We are almost done here for the day!

CMS PROPOSED REVISIONS OF THE NURSING HOME REGULATIONS

SNF Regulatory Day
September 17, 2015

CMS’s Major Initiatives

- Reduce unnecessary readmissions
- Reduce Healthcare Associated Infections (HAI)
- Reduce use of antipsychotic medications
- Improve behavioral healthcare
**Major Themes**
- Facility-based assessment
- Competency-based approach
- Incorporation of previous regulations and directives
- Improved readability
- Restructuring of current regulations
- Creation of new requirements
- Implementation of legislation

**Definitions**
Adds definitions for:
- "adverse event"
- "documentation"
- "posting/displaying"
- "resident representative"
- "abuse"
- "sexual abuse"
- "neglect"
- "exploitation"
- "misappropriation of resident property"
- "person centered care"

**Resident Rights**
CMS would retain all existing residents’ rights, but update language and organization & to include **advances such as electronic communications** in addition to:
- Eliminate language, such as "interested family member": replace "legal representative" with "resident representative."
- Clarify rights and limitations of resident representatives.
- Address roommate choice.
• Add language regarding physician credentialing to specify that the physician chosen by the resident must be licensed to practice medicine in the state where the resident resides, and must meet professional credentialing requirements of the facility.

• Ensuring residents are aware of and can contact an Aging and Disability Resource Center or other No Wrong Door program.

Facility Responsibilities (New Section)

Focuses on facility responsibilities for protecting the residents’ rights & enhancing quality of life. This section parallels many residents’ rights provisions.

- Would establish open visitation, similar to the hospital conditions of participation.

- Would revise “Resident behavior and facility practices,” to “Freedom from abuse, neglect, and exploitation”; and

- Prohibit employment of individuals with disciplinary actions against their professional license by a state licensure body following a finding of abuse, neglect, mistreatment, or misappropriation of property.

• Require implementation of written policies and procedures that prohibit and prevent abuse, neglect, mistreatment and/or misappropriation of property.

• Adds a new term "exploitation", that is added to address circumstances that may not rise to the level of abuse or neglect, but would nonetheless be prohibited (the unfair treatment or use of a resident or the taking of a selfish or unfair advantage of a resident for personal gain, through manipulation, intimidation, threats or coercion).
Transitions of Care

- Revises “admission, transfer and discharge rights,” to apply to all transfers of resident care.

- Would require specific information/data elements, e.g., demographic; history of present illness including, e.g., active diagnoses, functional status, medications; reason for transfer and past medical/surgical history, be exchanged with the receiving provider.

- CMS is not proposing a specific form, format, or methodology for the (above) specific information.

- Would required that the facility establish an admission policy.

- To specify that a nursing facility must disclose and provide to a resident or potential resident, prior to time of admission, a notice of any special characteristics or services limitations of the facility.

- Expanded expectations to provide quality data on post-acute providers upon discharge including information on follow-up care.

- To prohibit facilities from requesting or requiring resident or potential residents to waive any potential facility liability for losses of personal property.

- To add new requirement that a facility’s notice of its bedhold policy and readmission must also include information of the facility’s policy for readmission.
Resident Assessments

• Would clarify what constitutes appropriate coordination of resident assessment with the Preadmission Screening and Resident Review (PASARR).

• Would add exceptions to PASARR requirements for mental illness and intellectual disabilities for admission with respect to transfers to or from a hospital.

• Would require notification of state mental health or intellectual disability authorities promptly after a significant change in the mental or physical condition of a resident with a mental illness or intellectual disability.

• Would require the care plan to include any specialized services or specialized rehabilitation services the facility will provide as a result of PASARR; a rationale for disagreement with PASARR findings must be documented in the medical record.

Comprehensive Person-Centered Care Planning (CPCCP) (New Section)

• Interdisciplinary Team (IDT): Would add a nurse aide, food and nutrition services, and a social worker to the IDT that develops the comprehensive care plan.

• Comprehensive Care Plan: Would require written explanation in the medical record if participation of the resident and their resident representative is determined not practicable.

