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!

**Guidelines Related to OSHA’s Revisions to Injury and Illness Reporting Requirements**
*Prepared for AHCA/NCAL by Jackson Lewis P.C.*

OSHA released its [final rule](#) for Occupational Injury and Illness Recording and Reporting Requirements on September 18, 2014. The rule will become effective on January 1, 2015, for Federal Plan States. State Plan States will announce their dates independently, but are encouraged to meet the same deadline. (Find out more about State Plan States [here](#).)

The final rule expands the list of injuries that *must* be reported to OSHA and revises the requirements for when an employer must report work-related hospitalizations. The final rule also provides additional avenues for how to report to OSHA and more clearly identifies the information that must be reported to OSHA.

Under the final rule, all employers, **including all nursing home facilities and assisted living facilities** are required to report all fatalities, inpatient hospitalizations, amputations and losses of an eye as described below.

- All work-related fatalities *must* be reported within eight hours of the death or knowledge of the event. Only fatalities that occur within 30 days of the work incident are reportable to OSHA.

- All work-related inpatient hospitalizations that require care and treatment of a single employee, all amputations and all losses of an eye *must* be reported within 24 hours. Only inpatient hospitalizations, amputations and eye losses that occur within 24 hours of the work incident are reportable to OSHA. Inpatient hospitalization is defined as a formal admission to the in-patient service of a hospital or clinic for care or treatment. Inpatient hospitalization for observation or diagnostic testing only does not need to be reported to OSHA.

- All work-related fatalities or inpatient hospitalizations caused by a heart attack *must* be reported to OSHA. Heart attacks of workers where there is no indication that the work environment either caused, contributed to or significantly aggravated a pre-existing condition (e.g., sedentary workers who were not engaged in strenuous activities) may not be considered work related. To determine whether the heart attack is work-related, an employer must evaluate the employee’s work duties and work environment to decide whether or not the work environment either caused or contributed to or significantly aggravated a pre-existing condition.
Fatalities, hospitalizations, amputations and eye losses stemming from motor vehicle accidents that occur on a public street or highway (and not in a construction work zone) or on commercial or public transportation do not need to be reported to OSHA, but must be recorded on the OSHA 300 Logs.

Employers must report the work-related fatality, inpatient hospitalization, amputation or eye loss by:

- Calling OSHA’s confidential number (1-800-321-OSHA)
- Contacting the local OSHA Area Office via telephone or in person
- Electronic submission using OSHA’s (not-yet-available) web portal

Employers may not leave a message on OSHA’s answering machine, or send a fax or email to the OSHA Area Office. If the local OSHA Area Office is closed, employers must either call the confidential 800 number or use the web portal when available.

When making a report to OSHA, employers must provide the following information:

- The establishment name;
- The location of the work-related incident;
- The time of the work-related incident;
- The type of reportable event (i.e., fatality, hospitalization, amputation, or loss of an eye);
- The contact person and phone number; and
- A brief description of the work-related incident.

**Pneumonia Information**

*Pneumonia, an infection of the lungs, needlessly affects millions of people worldwide each year. Pneumonia infections can often be prevented and can usually be treated.*

Globally, pneumonia kills nearly 1 million children younger than 5 years of age each year. This is greater than the number of deaths from any infectious disease, such as HIV infection, malaria or tuberculosis.

Pneumonia isn’t just a public health issue in developing countries though. For example, each year in the United States, about 1 million people are hospitalized with pneumonia, and about 50,000 people die from the disease. Most of the hospitalizations and deaths from pneumonia in the United States are in adults rather than in young children.

Many of these deaths—both globally and in the United States—are preventable through vaccination and appropriate treatment (like antibiotics and antivirals).

**Your Risk with Vaccines**

In the United States, there are several vaccines that prevent infection by bacteria or viruses that may cause pneumonia:

- *Haemophilus influenzae* type b (Hib)
- Influenza (flu)
- Measles
- Pertussis (whooping cough)
- Pneumococcal
- Varicella (chickenpox)
These vaccines are safe, but side effects can occur. Most side effects are mild or moderate, meaning they do not affect daily activities. See the vaccine information statements for each vaccine to learn more about the most common side effects.

