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!

**Proposed CMS Rulemaking – Part 1**
My plan is, over the next several issues of Regulatory Beat, to take the various sections of the new CMS proposed rulemaking and explain the major/significant changes. I will do this from the regulatory side, but you, as providers, need to determine if the new or modified provisions are workable and can be implemented within your centers. For those provisions of this proposed rulemaking that are problematic or costly to implement, you need to forward your comments to both IHCA and CMS.

To help with this effort, AHCA has launched a massive grassroots campaign to impress upon CMS just how important this new Proposed Rule on Requirements of Participation (RoP) is to our profession. In addition, they have created a dedicated web page to help you submit comments to CMS regarding RoP. What CMS has developed simply goes too far, demands the changes too quickly and costs too much. There are too many provisions in this 400+ page rule that result in Washington micromanaging even basic functions in our centers.

The new AHCA webpage will make it easy for you to participate in this campaign. It includes suggested topics for commenting, sample comments, instructions for filing a comment, and a link to the filing site. Access the information by clicking here or by logging into the AHCA website and clicking on the "SNF Requirements of Participation" link under the "Facility Resources" tab.

The more comments CMS receives, the more review and changes will be made. **The comments are due to CMS no later than 5pm on September 14, 2015.** CMS will then be required review all comments, make any changes they believe are necessary and then do a final rulemaking in the Federal Register. They will also need to do new/revised F-tags and new/revised Interpretive Guidelines. It is believed that CMS will implement these new requirements in stages as opposed to all at one time.

This CMS proposed rule would revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. CMS believes these proposed changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These proposals are also an integral part of CMS’s efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

**A. Basis and Scope (§ 483.1)**
CMS proposes to revise § 483.1 “Basis and Scope” to include references to sections 1819(f), 1919(f), 1128I (b) and (c) and 1150B of the Act. These references include:
1) Sections 1819(f) and 1919(f) of the Act require that the current mandatory ongoing training for nurse aides include dementia management and resident abuse prevention training.

2) New section 1128I (b) of the Act requires the operating organizations for SNFs and NFs to have a compliance and ethics program.

3) New section 1128I(c) of the Act requires the Secretary to establish and implement a QAPI program for facilities.

4) New section 1150B of the Act establishes requirements for reporting to law enforcement suspicion of crimes occurring in federally funded LTC facilities.

5) In addition, CMS proposes to spell out the term “skilled nursing facility.”

B. Definitions (§ 483.5)

CMS’s current regulations at § 483.5 provide definitions for terms commonly used in the LTC requirements. CMS proposes to revise some of the existing terms for clarity and define new terms that they believe are widely used with the LTC setting, and that they believe would add value to the LTC requirements while promoting resident choice and safety. Revisions and additions include:

1) **Abuse** – Modified definition. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

2) **Adverse Event** – New definition. “An adverse event is an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof.”

3) **Common Area** – Modified definition. “Common areas are areas in the facility where residents may gather together with other residents, visitors and staff or engage in individual pursuits, apart from their residential rooms. This includes but is not limited to living rooms, dining rooms, activity rooms, outdoor areas and meeting rooms where residents are located on a regular basis.”

4) **Composite Distinct Part** – Modified definition. Same definition as in current standards with the exception of a new (v) which states: “(v) Use of composite distinct parts to segregate residents by payment source or on a basis other than care needs is prohibited.”

5) **Exploitation** – Modified definition. “Means the unfair treatment or use of a resident or the taking of a selfish or unfair advantage of a resident for personal gain, through manipulation, intimidation, threats or coercion.”

6) **Licensed Health Professional** – Same definition as in another part of the current requirements, just moved to the definition section.

7) **Misappropriation of Resident Property** – New definition for Part 483, but same definition as found in Part 488. “Means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.”

8) **Neglect** – New definition for Part 483. Neglect is defined in Part 488, but that definition is modified in Part 483 to read, “Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness.”
9) Nurse Aide – New definition for Part 483. Nurse Aide is defined in Part 488, but that definition is modified in Part 483 to read, “Nurse aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.”

10) Person-Centered Care – New definition. “For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.”

