February 9, 2016 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat will feature focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

Summary of PA 99-430 - Authorized Electronic Monitoring Devices

The Authorized Electronic Monitoring in Long-Term Care Facilities Act, Public Act 99-430 (click here), became effective January 1, 2016. This new Illinois Law provides that, subject to certain conditions, a resident of a facility licensed under the ID/DD Community Care Act (over 30 beds) or the Nursing Home Care Act (authorized electronic monitoring under this Act does not apply to Assisted Living Facilities (ALFs), Supportive Living Facilities (SLFs) or Community Integrated Living Arrangements (CILAs)) shall be permitted to install an audio and/or video surveillance system in his or her room at his or her expense with the proper consent. The purpose of this article is to summarize the key facility provisions of the new Act since this is all we will have to work from until the Illinois Department of Public Health adopts rulemaking, which probably won’t happen until fall 2016. Every identified facility will need to develop an initial policy with regard to electronic monitoring and then most likely revise it once the IDPH rules are adopted. When developing this facility policy, with regard to electronic monitoring, the facility should work closely with their legal counsel since there are no rules or guidelines (other than the Act) to work from.

The first step in understanding this new legislation is to review and understand some definitions.

- The Act defines “Facility” as “an intermediate care facility for the developmentally disabled licensed under the ID/DD Community Care Act that has 30 beds or more, a long term care for under age 22 facility licensed under the ID/DD Community Care Act, or a facility licensed under the Nursing Home Care Act.” The ICF/DD under 16 bed facilities are exempt from this Act by definition.
- The Act defines “Electronic Monitoring Device” as “a surveillance instrument with a fixed position video camera or an audio recording device, or a combination thereof, that is installed in a resident’s room under the provisions of this Act and broadcasts or records activity or sounds occurring in the room.” This is specific to a resident’s bedroom. Nothing in this Act shall be construed to allow the use of an electronic monitoring device to take still photographs or for the nonconsensual interception of private communications.

The second, and probably the most important concept of this Act, is that of consent. A resident, their guardian or resident representative must consent in writing on the notification and consent form prescribed by IDPH. IDPH released the Electronic Monitoring Notification and Consent Form on Friday (1-29-16). Click here to access the form. It also can be found through the following pages on the Department’s website:
http://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes
http://www.dph.illinois.gov/forms-publications
Section 15 of the Act discusses when and how resident versus guardian versus resident representative consent is permitted. Prior to another person (other than plenary guardian) consenting on behalf of a resident, the resident must be asked by that person in the presence of a facility employee, if they authorize electronic monitoring to be conducted. There are several items noted under Section 15 (a-5) that must be explained to the resident. A resident affirmatively objects when he or she orally, visually or through other means declines the use of electronic monitoring. The resident’s response must be documented on the required IDPH notification and consent form.

If the resident room is a multiple bed room, the resident wanting electronic monitoring must get written consent from any other resident residing in that bedroom. This written consent (along with any agreed upon conditions) must be recorded on the IDPH notification and consent form. The Act, under Section 15(c), explains the process for getting roommate consent from the roommate, their guardian or resident representative.

The IDPH Electronic Monitoring Notification and Consent Form discusses various conditions that either the resident or roommate may place on the electronic monitoring. They include, but are not limited to: prohibiting audio recording; prohibiting broadcasting of audio or video; turning the electronic monitoring device off or blocking the visual recording device during exams by a health professional; turning the device off during care treatments, dressing or bathing; turning the device off during a visit by a spiritual advisor, ombudsman, attorney, financial planner, intimate partner, any other visitor or during a private phone call. The resident or roommate may list other conditions or restrictions, in writing, on the IDPH Electronic Monitoring Notification and Consent Form. Another consideration that must be made is how the authorized electronic monitoring device can be turned on and off, from where, and by whom.

Any resident previously conducting authorized electronic monitoring must obtain consent from any new roommate before the resident may resume authorized electronic monitoring. Consent may be withdrawn by the resident or roommate at any time and the withdrawal of consent shall be documented in the resident’s clinical record. If the roommate withdraws consent, the electronic monitoring must stop immediately and if the resident refuses, the facility can turn off the electronic monitoring device.

