results.** On February 20, 2018, CMS announced the initial publication of results from the CAHPS® Hospice Survey on Hospice Compare. Hospice Compare is a user-friendly web tool found at [https://www.medicare.gov/hospicecompare/](https://www.medicare.gov/hospicecompare/). It provides information to help patients, their families, caregivers, and providers make more informed decisions about choosing a hospice. Hospice Compare allows users to select up to three hospices at a time to compare the clinical quality of care provided and patient experiences with these hospices.

  Survey results are published for all Medicare-certified hospices that had at least 30 completed surveys during the eight quarters from Quarter 2, 2015 (April 1, 2015) through Quarter 1, 2017 (March 31, 2017). In addition to the survey results, the Hospice Compare site provides a variety of other data about the quality of hospice care, including the Hospice Item Set (HIS).

  CMS works diligently to make healthcare quality information more transparent and understandable for consumers and is committed to helping individuals make informed healthcare decisions for themselves and their families based on objective measures of quality.
• **Hospice Compare Quarterly Refresh Available.** The February 2017 quarterly Hospice Compare refresh based on patient stays discharged for Q2 2017 – Q1 2017 is now available. Visit [Hospice Compare](https://www.hospicecompare.org) to view the data.

3) The federal Centers for Disease Control and Prevention (CDC) reports on:
   • **The Weekly U.S. Influenza Surveillance Report**
   • **Vaccine Administration Training and Resources**
   • **How Well Does the Flu Vaccine Work**

4) The federal Food and Drug Administration (FDA) reports [FDA Sets the Stage for Earlier-Stage Alzheimer’s Treatments](https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2018/02/alzheimers). The FDA has proposed new guidelines, which are aimed at lowering the clinical study goals of Alzheimer’s disease drugs for treating earlier-stage patients who have not yet displayed functional disability or clinical abnormality. This strategy, part of the FDA’s ongoing efforts to expand access to safe and effective treatment options for many serious conditions, suggests that the agency may be open to an accelerated approval process for such drugs.

5) **ASPR TRACIE** released their February 2018 issue of **The Express**.

6) The Illinois Department of Healthcare and Family Services released the following notices since the last issue of **Regulatory Beat**:
   
   
   • HFS posted a new provider notice regarding **Williams Consent Decree Requirement Regarding Access to Residents**. You may view the notice [here](https://www.hfs.state.il.us/)
   
   • HFS posted a new provider notice regarding **LTC Monthly Occupied Bed Provider Assessment**. You may view the notice [here](https://www.hfs.state.il.us/)

7) **The Illinois Department of Public Health** reported:
   
   • IDPH recently announced the list of **Town Hall Meetings for 2018**. Notices are being sent to the individual providers prior to the meeting in their location. Reservation information is included in that letter. The dates and locations are:
     
     - March 14, Marion Regional Office Building 1-3pm
     - March 20, The Elms, Macomb 1-3pm
     - April 26, Washington County Hospital, Nashville 1-3pm
     - May 15, Pine Crest Manor, Mt. Morris 1-3pm
     - June 12, Hope Creek, East Moline 1-3pm
     - July 10, DuPage County 1-3pm
     - August 14, Brookens Bldg, Urbana 1-3pm
     - September 11, Abington of Glenview 1-3pm
     - October 16, Pekin Manor 1-3pm
     - November 14, Oak Trace, Downers Grove 1-3pm
   
   • The Health Facilities Services Review Board (HFSRB) has sent out their annual Nursing Home **LTC Facility Questionnaire 2017** ([Annual LTC Questionnaire Form](https://www.hfs.state.il.us/)). They sent a separate (slightly different) questionnaire to the ID/DD facilities.

