
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!

Proposed CMS Rulemaking – Part 2

As I mentioned in our last issue, over the next several issues of Regulatory Beat, I will be taking the various sections of the new CMS proposed rulemaking and laying out the major/significant changes. Please remember, I will be doing 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 facility. 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 by no later than 5pm on September 14, 2015. CMS will then be required to 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.

This segment will focus on the New Section Facility Responsibilities (483.11) and Freedom From Abuse, Neglect, and Exploitation (483.12).
D. Facility Responsibilities (483.11) – New Section
This new section focuses on the responsibilities of the LTC facility (that is, protecting the rights of their residents, enhancing a resident’s quality of life, etc.) and brings together many of the facility responsibilities currently dispersed throughout existing regulations. This section parallels many residents’ rights provisions. The LTC facility must recognize each resident’s individuality and provide services in a person-centered manner.

a) Exercise of Rights
1) Restated resident rights in this provision as the responsibility of the facility to recognize and effectuate those rights without interference, coercion, discrimination or reprisal from the facility.

2) The LTC facility must provide equal access to quality care regardless of diagnosis, severity of condition or payment source and establish and maintain identical policies and practices regarding transfer, discharge and the provision of services for all residents regardless of payment source.

3) Restates that the facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or as delegated by the resident, with the condition that the facility could not extend greater authority to the resident representative than is permitted under applicable law.

b) Planning and Implementing Care
1) Ensure and emphasize that the resident is informed of and participates in their treatment to the extent possible and that the resident participates in care planning and making informed decisions.

2) The facility’s IDT team must determine (and document) if resident is able to self-administer their drugs and if the resident can self-administer to take part in other health care practices such as dialysis.

3) Requires that the facility ensures that the care planning process facilitates the inclusion of the resident or resident representative, includes an assessment of the resident’s strengths and needs and incorporates the resident’s personal and cultural preferences in developing goals of care.

c) Attending Physician
1) The LTC facility must ensure that each resident remains informed of the name, specialty and way of contacting their physician and any other primary care professionals responsible for their care.

2) The resident’s physician must be licensed in the state where the care is given and the physician must meet the facility’s professional credentials. If the physician does not meet these requirements, the facility is to assist the resident in finding an alternate physician who does meet the requirements. The facility must honor the resident’s choice if the physician meets the requirements.

d) Self-Determination
1) New provisions that allow for immediate access to the resident by the resident representative, to persons that provide health, social, legal or other services to the resident and to any visitor the resident agrees to see at any time/open visitation. Facility must have written policies and procedures regarding visitation rights of residents.

2) The facility-designated staff person who participates in a resident or family group must be approved by the resident or family group and the facility.

3) Any issues raised by a resident or family group must be responded to by the facility with a rationale for their response.

4) Revised requirements for the protection of resident funds (similar to current state requirements).
5) New requirement that the facility cannot charge for resident hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.

6) New provision that the facility may not charge for special food and meals ordered for a resident by a health care professional (MD, NP, PA, dietician).

7) Foods and meals that a facility generally prepares should be developed taking into consideration residents’ needs and individual preferences in addition to the overall cultural and religious make-up of the facility’s population.

8) Clarification on what a facility can charge for and what they cannot.

e) Information and Communications

1) With the exception of medical records, any other requirements for information must be provided in a way that ensures both resident access and understanding.

2) With regard to medical records, provide resident access to their medical records in a form and format requested by the resident if it is readily producible in such form and format, including electronic format if medical records are maintained electronically, and must they be made available with 24 hours excluding weekends and holidays.

3) Allow individuals access to surveys of the facility and any plans of correction in effect for the preceding three (3) years in a form and manner accessible to and understandable by the resident.

4) New requirement for the facility to post information that would allow individuals to contact pertinent client advocacy groups.

5) New provision to specify that when a facility notifies a physician of a change in a resident’s status, the facility must ensure that certain pertinent information/structured communication is available and is provided to the physician upon request. CMS suggests use of structured communication tools.

