Preparing for Change
Steps that SNFs can take now to prepare for the Inevitable

CMS Proposed Rule - SNF Mega-Rule

Phyllis Adams, Esq., Dykema
Joanne Lax, Esq., Dykema
Laura Funsch, RN, BSN, MS, LeadingAge Michigan

Basics on CMS SNF Mega-Rule

Mega-Rule published by CMS as proposed rule on July 16, 2015
- Final rule not yet published
- Voluminous comments from the industry

But, likely that CMS:
- Does not expect material changes
- Final rule to be posted around Oct./Nov. of 2016
- Implementation of entire rule will be phased

Application will be BURDENSOME so no time for the OSTRICH approach!
Major initiatives of the proposed revisions:
- Reduce costly unnecessary readmissions
- Reduce Healthcare Associated Infections (HAI)
- Reduce use of antipsychotic medications
- Improve behavioral healthcare

Major themes throughout the proposed revisions:
- Facility-based assessments
- Competency-based approach

Approach to Today’s Session
Identification of the themes of change throughout the Mega-Rule and where these revisions are reinforced in many sections by means of -
- Collaboration – think “Interlocking Teams”
- Accountability – think “High Court”
- Person-Centered care – think “The Resident is Queen or King”
- Data mining and utilization – think “Golden Opportunity”
Approach to Today’s Session

Goal is to present a framework that SNFs can start taking NOW to prepare your facility for the implementation of the Mega-Rule

Collaboration – “Interlocking Teams”
Collaboration – “Interlocking Teams”

Mega-Rule includes numerous staffing requirements and changes
- Assortment of staffing issues on staffing with assessment of staff competencies and numbers
- SNFs will need to address additional staff training and development, as well as other HR issues
- Push toward person-centered care will change staffing responsibilities and how staff collaborate

Regulations in Proposed Rule
- 42 CFR 483.5 (definitions)
- 42 CFR 483.21 (interdisciplinary team for care plan)
- 42 CFR 483.35 (nursing services)
- 42 CFR 483.40 (behavioral services)
- 42 CFR 483.60 (food and nutrition)
- 42 CFR 483.67 (outpatient rehab)
- 42 CFR 483.70 (administration)
- 42 CFR 483.80 (infection control)
- 42 CFR 483.95 (training)

Collaboration – The “Opening Move”

AI #1: Conduct a Facility-wide Assessment
- The resident population;
  ✓ including the number of residents and the facility’s resident capacity
  ✓ the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity that are present within that population
- The physical environment, equipment, and services that are necessary to care for this population.
- Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.
Collaboration – The “Opening Move”

| AI #1: Conduct a Facility-wide Assessment | The facility’s resources including but not limited to;  
|                                           | - buildings and other physical structures and vehicles;  
|                                           | - medical and non-medical equipment  
|                                           | The services provided, such as;  
|                                           | - physical therapy,  
|                                           | - pharmacy,  
|                                           | - specific rehabilitation and respiratory therapies  
|                                           | Personnel, including managers, employed and contracted staff, and volunteers, as well as their education and/or training and any competencies related to resident care.  

| AI #1: Conduct a Facility-wide Assessment | Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility both during normal operations and emergencies.  
|                                          | Health information technology resources, such as;  
|                                          | - systems for electronically managing patient medical records  
|                                          | - electronically sharing information with other organizations |
Collaboration – Action Item #1

AI #1: Staffing competencies

- After determining likely SNF population, evaluate staffing competencies for specific SNF population and determine the direct care staffing numbers by position and teamwork required;
  - the number of residents, resident acuity, range of diagnoses, and the content of care plans

- Develop hiring plan based on assessment and communicate with governance regarding budgeting priorities.

Collaboration: Action Item #2

AI #2: Evaluate Staff Training Programs

- Undertake a “360” review of SNF staff training programs;
  - How are these organized within the facility?
  - What is the leadership of these programs? Is it robust?
  - Have training programs been evaluated for effectiveness? Is more team training required?
  - How will new mandatory training elements under the SNF Mega-Rule be implemented? Who will be responsible for this assessment and what is the timetable?
Staff education/required training topics -

- Rights of the resident and the responsibilities of a facility to properly care for their resident - to specify that these rights cannot be construed as a right to receive medical care that is not medically necessary or appropriate.