11) Resident Representative – New definition. “For purposes of this subpart, the term resident representative means an individual of the resident’s choice who has access to information and participates in healthcare discussions or a personal representative with legal standing, such as a power of attorney, legal guardian or health care surrogate appointed or designated in accordance with state law. If selected as the resident representative, the same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.”

12) Sexual Abuse – Modified definition. “Sexual abuse is non-consensual sexual contact of any type with a resident.”

13) Transfer or Discharge - Same definition as in another part of the current requirements, just moved to the definition section.

C. Resident Rights (§ 483.10)
CMS proposes to retain all existing residents’ rights, but update the language and organization of the resident rights provisions to improve logical order and readability, to clarify aspects of the regulation that warrant it, and to update provisions to include technological advances such as electronic communications. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility, including those specified in this section. Section 483.10 will focus specifically on resident rights.

(a) Exercise of Rights.
1) Clarify the resident’s right to be supported in their exercise of their rights.

2) Eliminate language, such as “interested family member” and replace the term “legal representative” with “resident representative.”

3) Clarify the resident’s right to designate a resident representative, the resident’s retention of those rights not delegated, including the right to revoke a delegation.

4) Clarify the rights of the resident in the case of a resident being adjudged incompetent.

5) Add a new requirement that the same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

(b) Planning and Implementing Care.
1) Revise the requirements relating to the resident’s right to be informed of his or her total health status, including medical conditions; the right to be informed in advance of the risks and benefits of proposed care, including treatment and treatment alternatives or treatment options so that the resident can choose the alternative or option he or she prefers; the right to request, refuse and/ or discontinue treatment, including participating in or refusing to participate in experimental research; and the right to formulate
advance directives.

2) Add new requirements to specify that the resident has the right to participate in the care planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

3) Add resident has the right to receive the services and items included in the plan of care.

4) Add the resident’s right to self-administer medication if the interdisciplinary team has determined that doing so would be clinically appropriate.

5) Add new language to specify that these rights cannot be construed as a right to receive medical care that is not medically necessary or appropriate.

(c) Choice of Attending Physician.
1) Clarify that the resident has their choice of physician, but the physician must be licensed to practice in the state where the facility and care is given.

2) Add that the physician must meet the professional credentialing requirements of the facility.

3) Add that if the physician the resident chooses does not meet the requirements, the resident can choose a new physician that meets the requirements or the facility must seek an alternate physician that meets the requirements.

(d) Respect and Dignity.
1) Re-designate into this section, a number of provisions relating to resident respect and dignity that were previously scattered throughout the current regulation.

2) Add that a resident has the right to share a room with his or her roommate of choice, when both residents live in the facility, both residents consent to the arrangement and the facility can reasonably accommodate the arrangement. This provision will allow for a same-sex couple, siblings, other relatives, long term friends or any other combination if other requirements are met.

(e) Self-Determination.
1) Add that residents can receive their visitors of choice at the time of their choosing.

2) Clarify the resident has the right to participate in family groups and have their family members or resident representatives participate in family groups in the facility.

(f) Access to Information.
1) Clarify the resident has the right to access facility specific information, medical records, information about advocacy and fraud control organizations, Medicare and Medicaid coverage and notices such as legal rights, advance directives, how to apply for Medicare/Medicaid, filing a complaint, resolving grievances, etc. that the facility is required to provide the resident.

2) Clarify the resident has the right to receive notices verbally and in writing in a format and a language they understand.

3) Clarify the resident’s right to privacy under HIPAA and other privacy/security requirements.

4) Clarify the resident has the right to examine the most recent survey and any plan of correction in effect and the right to receive information from and contact client advocate agencies.
Privacy and Confidentiality.
1) Revise a number or of provisions related to resident privacy and confidentiality to update the language to accommodate electronic communications.

Communication.
1) New provisions to include TTY and TDD services and cellular telephones.
2) New provision to provide reasonable access and privacy for electronic communications such as email or internet-based interpersonal video communications.
3) Clarify the resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service.

Safe Environment.
1) Clarify the resident has the right to a safe, clean, comfortable, homelike environment and the right to receive treatment safely.

Grievances.
1) Clarify that the resident cannot be deterred from voicing a grievance for fear of reprisal or discrimination.
2) Clarify the resident has the right to prompt efforts by the facility to resolve grievances.