8) The American Health Care Association (AHCA) and the Illinois Health Care Association (IHCA) recently reported on:
   
   • **An Active Start to a Very Busy Year**. The pundits were wrong again. 2018 was supposed to be a slow year in DC. Traditional thinking was that with the election in November, Congress would vote to keep the government open and that would be about it for the year. They were wrong again! The first seven weeks of the year have been very active and decisions that will shape the future of our sector still lie ahead. Mark Parkinson provides you with an update of what has happened, what's next in DC, and how you can help.
• **Check Out Your Quality Progress in Your February Top-Line Publication.** On February 26, LTC Trend Tracker users received the latest Your Top-Line publication. This resource, produced by LTC Trend Tracker, highlights metrics and graphics outlining your facility's progress on Five-Star performance, the AHCA/NCAL Quality Initiative and other necessary data to help you achieve your desired goals. The 2018 Quarter 1 edition of Your Top-Line publication also includes a Resident Profile with the following new features that will:
  o Provide the information you need to begin Component 1 of the annual Facility Assessment required under CMS's Requirements of Participation ($483.70(e)).
  o Help your facility determine the resources required to provide person-centered care and the services your residents need in both day-to-day operations and emergencies.

As a reminder, LTC Trend Tracker also has a **new and improved Five-Star Predictor Tool** that allows users to see how potential changes in individual quality measures may impact that center's Five-Star QM rating. Users can enter potential rates for each individual QM to predict how that change will affect the facility's Five-Star QM total points and rating.

9) The [National Association of Health Care Assistants (NAHCA)](http://www.nahcaCNA.org) launched their new and updated website, complete with a revised logo. Go to [www.nahcaCNA.org](http://www.nahcaCNA.org) to check it out. After 23 years the golden key logo is being retired. The new look and updates are the result of a yearlong effort to position NAHCA to reach more certified nursing assistants (CNAs) for robust growth and recruitment of individuals to the CNA profession.

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

11) [Today's Geriatric Medicine](https://www.todaysgeriatricmedicine.com/) reports that [Drug Combo Cuts Fracture Risk for Women With Osteoporosis](https://www.todaysgeriatricmedicine.com/articles/2018/02/14/drug-combo-cuts-fracture-risk-for-women-with-osteoporosis). Taking a medication that builds bone mass followed by one that maintains it can significantly reduce the risk of fracture among postmenopausal women. Osteoporosis is a serious condition affecting both women and men, though postmenopausal women are particularly susceptible. The progressive loss of bone mass puts those with the condition at greater risk for fracture. To date there is no effective treatment or cure. This is the reason the promise of this study, demonstrating that bone mass can be regenerated with the novel bone anabolic medication romosozumab and sustained with antiresorptives, is of such importance.

12) [Newsweek](https://www.newsweek.com/) reports, [Alzheimer’s Disease is Completely Reversed by Removing Just One Enzyme in New Study](https://www.newsweek.com/alzheimers-disease-completely-reversed-removing-one-enzyme-new-study-1148481). An experimental treatment completely reversed Alzheimer’s disease in mice by reducing the levels of a single enzyme in the animals' brains. The results further bolster the theory that amyloid plaques are at the root of this mysterious brain disease, and that addressing these plaques could lead to an eventual cure for Alzheimer's. The study, published February 14 in the *Journal of Experimental Medicine*, found that slowly reducing levels of the enzyme BACE1 in mice as they aged either prevented or reversed the formation of amyloid plaques in the brain, a hallmark sign of Alzheimer’s disease.

13) [Becker’s Hospital Review](https://www.beckershospitalreview.com/) reports:

- **Can Healthcare Providers Afford Not to Have Cyber Insurance in 2018?** Determining the type of cyber insurance to purchase is no trivial matter. Cyberattacks targeted hospitals and health systems at an alarming pace in 2017 — nearly exceeding the rate of one breach per day. This white paper helps health care leaders assess the cost-benefit of cyber insurance for their organization by reviewing the scope of cyberattacks in 2017, examining various cyber risks and coverage opportunities and discussing key trends affecting insurance needs in the next three to five years.

- **Trump’s 2019 Budget Blueprint: 15 Healthcare Takeaways.** President Donald Trump recently [released](https://www.politico.com/2018/03/06/trump-budget-bipartisan-budget-deal-441758) his $4.4 trillion budget for fiscal 2019 with an [addendum](https://www.telligenqinqio.com/press-releases/2018/03/05/trumps-2019-budget-bipartisan-budget-deal) to partially account for the two-year [bipartisan budget deal](https://www.politico.com/2018/03/06/trump-budget-bipartisan-budget-deal-441758) reached in Congress last week. Released under the title "Efficient, Effective, Accountable: An American Budget," the proposal emphasizes austerity in nondefense programs while increasing funds to the Pentagon. President Trump's proposal would add $984 billion to the deficit in 2019 and more than $7 trillion over the next decade, which would bring the projected deficit down by $3.6 trillion, according to [Politico](https://www.politico.com/). The addendum calls
for $540 billion in nondefense discretionary spending next year, up $75 billion from the original budget to account for the two-year Bipartisan Budget Act enacted last week. However, this is still $57 billion below the cap of $680 billion set by Congress in their budget agreement. Here are 15 proposals related to healthcare in the president's budget.