• Would require development of a baseline care plan for each resident within 48 hours of admission, including instructions needed to provide effective and person-centered care meeting professional standards.
- Would implement IMPACT Act requirements for long term care facilities to take into account quality, resource use, and other measures to inform and assist the discharge planning process, while accounting for resident treatment preferences and goals.

- Would require facilities to document the resident’s goals for admission in the care plan; assess potential for future discharge; include discharge planning in the comprehensive care plan, as appropriate.

- To specify that a recapitulation of a resident’s stay would include diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

- Would require the discharge summary to include reconciliation of all discharge medications with pre-admission medications (prescribed and OTC).

- Would require addition to the post discharge care plan a summary of arrangements made for follow up and any post discharge services.

**Quality of Care & Quality of Life (Retitled)**

- Would clarify that quality of care and quality of life are overarching principles in all care and services.

- No proposal, but CMS is seeking comments on whether current requirements for activities’ director are appropriate; what minimum requirements should be.

- To establish specific requirements with a facility used bed rails on a resident’s bed.
Would clarify the requirements regarding a resident’s ability to perform ADLs. Establish what ADLs are:

- Hygiene, such as bathing, dressing, grooming and oral care
- Mobility which includes transfers and ambulation
- Toileting and use of the bathroom
- Dining, including eating meals and snacks
- Communication including speech, language and other functional communication systems

Would modify requirements for nasogastric tubes to reflect current clinical practice, and include enteral fluids in requirements for assisted nutrition and hydration.

Would add a new requirement that facilities ensure pain management needs are met.

Would move current provisions for unnecessary drugs, antipsychotics, medication errors, and influenza and pneumococcal immunizations to Pharmacy services.

**Special Care Issues**

- restraints;
- bed rails;
- vision and hearing;
- skin integrity;
- mobility;
- incontinence;
- colostomy, ureterostomy, or ileostomy;

- assisted nutrition and hydration;
- parenteral fluids;
- accidents;
- respiratory care;
- prostheses;
- pain management;
- dialysis, and
- trauma-informed care
Physician Services

- Would require an in-person evaluation by a physician, a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) before an unscheduled transfer to a hospital.
- Would allow physicians to delegate dietary orders to dietitians and therapy orders to therapists.

Physician Services Considerations

- Feasibility of in-person evaluation by a physician, a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) before an unscheduled transfer to a hospital.
- Definition of “emergency situation”, when an evaluation would be waived?

CAUTION

- Residents may deteriorate without prompt treatment when physician is not available for onsite assessment.
- Limitations of state practice laws that may impede ability to delegate dietary orders to dietitians and therapy orders to therapists.
- Need clarification of credentials of dietitian and therapy disciplines referred to.
Nurse Staffing

• Would add a competencies/skill set requirement for determining sufficient nursing and direct care staff based on a facility assessment. Competency-based staffing approach would be based on:
  ✓ Resident population
  ✓ Number and acuity of residents
  ✓ Range of diagnoses and resident needs
  ✓ Training, experience, and skill sets of staff

• To require facilities to make thoughtful, informed staffing plans and decisions that are focused on meeting resident needs, including maintaining or improving resident function and quality of life.

Nursing Services Considerations

• Determining sufficient nursing staff and making staffing plans based on resident numbers, acuity, diagnoses and care needs are given and are part of professional nursing care practices. Requiring documentation of the process is extraneous and diverts significant time and resources away from other resident needs.
Behavioral Health (New Section)

- Would focus on provision of necessary behavioral health care and services to residents in accordance with their comprehensive assessment and plan of care.

- Would add "gerontology" bachelor's degree to the list of acceptable minimum social worker educational requirements.

- To require facilities to determine their direct care staffing needs that is based on the facility's assessment.

- Would require staff to have appropriate competencies to provide behavioral health care and services, including care of residents with mental and psychosocial illnesses and implementing non-pharmacological interventions.

- CMS notes in the Preamble that reference to mental health/illness includes substance abuse disorders.

