Three Important CMS Survey and Certification (S&C) Letters Released

1) EXIT CONFERENCE

On March 11, 2016, the Centers for Medicare and Medicaid Services (CMS) released Survey and Certification (S&C) Letter 16-11 - Exit Conferences – Sharing Specific Regulatory References and Tags, clarifying guidance to surveyors with respect to procedures for conducting the exit conference in review of compliance with the federal Medicare/Medicaid program requirements. This S&C letter details the degree of specificity surveyors should give during the Exit Conference to Medicare/Medicaid providers regarding deficiencies found during the conduct of a federal survey. LTC providers need to be aware of these requirements and their rights during an exit conference.

The surveyors are to conduct an exit conference (“an exit”) with the entity’s administrator, designee, and other invited staff. The purpose of the exit conference is to informally communicate preliminary survey team findings and provide an opportunity for the interchange of information, especially if there are differences of opinion. Although it is CMS’s general policy to conduct an exit conference as a courtesy to the provider and to promote timely remediation of quality of care or safety problems, be aware of situations that would justify refusal to continue an exit conference. For example:

- If the provider is represented by counsel (all participants in the exit conference should identify themselves), surveyors may refuse to continue the conference if the entity’s attorney attempts to turn it into an evidentiary hearing; or

- Any time the provider creates an environment that is hostile, overly intimidating or inconsistent with the informal and preliminary nature of an exit conference, surveyors may refuse to conduct or continue the conference.

Additionally, as discussed in §2714 of the State Operations Manual (SOM), if the LTC provider wishes to audio tape the conference, it must inform the surveyors prior to the exit conference and tape the entire meeting and provide the surveyors with a copy of the tape at the conclusion of the conference. Videotaping is also permitted if it is not disruptive to the conference, if a copy is provided at the conclusion of the conference. It is at the sole discretion of the surveyor(s) to determine if videotaping is permitted.

As stated above, the findings or information conveyed at the exit conference are preliminary in nature and are subject to change pursuant to the state and CMS supervisory review processes. If the provider asks for the specific regulatory basis or the specific tag code, the surveyors should generally provide this information, but must always caution the facility that such coding classifications are preliminary and are provided only to help the provider gain
more insight into the issues through the interpretive guidance. If the facility does not specifically ask for the regulatory basis or tag, the survey team may use its own judgment in determining whether this additional information would provide additional insight for the facility.

However, if the survey team is still deliberating which tags will be most pertinent, the survey team is not to speculate at the exit conference as to the specific tag coding that will be applied. In these cases, the survey team should describe the general area of non-compliance without identifying a specific tag code. This is a judgment to be made by the survey team onsite, so in preparation for the exit conference the team should deliberate as to the degree of detail that will be appropriate. This is a survey-specific decision based on the evidence gathered.

Please be aware, that under no circumstances, would the surveyors provide the scope and severity of a given deficiency finding (unless it is an immediate jeopardy), as such finer degree of possible detail should await supervisory review. Instead, survey teams may describe the general seriousness (e.g., harm) or urgency that, in the preliminary view of the survey team, a particular deficiency may pose to the well-being of residents. If a provider asks whether the noncompliance is isolated, pattern, or widespread, the surveyor should respond with the facts (i.e., noncompliance was found affecting X number of residents). The survey team is prohibited from leaving draft CMS-2567 forms onsite after the survey.

Surveyors should present their findings but refrain from arguing with the provider. The surveyors should be mindful that providers are likely to react defensively to surveyor findings. The provider has a right to disagree with the findings and present arguments to refute them. Surveyors should be receptive to such disagreements. If the provider presents information to negate any of the findings, surveyors should indicate their willingness to reevaluate the findings before leaving the facility. The survey team’s reasonableness is to demonstrate their fairness and professionalism. The degree of receptivity displayed by providers during the exit conference often depends upon the attitudes and survey style of the survey team.

When the exit conference has concluded, the survey team leader should explain the remaining process to the provider. The survey team leader should inform the provider that the state and/or RO will send a formal statement of deficiencies to the facility after supervisory review. They should explain the due date for submitting a PoC and how the rest of the certification process works. If the survey team has identified an immediate and serious threat to patient health and safety, they are to explain the significance of that finding and the need for immediate corrective action. In this or any other instance when adverse action is anticipated, they should explain the implications. They should also make it clear that only compliance will stop the adverse action.