14) **Provider Magazine** reports on Rising Number of Medicare-Eligible Baby Boomers Will Increase Health Spending, CMS Report Finds. **Provider Magazine** recently reported that CMS' new "10-year outlook for national health spending and enrollment" suggests that the large number of baby boomers becoming eligible for Medicare will be a "major driver of the faster rate of spending." CMS' Office of Actuary projects that from 2017 to 2026, "national health expenditure growth is expected to average 5.5 percent annually over that time frame and reach $5.7 trillion by 2026." The report also found that "federal, state, and local governments are projected to finance 47 percent of national health spending" by the year 2026.

15) **McKnight's** reports, ACOs Save Money by Steering Care Away From Skilled Nursing Facilities. **McKnight's Long Term Care News** reported providers participating in the Medicare Shared Savings Program "saved money by funneling care away from skilled-nursing facilities and other settings, and toward physician services," according to a study published in the American Journal of Accountable Care. The researchers "found that money spent on SNFs, as well as what’s spent on ambulance services and durable medical equipment, decreased during the four years" from 2013 to 2016. Also, the piece says, "A 1% decrease in spending on SNFs, the authors found, accompanied a 0.82% increase in savings for ACO participants."

16) **The Bend (OR) Bulletin** reports that Opioid Limits Seen Impacting Palliative Care. The **Bend (OR) Bulletin** discussed new strategies "to rein in the overprescribing and misuse of opioid pain medications" have "almost universally" exempted patients with end-of-life or cancer pain, but physicians "are increasingly reporting challenges getting medications for patients who truly need them." Dr. Laura Mavity, a palliative care specialist who has seen sporadic shortages of intravenous morphine and hydromorphone, said, "We’re starting to see a little bit of difficulty locally and nationally in getting a hold of some opioids, especially in the inpatient setting." The article reported supply shortages from the hurricane that hit Puerto Rico in September and federal limits to opioid manufacturing in 2017 and 2018 "may have left little excess capacity to overcome the unexpected production shutdowns."

17) **Reuters** reports Intervention Program Emphasizing Social Interaction, Staff Training May Reduce Agitation in Nursing Home Dementia Patients. **Reuters** discussed a recent trial that found that nursing home care that "fosters interest and social interaction among patients and staff" could help "reduce agitation and other neuropsychiatric symptoms in dementia sufferers and improve their quality of life." Researchers, who published their findings in *PLoS Medicine*, determined that the intervention program produced "meaningful decreases in agitation and neuropsychiatric symptoms and increased quality of life" among participants.

18) **Medscape** reports:

- **Benzodiazepine Harms Overlooked, Especially in Older Adults**. As attention remains focused on opioid abuse, another drug epidemic rages outside the spotlight: inappropriate prescription of benzodiazepines. In an editorial published in the February 22 issue of the *New England Journal of Medicine*, Anna Lembke, MD, Jennifer Papac, MD, and Keith Humphreys, PhD, from Stanford University School of Medicine in California, point out that from 1996 to 2013, the number of adults who filled a benzodiazepine prescription rose from 8.1 million to 13.5 million, an increase of 67 percent. During roughly the same time (1999-2015), deaths from benzodiazepine overdose increased from 1135 to 8791.

- **Routine CT Scans May Identify Older Patients at High Risk for Fragility Fracture**. **Medscape** reports that "taking a simple measurement of bone quality during routine computed tomography (CT) scans of the chest or abdomen may help identify older patients, over 65 years, at high risk for fragility fracture over approximately 6 years of follow-up." The findings were published online in the *Journal of Bone and Mineral Research*. 
19) **Interesting Fact:** The most powerful computers on Earth cannot generate the number of computations it takes to run on two legs.

*If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don't hesitate to contact Bill Bell. If you'd like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!*