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IN THIS ISSUE

Good Nutrition Becoming a Potent Tool to Boost Immune System in Elderly

Christine Kilgore

Few nursing home residents have escaped the process of immunosenescence. With age comes a sweeping and well-studied decline in immune responsiveness that leaves older individuals increasingly susceptible to developing infections and more likely to have prolonged and difficult recoveries.

T-cell mediated activity is significantly altered, and a host of other changes occur in the composition and functioning of immune system components. Even "healthy aging," researchers believe, is accompanied by some level of impaired immune response.

The role of nutrition in reversing or diminishing this impaired immune function has also been studied for decades, and in recent years its umbrella has increasingly covered micronutrients as well as probiotics and prebiotics. Today, as nursing homes work to improve antibiotic stewardship, decrease hospital transfers, and strengthen their approaches to infection prevention and control, nutrition has increasing relevance, sources say.

"We need to appreciate that there is significant change in the immune system with aging, both in terms of reductions in the parts of the immune system that are involved in fighting bacteria and viruses, and increases in the formation of inflammatory products that can have an impact on other parts of the immune system," said Simin Meydani, PhD, director of the Jean Mayer U.S. Department of Agriculture Human Nutrition Research Center on Aging at Tufts University in Boston, and of the Center's Nutritional Immunology Lab.

Photo courtesy of Simin Meydani, PhD

Dr. Simin Meydani's study on nutrition found nursing home residents were deficient in zinc, and subsequent supplementation improved the number and function of T cells.

"And we also need to appreciate that changes in the nutritional status of older

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CMS Releases Final Rule Revising Nursing Home Regulations

Carey Cowles

The Centers for Medicare & Medicaid Services has issued the long-awaited final rule that will revise the requirements that long-term care facilities must meet to participate in Medicare and Medicaid programs. This is the first change in the nursing home regulations since the Omnibus Budget Reconciliation Act that was implemented in 1990. According to CMS, these changes reflect advances that have been made in the theory and practice of how care is administered to residents in these facilities, as well as address safety issues. "These revisions are also an integral part of our 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," CMS stated in the final rule.

The first phase of regulations will be implemented Nov. 28 of this year, while subsequent phases must be implemented by the same date in 2017 and 2019.

Resident Services

Facilities will be required to investigate and report allegations of abuse of residents and patients. In addition,

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Final Rule

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facilities cannot employ practitioners who have faced disciplinary action by a state licensure body resulting from a finding of neglect, abuse, mistreatment of residents, or misappropriation of the resident's property.

Transfers or discharges will be required to be documented in the patient's medical record, and specified information must be exchanged with the receiving facility or hospital upon transfer.

Look for a Society webinar on this final rule later this month.

Facilities will be required to develop and implement a discharge planning process that "focuses on the resident's discharge goals and prepares residents to be active partners in post-discharge care, in effective transitions, and in the reduction of factors leading to preventable readmissions," according to the final rule. Discharge planning requirements specific to LTC facilities will be added to the discharge planning requirements mandated by the IMPACT Act (Improving Medicare Post-Acute Care Transformation Act of 2014).

Attending physicians will be permitted to delegate dietary orders to qualified dietitians or other qualified nutrition professionals, and to delegate therapy orders to appropriate therapists.

A nurse aide and a member of the food and nutrition services staff will be required to participate on the interdisciplinary team that develops a resident's comprehensive care plan.

A competency requirement will be implemented to determine the sufficiency of nursing staff, "which includes but is not limited to the number of residents, resident acuity, range of diagnoses, and the content of individual care plans."

Residents must receive necessary behavioral health care and services based on their comprehensive assessment and care plan.

A pharmacist will be required to review the resident's medical chart during monthly drug regimen reviews. Particular attention will be focused on reducing and eliminating the need for psychotropic drugs.

SNFs and NFs will be prohibited from charging a Medicare resident for the damage to or loss of dentures, and facilities will be required to have a policy that identifies when such loss or damage is the facility's responsibility. A referral for lost or damaged dentures must be made within 3 business days.