- Behavioral health care and services, which include caring for residents with mental and psychosocial illnesses, as well as residents with a history of trauma and/or post-traumatic stress disorder and implementing non-pharmacological interventions.

- Effective communication.

- Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, and procedures for reporting these incidents.

- QAPI, infection prevention and control program, compliance and ethics programs - the written standards, policies, and procedures for each program.

Collaboration: Action Item #3

AI #3: Review ADA and OCR Policies and Compliance

- Mega-Rule emphasizes person-centered and nondiscriminatory treatment;
  - Good time to review your ADA and OCR policies, and admission policies, as to acceptance of residents with various physical or mental conditions.
  - Consider how SNF will balance its ADA/OCR obligations against its newly enhanced duty to ensure that it can adequately care for residents that it admits.
Collaboration – Action Item #4

AI #4: Review contracts and policies as to collaboration with physicians, PAs and NPs

◆ Consider comprehensive review of policies and procedures for physicians, PAs, and NPs with focus on:
  ✓ Their obligations to SNF residents
  ✓ How SNF may hold physicians and physician extenders accountable for inappropriate or noncompliant practices
  ✓ Do contracts include applicable standards of practice, require collaboration, and include consequences for noncompliance?

Collaboration – Action Item #5

AI #5: Review medical staff credentialing process

◆ Should the SNF have:
  ✓ A medical staff credentialing process with more formalized application and appointment process?
  ✓ Under current process, does SNF have ability to deny attending status if noncompliance by professional with applicable requirements, including Medicare regulations and SNF policies?
Collaboration – Action Item #6

AI #6:
Review relationships with physicians and Medical Director

Review should consider:

- Compliance requirements for those relationships, anti-kickback, Stark, physician supervision, general labor/employment
- Getting a good template for compliant physician contracts, including Medical Director agreements or requiring legal review of these types of agreements
- Ensure contracts require physicians and physician extenders to comply with more rigorous CMS certification requirements

Collaboration – Action Item #7

AI #7:
Review training systems and requirements for physician and physician extenders

See Action Item #2 as to evaluation of facility-wide training programs

- With respect to physicians and physician extenders, how is training addressed in your facility?
  - Is it mandatory or required by contract?
  - Should policies and procedures for training be updated?
  - Who will be responsible for educating physicians, PAs, and NP staff about the new CMS requirements once they are finalized?
### Collaboration – Action Item #8

<table>
<thead>
<tr>
<th>AI #8: Evaluate policies and procedures for transitions of care</th>
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<tbody>
<tr>
<td><strong>Transitions of care will require enhanced collaboration under Mega-Rule</strong></td>
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<tr>
<td><strong>Review admission and discharge practices to assure appropriate collaboration and accountability</strong></td>
</tr>
<tr>
<td><strong>Is transition process effective to assure resident safety and quality of care?</strong></td>
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<tr>
<td>✓ Develop care protocols and staff training to improve the care of residents with acute changes in condition.</td>
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<td><strong>More integrated approach and organizational changes may be required – start the dialogue with transfer hospitals and other transition partners</strong></td>
</tr>
<tr>
<td>✓ Identify conditions early and prevent them from becoming severe enough to require hospitalization</td>
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<td>✓ Understand that residents who are medically complicated may have acute exacerbations – but some that meet certain criteria can be safely managed when identified</td>
</tr>
<tr>
<td>✓ Improved advanced care planning</td>
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</table>
Transitions of Care requirements -

- Must develop and implement an effective discharge planning process
- Must ensure that the discharge goals and needs of each resident are identified –
  - should also result in the development of a discharge plan for each resident and any referrals to local contact agencies or other appropriate entities, should the resident have a desire to receive information about returning to the community –
- Facility’s discharge planning process require the regular re-evaluation of residents to identify changes that require modification of the discharge plan
- The IDT responsible for the developing a resident’s comprehensive care plan be involved in the ongoing process of developing the discharge plan
- The post-discharge plan be developed along with the participation of the resident and, with the resident’s consent, his or her resident representative.