The next Regulatory Beat will focus on Facility Responsibilities (483.11) and Freedom from Abuse, Neglect and Exploitation (483.12).

**How Can Health Professionals Enhance Cognitive Health in Older Adults?**

*Article highlights key action areas for better brain health*

An expert panel convened by the Institute of Medicine clarified the cognitive aging process by making a distinction from Alzheimer’s disease and related dementias, and provided recommendations to enhance cognitive health in older adults. Now a new article published in *Annals of Internal Medicine* highlights key points of that report and serves as a guide for health care professionals seeking to improve the quality of life of older adults by maintaining brain health.

Practitioners define "cognition" as mental functions encompassing attention, thinking, understanding, learning, remembering, problem solving, and decision making. As a person ages there is a gradual, but marked change in these cognitive functions, which is referred to as "cognitive aging."

"Cognitive aging is not a disease or a level of impairment--it is a lifelong process that affects everyone," explains lead author Dr. Sharon K. Inouye, Director of the Aging Brain Center at the Institute for Aging Research, Hebrew SeniorLife in Boston, Massachusetts and Professor of Medicine, Harvard Medical School. "Given the sizable number of adults approaching older age, understanding the impact of cognitive aging has become a significant health concern."

Older adults seem to share the same concern about their health as a 2014 survey by the AARP found that 93% of respondents said maintaining brain health was a top priority. In response, the Institute of Medicine committee created recommendations that focus on prevention and intervention opportunities, seek to educate health care practitioners, and help raise public awareness of cognitive health. Action areas for practitioners include:

- Conduct a formal cognitive assessment to detect cognitive impairment
- Screen for risk factors such as alcohol use, smoking history, and diet
Promote benefit of physical exercise, lifelong learning, social engagement and adequate sleep
Highlight importance of reducing cardiovascular risks such as hypertension and diabetes
Identify persons at high risk for delirium before or at hospital admission and institute preventive strategies
Minimize prescription of inappropriate medications

The article also covers cognitive health as it relates to driving safety, financial decision-making, use of nutraceuticals and effectiveness of brain games among older adults. "There is still more to learn about the biological process involved with cognitive aging, but there are interventions that can be made now," says Dr. Inouye. "Health care professionals play a vital role in working with older patients and their caregivers to maintain optimal brain health."

Journal Reference:

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

CDC: 53 Million Adults in the US Live With a Disability
New report provides state-by-state data on disability types

Disability Impacts ALL of US.

In the United States, one out of every five adults has a disability, according to a new study published by the Centers for Disease Control and Prevention. The most common functional disability type was a mobility limitation — defined as serious difficulty walking or climbing stairs — reported by one in eight adults, followed by disability in thinking and/or memory, independent living, vision, and self-care.

The researchers found that the highest percentages of people with disabilities are generally in Southern states, for example Alabama (31.5 percent), Mississippi (31.4 percent), and Tennessee (31.4 percent). The report did not determine why differences occur by state; however, states in the South tend to have some of the higher rates of chronic diseases, such as heart disease and diabetes, which may also be associated with disability.

“We are all at risk of having a disability at some point in our lifetime,” said CDC Director Tom Frieden, M.D., M.P.H. “Health professionals and health care systems need to meet the needs of this growing population.”

The report also revealed that non-Hispanic black (29 percent) and Hispanic (25.9 percent) adults were more likely to have a disability than were white non-Hispanic (20.6 percent) adults. Those with lower education levels, lower incomes, and those who are unemployed were also more likely to report a disability.
“For the past 25 years, the Americans with Disabilities Act (ADA) has made a positive difference in the lives of those who have disabilities by ensuring better access to buildings, transportation, and employment. Access to preventive health care is also critically important for those with disabilities,” said Georgina Peacock, M.D., M.P.H., Director of CDC’s Division of Human Development and Disability. “Many of the health issues that people with disabilities face may be addressed by making sure they have access to health promotion programs and health care services, including preventive health screenings, throughout their lifespan.”

CDC is committed to protecting the health and well-being of people with disabilities throughout their lives. Through its state-based disability and health programs and national collaborations, CDC will continue to work to reduce health disparities faced by people with disabilities by facilitating their inclusion in public health surveys, public health programs, emergency preparedness and planning efforts, and accessible health care services. To work toward this goal, CDC provides data, information and resources for public health practitioners, health care providers, and people interested in the health and well-being of people with disabilities.