Protect Your Health with These Healthy Living Practices
Try to avoid close contact with sick people. While sick, limit contact with others as much as possible to keep from infecting them. Following good hygiene practices can also help prevent respiratory infections. This includes washing your hands regularly, cleaning frequently touched surfaces, and coughing or sneezing into a tissue or into your elbow or sleeve. You can also reduce your risk of getting pneumonia by limiting exposure to cigarette smoke and treating and preventing conditions like diabetes.

What Is Pneumonia?
Pneumonia is an infection of the lungs that can cause mild to severe illness in people of all ages. Common signs of pneumonia can include cough, fever and trouble breathing.

Who Is At Risk for Pneumonia?
Certain people are more likely to become ill with pneumonia:

- Adults 65 years of age or older
- Children younger than 5 years of age
- People who have underlying medical conditions (like asthma, diabetes or heart disease)
- People who smoke cigarettes

Encourage friends and loved ones with certain health conditions, like diabetes and asthma, to get vaccinated against the flu and bacterial pneumonia.

Causes and Types of Pneumonia
Pneumonia can be caused by viruses, bacteria, and fungi. In the United States, common causes of viral pneumonia are influenza and respiratory syncytial virus (RSV), and a common cause of bacterial pneumonia is Streptococcus pneumoniae (pneumococcus).

When someone develops pneumonia in the community (not in a hospital), it's called community-acquired pneumonia. Pneumonia developed during or following a stay in a health care facility (like hospitals, long term care facilities and dialysis centers) is called health care-associated pneumonia, which includes hospital-acquired pneumonia and ventilator-associated pneumonia. The bacteria and viruses that most commonly cause pneumonia in the community are different from those in healthcare settings. It is important to know the specific cause of pneumonia to make the best decision about how to treat it.

New Pneumococcal Recommendations for 2014
CDC now recommends 2 pneumococcal vaccines for adults 65 years or older.

- You should receive a dose of the pneumococcal conjugate vaccine (PCV13) first, followed by a dose of the pneumococcal polysaccharide vaccine (PPSV23), ideally 6 to 12 months later.
- If you've already received any doses of PPSV23, the dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose.
- If you've already received a dose of PCV13 at a younger age, another dose is not recommended.

New IDPH Rulemaking
IDPH has recently adopted rulemaking to various health care facility codes to implement the statutory requirements of Public Act 98-0271, which removed language from the Nursing Home Care Act that limited the administration of pneumococcal vaccination to residents aged 65 or older.
Trending Statistics

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

Despite Risks, Benzodiazepine Use Highest in Older People
National Institutes of Health-supported study examines prescribing patterns

Prescription use of benzodiazepines — a widely used class of sedative and anti-anxiety medications — increases steadily with age, despite the known risks for older people, according to a comprehensive analysis of benzodiazepine prescribing in the United States. Given existing guidelines cautioning health providers about benzodiazepine use among older adults, findings from the National Institutes of Health-funded study raise questions about why so many prescriptions — many for long-term use — are being written for this age group.

The study found that among all adults 18 to 80 years old, about 1 in 20 received a benzodiazepine prescription in 2008, the period covered by the study. But this fraction rose substantially with age, from 2.6 percent among those 18 to 35, to 8.7 percent in those 65 to 80, the oldest group studied. Long-term use — a supply of the medication for more than 120 days — also increased markedly with age. Of people 65 to 80 who used benzodiazepines, 31.4 percent received prescriptions for long-term use, vs. 14.7 percent of users 18 to 35. In all age groups, women were about twice as likely as men to receive benzodiazepines. Among women 65 to 80 years old, 1 in 10 was prescribed one of these medications, with almost a third of those receiving long-term prescriptions.

“These new data reveal worrisome patterns in the prescribing of benzodiazepines for older adults, and women in particular,” said Thomas Insel, M.D., director of the National Institute of Mental Health (NIMH), which supported the study. “This analysis suggests that prescriptions for benzodiazepines in older Americans exceed what research suggests is appropriate and safe.”

Benzodiazepines — named for their chemical structure — are among the most commonly prescribed medications in developed countries. They include alprazolam (Xanax), diazepam (Valium) and lorazepam (Ativan). The most common uses of benzodiazepines are to treat anxiety and sleep problems. While effective for both conditions, the
medications have risks, especially when used over long periods. Long-term use can lead to dependence and withdrawal symptoms when discontinued. In older people, research has shown that benzodiazepines can impair cognition, mobility, and driving skills, and they increase the risk of falls.

