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 3
As you know, over the past several issues of Regulatory Beat, I have been taking the various sections of the new CMS proposed rulemaking and explaining the major/significant changes. I have been 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. Once you’ve submitted your comments, please just let us know you’ve done your part by completing our survey.

The more comments CMS receives, the more review and changes will be made. The comments are due to CMS by no later than 5 p.m. on September 14, 2015 (That’s Next Monday!!!! Just a few days left to submit comments!!). 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.

This segment will focus on Transitions of Care (483.15) and Resident Assessments (483.20).
F. Transitions of Care (483.15)
The current 483.12 “Admission, Transfer, and Discharge Rights” is now the newly titled “Transitions of Care” in order to reflect current terminology that applies to all instances where the care of a resident is transitioned between care settings. Transitions of Care include admissions to and discharges or transfers to or from a SNF or NF. This section also addresses bed-hold policies and therapeutic leaves.

a) Admissions Policy.
   1) New provision requiring that a facility must establish an admissions policy.

   2) New provision that prohibits facilities from requesting or requiring residents or potential residents to waive any potential facility liability for losses for personal property.

   3) New provision to specify that a nursing facility must disclose and provide to a resident or potential resident, prior to the time of admission, notice of any special characteristics or service limitations of the facility.

b) Transfer and Discharge.
   Facility Requirements
   1) Clarify that a resident could be discharged when the safety of other individuals is endangered due to the clinical or behavioral status of that resident.

   2) Clarify that provisions for discharge as a result of non-payment of facility charges would not apply unless the resident did not submit the necessary paperwork for third party payment or until the third party, including Medicare or Medicaid, denied the claim and the resident refused to pay for their stay.

   3) New provision that a facility may not transfer or discharge a resident while their appeal is pending.

Documentation
   1) Clarify that the transfer or discharge must be documented in the resident’s clinical record and that appropriate information must be communicated to the receiving setting.

   2) New provision that when a facility transfers or discharges a resident because the transfer or discharge is necessary for the resident’s safety or welfare, the facility would include in its documentation the specific resident needs that it cannot meet, facility attempts to meet the resident needs and the service(s) available at the receiving facility that will meet the resident’s needs.

   3) New provision that the transferring facility must provide necessary information to the resident’s receiving provider, whether it be a hospital, psychiatric facility, another LTC facility, hospice, home health agency or other community-based provider. CMS is emphasizing that they believe it is critical that timely and accurate clinical information follow the resident across care settings and providers.

4) CMS is not proposing or requiring the use of a specific form, format or methodology for this communication between providers, but they are proposing specific data elements or a set of information that must be communicated during the transfer process (The American Medical Directors Association has developed and recommends the use of a universal transfer form that meets the federal requirements and is available on their website). By aligning the proposed date elements, CMS believes that facilities will be well positioned to engage in manual and electronic communication of information necessary during the transfer process.

5) CMS is asking for comment with regard to establishing a time frame for this communication. They believe it should be shortly before or as close as possible to the actual time of transfer and the facility must document that this communication occurred. Also questions remain about the amount of information available in an emergency transfer.
**Notice Before Transfer**

1) New provision that the facility send a copy of the notice of transfer or discharge to the State Long-Term Care Ombudsman with the resident’s consent. If resident does not consent, the refusal must be documented in the resident’s medical record.

2) Clarifies that the facility must record the reasons for the transfer or discharge.

**Timing of the Notice**

1) Same as current language

**Contents of Notice**

1) Modify current language by adding the phrase “expected to be” to the requirement stating the notice must contain the location to which the resident is expected to be transferred or discharged.

2) New requirement that the notice include the name, address (mailing and email) and telephone number of the state entity that receives discharge or transfer appeal requests (IDPH) and information on how to obtain an appeal form, how to obtain assistance in completing the form and how to submit the appeal request.

**Changes to the Notice**

1) New requirement that when information in the notice changes, the facility must update the recipients of the notice as soon as practicable of the new information to ensure that residents are aware of and can respond appropriately to discharge information.