Although disability information has been collected in national surveys for many years, this was the first time that functional disability type was included in the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual, state-based telephone survey conducted by states in collaboration with CDC that gathers information on demographics, health status, health behaviors and disabilities.

More information about CDC’s work to support inclusive public health and health care settings is available at http://www.cdc.gov/disabilities.

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**Important Rules, Regulations & Notices**

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

- **S&C 14-42 REVISED – NH** - Release of Learning Tool on Building Respect for Lesbian, Gay, Bisexual, Transgender (LGBT) Older Adults. 07.17.15- Revised to update the Training Tool website link. CMS announced the release of a free learning tool on Building Respect for LGBT Older Adults. The learning tool addresses the needs and rights of older LGBT adults in long term care (LTC) and is presented in six online training modules. This learning tool is intended for LTC providers.

- No new S&C Letters were released since the last issue of *Regulatory Beat*.

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

- CMS released a fact sheet ([click here](#)) that explains the final fiscal year 2016 payment and policy changes for Medicare Skilled Nursing Facilities. On July 30, 2015, CMS issued a final rule [CMS-1622-F] outlining Fiscal Year (FY) 2016 Medicare payment rates for skilled nursing facilities (SNFs). The FY 2016 rates and other issues discussed in the final rule are summarized below. The final rule promotes policies that continue to shift Medicare payments from volume to value. The Administration has set measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. The final rule includes policies that advance that vision and support building a health care system that delivers better care, spends health care dollars more wisely and results in healthier people.

- CMS released a news brief ([click here](#)) regarding CMS and Rhode Island partnering to coordinate care for Medicare/Medicaid enrollees. On July 30, 2015, CMS announced that they are partnering with the state of Rhode Island to test a new model for providing Medicare-Medicaid enrollees with a more coordinated,
person-centered care experience. The demonstration builds upon Rhode Island’s existing Integrated Care Initiative. Under Phase I of the Integrated Care Initiative, Rhode Island established the Rhody Health Options (RHO) Medicaid managed care program. In RHO, Medicaid members – including Medicare-Medicaid enrollees – enroll in a health plan that coordinates their Medicaid services, including long term services and supports. The new demonstration will allow a contracted, qualifying RHO plan to also serve as a Medicare-Medicaid Plan (MMP) that will newly cover Medicare benefits in addition to the existing set of Medicaid benefits it currently offers, allowing for an integrated set of benefits for enrollees.

- CMS release a news brief (click here) regarding the Medicare prescription drug premiums being projected to remain stable. On the eve of the 50th anniversary of the signing of Medicare and Medicaid into law, CMS projected today that the average premium for a basic Medicare Part D prescription drug plan in 2016 will remain stable, at an estimated $32.50 per month.

- CMS issued a fact sheet that notes the final rules outlining the 2016 Medicare payment policies and rates for inpatient psychiatric facilities, hospice, inpatient rehabilitation facilities, and inpatient hospitals.

- CMS issued a news brief clarifying questions and answers related to the July 6, 2015 CMS/AMA joint announcement and guidance regarding ICD-10 flexibilities – Update. On July 6, 2015, CMS and the American Medical Association (AMA) released a joint statement about their efforts to help the provider community get ready for ICD-10. This statement included guidance from CMS that allows for flexibility in the claims auditing and quality reporting processes. In response to questions from the health care community, CMS has released “Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities,” which provides answers to the most commonly asked questions. Today CMS has reissued these Questions and Answers with revisions to questions 3 and 5.

- CMS’ Management Learning Network (MLN) – Countdown to ICD-10 updates:
  - Clarifying Questions and Answers Related to CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
  - MLN Connects National Provider Call: Countdown to ICD-10
  - List of Valid ICD-10-CM Codes
  - Use of Unspecified Codes in ICD-10-CM
  - Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
  - Claims that Span the ICD-10 Implementation Date

- MLN Connects National Provider Call on the Proposed Reform of Requirements for Long-Term Care Facilities. This MLN Connects National Provider Call provides an overview of the proposed rule to reform the requirements for long term care facilities. These requirements are the federal health and safety standards that long term care facilities must meet in order to participate in the Medicare or Medicaid programs. This presentation provides background for updating these requirements and briefly walks through many of the changes included in the proposal. A question and answer session will follow the presentation.