Pharmacy Services; Drug Regimen Review

- Would require pharmacist review of a resident's medical chart at least every 6 months and –

  - when the resident is new to the facility,
  - a resident returns or is transferred from a hospital or other facility, and
  - during each monthly DRR when a resident has been prescribed or is taking a psychotropic drug, an antibiotic or any drug the QAA Committee has requested be included in the monthly drug review.
• Would require the pharmacist to document any irregularities noted during the DRR, including at minimum, the resident’s name, the relevant drug and irregularity identified, to be sent to the attending physician, medical director, and director of nursing.

• Would require the attending physician to document that he/she has reviewed the identified irregularity and what, if any, action they have taken. “Irregularities” would include “unnecessary drugs”.

• Would require facilities to ensure residents who have not used psychotropic drugs not be given these drugs unless medically necessary; receive gradual dose reductions and behavioral interventions unless clinically contraindicated.

• “Psychotropic drug” would include any drug that affects brain activities associated with mental processes and behavior.

• PRN orders for psychotropic drugs would be limited to 48 hours unless the primary care provider reviews and documents the rationale.

Pharmacy Considerations

• Availability of pharmacist for increased requirements for medication reviews and review of antibiotic use – some only visit once per month (contractual amendment?)

• Review of the resident’s medical chart at least every 6 months and when the resident is new, or returns from the hospital will require additional pharmacist time.

• Concerns about 48 hour limit on pm use of antipsychotic medications and availability of physicians to meet requirements
• Changing the classification from “antipsychotic” to “psychotropic” is a drastic change in treatment practices.
• Psychotropic medications include anti-depressants.
• Requiring gradual dose reductions and behavior interventions for residents who are receiving anti-depressant medications may result in the inaccurate conclusion that a resident’s depression isn’t being treated or is being under-treated. May be clinically inappropriate.

Laboratory, Radiology and other Diagnostic Services (New)
• Would clarify that a PA, NP, or CNS may order laboratory, radiology, and other diagnostic services in accordance with state and scope of practice laws.
• Would clarify that the ordering practitioner be notified of abnormal laboratory results when they fall outside of clinical reference ranges, in accordance with facility notification policies and procedures.

Dental Services
• Would prohibit SNFs from charging a Medicare resident for the loss or damage of dentures determined to be the facility’s responsibility.
• Would require NFs to assist eligible residents to apply for reimbursement of dental services under the Medicaid state plan.
• Would clarify that a referral for lost or damaged dentures “promptly” means within 3 business days absent documentation of any extenuating circumstances.
- Would require facilities to employ sufficient staff with appropriate competencies to carry out dietary services in accordance with resident assessments, individual care plans, and facility census.

- A “qualified dietitian” is registered by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics or meets state licensure or certification requirements. Dietitians hired/contracted with prior to these regulations, would have 5 years to meet the new requirements.

- The director of food and nutrition service must be a certified dietary manager, certified food service manager, or be certified for food service management and safety by a national certifying body or have an associate’s or higher degree in food service management or hospitality; would have to meet any state requirements for food service managers.

- Would require menus to reflect religious, cultural and ethnic needs and preferences, be updated periodically, and reviewed by the qualified dietitian or other clinically qualified nutrition professional for nutritional adequacy while not limiting residents’ right to personal dietary choices.

- Would require facilities to consider resident allergies, intolerances, and preferences and ensure adequate hydration.

- Would allow attending physicians to delegate prescribing resident diets to registered or licensed dietitians, including therapeutic diets, in accordance with state law.

- Would require availability of suitable, nourishing alternative meals and snacks for residents who want to eat at non-traditional times or outside of scheduled meal times in accordance with the plan of care.
- Would require documentation in the care plan the clinical need for a feeding assistant and the extent of dining assistance needed.

- Would clarify facilities may procure food items directly from local producers and may use produce grown in facility gardens.

- Would clarify residents are not prohibited from consuming foods not procured by the facility.

- Would require a policy regarding use and storage of foods brought to residents by family and other visitors.