**Orientation for Transfer or Discharge**

1) New requirement that the facility must provide to the resident an orientation regarding their transfer or discharge in a form and manner that the resident can understand. The facility must also document this orientation, including the resident’s understanding of the orientation (teach back or other methodology).

**Notice in Advance of Facility Closure**

1) Same as current language

**Room Changes in a Composite Distinct Part**

1) Clarify that room changes in a composite distinct part are subject to the requirements in proposed 483.10(d)(7).

c) **Notice of Bed-Hold Policy and Readmission**

**Notice Before Transfer**

1) New provision that before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies certain things noted in this rule.

2) New requirement that a facility’s notice of its bed-hold policy and readmission must also include information on the facility’s policy for readmission under proposed 483.15(c)(3).

**Bed-Hold Notice Upon Transfer**

1) Clarifies that the facility must provide written notice specifying the duration of the bed-hold.

**Permitting the Resident to Return to the Facility**

1) New requirement that a resident who is hospitalized or placed on therapeutic leave with the expectation of returning to the facility, must be notified in writing by the facility when the facility determines that the
resident cannot be readmitted to the facility, the reason the resident cannot be readmitted to the facility, and the appeal and contact information specified in 483.15 (b)(5)(iv through vii).

Readmission to a Composite Distinct Part
1) Clarify the requirement of a resident being readmitted to a composite distinct part.

G. Resident Assessments 483.20
Resident Assessment Instrument
1) Clarifies that the resident assessment is not merely for the purpose of understanding the resident needs, but also to understand their strengths, goals, life history and preferences.

2) Revise the text from “discharge potential” to read “discharge planning” in an effort to encourage facilities to move the discussion of possible discharge away from a facility’s judgement and towards a resident’s preference and expectation.

Coordination
1) New requirement that clarifies that coordination with PASARR includes incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning and transition of care.

2) New requirement that facilities must refer all level II residents and all residents with newly evident or possible serious mental illness, intellectual disability or a related condition for level II resident review upon a significant change in status assessment.

Preadmission Screening for Individuals with Mental Illness and Individuals with Intellectual Disability
1) New 483.20(k)(2) would add to the regulation the statutory exception for readmission screenings that were inadvertently omitted when the current regulation was initially written.

2) New requirement that requires a nursing facility to notify the state mental health authority or state intellectual disability authority when there has been a significant change in the resident’s physical or mental condition so that a resident review can be conducted.

The next edition of Regulatory Beat will focus on Comprehensive Person-Centered Care Planning (483.21) and Quality of Care and Quality of Life (483.25).

Summary of Fire Situations in Illinois LTC Facilities
In 2006—2010, U.S. fire departments responded to an estimated average of 6,240 structure fires in or on health care properties per year. These fires caused an average of six civilian deaths, 171 civilian injuries and $52.1 million in direct property damage annually. Almost half (46 percent) were at nursing homes, and almost one-quarter (23 percent) were in hospitals or hospices. Cooking equipment was involved in three out of five (61 percent) fires; dryers were involved in 7 percent, 6 percent were intentionally set; another 6 percent were started by smoking materials and heating equipment was also involved in 6 percent. Only 4 percent of these fires spread beyond the room of origin; causes, circumstances and extent of fire spread varied by occupancy.

This 2014 Illinois specific report provides: reported causes of fire; methods of detection; methods of fire extinguishment; distribution of fire by shift; and occurrence of fire by hour.
Summary of Fire Situations

IDPH received 24 fire incident reports for LTC facilities in 2014. During this reporting period, no resident deaths occurred. The severity of fires in nursing homes remain at a minimal level due to IDHP's enforcement of life safety code standards that focus on early detection, extinguishment systems, staff education (fire drills) and effective maintenance programs.