If problems develop during the exit conference, contact the survey team’s Field Supervisor or the Regional Supervisor (before the exit is concluded) to discuss the situation and seek a resolution.

2) PAYROLL-BASED JOURNAL (PBJ)

On March 18, 2016, CMS released Survey and Certification (S&C) Letter 16-13 - Payroll-Based Journal (PBJ) – Implementation of Required Electronic Submission of Staffing Data for Long-Term Care (LTC) Facilities regarding the mandate for LTC facilities to electronically submit staffing data effective July 1, 2016. CMS believes the PBJ will bring consistency, transparency and validation to the facility staffing data.

In August of 2015, CMS finalized a rule implementing Section 6106 of the Affordable Care Act. The rule mandates submission of staffing information based on payroll data in a uniform format. LTC facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.
CMS wants to remind LTC providers that:

- The voluntary submission period ends June 30, 2016, and the mandatory submission period begins July 1, 2016.

- Instructions are available on how to register and where to find instructions to submit data.

- The posting of the revised and final PBJ policy manual and related information is located here.

- The Centers for Medicare & Medicaid Services (CMS) may use its enforcement authority for noncompliance with the requirement to submit data.

The materials on the PBJ webpage provides information such as the timing of submissions, sample entry screens, and how CMS expects facilities to electronically submit their staffing data, whether through an uploaded file (e.g., from a payroll system) or through manual entry.

The PBJ is a new system and will be used by CMS to electronically collect:

- Employee tenure information;
- Direct care hours worked – including agency and contractor hours;
- Census data.

Failure to submit or reporting inaccurate data can be costly, potentially leading to citation and civil money penalties. The information will also be used on CMS’s Nursing Home Compare and it is also expected to be used in the Five-Star Quality Ratings starting in 2018.

The PBJ data will be reported electronically on a quarterly basis; reported using the Payroll-Based Journal QIES system; will account for all direct care hours – including contractor and agency – for each day of the year; and include employee tenure information. Also note that current staffing reporting practices will still remain in place even after the July 1, 2016 start date.

With regard to the data to be submitted:

- Tenure data – hire and termination date;
- Direct care hours worked – per employee per day;
- Census information – last day of each month.

CMS defines direct care staff as those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental and psychosocial well-being. Direct care does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping, maintenance workers).

What hours count, and what don’t?

- LTC facilities must submit the number of hours each staff member (including agency and contract staff) is paid to deliver services for each day worked;
- Do not count hours paid for any type of leave or non-work related absence from the facility, including paid meal breaks, training, etc.;
- Do not count any unpaid hours (for example, if a salaried employee works 10 hours but is only paid for 8 hours, only 8 hours should be submitted);
- Do not count hours for services to residents in non-certified beds (licensed only, assisted living, shelter care);
- Do not count hours for services performed that are billed to FFS Medicare or other payer;
If employees perform different roles throughout their day, the facility must have a system of record (e.g. time clock) to account for time worked in different positions;

Hours are to be recorded for each individual day. So, if you have workers whose shift covers both sides of midnight, the hours have to be reported separately for each day.

**ARE YOU PREPARED FOR PBJ?** Don’t miss the PBJ article in the Spring/Summer issue of *LTC Today!* Look for this issue in your mailbox next month.

**3) SURVEYOR GUIDANCE REVISIONS RELATED TO PSYCHOSOCIAL HARM IN NURSING HOMES**

On March 25, 2016, CMS published Survey and Certification Letter 16-15 – *State Operations Manual (SOM) Surveyor Guidance Revisions Related to Psychosocial Harm in Nursing Homes*. It is very important that LTC providers review this new guidance because the surveyors will be using it to review the psychosocial outcomes of your facility. You need to be aware of what requirements IDPH or federal surveyors will be reviewing/surveying you against so that you are prepared and prevent any possible deficiencies in this area. Attached to the S&C Letter is the SOM revisions that you need to review and train your staff to understand and implement.

In 2006, CMS issued the Psychosocial Outcome Severity Guide in Appendix P of the SOM. The guide provided instructions, definitions and criteria to help surveyors determine the correct levels of negative psychosocial outcomes that developed, continued or worsened because of a facility’s noncompliance. While surveyors currently cite instances of psychosocial harm, CMS believes these revisions will help guide surveyors to identify psychosocial harm or potential harm. The revisions also support activities or actions to improve resident safety and increase quality and reliability of care for better outcomes.