6) Added new language that the facility must immediately inform the resident, consult with the resident’s physician and notify the resident’s representative of accidents, significant changes in condition, need to alter treatment and decisions to transfer or discharge.

7) Facility must inform each resident, in writing, at the time of admission to a Medicaid-participating nursing facility and when the resident becomes eligible for Medicaid as to what items/services are provided and what items/services can be charged for and the amount of such charges.

8) Facility must provide notice to residents when changes are made to the items/services covered by Medicare and/or Medicaid or to the amount that the facility charges for items and services.

9) Require that the facility provide the residents with a “list of names, addresses (mailing and email) and telephone numbers of all pertinent state regulatory and informational agencies and resident advocacy groups.”

10) Facility must protect and facilitate a resident’s right to communicate with individuals and entities both inside and external to the facility; including reasonable access to the internet to the extent it is available to the facility.

f) Privacy and Confidentiality

1) Facility must respect the resident’s right to personal privacy.
2) Facility is required to allow ombudsman to examine a resident’s medical, social and administrative records in accordance with state law.

g) Safe Environment
1) Facility must ensure a safe environment and ensure that the physical layout of the facility maximizes independence and does not pose a safety risk.

h) Grievances
1) Facility must establish a grievance policy to ensure the prompt resolution of grievances, and identify a Grievance Officer.

2) Facility must provide a copy of the grievance policy upon request and make information about filing grievances available to residents. Facility must act upon grievances.

3) Facility cannot prevent or discourage a resident from filing a complaint or communicating with federal, state or local officials freely.

E. Freedom From Abuse, Neglect and Exploitation (483.12)
Revised title, formerly “Resident Behavior and Facility Practice.” The proposed updates and revisions to this section are intended to both recognize that abuse continues to occur and to provide language that will build on progress to improve conditions in nursing homes begun by the nursing home reforms of OBRA 87.

a) General

1) Added the newly defined term of “exploitation.”

2) Continue to prohibit the inappropriate use of restraints and note that there are very limited circumstances where restraints would be appropriate in a nursing facility.

3) Add a new provision that expands the employment prohibition to include licensed professionals who have had a disciplinary action taken against them by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of resident property.

4) Facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property.

5) New training requirements on resident rights, facility responsibilities and recognition and reporting of abuse, neglect and exploitation.

6) New requirement that facilities establish policies and procedures to ensure reporting of crimes. The policies and procedures would have to include, at a minimum, annual notification of covered individuals, posting a conspicuous notice of employee rights and prohibiting and preventing retaliation. Reporting of crimes must occur not later than two (2) hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

The next edition of Regulatory Beat will focus on Transitions of Care (483.15) and Resident Assessments (483.20).

MDS Special Focused Surveys
The next round of MDS Focused Surveys has started in Illinois and in all of the other 49 States. CMS decides the number of these special surveys to be conducted in each state and also what facilities will get them. The states have no control over this CMS project. CMS is also very secretive about the content of these surveys and is not
providing any information to help the facilities prepare for these surveys. As we have told you before, based off the pilot MDS surveys completed, the following general guidance is strongly suggested:

- All direct care staff need to know their residents, including their needs, abilities, deficits and general demeanor. Facilities that had a good MDS Pilot Survey knew their residents inside and out.
- Make sure your MDS and medical records are in agreement and that there is documentation to support what was coded on the MDS.
- An RN must conduct/coordinate the MDS assessment.
- Be aware of and in compliance with the time frames for assessments and updates.