Categories used for graphic purposes:
- Reported causes of fire
- Methods of detection
- Methods of fire extinguishment
- Distribution of fire by shift
- Occurrence of fire by hour
- Reported causes of fire

Major causes of fires were electrical (8 incidents or 33 percent), dryer (8 incidents or 33 percent) and kitchen (4 incidents or 17 percent), Figure 1. The number of arson fires decreased in 2014 from five in 2013 to two. In both arson fires, the residents were identified as the perpetrators. This supports the importance of resident assessment and subsequent planning of care and resident supervision. The reductions in number and severity can also be attributed, in part to, the maintenance of smoke and fire detection systems, fire extinguishment systems, and the practice of fire drills, as part of staff education.

Electrical fires involved primarily electrical outlets and faulty plug-ins on electrical devices. Kitchen-related fires occurred during food preparation. The causes of these fires support the need for continuing staff education and preventative maintenance programs for cooking, laundry, cooling, heating, ventilation and electrical systems.

The most successful means of detection was facility staff (15 incidents or 62 percent), Figure 2 at left. This illustrates the importance of staff education to include properly conducted fire drills. The 2nd most successful means of detection was the fire alarm system (8 incidents or 33 percent). This demonstrates the importance of properly maintaining and testing all components of the fire alarm system.

Staff continues to be an important part of fire extinguishment. Staff members extinguished 17 fires. The fire department extinguished five fires, a resident extinguished one fire and the sprinkler system extinguished one fire (see Figure 3 at right).

The information obtained allows other statistics relating to fires to be evaluated. An often-asked question is related to distribution of fires by shift times, Figure 4 (at left). For report purposes, shifts are presumed to be 1st shift - 7 a.m. to 3 p.m., 2nd shift, 3 p.m. to 11 p.m., 3rd shift, 11 p.m. to 7 a.m. The greatest number of fires (15 incidents or 62 percent) occurred during 2nd shift. The 2nd highest number of fires (5 incidents or 37 percent) occurred during 1st shift. The specific hourly periods of occurrence are shown in Figure 5 (below).
**Trending Statistics**

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

**Older Americans Receive Prescriptions for Mental Health Medications at More than Twice the Rate that Younger Adults Do, a New Study Finds.**

*High use of psychotropic medications in seniors raises possibility of interactions with their other prescriptions.*

But they’re much less likely to be getting their mental health care from a psychiatrist, the results also show.

That raises questions about whether they could be at risk of problems caused by a collision of multiple medications – and about whether primary care doctors may need more support to care for older people with depression, anxiety and other conditions.

The new findings, published in the *Journal of the American Geriatrics Society* by a team from the University of Michigan Medical School and VA Ann Arbor Healthcare System, come from the first study to compare overall outpatient mental health treatment in adults over age 65 with that of patients between ages of 18 and 64.

The authors probed nationally representative outpatient visit data, combined with U.S. Census data, to come up with rates of different types of care.

The worry of previous decades – that America’s seniors weren’t receiving attention for mental health issues – may now need to shift, says Donovan Maust, M.D., M.S., the geriatric psychiatrist who led the analysis.

“Our findings suggest that psychotropic medication use is widespread among older adults in outpatient care, at a far higher rate than among younger patients,” he says. “In many cases, especially for milder depression and anxiety, the safer treatment for older adults who are already taking multiple medications for other conditions might be more therapy-oriented, but very few older adults receive this sort of care.”

The issue of medication use is particularly concerning for older adults, because the risk/benefit balance can shift as they become more likely to experience side effects or other adverse events.
For instance, anti-anxiety benzodiazepine drugs such as Valium, Xanax, Klonopin and Ativan (and their generic counterparts) may be relatively safe for younger adults, but carry a higher risk of car accidents, falls, fractures and worsening of thinking ability or memory for older patients.

Antidepressants can interact with blood thinners and painkillers and can raise blood pressure, all of which are more likely to be problems for older adults, who are generally on more medications than their younger counterparts.

“We need to pay special attention to polypharmacy, or multiple drugs taken at once, when prescribing psychotropic drugs in this population, because so many older adults are already on multiple medications,” says Maust, an assistant professor in the U-M Department of Psychiatry.