### Specialized Rehabilitative Services

- Would add respiratory services to specialized rehabilitative services.

- Would clarify what constitutes rehabilitative services for mental illness and intellectual disability.

- Would establish new health and safety standards for provision of outpatient rehabilitative therapy services.

### Facility Assessment – would require facilities to conduct, document, and update annually and when needed an assessment to determine resources necessary to care for its residents competently during both day-to-day operations and emergencies.

- Would include resident population (#, overall care needs and staff competencies required, cultural aspects); resources (e.g., equipment, and overall personnel); and a facility-and community-based risk assessment.
Administration

- Would require the facility to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during day-to-day operations and emergencies which must be reviewed and updated as necessary, but at least annually.

- To address in the facility assessment the number of residents, the overall types of care and staff competencies required by the residents including their cultural aspects, resources such as equipment and overall personnel, and a facility-based and community-based risk assessment.

- Would establish requirements that mirror some found in the HIPAA Privacy Rule.

- Proposes specific requirements for the facility and the agreement itself to ensure that if a facility presents binding arbitration agreements to its residents:
  - that the agreements be explained and acknowledged regarding understanding;
  - that they be entered into voluntarily; and
  - arbitration sessions be conducted by a neutral arbitrator in a location that is convenient to both parties.

- Admission to the facility could not be contingent upon signing of a binding arbitration agreement.

- The agreement could not prohibit or discourage communication with federal, state, or local health care or health-related officials, including representatives of the Office of the State Long-Term Care Ombudsman.

- To specify that the governing body is responsible and accountable for the Quality Assurance and Performance Improvement (QAPI) program.
Quality Assurance and Performance Improvement (QAPI) (New)

- Would require all LTC facilities to develop, implement, and maintain an effective comprehensive, ongoing, data-driven QAPI programs that focus on systems of care, outcomes of care and quality of life.

- Facilities would submit the QAPI plan at the 1st standard survey after 1 year from the final rule effective date; and –
  - at each subsequent standard survey upon request;
  - documentation and evidence of ongoing implementation also required upon request.

- Facilities would —
  - maintain effective feedback systems from staff, residents/resident representatives;
  - establish priorities;
  - have a process for identifying, reporting, analyzing, and preventing adverse/potential adverse events;
  - have a systematic process for determination of underlying causes;
  - measure/monitor the success of actions taken and track performance for sustainability; and
  - include Performance Improvement Projects (PIPS)

- To require that the facility ensure, through the governing body or executive leadership;
  - an ongoing QAPI program is defined, implemented and sustained during transitions in leadership and staffing and,
  - the QAPI program is adequately resourced, including ensuring staff time, equipment and technical training as needed.
QAPI Considerations

• Demonstration of compliance with the requirements may require State and federal surveyor access to –
  - Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events;
  - Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities and;
  - Other documentation considered necessary by a State or Federal surveyor in assessing compliance.

CAUTION

• Significant amount of time, staff and financial resources will be necessary to comply – such as “meaningful participation” time of Medical Director is estimated by CMS as only being 1 hour of time. It is more realistically estimated to be 5 or more hours.

Infection Control

• Would require an Infection and Control Program (IPCP)
  - for preventing, identifying, surveillance, investigating, and controlling infections and communicable diseases for:
    - residents, staff, volunteers, visitors, and other individuals providing services based upon facility and resident assessments as reviewed and updated annually;
  - also require incorporation of an antibiotic stewardship program.
• Would require designation of an Infection and Prevention Control Officer (IPCO) for whom the IPCP is their major responsibility and who would serve as a member of the facility's quality assessment and assurance (QAA) committee.

• The IPCO has received specialized training in infection prevention and control beyond their initial professional degree.

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Infection Control Considerations (cont)

• The facility must designate one individual as the infection prevention and control officer (IPCO) for whom the IPCP at that facility is a major responsibility.

• The IPCO must:
  • Be a clinician who works at least part-time at the facility
  • Have specialized training in infection prevention and control beyond their initial professional degree.