Debbie Jackson RN, LNHA, IHCA’s Vice President of Education and Clinical Services, is in communication with and is receiving information from her counterparts in other states based off of MDS Special Surveys conducted in their states. The following is information we have received so far:

- **Click here** for the Entrance Conference Form
- **Click here** for the MDS Worksheet Form
- It is our understanding that the MDS Special Focus Survey surveyors want to look at staffing schedules for the past 18 months – who actually worked and when
- The posted staffing forms must include:
  - At the beginning of each shift, the LTC facility must post the following data:
    - Facility name
    - Current date
    - Resident census
    - The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift – RN, LPN, CNA
  - The data must be posted as follows:
    - Clear and readable format
    - In a prominent place readily accessible to residents and visitors
  - The facility must upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard
  - The facility must maintain the posted daily nurse staffing data for a minimum of 18 months
- CMS has not and will not release any instructions for the MDS Worksheet for provider use until at the time of the actual focused survey
- The facility must complete the Resident Census Sheet (Worksheet #1) that includes:
  - Identifying the residents by:
    - Name
    - Room number and Unit
    - If the resident has any of the following issues within the last 90 days – restraints, falls with major injury, pressure ulcers, urinary catheter, UTI, antipsychotic meds, ext. assist of 2, skilled or LTC
  - Most facilities are keeping track of the data by starting the worksheet in pencil and noting related conditions. Another suggestion is to date an entry so you would know if that pertains to the 90 days. The worksheet would need to be updated on a routine basis.
- What we have learned based off of surveys conducted is that on the MDS Worksheet, CMS wants all payer types and that number should match your census. Every resident will be listed and checked as either skilled or LTC (last two columns).
- Many facilities are tracking the way it used to be done for the 802 (Resident Matrix) – in pencil – updating weekly or more often as needed. Depending on the size of your facility, each facility needs to figure out how they want to gather and keep this data. No one system will work for everyone. The responses do not just come for the MDS alone. In the last 90 days – did any of the residents experience any of these noted issues? Depending upon the timing of an MDS, the info might not be captured.
We have also learned that CMS wants all residents listed, even those in the hospital or on a LOA. You would just mark the conditions if they are applicable.

As more information becomes available, we will pass it on to our members.

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**Trending Statistics**

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

**Partnership to Improve Dementia Care in Nursing Homes Antipsychotic Drug use in Nursing Homes: Trend Update**

The National Partnership to Improve Dementia Care in Nursing Homes is committed to improving the quality of care for individuals with dementia living in nursing homes. The Partnership has a mission to deliver health care that is person-centered, comprehensive and interdisciplinary with a specific focus on protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual's need. The Centers for Medicare & Medicaid Services (CMS) promotes a multidimensional approach that includes; research, partnerships and state-based coalitions, revised surveyor guidance, training for providers and surveyors and public reporting.

CMS is tracking the progress of the Partnership by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome. In 2011Q4 23.9% of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 21.7% to a national prevalence of 18.7% in 2015Q1. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 20%.

A three-quarter measure is posted to the Nursing Home Compare website at [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare). The long-stay measure on Nursing Home Compare, is the exact same measure as follows, except each facility's score is averaged over the last three quarters in order to give consumers information on the past history of each facility.

To view the full article, including the breakdown in several useful charts, [click here](http://www.medicare.gov/nursinghomecompare).

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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 15-49 – NH** - Final Rule: SNF Medicare FY 2016 Payments, Quality Reporting, Value-Based Purchasing and Staffing Data Collection Requirements – Informational Only. Publication of Medicare Program; Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNF) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection: The final rule published on August 4, 2015 implements the new requirements regarding the submission of staffing data to CMS based on payroll and other verifiable and auditable data. The full text document can be found [here](http://www.medicare.gov/nursinghomecompare). Effective July 1, 2016 long term care facilities that participate in Medicare and Medicaid must electronically submit direct care staffing information (including information for agency and contract
staff) based on payroll and other verifiable and auditable data in a uniform format to CMS. Registration began August 4, 2015 for facilities to register for the voluntarily submission period, which begins October 1, 2015.

2) Federal CMS/HHS released several notices/announcements since the last issue of Regulatory Beat that are noted below:

- The annual Medicare Trustees Report estimates program solvency until 2030, unchanged from the last report, but notes continued low cost increases. While recent expenditure increases have been modest, the actuaries expect annual cost hikes of approximately 5 percent going forward. House Energy and Commerce Republicans issued a summary of the report that was not as hopeful as the press release from CMS.