He and his colleagues started with information from over 100,000 outpatient visits to outpatient physicians between 2007 and 2010 collected by the National Ambulatory Medical Care Survey, a national survey administered by the National Center for Health Statistics of the Centers for Disease Control and Prevention.

They examined four types of visits: ones where patients received a mental health diagnosis; saw a psychiatrist; received psychotherapy; and/or received a prescription or renewal of a psychotropic medication (including antidepressants, anxiety-calming drugs called anxiolytics, mood stabilizers, antipsychotics, or stimulant drugs).

They converted their results to a population-based visit rate, which helps consider the number of visits out of the eligible pool of potential outpatients in the community.

A comparison of mental-health-related outpatient visit rates (per 100 people per year)

In this light, for example, visits related to antidepressant and anti-anxiety drug use among older adults (63 and 62 visits per 100 people per year, respectively) occurred at nearly double the rates of such visits by younger adults (36 and 29 visits per year per 100 people, respectively). In contrast, older adults see psychiatrists at about half the rate of younger adults (6.3 versus 12 visits per year per 100 people).

“While it’s still true that we have patients who are not getting treated for mental health concerns, these data suggest that we also need to be mindful of the possibility of overtreatment, especially given the changing balance of risk and benefit as patients age,” says Maust. “Collaborative care efforts in primary care that seek to create structure and support for these patients, along with appropriate reimbursement for this type of service, could be key.”

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 15-42 (Revised) – All** - Guidance to State Survey Agencies (SA) Regarding Release of Information and Data to State Medicaid Fraud Control Units (MFCU). “This guidance supersedes the previous guidance issued on June 19, 2015 and new to the memo is a Sample Request Letter attachment.” • CMS has revised this guidance to further clarify policies regarding SA release of data and documents to MFCUs. • State Survey Agencies are reminded of the regulatory requirement to share Automated Survey Processing Environment (ASPEN) Complaint Tracking System (ACTS) data, Long-Term Care Minimum Data Set (MDS) data, and survey documents with their State MFCU upon receipt of a written request.

- **S&C 15-50 – NH** - Revised Quality Indicator Survey (QIS) Training Process and Clarification of Trainer Roles and Responsibilities. CMS has revised the training procedures for State Survey Agencies (SA) and Regional Offices (ROs) utilizing the QIS to eliminate the mock survey and replace it with a survey of record; eliminate the T3.5 process formerly called “The Trainer Instructor Training”; update the compliance process and associated tool used for evaluating surveyors; and clarify the role of Certified Trainers. This revised QIS training protocol does not replace the structured training program each SA and RO is required to have as outlined in Exhibit 42 of the State Operations Manual (SOM).

- **S&C 15-51 – HHA** - Home Health Agencies (HHAs): Change of Address – Notification of the Medicare Administrative Contractor (MAC). State Operations Manual (SOM) Section 2185 “HHA Change of Address”: HHAs must notify their respective MAC of a change of address and the notification time frame in SOM Section 2185 has been revised from 30 days to 90 days to be consistent with the Provider Enrollment regulations at 42 CFR 424.516(e)(2).

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

- Noted below are the CMS Medicare Learning Network guidance documents for Countdown to ICD-10.
  - Access the ICD-10 Code Set
  - List of Valid ICD-10-CM Codes
  - “General Equivalence Mappings Frequently Asked Questions” Booklet — Revised
  - “ICD-10-CM/PCS ICD-10-CM/PCS Myths and Facts” Fact Sheet — Revised
  - “ICD-10-CM Classification Enhancements” Fact Sheet — Revised
  - “ICD-10-CM/PCS The Next Generation of Coding” Fact Sheet — Revised
  - Get Ready Now: Assess How ICD-10 Will Affect Your Practice
  - Prepare for ICD-10 with MLN Connects Videos

- **Staffing Data Submission PBJ.** CMS has long identified staffing as one of the vital components of a nursing home’s ability to provide quality care. Over time, CMS has utilized staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes. Staffing information is also posted on the CMS Nursing Home Compare website, and it is used in the Nursing Home Five Star Quality Rating System to help consumers understand the level and differences of staffing in nursing homes.