The facility shall make reasonable effort to accommodate the resident who wants to conduct authorized electronic monitoring when upon notification that a roommate has not consented to the use of an electronic monitoring device in his or her room. The facility must offer to move either resident to another shared room if there is such a room available. If a resident chooses to reside in a private room in order to accommodate the use of an electronic monitoring device, the resident must pay the private room rate. If the facility is not able to accommodate a resident request for an electronic monitoring device due to lack of space/room, the facility must reevaluate the request every 2 weeks until the request is fulfilled.

The third issue is that of notice to the facility. Authorized electronic monitoring may begin only after a notification and consent form prescribed by IDPH has been completed and submitted to the facility. The resident must notify the facility in writing of their intent to install an electronic monitoring device by providing a completed notification and consent form prescribed by IDPH and must include, at a minimum the following information:

- The resident’s signed consent to electronic monitoring or the signature of the person consenting on behalf of the resident in accordance with Section 15 of the Act; if a person other than the resident signs the consent form, the form must document the following:
  - The date the resident was asked if she or she wants authorized electronic monitoring to be conducted;
  - Who was present when the resident was asked; and
  - An acknowledgement that the resident did not affirmatively object.
- The resident’s roommate’s signed consent or the signature of the person consenting on behalf of the roommate, in accordance with Section 15 of the Act, along with any conditions the roommate or
person consenting on behalf of the roommate has placed on the consent. If a person other than the 
roommate signs the consent form, the form must document the following:
  o The date the roommate was asked and if he or she wants authorized electronic monitoring to 
    be conducted;
  o Who was present when the roommate was asked; and
  o An acknowledgement that the roommate did not affirmatively object

- The type of electronic monitoring device to be used;
- Any installation needs, such as mounting of a device to a wall or ceiling;
- The proposed date of installation for scheduling purposes;
- A copy of any contract for maintenance of the electronic monitoring device by a commercial entity;
- A list of standard conditions or restrictions that the resident or roommate may elect to place on use of 
  the electronic monitoring device, including, but not limited to:
    o Prohibiting audio recording;
    o Prohibiting broadcasting of audio or video;
    o Turning off the electronic monitoring device while dressing of bathing is performed; and
    o Turning the electronic monitoring device off for the duration of a visit with a spiritual advisor,
      ombudsman, attorney, financial planner, intimate partner, physician, or other visitor.
- Any other condition or restriction elected by the resident or roommate on the use of an electronic 
  monitoring device.

A copy of the completed notification and consent form shall be placed in the resident’s and any roommate’s 
clinical record and a copy shall be provided to the resident and his or her roommate, if applicable.

The fourth issue is that of cost and installation. A resident choosing to conduct authorized electronic 
monitoring must do so at his or her own expense, including paying for the purchase, installation, maintenance 
and removal costs. If a resident chooses to install an electronic monitoring device that uses Internet 
technology for visual or audio monitoring, that resident is responsible for contracting with an Internet service 
provider. The facility shall make a reasonable attempt to accommodate the resident’s installation needs, 
including, but not limited to, allowing access to the facility’s telecommunications or equipment room. The 
facility has the burden of proving that a requested accommodation is not reasonable. The electronic 
monitoring device must be placed in a conspicuously visible location in the room and be in a fixed position. 
Privacy curtains should be taken into account with regard to location of the camera. A facility cannot charge a 
fee for the cost of electricity used by the electronic monitoring device. All electronic monitoring device 
installations and supporting services shall comply with requirements of the National Fire Protection 

The fifth issue is that of notice to visitors. If a resident of a facility conducts authorized electronic monitoring, a 
sign shall be clearly and conspicuously posted at all building entrances accessible to visitors. The notice must 
be entitled “Electronic Monitoring” and must state, in large, easy-to-read type, “The rooms of some residents 
may be monitored electronically by or on behalf of the residents.” A sign shall be clearly and conspicuously 
posted at the entrance to a resident’s room where authorized electronic monitoring is being conducted. The 
notice must state, in large, easy-to-read type, “This room is electronically monitored.” The facility is 
responsible for installing and maintaining the required signage.