- Approved unanimously by House and Senate, the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act was signed into law by President Obama. The purpose of the law is to advise Medicare beneficiaries when they are in hospitals under "observation" status and inform them of the implications of this status if they are admitted to skilled nursing facilities. Hospitals often keep beneficiaries in observation status, rather than admitting them, which does not allow the beneficiary to qualify for Medicare Part A admission to a SNF because the 72-hour requirement has not been met. This legislation, while not fixing the problem, requires the beneficiary to be notified of their status.

- The opioid crisis is affecting communities across the country. Deaths from drug overdose have risen steadily over the past two decades and have become the leading cause of injury death in the United States. Prescription drugs, especially opioid analgesics—a class of prescription drugs such as hydrocodone, oxycodone, morphine and methadone used to treat both acute and chronic pain—have increasingly been implicated in drug overdose deaths over the last decade. From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled. Deaths related to heroin have also increased sharply since 2010, with a 39 percent increase between 2012 and 2013. Given these alarming trends, it is time for a smart and sustainable response to prevent opioid abuse and overdose and to treat people with opioid use disorder. Combating opioid abuse, dependence, and overdose is a priority for Department of Health and Human Services Secretary Sylvia M. Burwell and the Obama Administration at large. The Secretary’s evidence-based opioid initiative focuses on three targeted areas: informing opioid prescribing practices, increasing the use of naloxone (a drug that reverses the deadly respiratory effects of opioid drug overdose), and expanding the use of medication-assisted treatment to treat opioid use disorder.

- New analysis of data from the 2012 National Health Interview Survey (NHIS) has found that most American adults have experienced some level of pain, from brief to more lasting pain, and from relatively minor to more severe pain. The analysis helps to unravel the complexities of a Nation in pain. It found that an estimated 25.3 million adults (11.2 percent) had pain every day for the preceding three months. Nearly 40 million adults (17.6 percent) experience severe levels of pain. Those with severe pain are also likely to have worse health status. The analysis was funded by the National Institutes of Health’s National Center for Complementary and Integrative Health (NCCIH) and was published in The Journal of Pain. Read more about the report here.

- The next MLN Connects National Provider Call on the National Partnership to Improve Dementia Care and QAPI is September 3, 1:30 to 3:00 Eastern time. During this MLN Connects National Provider Call, two nursing homes will share how they successfully implemented person-centered care approaches and overcame the barriers of cost and staff. Additionally, CMS subject matter experts will update you on the progress of the National Partnership and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations. The National Partnership to Improve Dementia Care in Nursing Homes and QAPI are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care, and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to
reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to ensure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.

Topics to be discussed on the September 3 call are as follows: Person-Centered Care Implementation Success - Hillcrest Health Services and Washington Rehabilitation & Nursing; QAPI, and the National Partnership. The target audience is Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders. Continuing education credit may be awarded for participation in certain MLN Connects Calls. To register for the call, visit MLN Connects® Upcoming Calls. Space may be limited, register early.

3) The Illinois Department of Healthcare and Family Services (HFS) released a couple of notices. They were:
   • HFS IDC-10 Readiness Survey (click here). The purpose of this survey is to determine provider readiness towards ICD-10 Implementation.
   • Per Informational Notice dated June 17, 2015, providers that bill on the HFS 2210 (Medical Equipment/Supplies Invoice); the HFS 2211 (Laboratory/Portable X-Ray Invoice); and the HFS 2212 (Health Agency Invoice) were notified that these claim forms have been revised to accommodate expanded ICD-10 diagnosis coding. Dates of service on or after October 1, 2015 must be billed on the revised forms, which have a revision date of R-2-15 in the bottom left corner of the form. These revised forms may be ordered from the Medical Forms Request page of the department’s website.