  Section 6106 of the Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information, can then be used to not only report on the level of staff in each nursing home, but also to report on employee turnover and tenure, which can impact the quality of care delivered.
Therefore, CMS has developed a system for facilities to submit staffing and census information – Payroll-Based Journal (PBJ). This system will allow staffing and census information to be collected on a regular and more frequent basis than currently collected. It will also be auditable to ensure accuracy. All long term care facilities will have access to this system at no cost to facilities.

CMS intends to collect staffing and census data through the PBJ system on a voluntary basis beginning on October 1, 2015, and on a mandatory basis beginning on July 1, 2016. Registration for voluntary submission will begin in August 2015, and CMS will communicate more information at that time. Training will also be provided on registration and for both voluntary and mandatory submissions.


3) The Illinois Department of Healthcare and Family Services (HFS) released two notices. They were:

- This Notice (http://www.hfs.illinois.gov/assets/082815n.pdf) informs facilities that HFS, in partnership with the federal CMS, is preparing to passively enroll additional beneficiaries into the Illinois Medicare-Medicaid Alignment Initiative (MMAI). Approximately 14,000 beneficiaries living in the Greater Chicago region eligible for MMAI, who have not previously opted-out of the program and have not been auto-enrolled or reassigned into a Medicare Part D plan will begin receiving letters from HFS’ Client Enrollment Broker in mid-August 2015, with MMAI enrollment effective dates of November 1, 2015 and December 1, 2015. To efficiently manage the high volume calls letters will be mailed out over an eight week span.

- This Notice (http://www.hfs.illinois.gov/ltc/) provides an overview of the requirement to submit monthly billing claims for reimbursement purposes pursuant to Public Act 98-0104. This Notice informs long term care facilities of the provision of Public Act 99-0236 allowing the department to delay the implementation of this requirement until July 1, 2016. All current system processing will remain in place until the new system is operational. Future Informational Notices will continue to be released which will explain any necessary operational or structural changes, policies and procedural changes, instruction and training, and Administrative rule revisions.

4) IHCA has been informed that Illinois was chosen to be one of the several states to do a second round of dementia special focus surveys. We are not aware of the number or any other information regarding the surveys and/or the survey process. CMS is being very secretive with this information. We were informed that the surveys are to conclude by the end of September. If any members have one of these surveys, please contact us.

5) Debbie Jackson recently sent out an IHCA Educational Update (click here).

6) Infection Control Today recently published an article entitled, “Early Flu Treatment Reduces Hospitalization Time, Disability Risk in Older People.” Early treatment of flu-hospitalized people 65 and older with flu antiviral medications cuts the duration of their hospital stay and reduces their risk of needing extended care after discharge, a new CDC study finds. The study is the first to look at the benefits of early antiviral treatment on preventing the need for extended care in community-dwelling flu-hospitalized people 65 and older. Because people 65 and older are at high risk of serious flu complications, CDC recommends that they be treated for flu with influenza antiviral medications as early as possible because these drugs work best when started early. The study, published today in the journal Clinical Infectious Diseases, supports this recommendation.

7) Reuters Health recently published an article entitled, “Pilates Linked to Better Balance in Older Women with Back Pain.” Older women with lower back pain who add Pilates to their physical therapy routine may see improvements in balance and reductions in fear of falling that don't result from other types of exercise, a Spanish study suggests.

8) Medical Daily reports that for people with Alzheimer’s disease and dementia, identity is defined more by moral behavior than personality. It is our moral behavior that is the most important indicator of our identity as we
get older and our minds degenerate — more so than memory loss or any other kind of personality change, according to a new study published in Psychological Science. Researchers from the University of Arizona studied 248 participants who had family members suffering from neurodegenerative diseases, including amyotrophic lateral sclerosis (ALS), frontotemporal dementia, and Alzheimer’s. Frontotemporal dementia is a disease that changes frontal lobe function, affecting regions associated with moral behavior — these changes also emerge with Alzheimer’s, but later on in the disease’s progression. ALS, meanwhile, is commonly associated with the loss of motor control.