Finally, there are several miscellaneous provisions that need to be considered. They include:
- A person or entity is prohibited from knowingly hampering, obstructing, tampering with, or destroying 
an electronic monitoring device installed in a resident’s room without the permission of the resident or 
individual who consented on behalf of the resident in accordance with Section 15 of the Act.
• A facility may not access any video or audio recording created through authorized electronic monitoring without the written consent of the resident or the person who consented on behalf of the resident.
• Each facility shall report to IDPH, in a manner prescribed by IDPH, the number of authorized electronic monitoring notification and consent forms received annually.
• The facility is not civilly or criminally liable for the inadvertent or intentional disclosure of a recording by a resident or a person who consents on behalf of the resident for any purpose not authorized by this Act.
• IDPH is required to adopt rulemaking necessary to implement this Act. However, the rulemaking process takes 6 to 9 months to complete and IDPH has not proposed any rulemaking to date, so we probably won’t see any rules until late 2016. Providers will have to prepare their implementation and facility policies off of the Act until such time the rules are finalized. Again, we urge providers to work closely with their legal counsel to develop their electronic monitoring policies. As information becomes available, we will inform or members immediately.

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**Trending Statistics**

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

**CMS Publishes Medicare Chronic Conditions by County**

Have you ever wondered what percentage of Medicare beneficiaries in your county are diagnosed with Alzheimer's disease or diabetes? Well, wonder no more. CMS has released a [data file](#) of 19 chronic conditions and their prevalence in the Medicare population from 2007 to 2014.

Prevalence and Medicare utilization and spending are presented for the 19 chronic conditions listed below. Information is presented for (1) U.S. counties, (2) U.S. states, including Washington, DC, Puerto Rico, and the U.S. Virgin Islands, and (3) hospital referral regions (HRR) and is available for the years 2007-2014.

- Alzheimer’s Disease and Related Dementia
- Arthritis (Osteoarthritis and Rheumatoid)
- Asthma
- Atrial Fibrillation
- Autism Spectrum Disorders
- Cancer (Breast, Colorectal, Lung, and Prostate)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Hepatitis (Chronic Viral B & C)
- HIV/AIDS
- Hyperlipidemia (High cholesterol)
- Hypertension (High blood pressure)
- Ischemic Heart Disease
- Osteoporosis
- Schizophrenia and Other Psychotic Disorders
- Stroke
- Type 2 Diabetes

The data are available in two Excel file formats. The “Reports” allow users to compare geographic areas to national Medicare estimates. The corresponding “Tables” are traditional excel files that can be exported into other programs.

Inquiries regarding this data can be sent to [MedicareChronicConditions@cms.hhs.gov](mailto:MedicareChronicConditions@cms.hhs.gov).
1) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 16-06 – All** - Medicare Learning Network (MLN) Infection Control Courses - Infection Control Courses: MLN has created infection control courses based on the CMS Ambulatory Surgery Center (ASC) surveyor online training course. Continuing Education Credits: MLN courses can be accessed by surveyors to reinforce their infection control knowledge and receive continuing education credits.

- **S&C 16-07 – AO** - FY 2015 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program. Section 1875(b) of the Social Security Act (the Act) requires CMS to submit an annual report to Congress on its oversight of national AOs and their CMS-approved accreditation programs. Section 353(e)(3) of the Public Health Service Act (PHSA) requires CMS to submit an annual report of the CLIA validation program results.

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

- In order to effectively implement provisions of the Affordable Care Act, CMS finalized a rule (click here) detailing reforms to the rebate and reimbursement systems for Medicaid prescription drugs, which will save federal and state governments an estimated $2.7 billion over five years.

- A revised **Skilled Nursing Facility (SNF) Billing Reference** Fact Sheet is available. Learn about SNF:
  - Coverage
  - Payment
  - Billing requirements

- Have you accessed your Program for Evaluating Payment Patterns Electronic Report (PEPPER)? PEPPERS are available for Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), hospices, Critical Access Hospitals (CAHs), Long Term Care Hospitals (LTCHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs) and Partial Hospitalization Programs (PHPs). CMS contracts with TMF to produce and distribute these comparative billing reports that summarize Medicare claims data to help providers identify and prevent improper Medicare payments. Providers can access their PEPPER electronically through the PEPPER Resources Portal.