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CAUTION

• The person designated as the IPCO must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.

• The level of staff expertise in infection control is unclear, open again to surveyor interpretation and potentially unachievable if sufficient numbers of staff with the necessary credentials are not available.
Compliance and Ethics Program (New)

- Would require each facility to have in operation a compliance and ethics program with established written compliance and ethics standards, policies and procedures capable of reducing the prospect of criminal, civil, and administrative violations in accordance with section 1128I(b) of the Act.

- Required components:
  - established written standards, policies, procedures;
  - assignment of high-level personnel;
  - sufficient resources and authority for these individuals;
  - due diligence to prevent delegation to individuals with propensity for criminal, civil, administrative violations;
  - effective communication and mandatory training;
  - reasonable steps, e.g., monitoring/auditing systems, to achieve compliance;
  - consistent enforcement;
  - appropriate response to correct and prevent future occurrences.

Compliance/Ethics Program Considerations

- Implementation timeframe is short.

- Although facilities may have a corporate compliance program, this carries additional requirements and the addition of an Ethics program.

- Concerns about how compliance would be determined.
Physical Environment

- Facilities initially certified after the effective date of this rule would be limited to two residents per bedroom.
- Facilities initially certified after the effective date of this rule would have to have a bathroom equipped with at least a toilet, sink and shower in each room.
- Would require policies, in accordance with applicable federal, state and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety.

Physical Environment Considerations

- Changes to the physical environment and construction could force homes with major reconstruction project currently in the works to go back and re-figure.
- Requiring each room that is newly built to have its own shower in the room is not feasible. Some residents require a gurney to lay on for showers and others may enter the shower are without supervision – safety.

Training Requirements (New)

- Would add a new section setting forth all requirements of an effective training program for new and existing staff, contract staff, and volunteers.
- Proposed topics include:
  - Effective communication;
  - Resident rights and facility responsibilities;
  - Abuse, neglect, and exploitation;
  - QAPI & infection control;
  - Compliance and ethics.
Annual training would be required for organizations operating five or more facilities.

Would require dementia management and resident abuse prevention training as part of the 12 hours per year in-service training for nurse aides.

Would require facilities to provide behavioral health training to all staff, based on the facility assessment.

Training Requirements Considerations

- Not clear without Interpretive Guidelines as to what is expected and whether current processes already in place would constitute compliance.
- Not clear as to how the assessment would be used by survey staff.

LeadingAge additional requests:

- Will recommend to CMS that the new requirements be phased in over a five-year period to allow adequate opportunity for the significant new staff training and other changes nursing homes will have to make. We want these improvements to succeed, which will not happen unless sufficient time is provided for nursing homes to properly comply.
- We will also point out to CMS that the proposed changes in the requirements of participation are taking place in the context of other major changes in payment systems. Medicare sequestration is giving nursing homes a likely cut in reimbursement for 2016.
- Value-based purchasing will result in another 2% “withholding”, which will at best be only partially returned to those nursing homes achieving the lowest rates of re-hospitalizations.
CMS has extended the comment period for proposed rule entitled “Reform of Requirements for Long-Term Care Facilities” through 10/14/15. The following is the CMS justification:

“We have received inquiries from Hospital Associations and national industry organizations regarding the 60 day period to submit comments regarding this proposed rule. The organizations stated that they needed additional time to respond to the rule due to the scope and complexity of the proposal. Because of the scope of the proposed rule, and since we have specifically requested the public’s comments on various aspect of the rule, we believe that it is important to allow ample time for the public to prepare comments on this proposed rule.”


We will be there with and for you!

LeadingAge Michigan, with the assistance from Dykema will be providing a presentation (date TBD) focusing on practical thing to do now in preparation for the final changes to the Conditions of Participation for Long Term Care.

Tasks such as policy development and considerations of clauses to include in contracts etc. that would be applicable to a number of the proposed revisions which include infection control, resident rights, transitions of care, comprehensive resident-centered care plans, physician and nursing services regulations.