  Agenda:
  - Highlights of the proposed rule
  - Overarching themes of the proposed rule
  - Methods for reviewing and commenting on the proposed rule

  Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.
Visit MLN Connects Event Registration to register for this National Provider Call. Space may be limited, register early.

3) The Illinois Department of Healthcare and Family Services (HFS) released several notices. They include:
   - HFS notes (click here) that state Medicaid agencies are required to provide quality assurance and fee-for-service utilization review in the inpatient hospital settings for services provided to participants in the Medical Assistance program and Illinois contracts with a PRO/QIO to conduct this function. The department requires the PRO/QIO to assist the department in assuring that quality care is being provided to Medical Assistance program participants. The department has executed a contract with eQHealth Solutions (eQH). eQH provides concurrent, retrospective prepayment and post payment reviews for services provided in the inpatient hospital setting for participants eligible for Medical Assistance. eQH provides quality of services review including medical necessity, reasonableness and appropriateness of care using telephonic, and web-based interactions. Please view eQHealthSolutions' (eQH) website for additional information.
   - Chapter L-200, Handbook for Providers of Laboratory Services - Requirement for Billing International Classification of Diseases (ICD)-10-CM Diagnosis Codes Effective October 1, 2015. This bulletin (click here) revises HFS billing instructions to require an ICD-10-CM primary diagnosis code on claims billed on the HFS 2211 paper claim form. Effective with dates of service on and after October 1, 2015, all providers utilizing the HFS 2211 claim form will be required to complete Item 24 with a valid ICD-10-CM diagnosis code.
   - Claims Processing System Issues - HFS is experiencing the following system problems. Once the system problems have been resolved, they will notify the providers by updating this website. If your question is not answered by the HFS Claims Processing System Issues informational pages, please send your question to us via: E-mail HFS Claims Processing System Issues. This link (click here) will provide you with the most current system issues that the department is experiencing as well as information regarding resolutions.

4) The American Health Care Association (AHCA) issued several notices. They include:
   - AHCA Update on Targeted Therapy Manual Medical Review (MMR) Implementation. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) enacted in April contained provisions to replace the problematic Part B therapy Manual Medical Review (MMR) process, which required 100 percent review of all claims above a $3,700 annual per-beneficiary threshold with a targeted review program for claims over the $3,700 threshold. CMS was instructed to implement the targeted approach no later than 90 days of enactment, and that deadline has recently expired. Several of you have been contacting us recently as CMS has not posted any substantive updates to date, and you continue to receive therapy MMR ADRs.
   - AHCA notes HCBS Final Rule Information. This is an alert to new information (click here) from the CMS regarding the HCBS final rule. The agency recently posted on its website new information regarding its review of Statewide Transition Plans (STPs). I was able to speak with CMS and Administration for Community Living (ACL) officials yesterday about this and other issues of concern to providers.
   - AHCA SNF PPS FY 2016 Rule Summary Now Available. Last week, AHCA shared a brief overview of the FY 2016 SNF PPS final rule released by CMS on July 30, 2015. They have since developed a more detailed summary, which highlights the following:
     - Comments submitted to and responses received from CMS regarding payment provisions;
     - SNF Value-Based Purchasing (VBP);
     - SNF Quality Reporting Program (QRP);
     - Changes to MDS 3.0 data collection; and
     - Staffing data collection.
5) MedlinePlus had several article of interest. They include:

- **Expert Panel Recommends Questionnaire to Help Spot Depression - Form could be filled out during visit to family doctor, and patient could be referred for follow-up care.** Part of your next visit to your family doctor's office should be spent filling out a questionnaire to assess whether you're suffering from depression, an influential panel of preventive medicine experts recommends. What's more, people concerned that they might be depressed could download an appropriate questionnaire online, fill it out ahead of time and hand it over to their doctor for evaluation, the panel added. In an updated recommendation released Monday, the U.S. Preventive Services Task Force urged that family doctors regularly screen patients for depression, using standardized questionnaires that detect warning signs of the mental disorder.