3) The Agency for Healthcare Research and Quality announced the following:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** surveys ask consumers about their experiences with health care. The CAHPS program at the U.S. Agency for Healthcare Research and
Quality (AHRQ) supports the development and promotion of CAHPS surveys, instructional materials, and comparative databases, and provides technical assistance to users. Learn more about AHRQ’s CAHPS program at: www.cahps.ahrq.gov. The 2015 CAHPS® Health Plan Survey Chartbook is now available at www.cahpsdatabase.ahrq.gov. The Chartbook presents highlights of CAHPS Health Plan Survey results in narrative summaries and bar charts, which can be downloaded for free.

- **Data Submission 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. The results of this database will be compiled into the Nursing Home Comparative Database Report. Average scores and percentiles on the survey items and composites will be included to help nursing homes assess their own results in order to identify strengths and opportunities for improvement. Nursing homes who have not previously administered the survey may still do so. The survey, toolkit materials, and general data submission information are available at http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/nursing-home/index.html.

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

- **Revision of Form HFS 1409 Prior Approval Request and Availability on the Website.** The Department has recently reformatted the HFS 1409 Prior Approval Request form. There are no changes to the content of the form. It has been assigned a revision date of R-11-15 in the bottom left corner of the form. Please ensure that you are using this most current version when submitting a prior approval request. As had been the case with earlier versions of this form, the new version is available in a PDF-fillable format on the Medical Forms Page of the website. Please begin using this new version of the Prior Approval Request form immediately. The Department will no longer stock a paper version of the HFS 1409 for ordering from the HFS warehouse. Providers must print off the website version for submission to the Department.

- **New Two-Tier Routine Home Care (RHC) Rates and End of Life Service Intensity.** CMS, per a final rule in the August 6, 2015 Federal Register, identified changes to the Medicare hospice program related to payment for routine home care (RHC) and payment for a new service intensity add-on (SIA) payment. By letter to CMS associate regional administrators on September 1, 2015, CMS verified to states that these payment changes also affect Medicaid hospice payments, as Medicaid hospice rates are calculated based on the annual hospice rates established under Medicare.

5) The Illinois Department of Public Health is proposing new rulemaking (Illinois Register, Volume 40, Issue 4 - starting on page 1508) to adopt and incorporate the United States Food and Drug Administration’s Food Code 2013, which is a model food code for states. With this adoption, a majority of the current Sections in the Code are being repealed to eliminate duplication and inconsistencies with the Food Code 2013.

6) The American Health Care Association (AHCA) notified the State AHCA Affiliates of a CMS Update to 2016 Medicare Part B Physician Fee Schedule File – Updated Therapy File Posted on AHCA Website. On November 25, 2015 they posted a Long Term Care Leader article regarding the calendar year 2016 Medicare Part B physician fee schedule update including a link to a useful therapy-specific file posted on the AHCA website that provided the 2016 therapy fees for each CPT/HCPCS code in each geographic area. However, that file is no longer correct. The updated new file is here.

7) The latest Telligen events can be found at https://www.telligenqingio.com/.

8) **USA Today** recently published “Task Force: Doctors Should Screen All Adults for Depression.” Primary care doctors should screen all adults for depression, an expert panel recommended. In its previous recommendation, the U.S. Preventive Services Task Force, which advises the federal government on
health, had recommended screening adults for depression only when mental health services were available. In its new report, the task force said this limitation is no longer needed, because mental health services are more widely available today than in 2009, when its last recommendations were published. Federal law now requires that private insurers cover mental health and physical conditions equally.

9) **PennState** recently published an article entitled, “**Anticholinergics May Not be Best Choice for Rehab Patients With Dementia.**” During rehabilitation following an acute hospital stay, medications that block neurotransmitters may be overprescribed to older patients suffering from delirium superimposed on dementia, according to health researchers. Specifically, strong anticholinergic medications may be prescribed to older adults when there are other suitable options. An anticholinergic medication blocks the neurotransmitter acetylcholine in the nervous system. These drugs are prescribed for a variety of symptoms, including incontinence, depression and insomnia. While their use can be very beneficial to some, they are also known to have significant adverse effects.