Despite the large number of prescriptions in the United States — 85 million in 2007 — relatively little was known prior to this study about the specifics of benzodiazepine prescribing in the United States relative to other countries. Mark Olfson, M.D., M.P.H., at the New York State Psychiatric Institute and Columbia University; Marissa King, Ph.D., at Yale University; and Michael Schoenbaum, Ph.D., at NIMH used data from a national prescription database (IMS LifeLink LRx Longitudinal Prescription database) and a national database on medical expenditures collected by the Agency for Healthcare Research and Quality to examine prescription patterns from 2008.

These medications can pose real risks, and there are often safer alternatives available,” said Dr. Schoenbaum, who was senior author. “Our findings strongly suggest that we need strategies to reduce benzodiazepine use, particularly for older women.”

Among the findings:

- Use of benzodiazepines increased steadily with age: 5.2 percent of adults 18 to 80 years old received one or more benzodiazepine prescriptions in 2008; 2.6 percent of those 18 to 35, 5.4 percent of those 36 to 50, 7.4 percent of those 51 to 64, and 8.4 percent of those 65 to 80.
- Overall, about one quarter of prescriptions involve long-acting formulations of benzodiazepines.
- Most prescriptions for benzodiazepines are written by non-psychiatrists. For adults 18 to 80 years old, about two thirds of prescriptions for long-term use are written by non-psychiatrists; for adults 65 to 80, the figure is 9 out of 10.

Benzodiazepines are effective in relieving anxiety and take effect more quickly than antidepressant medications often prescribed for anxiety. However, the prevalence of anxiety disorders declines with age. Practice guidelines recommend nonpharmacologic approaches and antidepressants over benzodiazepines as first-line treatment. Rates of insomnia increase with age, but practice guidelines recommend that health care providers consider behavioral interventions as first-line treatment over medication. Neither of these conditions explains the rates of prescribing benzodiazepines for older age groups.

Adding to concerns about the possible health consequences of benzodiazepine use, a recently reported study found an association between benzodiazepine use in older people and increased risk of Alzheimer’s disease. The association was stronger with increasing length of use; the risk was nearly doubled for those using benzodiazepines for more than 180 days.

The study appears online December 18 in JAMA Psychiatry.

About the National Institute of Mental Health (NIMH): The mission of the NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure. For more information, visit http://www.nimh.nih.gov.

About the National Institutes of Health (NIH): NIH, the nation’s medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.
• **S&C 15-17 – CLIA** - Revisions to State Operations Manual (SOM), Appendix C – Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services (Clinical Laboratory Improvement Amendments (CLIA)).

• **S&C 15-18 – HHA** - Outcome and Assessment Information Set (OASIS) transition to the Automated Submission and Processing System (ASAP) and OASIS Correction policy.


• **S&C 15-20 – ICD/IID** - CMS has revised the ICF/IID SOM Appendix J – Interpretive Guidelines (IGs) to clarify the intent of the Conditions of Participation (CoPs) for ICF/IID as well as represent current standards of practice in the field. In addition, the probes and procedures have been removed from the IGs and placed into an Exhibit in the SOM.

• **S&C 15-21 – ESRD** - Use of Invalid End Stage Renal Disease (ESRD) “Temporary” CMS Certification Numbers (CCN).

2) CMS released two notices of interest. They were:

   • CMS sent notice that there was an error in the earlier transmittal (127) that CMS has corrected in **Transmittal 130**. The error was in F309 and related to nurse assistant performance review frequency. The earlier document stated this review needed to occur every two months. Transmittal 130 corrects the error and includes language that was in the original issuance of updates to F309. This updated version now states: *Nursing assistants must receive a performance review at least once every 12 months and receive regular in-service education based on the outcome of the reviews. (See F497)*

   • CMS released a list of FAQs regarding the Marketing regulations at 42 CFR 438.104. It addresses activities by issuers that offer both a qualified health plan (QHP) and a Medicaid managed care plan; responding to consumer inquiries; and plans’ ability to conduct outreach for eligibility renewal. The FAQs can be accessed on Medicaid.gov by [clicking here](#) and also [here](#) under the Technical Support tab.