**Psychosocial Harm Revisions**

The CMS has revised guidance at F329 in Appendix PP. Revisions include:
- Removing medication tables to make F329 easier to use.
- Replacing medication tables with up-to-date medication resources.
- Revising Deficiency Categorization examples to show that noncompliance at F329 can cause significant psychosocial harm.

The CMS requested feedback from surveyors about the medication tables. While the tables contain useful information, they have not been routinely updated and CMS determined that providing up-to-date medication resources would be more helpful to surveyors. The new resources provide information on use, side effects, adverse consequences, drug classifications and interactions. Additionally, some of the current deficiency categorization examples show a combination of psychosocial and physical harm. The revised examples show how surveyors may cite F329 when psychosocial harm alone occurs.

The CMS has also added language to other F tags listed below. While surveyors may find negative psychosocial outcomes related to any regulations, these areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome:

- F221/222
- F223/224/225/226
- F241
- F242
- F246
- F248
- F250
- F310
- F320
- F353

The new language in each tag emphasizes the risk of psychosocial harm associated with noncompliance at specific regulations and refers surveyors to the Psychosocial Outcome Severity Guide.
Lastly, language has been added to the Psychosocial Outcome Severity Guide in Appendix P to reference F tags where residents may be more at risk for actual or potential psychosocial harm.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum. The contents of this letter support activities or actions to improve resident safety and increase quality and reliability of care for better outcomes.

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**Trending Statistics**

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

**OSHA’s Severe Injury Reporting Program – Year One Report**

Every year, tens of thousands of men and women across the United States are severely injured on the job, sometimes with permanent consequences to themselves and their families. But until last year, the Occupational Safety and Health Administration (OSHA) lacked timely information about where and how most of those injuries were occurring, limiting how effectively the agency could respond. Too often, we would investigate a fatal injury only to find a history of serious injuries at the same workplace. Each of those injuries was a wake-up call for safety that went unheeded.

Now, under a requirement that took effect January 1, 2015, employers must report to OSHA within 24 hours any work-related amputation, in-patient hospitalization or loss of eye. (The requirement to report a fatality within 8 hours was unchanged.) Injuries may be reported directly to an OSHA field office, to the OSHA toll-free number, or via an online form; details are available at [www.osha.gov/report.html](http://www.osha.gov/report.html). OSHA instituted the new reporting requirements to:

1. Enable the agency to better target our compliance assistance and enforcement efforts to places where workers are at greatest risk, and;
2. Engage more high-hazard employers in identifying and eliminating serious hazards.

Experience in the field and data from more than 10,000 reports of severe injuries tell us that both goals are being met. We are confident that the events triggered by these reports have eliminated the potential for many more thousands of injuries in U.S. workplaces.

**The 2015 experience**

In the first full year of the reporting program, employers notified OSHA of 10,388 incidents involving severe work-related injuries, including 7,636 hospitalizations and 2,644 amputations.

The reports were from federal OSHA states only and do not include injuries from states that administer their own safety and health programs. Even so, the numbers amount to 30 work-related severe injuries a day — evidence that, despite
decades of progress, many U.S. worksites remain hazardous to workers.

Injury reports were filed from towns and cities across the country, by businesses large and small: A pharmaceutical lab in New Jersey, a supermarket in Florida, a boat builder in Connecticut, and an erosion control firm in Pennsylvania were among the broad range of affected workplaces.

For a breakdown of hospitalization and amputation reports by industry, please see the figures to the right. The 25 industry groups reporting the largest number of severe injuries can be found in Table One. A complete list of injury reports by industry is available at https://www.osha.gov/injuryreport/2015_by_industry.pdf.

Most of the hazards that led to these severe injuries are well-understood and easily prevented. They also account for a majority of work-related fatal injuries. And we know that, in most cases, employers can abate them in straightforward, cost-effective ways, such as by providing fall protection equipment, installing guarding over dangerous machinery, or clearly marking pathways.

Click here to view the Year One Report in its entirety.

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

1) **RN Licensing:** or those RNs out there, remember that your licenses are due for renewal by **May 31, 2016**. The state is not sending notices anymore, so you’ll need to renew on your own through IDFPR. They recently announced implementation of electronic renewals for professions licensed and regulated by the Divisions of Real Estate and Professional Regulation. License renewals can be completed online via the agency website ([click here](#)). Proof of licensure can be found at the License Lookup page. And if you want to be reminded electronically, just visit the online address change site to provide a current email address and contact information.