4) Two items of interest from the Illinois Department of Public Health. They are:
   • The Illinois Department of Public Health (IDPH) adopted a final rulemaking in the Friday (8-14-15) Illinois Register to the Assisted Living and Shared Housing Establishment Code regulates all aspects of licensure for assisted living and shared housing establishments, including the licensure fees. As of June, 2015, there were 364 licensed establishments in the state, with 20 pending license applications for new establishments. The Department's Division of Assisted Living averages four new license applications per month. The Department’s regulatory responsibility over these facilities includes annual on-site surveys and investigating complaint allegations. Assisted Living establishments continue to outgrow skilled nursing facilities by a two-to-one margin, and with the continued rapid growth of the assisted living industry the Division's current staff of one division chief, six health facilities surveillance nurses and three clerical staff is not enough to meet demand. Doubling the license fees to $2,000, plus $20 per unit for assisted living establishments, and to $1,000 for shared housing establishments, will allow the Department to create two additional survey positions and two clerical positions for the Division, enhancing its ability to protect the health and safety of the State's vulnerable populations. This rule was effective July 31, 2015.
   • CMS is partnering with the state of Illinois to expand upon the work of the 2014 Focused Dementia Care Survey Pilot. CMS invited states to conduct such surveys in FY2015 on a voluntary basis using revised survey tools. The expansion project involves a more intensive, targeted effort to improve surveyor effectiveness in citing poor dementia care and the overutilization of antipsychotic medications than was previously done in FY2014. CMS will provide criteria for determining specific facilities to be surveyed and will work with states to identify dementia care experts to accompany surveyors for the first survey, whenever possible. In partnership with the Illinois State Agency and CMS Regional Office, a focused survey effort has been initiated in Illinois. Illinois will be conducting focused reviews in selected areas of the state. The surveys are expected to be completed by the end of September. In addition, CMS will work with the Illinois State Agency and other stakeholders to discuss key components of the National Partnership to Improve Dementia Care, as well as other quality improvement opportunities for nursing home providers. We look forward to this collaborative effort and appreciate your continued partnership. Click here to view the recent S&C memo relating to this topic.
5) The Kaiser Family Foundation recently published an executive summary regarding, “Nursing Facilities, Staffing, Residents and Facility Deficiencies 2009 Through 2014.” This report provides information on recent trends in nursing facilities in the United States, drawing on data from the federal On-line Survey, Certification, and Reporting system (OSCAR) and Certification and Survey Provider Enhanced Reports (CASPER), to provide information on nursing facility characteristics, resident characteristics, facility staffing, and deficiencies by state from 2009 through 2014. Additional detail on the survey and methods underlying the data in this report are provided in the Appendix at the end of the report. This data enables policymakers and the public to monitor and understand recent changes in nursing facility care in the United States and help highlight areas of ongoing concern for current and future policymaking.

6) PricewaterhouseCoopers LLP recently published an article entitled, “Healthcare Growth Rate Projected to Dip in 2016.” PwC’s Health Research Institute (HRI) projects a medicals cost trend of 6.5 percent, with a projection of 4.5 percent after benefit design changes. Ten years after HRI began issuing projections, challenges remain despite improvements in efficiency and quality that have begun to bend the cost curve. Much of the slowing growth can be attributable to cost shifting. Consumers, who consequently bear more decision-making on health services, are looking for greater value.

7) The federal Centers for Disease Control (CDC) is offering a webinar on CRE and C. Difficile Prevention Efforts. We're at a tipping point -- an increasing number of germs no longer respond to the drugs designed to kill them. Inappropriate prescribing of antibiotics and lack of infection control actions can contribute to drug-resistant infections such as carbapenem-resistant Enterobacteriaceae (CRE) and put patients at risk for deadly diarrhea (caused by Clostridium difficile). Even if one facility is following recommended infection controls, germs can be spread inside of and between health care facilities when patients are transferred from one facility to another without appropriate actions to stop spread. During this call, clinicians will hear from clinical experts on preventing antibiotic-resistant infections and improving antibiotic stewardship. Join the discussion to learn about work being done to implement a coordinated approach to protect patients from these potentially deadly infections. The CDC will offer the webinar on Thursday, Aug. 20, 2015 from 2 p.m. to 3 p.m. Eastern Time. Participants can join by phone; registration not required. Audio required for webinar is as follows: 888-469-1370 (U.S. callers) or 517-308-9046 (international callers). The passcode is 3791890. To join by Webinar: https://www.mymeetings.com/nc/join.php?i=PW5080898&p=3791890&t=c. Materials (slides, audio and transcript) will be posted to the webpage a few days after the live call at: http://emergency.cdc.gov/co/calls/2015/callinfo_082015.asp.