3) HFS released several Informational Notices since the last issue of *Regulatory Beat*. They include:

   • Hospital Assessments for Skilled Nursing Services ([click here](#)).
   • Updates to Hospital Medicare Inpatient Prospective Payment System (IPPS) Outlier Cost to Charge Ratios ([click here](#)).
   • New Web Based Application to Update or Change Enrollment Information for Currently Enrolled Providers ([click here](#)).
   • Payment Error Rate Measurement (PERM) Audit ([click here](#)).
   • Medicare Coinsurance Policies Not Allowed for Dual-Eligible Individuals ([click here](#)).

4) IDPH has adopted the new Physician Orders for Life-Sustaining Treatment (POLST) form for use. In August, 2014 Governor Quinn signed into law Public Act 98-1110 which requires some important changes to the current Illinois POLST form. The changes also bring the state another step closer to being in compliance with national POLST standards. The POLST Illinois Taskforce is working with the IDPH to create form revisions that include both the legislated changes as well as some additional changes to the form that
make it more effective. This form will soon be published for use and will be available at www.POLSTIL.org and on the IDPH website. Old versions of the form will continue to be honored. Click here for some additional information on the POLST changes.

5) The U.S. Department of Health and Human Services’ Office of Inspector General (OIG) released its much-anticipated report on hospice care in assisted living. Titled “Medicare Hospices Have Financial Incentives To Provide Care In Assisted Living Facilities,” the report found, among other things, that Medicare payments for hospice care in assisted living more than doubled between 2007 and 2012, totaling $2.1 billion in 2012. Also highlighted in the report was OIG’s finding that hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings. Hospices typically provided fewer than five hours of visits and were paid about $1,100 per week for each beneficiary receiving routine home care in assisted living, according to the report. Click here for the NCAL summary and access to the full OIG report.

6) ICD-10 Updates. CMS has released two updates since the last issue of Regulatory Beat. They were:

- Updated links related to NCD ICD-10 conversion charts (click here).
- Share your ICD-10 Story – (click here).

7) HealthData Management reported that The HHS Office for Civil Rights continues to develop its random HIPAA security audit program, and anticipates implementing it “expeditiously,” OCR Director Jocelyn Samuels said during a discussion with reporters on January 13. But she wouldn’t say if the long-delayed program will start this year. OCR is working “very proactively” in developing the protocols for the program. They want to make sure they get it right. They will be making announcements in the weeks and months to come so the profession will understand what to expect. OCR will continue to focus on “high impact” breaches that demonstrate systematic deficiencies to send a message to organizations that fail to conduct risk analyses, ignore known threats or have insufficient workforce training.

8) The federal Agency for Healthcare Research and Quality (AHRQ) recently published two reports that might be of interest to you. They were:

- AHRQ Finds Hospital Readmission Rates High Among Medicaid “Super-Utilizers” (click here).
- AHRQ Stats: Medicaid and Private Insurance – Characteristics of Medicaid and Uninsured Hospitalizations (click here).

9) Click here for the last two weekly issues of the CDC Influenza News and Highlights.

10) CMS’s Medicare Learning Network (click here) had several news items of possible interest released since the last Regulatory Beat that include:

- Monthly Spotlight Video: The 2-Midnight Rule
- ICD-10 Clinical Documentation Improvement Webinar Recording Available
- Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations – Article released
- Discharge Planning Booklet – revised
- The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners -Fact Sheet
- January Quarterly Provider Update Available

11) McKnight’s has several recent articles that might be of interest to you. They include:

- Failure to administer meds and poor supervision are linked to nursing home UTIs (click here)
- New antibiotic could be a silver bullet against MRSA (click here)
• Special gas kills norovirus on surfaces (click here)
• ADL Coding: The importance of being accurate (click here)

12) Other various LTC articles of possible interest

• The Pioneer Network has developed a new tool kit (click here) entitled “Engaging Staff in Individualizing Care.” This Toolkit is a product of the Pioneer Network’s National Learning Collaborative on Using the MDS as an Engine for High Quality Individualized Care, made possible with the support of The Retirement Research Foundation. The Collaborative incubated B&F Consulting’s method for engaging staff in individualizing care to improve outcomes for residents. The method first puts in place four foundational organizational practices – consistent assignment, huddles, involving CNAs in care planning and Quality Improvement (QI) closest to the resident. These practices create a forum for regular communication, critical thinking, and problem solving among and with staff closest to the residents.