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

   - **S&C 16-11 – All** - Exit Conferences-Sharing Specific Regulatory References or Tags - Advance Guidance – Procedures for Conducting the Exit Conference. See the first article in this issue for more information.
• **S&C 16-13 – NH** - Payroll-Based Journal (PBJ) - Implementation of required electronic submission of Staffing Data for Long Term Care (LTC) Facilities. See the first article in this issue for more information.

• **S&C 16-14 – NH** - Release of 2015 Nursing Home Data Compendium - The 11th edition of the CMS Nursing Home Data Compendium contains figures and tables presenting data on all Medicare and Medicaid-certified nursing homes in the United States as well as the residents in these nursing homes. A series of graphs and maps highlights some of the most interesting data, while detailed data are available in accompanying tables. The data compendium is divided into three sections. Section 1 presents information on nursing home characteristics; Section 2 focuses on nursing home survey results; and Section 3 presents information on the demographic, functional and clinical characteristics of nursing home residents. The data compendium presents five years of nursing home survey outcomes for the more than 15,000 nursing homes participating in Medicaid and Medicare, and four years of data on the more than 1.4 million residents who reside in nursing homes each day. To access the compendium: click here.

• **S&C 16-15 – NH** - State Operations Manual (SOM) Surveyor Guidance Revisions Related to Psychosocial Harm in Nursing Homes - F329 Draft Revision. See the first article of this issue for more information.

• **S&C 16-16 – CLIA** - Guidance for the Deployment of the Emergency Use Approval (EUA) Zika Virus Tests - Deployment of the EUA Zika Virus Tests. CMS is providing guidance regarding the deployment of the EUA Zika Virus Tests, approved by the Clinical Laboratory Improvement Amendments (CLIA), to state and local Public Health Laboratories (PHLs) by the Centers for Disease Control and Prevention (CDC). Two Zika virus tests with corresponding protocols have been developed by the CDC for use by State PHLs and have received EUA by the FDA.

• **S&C 16-17 – NH** - Affordable Care Act Section 6103: Guidance for State Consumer Oriented Websites - Update to Survey and Certification Letter 11-41-NHs. CMS has provided a list of key elements for state website development for states to qualify for federal funding. The costs for development of the websites and operation are allowable expenses for reimbursement through a combination of Medicaid, Medicare survey and certification and state-only funds under standard cost-allocation procedures. Effective March 23, 2010, states must maintain consumer-oriented websites providing information regarding all skilled nursing facilities and nursing facilities within in their state. State websites are expected to be completed and be accessible to consumers as soon as possible, but not later than January 1, 2018.

3) Federal HHS/CMS released several notices/announcements since the last issue of Regulatory Beat:

• National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open — Thursday, April 28 from 1:30 to 3 p.m. ET. To Register: Visit MLN Connects Event Registration. Space may be limited, register early. This call focuses on infection control, highlighting Antibiotic Stewardship and community-wide efforts, including a presentation from a nursing home administrator. Common concerns related to the clash between individualized, person-centered care and the medical model of controlling infections will also be addressed. This is critical for residents with dementia, who often struggle to complete complex tasks and may have issues with continence. Additionally, CMS subject matter experts will share information about the upcoming Infection Control Pilot Project, as well as updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations.
CMS Launches New Effort to Improve Care for Nursing Facility Residents. On March 24, CMS announced it will test whether a new payment model for nursing facilities and practitioners will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents. This next phase of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents seeks to reduce avoidable hospitalizations among beneficiaries eligible for Medicare and/or Medicaid by providing new payments to practitioners for engagement in multidisciplinary care planning activities. In addition, the participating skilled nursing facilities will receive payment to provide additional treatment for common medical conditions that often lead to avoidable hospitalizations. This new four-year payment phase of the Initiative, slated to begin fall 2016, will be implemented through cooperative agreements with six Enhanced Care and Coordination Providers. See full text of this excerpted CMS press release (issued March 24).