9) HCPLive recently reported that dementia drugs can be tied to increased mortality risk. Dementia drugs may pose a risk for patient death more than previously understood, according to findings published in JAMA Psychiatry. Researchers from the University of Michigan Health System retrospectively examined about 45,000 patients aged 65 years or older with a diagnosis of dementia in order to determine mortality risk increase among patients using therapy drugs. Patients who received treatment antipsychotic (haloperidol, olanzapine, quetiapine, and risperidone), valproic acid and its derivatives, or an antidepressant between October 1, 1998 and September 30, 2009 were observed. Then, the researchers compared the mortality of these patients with about 45,000 non-medicated participants. They were compared using the antidepressant group as the reference, and the findings were adjusted for age, sex, years with dementia, presence of delirium, and other clinical and demographic characteristics.

10) The National Institute on Aging – Alzheimer’s Disease Education and Referral Center recently released an Alzheimer’s Disease Medications Fact Sheet. Several prescription drugs are currently approved by the U.S. Food and Drug Administration (FDA) to treat people who have been diagnosed with Alzheimer’s disease. Treating the symptoms of Alzheimer’s can provide patients with comfort, dignity, and independence for a longer period of time and can encourage and assist their caregivers as well. It is important to understand that none of these medications stops the disease itself.

11) DailyMail recently published an article entitled, “Are You At Risk of Developing Dementia? Revealed, the 9 Factors that Increase Your Risk of Alzheimer’s…and How You can Reduce Your Risk.” Scientists have discovered that just nine risk factors are to blame for two thirds of cases of Alzheimer’s disease. Most of the factors are avoidable or down to lifestyle, they found, suggesting that people could go a long way to avoiding dementia late in life by adopting healthy practices in their youth. Because there is no cure for Alzheimer’s, the experts say avoiding these risks may be the best way to stave off dementia.

12) The Lancet recently published an article entitled, “Sepsis: A Roadmap for Future Research.” Sepsis is a common and lethal syndrome: although outcomes have improved, mortality remains high. No specific anti-sepsis treatments exist; as such, management of patients relies mainly on early recognition allowing correct therapeutic measures to be started rapidly, including administration of appropriate antibiotics, source control measures when necessary, and resuscitation with intravenous fluids and vasoactive drugs when needed. Although substantial developments have been made in the understanding of the basic pathogenesis of sepsis and the complex interplay of host, pathogen, and environment that affect the incidence and course of the disease, sepsis has stubbornly resisted all efforts to successfully develop and then deploy new and improved treatments. Existing models of clinical research seem increasingly unlikely to produce new therapies that will result in a step change in clinical outcomes. In this Commission, we set out our understanding of the clinical epidemiology and management of sepsis and then ask how the present approaches might be challenged to develop a new roadmap for future research.

13) MedlinePlus had several articles of interest. They include:

- **Seniors Often Underestimate Their Frailty, Study Finds.** Nearly one-quarter had trouble getting out of hospital bed, walking 10 feet and getting back in bed. Many American seniors seen at emergency departments overestimate their mobility, according to a recent study. Researchers asked seniors who visited an ER to get out of bed, walk 10 feet and return to bed. The investigators found that almost one-quarter of these patients inaccurately assessed their ability to complete these tasks. Of those who said they could do the tasks without assistance, 12 percent required some help or were unwilling to complete
the tasks. Of those who said they could do the tasks without a cane or walker, 48 percent required some help or were unable to complete the tasks, the investigators found. Of the seniors who said they could do the tasks with some assistance from another person, 24 percent were unable to do so even with someone helping them, the study revealed.