10) **Health In Aging** recently reported in a research summary that “**Infectious Diseases Cause Significant Number of Emergency Room Visits and Hospitalizations for Older Adults.**” In a first-of-its-kind study published in the *Journal of the American Geriatrics Society*, researchers calculated that infectious diseases account for 13.5 percent of emergency room (ER) visits involving older adults—a higher percentage than ER visits for heart attacks and congestive heart failure combined. Infectious diseases are those that can be passed from person-to-person and caused by viruses, bacteria, or parasites. In their study, researchers examined claims data involving some 134 million ER visits and focused on those made by adults aged 65 and older. Here’s what they learned:

- Lower respiratory tract infections, such as pneumonia, account for 26 percent of all ER visits for infectious diseases. They also accounted for 15 percent of the infectious disease-related deaths during ER visits and hospitalizations.
- Pneumonia alone accounts for 17.5 percent of ER visits.
- **Septicemia**, a serious blood infection, accounted for 32 percent of infectious disease-related hospitalizations and 75 percent of infectious disease-related deaths during ER visits and hospitalizations.
- People age 85 and older have the highest rate of ER visits for infectious diseases.

11) **MedlinePlus** recently published an article entitled, “**Brain Protein Might Offer New Clues to Alzheimer’s Treatment.**” A protein in the brain may hold a key to slowing progression of Alzheimer's disease, a new study suggests. And boosting this protein might be as simple as increasing exercise and social activity, experts say. The protein is encoded by a gene called brain-derived neurotrophic factor, or BDNF. Researchers found that seniors with the highest levels of BDNF gene function had a 50 percent slower loss of memory and thinking than those with the lowest levels.

12) **HealthDay News** reported on a study that noted, “**New Blood Pressure Guidelines a Danger to Patients.**” Scientists continue to debate when doctors should prescribe blood pressure medication for older Americans, with a new study saying delayed treatment puts people at greater risk of stroke. For people 60 and older, a U.S. panel in 2014 recommended raising the blood pressure rate at which doctors prescribe treatment from 140 to 150 systolic blood pressure. Systolic blood pressure is the top number in a blood pressure reading. But the new study finds that people with systolic blood pressure of 140 to 149 have a 70 percent increased risk of stroke compared to people with lower blood pressure.

13) **Medscape** published several articles of interest. They include:

- **CDC Alert: Severe Influenza Illness Reported.** The Centers for Disease Control and Prevention (CDC) has received reports of severe influenza illness and some deaths and has issued an alert recommending that physicians quickly treat suspected cases in high-risk patients. Clinicians are advised to quickly treat suspected influenza in high-risk outpatients, those with progressive disease and all
hospitalized patients with antiviral medications, regardless of negative rapid influenza diagnostic test (RIDT) results and without waiting for results of reverse-transcriptase polymerase chain reaction. RIDTs have a high potential for false-negative results, so treatment should not be withheld on the basis of the test.

- **Where the Candidates Stand on Healthcare.** Although terrorism and the economy have topped Americans’ list of concerns in recent polls, health care is still on voters’ minds. WebMD looked at where presidential hopefuls from both parties stand on various health care issues, including the health care reform law (the Affordable Care Act, or "Obamacare"), Medicare and Medicaid, the price of prescription drugs, and abortion. Candidates included are those who received 5 percent or higher in the January 12 New York Times/CBS News national poll. Here’s what they said off and on the podium on these topics. If the candidate has not spoken about a topic or offered information on his or her website, it will say “No information available.”

- **Using ‘Mortality Risk’ to Guide Advanced Care Planning in the Elderly.** With an aging population, the quality and cost of end-of-life care are critical issues. This mixed-methods study examined the impact of mortality risk assessments (MRAs) and advanced care planning discussions, documented by nurse practitioners (NPs), on clinical outcomes of newly enrolled nursing home patients. An MRA stratifies patients into low, moderate, or high risk for mortality in the next 6-12 months. It includes age, history of chronic diseases (congestive heart failure, chronic obstructive pulmonary disease, dementia, chronic kidney disease and arrhythmia), intubation, recurrent infections, repeated emergency department visits or hospitalization, functional status, unintended weight loss, body mass index and sex.