2016 CDC Guideline for Prescribing Opioids for Chronic Pain. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse or overdose from these drugs. CDC developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

On Wednesday (3-30-16), the U.S. Department of Justice (DOJ) and the U.S. Department of Health and Human Services Administration on Aging and Office of Inspector General (OIG), along with the National Association of Medicaid Fraud Control Units (NAMFCU) and National Adult Protective Services Association (NAPSA) announced the launch of 10 regional Elder Justice Task Forces in the Northern District of CA, Northern District of GA, District of KS, Western District of KY, Northern District of IO, District of MD, Southern District of OH, Eastern District of PA, Middle District of TN and the Western District of WA. These task forces will “[coordinate] and [enhance] efforts [among federal, state and local prosecutors, law enforcement, and various other agencies] to identify and bring to justice nursing homes that provide grossly substandard care to their residents.” AHCA/NCAL has responded to the press with this statement, expressing concern with the overstatements in both the press release and the statement from DOJ, Assistant Attorney General Benjamin C. Mizer. Additionally, AHCA/NCAL staff are meeting with federal officials for an in depth briefing on the new effort. We will continue to keep you informed.

The Medicare Learning Network (MLN) recently posted the National Provider Call Schedule for the remainder of the current year for the National Partnership to Improve Dementia Care in Nursing Homes. The dates are: April 28; September 15; and December 6, 2016. All of the calls are scheduled for 1:30 p.m. to 3:00 p.m. Eastern time (12:30 - 2:00 p.m. CST). Participants need to register for these calls at http://www.eventsvc.com/blhtechtechnologies.

4) The Illinois Department of Healthcare and Family Services (HFS) released the following Provider Notices:

- The Illinois Department of Healthcare and Family Services has posted a new Preferred Drug List (PDL) for Medicaid. You can view the PDL here.

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice for enrolled ambulance providers regarding prior approval for non-emergency specialty care transportation.

5) The latest Telligen events/announcements can be found at https://www.telligenqinqio.com/.
6) The Agency for Healthcare Research and Quality (AHRQ) released:

- The **New AHRQ Chartbook Shows 17 Percent Decline in Hospital-Acquired Conditions**. Patient safety in hospitals nationwide continued to improve from 2010 to 2014, as the overall rate of hospital-acquired conditions (HACs) declined by 17 percent, according to the 2015 National Healthcare Quality and Disparities Report's **Chartbook on Patient Safety**. Examples of HACs include surgical site infections, adverse drug events, pressure ulcers and catheter-associated urinary tract and vascular infections. The overall HAC rate declined from 145 per 1,000 hospital stays in 2010 to 121 per 1,000 stays in 2013, remaining at that lower rate in 2014. Approximately 2.1 million harmful events were avoided from 2010 to 2014, saving an estimated 87,000 lives and $20 billion in healthcare costs. Among patient safety measures with trend data available from 2001-2002 through 2013, more than 60 percent showed improvement over time. However, for about one-third of patient safety measures, high-income households received better care than poor households, or whites received better care than some minority groups. The chartbook provides a summary of trends across patient safety measures and a data query tool to access data tables. Also available is a **PowerPoint version of the chartbook** that can be used for presentations. For more information on AHRQ’s patient safety resources, click [here](#).

- **Data Submission Open for AHRQ Nursing Home Survey** - Nursing Homes that have administered AHRQ’s Nursing Home Survey on Patient Safety Culture can submit their data to the Comparative Database April 1-21, 2016. Once submitted to the database, these nursing homes will receive individual and health system feedback reports comparing their results to the overall comparative results. Nursing Homes must be in the U.S. or U.S. territories in order to submit. To submit data, please [click here](#). The results of this database, a Nursing Home Comparative Database Report, will provide average scores and percentiles on the survey items and composites. Nursing homes will be able to assess their own results to identify strengths and opportunities for improvement. Comparative results are reported in the aggregate and do not include any information identifying participating nursing homes.

7) **MedPage Today** published an article entitled, “**Fast-Acting Opioids Get New Boxed Warning – FDA Strengthens Risk Labeling for Drugs Such as Vicodin**.” The FDA is updating the labels on immediate-release opioids like Vicodin with new boxed warnings, and an indication for use only in the most severe pain, the agency announced. The agency is also updating label safety information on both immediate-release (IR) and extended-release/long-acting (ER/LA) opioids about the risk of drug interactions that can lead to serotonin syndrome, as well as effects on the endocrine system, including adrenal insufficiency, and on decreased sex hormone levels. The updated label won't have specific information on limits regarding dose or duration of use. Though the press release mentioned changes to dosing information -- including initial dosage and changes during therapy -- Sharon Hertz, MD, director of FDA Center for Drug Evaluation and Research's (CDER) anesthesia and analgesic drugs division, told reporters on a conference call that there are no specific recommendations, and this labeling will depend on the product.