- **High Blood Sugar May Boost Alzheimer's Risk - Insulin resistance can inhibit signaling between brain cells and affect memory, study suggests.** High blood sugar associated with prediabetes may increase the risk for Alzheimer's disease, a new study suggests. Researchers found that insulin resistance -- higher-than-normal levels of blood sugar that often precede type 2 diabetes -- was related to poorer performance on memory tests taken by late-middle-age adults.

- **Just 1 in 3 Seniors With Diabetes Has Disease Under Control - Blood sugar, blood pressure and cholesterol levels key to managing disease, experts say.** Only one-third of American seniors with diabetes have their disease under control, a new study finds. "This research gives us a good picture of diabetes control in older adults and gets us thinking about what it means that older Americans are not meeting clinical targets and how we should address this from a public health perspective," study leader Elizabeth Selvin, a professor of epidemiology at the Johns Hopkins Bloomberg School of Public Health in Baltimore, said in a school news release.

- **Deaths, Hospital Stays and Costs All Down Among U.S. Seniors - Study finds steady improvement among Medicare enrollees from 1999 through 2013.** In a rare piece of good news about the U.S. health care system, a new study finds that deaths, hospital stays and spending are all falling among older Americans. Between 1999 and 2013, yearly rates of death and hospitalization steadily declined among Americans in the traditional fee-for-service Medicare program. Meanwhile, spending on inpatient care showed the same pattern.

6) The Washington Post published an article entitled “Feds: More scrutiny needed of nursing home errors involving blood thinner.” The federal government is asking health inspectors nationwide to be on the lookout for errors by nursing homes in managing the blood thinner Coumadin, including those that lead to patient hospitalizations and deaths. In a memo sent last month to state health departments, CMS cited a report by ProPublica and The Washington Post that focused on the harm caused by homes’ failure to manage the drug. The analysis of government inspection reports found that, between 2011 and 2014, at least 165 nursing home residents were hospitalized or died after errors involving Coumadin or its generic version, warfarin. In some cases, homes gave residents too much of the drug, which caused internal bleeding. In other cases, they gave residents too little, leading to blood clots and strokes.

7) HealthData Management recently reported on a “New Tool IDs Patient Fall Risk in 10 Minutes.” A new electronic health records-agnostic tool from Cerner can identify patients at risk for falls with a 90 accuracy rate, according to the vendor. The tool measures how a patient is walking, the speed of walking and every aspect of acceleration around the body's center of gravity as the patient moves, the company explains. Used on a patient with knee surgery, for instance, the tool would read that the patient is accelerating differently by putting more pressure on one knee and the stride is off-balance.

8) Kaiser Health News recently published an article entitled “Lack Of Cooperation Among Health Facilities Mars Antibiotic Resistance Fight, CDC Says.” Unless hospitals and other health care facilities begin cooperatively fighting the country’s most aggressive antibiotic-resistant germs, infection rates could increase as much as 10 percent
over the next five years, hitting about 340,000 people annually, the CDC said in a report released today. Individual institutional efforts, the study said, will not be sufficient to combat these germs. Part of the problem, it notes, is that they are spreading as infected patients move between hospitals, nursing homes and long term care facilities. For the most part, however, efforts to catch and prevent these infections are being done autonomously.

9) **McKnight’s** had several articles of interest. They Include:

- **Eye drops could help clear cataracts without surgery.** Eye drops containing a natural chemical could help seniors avoid cataract surgery, according to new research. Researchers at the University of California, San Diego, found that an enzyme-created compound called lanosterol prevents the clumping of proteins in the human eye that can lead to obstructed vision. A six-week study found applying lanosterol eye drops to dogs with age-related cataracts decreased lens cloudiness, and subsequently reversed the course of the disease. The researchers note the drops won’t likely be able to clear up dense cataracts, but may be effective in early intervention in mild to moderate cases.