- **Too Much Weight in Midlife Tied to Earlier Alzheimer’s.** Slimming down might delay dementia, research suggests. Avoiding middle-age spread could be one way to delay the onset of dementia, a new study hints. Researchers found that among 142 elderly adults with Alzheimer’s disease, those who were overweight at age 50 tended to develop the memory-robbing disorder earlier. On average, the study participants were 83 years old when diagnosed with Alzheimer’s. But that age of onset varied according to people’s weight at age 50: For each unit increase in body mass index (BMI), Alzheimer’s set in about seven months earlier, on average. Other studies have found that obesity may boost the risk of developing Alzheimer’s. But this research suggests it also speeds the onset, said senior researcher Dr. Madhav Thambisetty, of the U.S. National Institute on Aging.

- **Many Say Mental Health Care is Vital, But Often Tough to Get.** Survey of U.S. adults finds concerns about accessibility, expense. Although most Americans think mental health care is important, they often believe it’s expensive and hard to get, a new survey shows. In questioning more than 2,000 adults, nearly 90 percent said they place equal value on mental and physical health. But one-third said mental health care is inaccessible. And 40 percent said cost is a barrier to treatment for many people, the survey found. Forty-seven percent of respondents thought they had a mental health condition, but only 38 percent of them had received treatment. Of those who were treated, most thought it was helpful, including 82 percent who got psychotherapy and 78 percent who received medications. The survey also found that 86 percent of participants knew that mental health disorders such as depression are risk factors for suicide. Only 47 percent knew that anxiety disorders also increase suicide risk, according to the survey.

14) *Medicalxpress* recently published an article entitled, “**Growth Hormone Reduces Risk of Osteoporosis Fractures in Older Women.**” For years after it was administered, growth hormone continued to reduce the risk of fractures and helped maintain bone density in postmenopausal women who had osteoporosis, according to a new study published in the Endocrine Society’s *Journal of Clinical Endocrinology & Metabolism*. Osteoporosis is a progressive condition that causes the bones to become weak and more likely to break. More than 10 million American adults have osteoporosis, and 80 percent of the people being treated for the condition nationwide are women, according to the Society’s *Endocrine Facts and Figures Report*. Women are three times more likely to experience an osteoporosis-related bone fracture in their lifetimes than men.

15) *Medical News Today* recently reported that one-third of very elderly Americans’ are on statins without any evidence on need. Statins are being used "without any evidence from testing" among very elderly people in the U.S., with levels of prescribing rising from 8.8 percent in 1999-2000 to 34.1 percent in 2011-2012 for people who have no vascular disease. The oldest age group, over 79 years, have the highest rate of statin use in the U.S., according to the study published in *JAMA Internal Medicine*, but this had not been investigated previously.

16) *McKnight’s* had several interesting articles. They include:
- **Top Spots Missed When Healthcare Workers Use Hand Sanitizer.** More than half of healthcare workers commonly miss parts of their hands when applying hand sanitizer, a new study has found. Researchers investigated 705 clinicians working in their regular shifts who used an alcohol-based hand sanitizer mixed with a fluorescent marker. Workers’ hands were then viewed under a UV lamp to show where the hand sanitizer had been rubbed. Results found that thumbs were the spot most often missed by sanitizer, with only 37.45 percent of clinicians completely covering the area. Fingertips and the back of hands rounded out the top three “missed” areas, with just 44.54 percent and 46.38 percent of the study subjects completely covering the area, respectively. Researchers found that the areas in between fingers were reached more regularly, with 74.75 percent of clinicians covering the area with sanitizer. Palms ranked highest in sanitizer coverage, with 98.87 percent.
• **Structure, Strategy key to Implementing IPMAct Act Standards.** Long term care providers work with four “building blocks” of standards under the Improving Medicare Post-Acute Care Transformation Act, experts said during a McKnight’s Super Tuesday webcast. The IMPACT Act, which was signed into law in October 2014, requires standardized patient assessment data for care coordination, discharge planning and interoperability. Interoperability improves patient safety and service quality, but the journey can be a long road, said Lynn Perrine, MSN, RN, a nursing informaticist at Latana Consulting Group.