8) **Medline Plus** published several article of interest:

- **Kidney Dialysis Might Not Extend Survival of Elderly** – Study suggests conservative care may be suitable for some patients over 80. Dialysis does not significantly improve survival for elderly kidney failure patients, a new study indicates. The findings suggest that conservative care may be a reasonable option for some kidney failure patients over 80. The researchers don't say that dialysis treatment should not be given to anybody older than 80 or with severe co-occurring conditions. "But we show that the treatment is on average of little advantage regarding survival," said study co-leader Dr. Wouter Verberne of St. Antonius Hospital in Nieuwegein, the Netherlands. The findings were
published online March 17 in the *Clinical Journal of the American Society of Nephrology*.

- **1 in 6 Seniors Takes Dangerous Combos of Meds, Supplements** – Researchers say patients should tell doctors every treatment they are taking. More seniors than ever are taking supplements alongside their medications, a practice that puts them at risk for dangerous drug interactions, researchers report. More than 15 percent of older Americans took potentially life-threatening combinations of prescription medications, over-the-counter drugs and dietary supplements in 2011, the study showed. That was almost a twofold increase from 2005, when 8.4 percent of seniors did so. To be on the safe side, patients should always tell their doctor and pharmacist about all of the drugs and supplements they are taking, or plan to take, including over-the-counter medications, she said.

- **Exercise May Keep Your Brain 10 Years Younger** – Physically active seniors stayed mentally sharper than their sedentary peers. Older adults who exercise regularly could buy an extra decade of good brain functioning, a new study suggests. The study found that seniors who got moderate to intense exercise retained more of their mental skills over the next five years, versus older adults who got light exercise or none at all. On average, those less-active seniors showed an extra 10 years of “brain aging,” the researchers said.

- **World’s Senior Population Forecast to Boom by 2050** – Public health challenges will mount with 1.6 billion people worldwide age 65 or older. The percentage of the world's population aged 65 and older is expected to double by 2050, a new report says. People who are 65 and older now make up 8.5 percent of people (617 million) worldwide. By 2050, they are expected to represent nearly 17 percent (1.6 billion), according to the U.S. Census Bureau report commissioned by the U.S. National Institute on Aging (NIA). Over that time, the number of Americans 65 and older is projected to grow from 48 million to 88 million. Worldwide, life expectancy is expected to rise from 68.6 years in 2015 to 76.2 years in 2050. The number of people 80 and older is forecast to more than triple, from 126.5 million to 446.6 million worldwide, while their ranks in some Asian and Latin American countries could quadruple.

- **Antipsychotics Don’t Ease Delirium In Hospitalized Patients** – These drugs won’t prevent or effectively treat the condition. Antipsychotic medications, such as haloperidol (Haldol) or clozapine (Clozaril), aren't appropriate for preventing or routinely treating delirium in hospitalized patients, a new study suggests. The researchers reviewed past studies and found that antipsychotic drugs given before surgery didn't prevent delirium. These drugs also didn't make any difference in the course of delirium in medical or surgical patients, the study authors said. "The American Geriatrics Society guidelines suggest avoiding using these medications as a part of routine care of a patient with delirium," said lead researcher Dr. Karin Neufeld, clinical director of psychiatry at Johns Hopkins Bayview Medical Center in Baltimore.

9) **Medical News Today** published a couple articles of interest:

- **Implantable Capsule Shows Promise for Alzheimer’s Prevention**. There is currently no way to prevent or slow Alzheimer's disease, but a new study details the creation of an implantable capsule that researchers say could stop the condition in its tracks. In the journal *Brain*, researchers from the École Polytechnique Fédérale de Lausanne (EPFL) in Switzerland reveal how, when implanted under the skin, the capsule releases antibodies that travel to the brain and trigger the patient’s immune system to clear beta-amyloid protein. Beta-amyloid protein is believed to be a key player in the development of *Alzheimer’s disease*. The protein clumps together in the brain, forming plaques that accumulate in the spaces between nerve cells, which researchers suggest interfere with the processes these cells need to survive.
• **For Older Adults with Dementia, Transitions in Care Can Increase Risk for Serious Problems.** A transition is a physical move from one location to another with a stay of at least one night. For older adults, especially those with dementia, some transitions may be unavoidable and necessary. However, unnecessary transitions are linked to problems such as medication errors, hospital readmissions and increased risk of death. What's more, good dementia care emphasizes the need for familiar people and environments, and this can be more difficult to support when too many transitions take place. Having coordinated care and a long-term care plan in place that considers the needs of a person with dementia may reduce unnecessary transitions, say the authors of a study published in the *Journal of the American Geriatrics Society.*