- **Healthcare workers rank selves high in ‘most meaningful’ jobs list.** A majority of the jobs with both high annual pay and high job meaning are in the healthcare industry, according to an interactive chart from PayScale, a compensation data website. Eighty-two percent of health care practitioners, such as registered nurses, surgeons, specialized doctors, technicians and educators, felt their job was meaningful. They also earned the highest median annual pay out of the 24 job categories, at $83,500 per year. Home health aides, nursing aides, therapists and medical assistants were classified as healthcare support workers, and averaged a 78 percent “job meaning” rate. Their median annual pay was reported at $33,800. Job satisfaction was also part of the analyzed data. Approximately 74 percent of health care practitioners and 72 percent of health care support workers felt gratification from their jobs.

- **Skilled nursing, CCRC spending being driven to new heights — moderately: report.** The rapid growth of America’s aging population will cause long-term care spending to continue to climb over the next 10 years, reaffirmed the latest CMS National Health Expenditures report. The NHE report shows that spending on skilled nursing and continuing care retirement communities will grow at an average rate of 5.2 percent per year until 2024. The annual growth rate for 2015 checks in at 4.3 percent, a significant jump from 2.8 percent in 2014 but lower than pre-recession rates. That growth will increase total spending on SNFs and CCRCs to $196 billion in 2018, and $274 billion by 2024, according to the NHE report. By comparison, Medicare beneficiaries spent $160 billion on both SNF and CCRC facilities last year. This year, the figure is set to be $167 billion.

- **Common medications inflate risks for serious falls in older men, study shows.** Older men taking a particular group of commonly used medications have a higher risk of getting injured from a fall, according to a study published in the latest *Journal of the American Geriatrics Society*. Using data from the The Irish Longitudinal Study on Ageing, scientists analyzed the types of medications the participants were taking compared to the types of falls they experienced. They concluded that men over 65 who took medicines with anticholinergic effects, which block the part of the brain that passes messages between nerve cells, were twice as likely to suffer serious falls. Medicines that are commonly prescribed for older people for bladder problems, depression, psychosis, insomnia and respiratory problems have anticholinergic effects, and can cause blurred vision, increased heart rate, sedation and confusion.

- **Popular dementia meds could cause harmful weight loss.** Cholinesterase inhibitors, a class of medications commonly used to treat dementia, could cause older adults to lose a “harmful” amount of weight, new research suggests. University of California – San Francisco researchers compared data from a group of seniors. After 12 months, 29.3 percent of the patients on inhibitors had “significant” weight loss of 10 or more pounds, compared to 22.8 percent of patients on other medications. Weight loss is a common problem in dementia patients, and is often linked with increased mortality, the researchers wrote. “Clinicians should take into account the risk of weight loss when weighing the risks and benefits of prescribing cholinesterase inhibitors in patients with dementia,” the authors wrote. “In addition, clinicians
should monitor for weight loss if these medications are prescribed and consider discontinuing cholinesterase inhibitors if significant weight loss occurs.”

- **Eliminating '3-day stay' rule doesn't increase SNF admissions: study.** Skilled nursing facility admissions don't increase when Medicare Advantage plans waive the three-day stay rule, new research asserts. The study also found SNF lengths of stay don't increase with the rule eliminated. Researchers from Brown University compared hospital and SNF use among Medicare Advantage enrollees in plans that kept the three-day stay requirement against those that did not. The study analyzed data collected between 2006 and 2010. Investigators found that eliminating the three-day requirement resulted in a 10 percent decrease in hospital stay lengths, but had no association with rehospitalizations or SNF admissions, or with longer SNF stays.

- **SNFs can ask for three-month quality reporting reprieve.** Skilled nursing facilities unable to provide data to CMS's new quality reporting program will have a 90-day window to request an exception or extension, officials said during an Open Door Forum call Thursday. Written requests for data submission exceptions or extensions are required to be sent within 90 days of “extraordinary circumstances” occurring that would prevent data submission. The data submission deadline for CMS's recently finalized quality measures is May 15, 2017. The quality measures, announced last week as part of a barrage of policy changes for Medicare SNFs, include skin integrity and changes in skin integrity, changes in functional status and cognitive function and incidence of major falls. Providers who do not provide quality-indicator information by the deadline will face a 2 percent reduction to their fiscal year 2018 market basket payment.

10) **Interesting Fact:** A sneeze generates a wind of 166 km/hr (100 mi/hr), and a cough moves out at 100 km/hr (60 mi/hr).