8) ScienceDaily recently published a report from Northwestern University entitled, “Seniors at High Risk for Readmission After Ambulatory Surgery – Medication Errors, Confusion About Post-Surgical Care Lead to Costly Readmission.” Patients 65 and older who have ambulatory surgery are 54 percent more likely to be readmitted to the hospital within 30 days than younger patients, regardless of their health before surgery, reports a large national study. The likely cause, based on previous research, is difficulty understanding medication dosing and discharge instructions, as well as cognitive impairment among older patients. About 9 million ambulatory surgeries annually are performed on patients 65 and older.

9) The Atlantic recently published an article entitled, “The Challenge of Being Transgender in a Nursing Home.” Many elder-care facilities are ill-equipped to deal with the needs of transgender seniors, who fear that a move to assisted living may leave them vulnerable to discrimination and harassment.

10) Medicalxpress recently published an article entitled, “New, Rapid Dementia Screening Tool Rivals ‘Gold Standard’ Clinical Evaluations.” Determining whether or not an individual has dementia and to what degree is a long and laborious process that can take an experienced professional such as a clinician about four to five hours to administer, interpret and score the test results. A leading neuroscientist at Florida Atlantic University has developed a way for a layperson to do this in three to five minutes with results that are comparable to the "gold standard" dementia tests used by clinicians today. The "Quick Dementia Rating System" (QDRS), which uses an evidence-based methodology, validly and reliably differentiates individuals with and without dementia. When dementia is present, it accurately stages the condition to determine if it is very mild, mild, moderate or severe.
QDRS has applications for use in clinical practice, to pre-qualify patients in clinical trials, prevention studies, community surveys and biomarker research.

11) HealthDay recently published an article entitled, “1 in 4 Senior Women in U.S. Has Osteoporosis: CDC.” The weakening bones of osteoporosis greatly raise a person's odds for dangerous fractures, and a new report finds that one-quarter of all American women aged 65 or older suffer from the condition. Close to 6 percent of men in this age group also have osteoporosis, according to the report from the U.S. Centers for Disease Control and Prevention. Experts weren't surprised, and said more must be done to test for and treat the loss of bone density that often comes with age.

12) HealthData Management had a couple of articles of possible interest. They were:
   - “Legislative Support for Telemedicine Growing in Congress.” Sen. Angus King (I-Maine) is among a growing chorus of U.S. senators that has called for greater federal investment in telehealth technologies and regulatory changes that can help improve access to vital healthcare services for people, especially the elderly, in rural states.
   - “10 Strategies for Protecting Patient Data.” With cyber criminals actively targeting healthcare, Rick Kam, president and co-founder of security firm ID Experts, argues that the threats to protected health information have never been greater. He believes there are some critical strategies healthcare organizations can employ for protecting patient information. The best place to start, he notes, is with a risk assessment that serves as an inventory of where an organization’s patient information lies within and outside of the organization. But, 10 other steps are just as necessary.

13) MedlinePlus recently published an article entitled, “Poorly Maintained Plumbing Often Leads to Legionnaires' Disease, CDC Says.” As New York City struggles to contain an outbreak of Legionnaires' disease, two new U.S. government reports show the bacteria that causes the potentially deadly illness can take root in a myriad of water sources. Those sources can include poorly maintained hot tubs, water fountains and cooling towers, the researchers said. "The variety of settings and water sources implicated in the Legionella outbreaks reported here highlights the complexity of Legionella control... particularly in settings where susceptible persons congregate, such as hospitals, long term care facilities, and other health-care settings," Karlyn Beer, of the U.S. Centers for Disease Control and Prevention, and colleagues wrote.