10) **The Chicago Tribune** reports, **Almost All Doctors Routinely Overprescribe Pain Pills.** Ninety-nine percent of primary care doctors routinely prescribe potentially addictive opioid painkillers for longer than the three-day period recommended by the **Centers for Disease Control and Prevention,** according to survey results released Thursday by the National Safety Council. The Itasca-based nonprofit also found that doctors routinely prescribe the drugs for unsuitable conditions, such as lower back and dental pain, and that they often overlook nonaddictive medications some research has shown to be more effective. "Studies have shown that once we get beyond seven days of these opiate prescriptions for acute pain, the outcomes become much worse," said Dr. Donald Teate, the group's medical adviser. "... They get on these for a long time and have a hard time getting off them." The CDC last week announced new guidelines meant to curb the proliferation of opioid prescriptions, which have quadrupled since 1999. Some experts say that has contributed to a sharp spike in addiction — both to pain pills and the street opioid heroin — along with overdose deaths related to the medications, which approached 19,000 in 2014.

11) **Medscape** reports **Number of Elderly at Risk for Major Drug-Drug Event Doubles.** The proportion of elderly patients concurrently using five or more prescription medications increased from 30.6 percent to 35.8 percent between 2005-2006 and 2010-2011, new data show. Results of a study published online March 21 in *JAMA Internal Medicine* also show the use of five or more medications or supplements of any type among those aged 62 to 85 years increased from 53.4 percent to 67.1 percent during the same period. Moreover, 15.1 percent (95 percent confidence interval [CI], 13.2 percent - 17.1 percent ) of older adults were using medication combinations with the potential for a major drug–drug interaction in 2010 to 2011, up from an estimated 8.4 percent (95 percent CI, 7.2% - 9.8 percent) in 2005 to 2006 (P < .001), according to the study by Dima M. Qato, PharmD, MPH, PhD, from the Department of Pharmacy Systems, Outcomes, and Policy at University of Illinois at Chicago, and colleagues. "These findings suggest that the unsafe use of multiple medications among older adults is a growing public health problem. Therefore, health care professionals should carefully consider the adverse effects of commonly used prescription and nonprescription medication combinations when treating older adults and counsel patients about these risks," the authors conclude.

12) **Medicalxpress** published an article entitled, **Antipsychotic Drugs Linked to Increased Mortality Among Parkinson’s Disease Patients.** At least half of Parkinson's disease patients experience psychosis at some point during the course of their illness, and physicians commonly prescribe antipsychotic drugs, such as quetiapine, to treat the condition. However, a new study by researchers at the Perelman School of Medicine at the University of Pennsylvania, the University of Michigan Medical School, and the Philadelphia and Ann Arbor Veterans Affairs (VA) Medical Centers and suggests that these drugs may do significantly more harm in a subset of patients. The findings will be published in the March 21, 2016 issue of *JAMA Neurology.*

13) **McKnight’s** had several recent articles of interest:

- **Women, Medicare Beneficiaries More Prone to Hospital Readmissions.** New research is shedding light on the impact of socioeconomic factors, including income, race and payer status, on 30-day readmission rates. The study, published recently in the *Journal of Healthcare Quality,* analyzed data
from nearly 15 million inpatient discharges from more than 600 hospitals. The hospitals selected for research are located in “geographically diverse” areas including large urban centers and small rural hospitals, researchers said. Results showed that, compared to men, women who have heart attacks have a 17 percent higher risk of being readmitted to the hospital within 30 days. Medicare beneficiaries being treated after a heart attack had a 24 percent higher risk of readmission than patients with commercial insurance.