- **New Guidelines on Diabetes Care in Elderly Residential Facilities.** New American Diabetes Association (ADA) guidelines addressing diabetes management in long term care and skilled nursing facilities emphasize treatment simplification, avoidance of hypoglycemia, and the need to reassess therapeutic goals for patients who are nearing the end of life. The guidelines were published in the February issue of Diabetes Care by Medha N Munshi, MD, director of the Joslin Geriatric Diabetes Program, Boston, Massachusetts, and colleagues. Previous statements from the ADA have addressed care for the elderly in community settings and diabetes care among hospitalized patients, but this is the first to specifically address the unique needs of patients in long term care settings, where the approach to diabetes management often needs to be dramatically altered from those in younger and healthier patients, Dr. Munshi told Medscape Medical News.

- **2016 Adult Immunization Schedule Includes New Vaccines.** The 2016 adult immunization schedule contains several changes from past years, including the addition of recently licensed meningococcal serogroup B and human papillomavirus vaccines and a revision to the recommendation for pneumococcal vaccination. The Recommended Adult Immunization Schedule: United States, 2016, was approved by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices in October 2015 and published online February 2 in the Annals of Internal Medicine and on the Centers for Disease Control and Prevention website. The 2016 adult immunization schedule, including separate charts for routine immunizations and for vaccines that might be indicated on the basis of medical or other indications, plus footnotes, was reviewed and approved by the American College of Physicians, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, and American College of Nurse-Midwives. New recommendations have been added for use of two recently licensed serogroup meningococcal B vaccines: Trumenba (Wyeth Pharmaceuticals), licensed in October 2014, and Bexsero (Novartis), licensed in January 2015.

14) **Medical News Today** also published several articles of interest. They include:

- **A Key Mechanism has Been Discovered Which Prevents Memory Loss in Alzheimer’s Disease.** Neurons communicate with one another by synaptic connections, where information is exchanged
from one neuron to its neighbor. These connections are not static, but are continuously modulated in response to the ongoing activity (or experience) of the neuron. This process, known as synaptic plasticity, is a fundamental mechanism for learning and memory in humans as in all animals. In fact, we now know that alterations in synaptic plasticity are responsible for memory impairment in cognitive disorders such as Alzheimer's disease. Nevertheless, the mechanisms by which these alterations take place are still starting to be uncovered. This new research work, published in Nature Neuroscience, has been led by Dr. Shira Knafo (Ikerbasque, Biophysics Unit: CSIC/The University of the Basque Country), Dr. Jose A. Esteban (Severo Ochoa Center for Molecular Biology, National Research Council/Autonomous University of Madrid), and Dr. César Venero (Univ. Nacional de Educación a Distancia). These investigators have discovered that in Alzheimer's disease, synaptic plasticity is altered by a protein originally described as a tumor suppressor: PTEN. In 2010, the research group of Dr. Esteban discovered that PTEN is recruited to synapses during normal (physiological) synaptic plasticity. This new investigation by Drs. Knafo, Venero and Esteban, now indicates that this mechanism runs uncontrolled during Alzheimer's disease. One of the pathological agents of the disease, the beta-amyloid, drives PTEN into synapses excessively, unbalancing the mechanisms for synaptic plasticity and impairing memory formation.

- **New Test Could Detect Elusive Pathogens in Patients at High Infection Risk.** Researchers from the University of Pennsylvania have created a test that they say has the potential to quickly detect ambiguous pathogens among patients with compromised immune systems, for whom certain infections can be life-threatening.

- **Fewer Than 1 in 5 Nurses Comply with Guidelines for Standard Precautions.** Only 17.4 percent of ambulatory care nurses reported compliance in all nine standard precautions for infection prevention, according to a study published in the January issue of the American Journal of Infection Control, the official publication of the Association for Professionals in Infection Control and Epidemiology (APIC). The highest rate of compliance was reported with always wearing gloves (92 percent), followed by always wearing a face mask (70 percent). Only 63 percent of participants reported that they always wash hands after removal of gloves and 82 percent reported that they always wash hands after provision of care.