• **Illinois Becomes the Sixth State to Allow Cameras in Nursing Home Rooms.** Legislation allowing families to install cameras in nursing home rooms was signed into law by Illinois Gov. Bruce Rauner (R) last week. The [law](#), which will take effect in January, includes specifications for video, audio and still cameras in nursing home rooms. It also requires facilities to obtain consent from roommates when one resident requests having a camera installed in their room. Nursing homes must post signs notifying residents and visitors that rooms may be monitored. Illinois is the sixth state to pass legislation allowing cameras to be installed in nursing home rooms — New Mexico, Oklahoma, Texas, California and Washington have similar laws. Missouri is reportedly considering similar legislation. Maryland has guidelines for facilities that choose to allow residents to install cameras upon request.

• **Seniors Have Higher Risk for Hospital Admission After Outpatient Surgery.** Seniors are more likely to be admitted to a hospital after outpatient surgery due to misunderstanding discharge and medication instructions, a new study shows. Researchers looked at data from more than 53,000 Americans who had outpatient surgeries in 2012. Of those patients, those over age 65 were 54 percent more likely to be readmitted to the hospital within 30 days than those younger than 65. Researchers did not include patients' health before surgery as a factor in the study.

• **GAO Will Investigate Five-Star Rating System.** In a move sure to surprise many providers, the Government Accountability Office will investigate the CMS’s Five-Star Quality Rating System, according to a published report. Notice of the investigation appeared in a [Bloomberg BNA article](#), following a [request](#) first reported by McKnight's from Sens. Robert Casey (D-PA) and Ron Wyden (D-OR). The lawmakers want the government watchdog to investigate the system, which is part of the CMS' Nursing Home Compare web tool. Casey and Wyden’s request for the examination specifically called for the GAO to examine how CMS ensures the data used in the Five-Star system is reliable and timely; if there are meaningful differences between the star levels; and how the number and types of complaints a facility receives align with the rating system. Casey also asked that stakeholders identify what they believe to be the strengths and weaknesses of the system, and for insights into how residents and their families use the Nursing Home Compare web tool.

• **CMS Extends Nursing Home Improvement Initiative.** CMS will extend its initiative to improve care in nursing facilities, the agency announced Thursday. CMS's Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents will provide a new funding opportunity for organizations currently participating in the initiative to test the efficacy of a new payment model. The new payment model aims to improve care and reduce hospitalizations by funding higher-intensity interventions for nursing home residents who may otherwise be hospitalized for acute changes in their condition. The model also includes payments to physicians, nurse practitioners and physician assistants similar to payments they would receive treating patients in a hospital. The new payment phase of the initiative is slated to begin in October 2016, and last four years. The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents is [now in its third year](#), and includes 144 nursing facilities in Alabama, Indiana, Missouri, Nebraska, New York and Nevada.

• **SNF Cost-Comparison Report: Occupancy Rates Down, Cash-On-Hand Increases.** A decline in occupancy rates and an increase in days cash-on-hand are among the findings included in CliftonLarsonAllen’s sweeping [Skilled Nursing Facility Cost Comparison Report](#). Skilled nursing facilities saw a decrease in occupancy rates from 91.9 percent in 2010 to 90.4 percent in 2014, according to the report, released last
Thursday. This decrease could be traced to shorter stays, use of SNF alternatives like home and community services and changes in hospital referral patterns, the report’s authors wrote. Days cash-on-hand, which refers to a facility’s liquidity, increased from 36.2 days in 2010 to 45.7 days in 2014, a modest boost that could be the result of increases in operating margins. Between 2010 and 2014, total earnings before interest, taxes, depreciation, and amortization increased from 6.2 percent to 6.4 percent, the report found.

17) **Interesting Fact:** The odds of having a medical emergency on a particular airline flight are about 1 in 600. The good news for passengers is that a doctor was on the plane in 45 percent of the cases of an in-flight medical emergency.