- **CMS Pushes Back Explanation of Controversial Two-Midnight Rule**. An explanation from CMS on a section of its controversial two-midnight policy will be published more than a month later than expected, the agency announced last month. CMS originally slated its explanation of the rule, which would cut payments to inpatient hospitals by 0.2 percent, to be published on March 18. It will now be released April 27, the agency said in the Federal Register. A court ordered CMS in September to publish an explanation and response to public comments on the pay cuts, which are expected to reduce hospital payments by roughly $220 million annually. Department of Health and Human Services Secretary Sylvia M. Burwell has stated the cuts would help offset the cost of moving patients from outpatient to inpatient status under the two-midnight rule.

- **FDA Proposes Ban on Powdered Medical Gloves**. The Food and Drug Administration proposed a ban on most powdered medical gloves recently, saying that they “pose an unreasonable and substantial risk” to healthcare workers and patients. The proposed ban would apply to powdered surgeon’s gloves, powdered patient examination gloves and an absorbable powder used for lubricating surgeon’s gloves. Use of the gloves has been decreasing, but they still carry a risk that can’t be corrected through new or updated labeling, the FDA noted. Powdered synthetic medical gloves, as well as the aerosolized powder used on natural rubber latex gloves, can cause severe airway inflammation, wound inflammation and post-surgical adhesions, or fibrous scar tissue that forms between internal organs and tissues. The powder used on natural gloves can also pose a risk of respiratory allergic reactions.

- **CDC Releases New ICD-10 Diagnosis Codes**. The Centers for Disease Control and Prevention released nearly 1,900 new diagnosis codes to be added to the ICD-10 system. The codes, which includes entries for conditions related to diabetes, mental health disorders, eye diseases and lower joint issues, will be added to the ICD-10 system in fiscal year 2017. In addition to the new diagnosis codes, more than 3,600 inpatient procedure codes will be added. The new codes will be implemented on October 1, 2016. The updated codes mark the end of a partial freeze on updates to the diagnosis codes prior to the ICD-10 implementation on October 1, 2015. The transition from ICD-9 to ICD-10 added roughly 68,00 new codes to the previous 13,000 billing codes.

- **DOL Releases Final Rule Requiring Employers to Disclose Anti-Union Activity**. Employers will be required to report any anti-union and collective bargaining activity to employees under the final version of a “persuader” rule issued by the Department of Labor on Thursday. The rule will require employers to disclose any relationships they have with labor consultants they hire to dissuade employees from unionizing, including developing plans for supervisors to persuade workers, creating anti-union materials and leading seminars against forming unions or collective bargaining.

- **Relatively Low Percentage of U.S. Residents in Long Term Care**. The percent of the over-65 population living in skilled nursing facilities or other residential care settings or receiving care at home ranges from 0.8 percent in Poland to 22.1 percent in Israel, according to a new report from the U.S. Census Bureau. Of 26 countries ranked in 2013 by the Organization for Economic Cooperation and Development in research cited in the report, the United States ranked seventh lowest, with 6.4 percent of the 65+ population living in SNFs or other residential care settings or receiving home healthcare. The bureau released “An Aging World: 2015” (PDF) on March 28. This year’s report, the fifth commissioned by the Division of Behavioral and Social Research at the National Institute on Aging,
uses data from several sources to examine health, economic and demographic characteristics of the older population throughout the world. Provisions for healthcare at older ages more often are available in countries that have social protection systems or universal care schemes, the report states.

- **Nursing Home Deficiencies, Substandard Care Declining, Federal Regulators Say.** The percentage of nursing homes that received deficiency-free surveys is steadily increasing, according to a new data report released by CMS. The Nursing Home Data Compendium for 2015 includes data on nursing home characteristics, survey results and resident information. Data for the report was primarily gathered through the CASPER database for survey and certification information, population data from the U.S. Bureau of the Census, and the Minimum Data Set. Data on nursing home surveys showed the likelihood that a facility would receive at least one health deficiency on a survey increased from 2005 to 2008, but reversed after that. The percentage of nursing home surveys that were deficiency-free increased from 8.8 percent in 2009 to 10.2 percent five years later. The percentage of surveys that resulted in a finding of substandard quality of care also declined in recent years, from 4.4 percent of surveys in 2008 to 3.2 percent in 2014.

14) **Interesting Fact:** Less than 3 percent of Americans live a healthy lifestyle. The four general principles reviewed in this study were: a good diet; moderate exercise; not smoking; and keeping body fat under control. Less than 3 percent of the adults in the study achieved all four of the healthy living measures.

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