14) PCWorld recently published an article entitled, “Toshiba Rolls Out Activity Trackers for Seniors.” Toshiba is rolling out two activity trackers that can help caregivers monitor seniors remotely. Through an analysis of sensor data, the Silmee W20 and W21 wristbands can help track the amount of time a user spends eating as well as conversing with others. The bands can compile the data into life logs to be shared with caregivers. The sensors on the bands include a skin temperature sensor, a pulse monitor and an ultraviolet light sensor, as well as an accelerometer. An emergency button on the bands can alert caregivers or loved ones. The bands also have Bluetooth connectivity for linking with iOS and Android mobile devices, and lithium-ion batteries that can last about two weeks on a charge. The W21 also features a GPS module for location tracking.

15) McKnight's had several articles of interest. They include:
   - “CDC Releases 2015-2016 Flu Shot Recommendations.” Seniors should be vaccinated for the flu before December, according to new vaccination recommendations from the Centers for Disease Control and Prevention. The influenza season typically peaks between December and February. For adults over the age of 65, the flu vaccine's effectiveness can decline “significantly” in the months following vaccination, the CDC noted. While delaying vaccination may help older adults have greater immunity later in the flu season, the CDC encourages seniors to get vaccinated before the virus begins to circulate in order to avoid “difficulties in vaccinating a population within a more constrained time period.” The 2015-2016 recommendations were released through this week's issue of the CDC's Mortality and Morbidity Weekly Report.
“CMS Extends Enforcement Delay for ‘Two-Midnight’ Rule.” CMS has extended the partial enforcement delay of its controversial “two-midnight” rule, which was set to expire on Sept. 30. The delay will now last until Dec. 31. The Medicare policy requires patients to be hospitalized for two midnights before they qualify as an inpatient, which can allow beneficiaries to qualify for skilled nursing coverage. With the extension, Recovery Audit Contractors cannot conduct post-payment reviews for claims with dates of admission from Oct. 1 through Dec. 31. Quality Improvement Organizations will conduct patient status reviews to determine whether inpatient status is appropriate during that time period. Starting on Jan. 1, the initial status reviews will be handled by QIOs, with Recovery Auditor Contractors conducting follow up reviews upon referral by QIOs.

“CMS Announces Participants in Bundled Payment Pilot Program.” CMS announced last week that 2,100 participants have moved to the contract, risk-bearing period of the agency’s Bundled Payments for Care Improvement pilot program. The initiative, started under the Affordable Care Act, originally had 7,000 providers sign on to review how they would implement bundled payment contracts. The pilot seeks to test bundled payments for 48 different health conditions, including stroke, heart failure or joint replacement. According to CMS, “Phase 2” of the pilot includes 1,071 skilled nursing facilities and 101 home health agencies, among other participants.

“New Guide Seeks To Improve Physicians’ End-Of-Life Conversations.” A new guide has been developed to advise physicians on having end-of-life conversations with patients and their families. The “Serious Illness Conversation Guide” is composed of seven questions that focus on helping patients understand the reality of their medical situation without causing emotional distress. Questions include the patient’s concerns and fears and factors they believe are important to their quality of life. The guide, which was developed through a collaboration between Brigham and Women's Hospital and the Harvard School of Public Health, is in its second year of efficacy trials. After four years of research, experts hope to determine if the guide helps physicians and patients have more conversations about end-of-life care, and if those conversations take place earlier in the patient’s disease progression. Last month, the CMS released a proposal that would reimburse health care practitioners for discussing advanced care planning with patients. CMS is seeking public comments on the proposal, which is part of the 2016 proposed physician fee schedule.

16) Interesting Fact: Currently people over 65 years number 483 million in the world and by 2030 the number will reach 974 million. By the year 2025 approximately 18 percent of the world population will be seniors. There are 72 men for every 100 women in the age group ‘above 65 years’ and there are 45 men per 100 women in the age group ‘above 85 years.’