• MedlinePlus recently noted a CDC report that notes that hospital infection rates are falling, but more improvement is needed. The study used national data to track outcomes at more than 14,500 health care centers across the United States. The researchers found a 46 percent drop in "central line-associated" bloodstream infections between 2008 and 2013. This type of infection occurs when a tube placed in a large vein is either not put in correctly or not kept clean, the CDC explained. During that same time, there was a 19 percent decrease in surgical site infections among patients who underwent the 10 types of surgery tracked in the report. These infections occur when germs get into the surgical wound site. Between 2011 and 2013, there was an 8 percent drop in multidrug-resistant Staphylococcus aureus (MRSA) infections, and a 10 percent fall in C. difficile infections. Both of these infections have prompted concern because some strains have grown resistant to many antibiotics. Catheter-associated urinary tract infections rose 6 percent since 2009, but initial data from 2014 suggests that these infections have also started to decrease, according to the annual CDC report. The CDC also noted that on any given day, about one in 25 hospital patients in the United States has at least one infection acquired while in the hospital, which highlights the need for continued efforts to improve infection control in U.S. hospitals.

• There were two recent articles in the National Law Review that are of interest. They were:
  o Skilled Nursing Facilities: Steps for Reducing False Claims Act Liability (with respect to therapy services - click here).
  o CMS Initiates Changes to Recovery Audit Program as Contracts are Rolled Out (click here)

• The Consumer Voice recently published a new brochure and fact sheet on resident to resident Aggression. Aggression between residents of long term care facilities is a serious yet hidden problem. All residents have the right to be free from all forms of abuse, neglect and exploitation, and have rights if they have been subjected to mistreatment. Newly released from the National Consumer Voice for Quality Long-Term Care and the National Center on Elder Abuse, this brochure (and large print fact sheet) identifies mistreatment, shares information about an individual’s rights, and offers resources where they can go for help.
  o Resident to Resident Mistreatment Brochure
  o Resident to Resident Mistreatment Factsheet - Large Font

• Researchers at the University of North Carolina at Chapel Hill and North Carolina State University have uncovered a novel approach to creating inhalable vaccines using nanoparticles that shows promise for targeting lung-specific diseases, such as influenza, pneumonia and tuberculosis. The work, led by Cathy Fromen and Gregory Robbins, members of the DeSimone and Ting labs, reveals that a particle’s surface charge plays a key role in eliciting immune responses in the lung. Using the Particle
Replication in Nonwetting Templates (PRINT) technology invented in the DeSimone lab, Fromen and Robbins were able to specifically modify the surface charge of protein-loaded particles while avoiding disruption of other particle features, demonstrating PRINT’s unique ability to modify particle attributes independently from one another. When delivered through the lung, particles with a positive surface charge were shown to induce antibody responses both locally in the lung and systemically in the body. In contrast, negatively charged particles of the same composition led to weaker, and in some cases undetectable, immune responses, suggesting that particle charge is an important consideration for pulmonary vaccination.

- Vanderbilt investigators are studying curcumin, which is found in the spice turmeric, as a treatment for Alzheimer’s disease. One of the most promising new treatments for Alzheimer’s disease may already be in your kitchen. Curcumin, a natural product found in the spice turmeric, has been used by many Asian cultures for centuries, and a new study indicates a close chemical analog of curcumin has properties that may make it useful as a treatment for the brain disease. “Curcumin has demonstrated ability to enter the brain, bind and destroy the beta-amyloid plaques present in Alzheimer’s with reduced toxicity,” said Wellington Pham, Ph.D., assistant professor of Radiology and Radiological Sciences and Biomedical Engineering at Vanderbilt and senior author of the study, published recently in the *Journal of Alzheimer’s Disease*. Accumulation and aggregation of protein fragments, known as beta-amyloid, drives the irreversible loss of neurons in Alzheimer’s disease. Developing small molecules to reduce this accumulation or promote its demolition is crucial, but the ability of these small molecules to cross the blood-brain barrier has been a restricting factor for drug delivery into the brain.

- *MedPage Today* published a recent article entitled “More Falls for Those Starting Newer Antipsychotics” – Falls, fractures up 50 percent in patients with new prescriptions for atypical antipsychotics. ([Click here](#))

13) Interesting Fact: Banging your head against a wall burns 150 calories an hour. This has become a common practice amongst LTC providers trying to care for their residents, recruit and retain staff, and most notably, trying to keep current with all the state and federal requirements.