- **Blood Test Could Identify Which Patients Need Antibiotics.** One of the main drivers of antibiotic resistance is over-prescription and misuse of antibiotics. But in a new study, researchers reveal how they are a step closer to developing a blood test that can identify whether a respiratory illness is caused by a viral or bacterial infection, allowing more accurate antibiotic prescribing. According to the CDC, more than 262.5 million courses of antibiotics are written in the outpatient setting each year in the US, but around 50 percent of these are prescribed unnecessarily. Misuse of antibiotics is a key contributor to antibiotic resistance; if a patient takes antibiotics for a viral infection, the drug will still attack bacteria in the body, but it will attack healthy or beneficial bacteria. This can cause antibiotic-resistant properties that can be passed on to other bacteria.

- **A New Non-Invasive Methodology, Developed by UGR Researchers, Allows for Early Diagnosis of Diseases Such as Osteoporosis and Alzheimer's.** Scientists from the University of Granada have developed a new fluorescent dye capable of detecting, in a single test lasting 20 minutes, the presence of phosphate and biothiol inside living cells. This scientific breakthrough could contribute significantly to the early diagnosis of diseases such as osteoporosis, Alzheimer's, type 2 diabetes, and prostate cancer, since abnormal levels of both substances are associated with these diseases.

15) **McKnight's** published several articles of interest. They include:

- **Not Such a Happy New Year on the Regulatory Front.** And as a new year dawns, senior living operators need to be preparing for some notable rules and regulations that are fast approaching.
• **No ‘Midnight Regulations’ in Last Year of Administration, Feds Say.** There should not be any last-minute regulations in the last year of the Obama administration, according to the Office of Management and Budget. Priority regulations must be submitted no later than this summer if they are meant to be finalized before 2017, the administrator of the Office of Information and Regulatory Affairs said in a memo obtained by *Bloomberg BNA*. That could be good news for healthcare providers, especially as long-term care continues to wade through its 403-page “mega-rule” proposed rule released last July. The American Health Care Association’s top government lobbyist also said this month that 2016 is expected to be quiet on the legislative front due to the presidential election.

• **Zinc Boosts Immunity in Seniors in Nursing Homes, Study Finds.** A zinc supplement may help improve immunity for older adults living in nursing homes, according to a new study. The study’s findings suggest that “ensuring adequate zinc consumption by older adults could have a significant impact on reducing the incidence of and morbidity from infection,” wrote lead research Simin Nikbin Meydani, D.V.M., Ph.D.

• **Care Transitions, Health Literacy Among Leading Readmission Causes for Minorities.** Lack of communication about care transitions and limited health literacy are among the primary reasons minority patients are readmitted to the hospital, according to a new federal guide. The CMS guide, released last month, aims to prevent readmissions among “racially and ethnically diverse” Medicare beneficiaries. These populations are readmitted more often than white patients due to cultural, social and health barriers including limited English proficiency, a lack of socioeconomic resources and multiple co-morbidities. Discharge plans are often a factor in whether a minority patient will be readmitted to the hospital. Providers should give early discharge planning and follow-up instructions for patients at high readmission risk, and provide support to patients who may need assistance with follow-up care due to issues like language barriers or lack of transportation.

• **Number of Americans Living Past 100 Jumps 44 Percent.** The number of American centenarians — people who live past 100 years old — has increased by 44 percent since 2000, according to federal health officials. More than 72,000 people age 100 and older lived in the United States in 2014, the Centers for Disease Control and Prevention said in a report released Thursday. That’s up from 50,281 in centenarians 2000, and around just 15,000 in 1980. Women make up the majority of those who live past 100, representing more than 80 percent of centenarians in 2014, the report found.

16) **Interesting Fact:** The human lungs contain approximately 2,400 kilometers (1,500 mi) of airways and 300 to 500 million hollow cavities, having a total surface area of about 70 square meters, roughly the same area as one side of a tennis court. Furthermore, if all of the capillaries that surround the lung cavities were unwound and laid end to end, they would extend for about 992 kilometers. Also, your left lung is smaller than your right lung to make room for your heart.

*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!*

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Illinois Health Care Association | info@ihca.com | www.ihca.com
1029 S. Fourth Street
Springfield, IL 62703
(800) 252-8988 | (217) 528-6455 | Fax: (217) 528-0452

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