Facilities will be required to provide residents with a "nourishing, palatable, well-balanced diet" that addresses special dietary needs and preferences.

Respiratory services will be considered a specialized rehabilitative service.

Administration

Facilities must "conduct, document and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently" during daily operations and emergencies.

The use of predispute binding arbitration agreements will be prohibited.

All LTC facilities will be required to develop, implement, and maintain a comprehensive quality assurance/performance improvement program that focuses on outcomes and systems of care, as well as quality of life.

All LTC facilities will be required to have an infection control and prevention program that includes an "antibiotic stewardship program and at least one infection preventionist."

New Sections

Comprehensive person-centered care planning (§483.21). CMS will require facilities to develop an individualized baseline care plan for each resident within 48 hours of admission. The care plan should include instructions necessary to "provide effective and person-centered care that meets professional standards of quality care," according to the final rule.

Laboratory, radiology, and other diagnostic services (§483.50). This section will clarify that a physician's assistant, nurse practitioner, or clinical nurse specialist may order these services.

Compliance and ethics program (§483.85). Facilities will be required to have a compliance and ethics program with written standards, and policies and procedures that can reduce the prospect of criminal, civil and administrative violations.

Training requirements (§483.95). A section on training will require facilities to develop, implement, and maintain an effective training program for new and existing staff, contracted individuals, and volunteers.

CMS estimated that the projected estimated cost of the final rule will be $831 million in the first year, and $736 million annually thereafter. The average facility costs are estimated to be $62,900 the first year, and $55,000 per year for subsequent years.

The Society and many other stakeholders submitted comments to the proposed rule last summer, and CMS clearly responded to these by removing some of the original regulations, including a requirement that every resident be evaluated by a physician or non-physician practitioner before any transfer to the emergency department.

Caring will provide more information on the final rule in future issues. The Society also will post a webinar on this topic sometime in November. For more information, go to https://federalregister.gov/d/2016-23503.

Carey Cowles is the managing editor of *Caring for the Ages*.

FDA: New Boxed Warning on Combining Opioids, Benzodiazepines

Sharon Worcester

Labeling for prescription opioid pain or cough medicines and benzodiazepines will now carry the strongest available warning regarding serious side effects and death associated with their combined use, according to the Food and Drug Administration.

The new boxed warnings urge health care professionals to limit prescribing opioid pain medicines with benzodiazepines or other central nervous system depressants only to patients for whom alternative treatment options are inadequate, and to limit dosages and treatment duration to the minimum possible while achieving the desired clinical effect.

Opioids will include a warning regarding prescribing with benzodiazepines and other central nervous system depressants, including alcohol. Benzodiazepines will include a warning regarding prescribing with opioids.

The action comes amid ongoing efforts to address an epidemic of opioid addiction across the United States, and in response to a first-of-its-kind "citizen petition" calling for the boxed warnings.

Sharon Worcester is with the Southeast bureau of Frontline Medical News.

EDITOR'S NOTE

Most of us should know the potentiation of respiratory depression with concomitant administration of benzodiazepines and opioids. Although the risk of clinically significant respiratory depression with pure opioids (e.g., morphine) has been overblown and is rare in clinical practice, mixing opioids with benzos is known to increase the risk of serious respiratory compromise. The new boxed warning won't mean we can't use them together, but we can expect to get the usual communications from our consultant pharmacists when we do. Benzodiazepines —- although most of us still prescribe them at times — are pretty risky and not that effective for many conditions they're commonly used for, most notably dementia-related agitation. They disinhibit behavior and increase the risk of falls, among other adverse effects. The FDA is taking an appropriate step to remind us not to combine opioids and benzos indiscriminately. As always, let's keep our individual patients' situations always at the forefront of decision making.

—Karl Steinberg, MD, CMD, HMDC
Editor in Chief