Transitions of Care requirements -

- If discharge to the community were determined to not be feasible, the facility would document who made the determination and why
- To assist residents and their resident representatives in selecting a post-acute care provider by using data that includes -
  - SNF, HHA, IRF, or LTCH standardized patient assessment data,
  - data on quality measures, and
  - data on resource use to the extent the data are available!
- The facility would have to ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use are relevant and applicable to the resident’s goals of care and treatment preferences
Transitions of Care requirements-

- Specify that a recapitulation of a resident’s stay is documented and include:
  - diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results
  - explicitly include what arrangements have been made with other providers for the resident’s follow-up care and any post-discharge medical and non-medical services as needed
  - These arrangements should include community care options, resources, and available supports and services presented and arranged by the community care provider as needed.

- To reconcile all pre-discharge medications both prescribed and non-prescription, with the resident’s post discharge medications. This medication reconciliation would be included as part of the discharge summary.

Accountability Never Ends!
Accountability Never Ends!

Under the Mega-Rule, CMS makes the SNF accountable for everything that occurs in facility and to its residents:

- Essentially “strict liability” for the SNF to assure appropriate care and outcomes
- How does a SNF ensure that others involved in the provision of care and services are responsible? (pharmacy, lab, dental, physicians, rehab)

Regulations:

- 42 CFR 483.11 (facility responsibilities)
- 42 CFR 483.12 (abuse, neglect, exploitation)
- 42 CFR 483.15 (transitions of care)
- 42 CFR 483.20 (resident assessment)
- 42 CFR 483.21 (person-centered care plan)
- 42 CFR 483.25 (quality of care)
- 42 CFR 483.30 (physician services)
- 42 CFR 483.70 (administration)
- 42 CFR 483.75 (QAPI)
- 42 CFR 483.85 (compliance and ethics)

Accountability Never Ends – Action Item #1

**AI#1:** Contract review

- Very good time to review your contracts with therapy, dietary, pharmacy and other providers
  - What is current term? Can contracts be amended to address requirements of Mega-Rule?
- Do contracts require:
  - Collaboration, appropriate standards for quality of service and termination if not?
  - Pristine record keeping?
- Consider development of standardized addendum that addresses key compliance requirements including abiding by SNF’s compliance program, record-keeping, cooperation, confidentiality, and, if possible, indemnification.
Accountability Never Ends – Action Item #2

**AI #2:**
Perfect time thoroughly analyze your facility-wide assessment!

- Get benchmarks on current practices and procedures, including your contracting process
- Confirm strengths in organization, but to take a hard look at weaknesses and challenges on wide range of compliance issues

Accountability Never Ends – Action Item #3

**AI #3:**
Assess Board involvement and accountability

- OIG and CMS are clear that governing body must be involved and is ultimately accountable for the operation of your SNF
  - Are board documents and policies clear as to board’s role in assuring quality/accountability?
  - Is there a board-level committee that receives and participates in quality review?
  - Is there a quality report at every board meeting?
  - What quality metrics are shared with board? Are these metrics meaningful and sufficient for board to assess quality of services?
Accountability Never Ends – Action Item #3

**AI #3:**
Assess Board involvement and accountability

- Does the board participate in compliance training? How often and what is the content?
- What is your board selection process? Are your board members “invested” in the facility and committed to assuring compliant and ethical practices? Do you have the right leadership within the board?

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The Resident is Queen (or King)
Think Person-Centered Care

<table>
<thead>
<tr>
<th>Under the Mega-Rule, there will be a huge focus on individual/person-centered care in all areas of operation</th>
<th>Mega-Rule will:</th>
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<tbody>
<tr>
<td></td>
<td>❖ Effectively impose culture change</td>
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<td>✓ Encompasses qualities of compassion and responsiveness to the needs, values and expressed preferences of the resident.</td>
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<tr>
<td></td>
<td>✓ Emphasis on resident centeredness means the culture of care delivery is more flexible while maintaining responsibility for protecting the health and safety of the residents.</td>
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</table>

Regulations:

- 42 CFR 483.10 (resident rights)
- 42 CFR 483.11 (facility responsibilities)
- 42 CFR 483.21 (person-centered care plan)
Think Person-Centered Care – Action Item #1

**AI #1:**
Review of operating policies and procedures to optimize resident choice

- Do your facility wide policies & procedures and documentation tools reflect resident options and choices including respecting the resident wishes?
- Do SNF policies regarding to key activities like dining and bathing optimize resident choice? How is choice documented?
- Do facility planned activities address a variety of resident interests and activity level?
- Can individual requests regarding sleeping, bathing, grooming, daily and special activities be accommodated?

Think Person-Centered Care – Action Item #1

**AI #1:**
Review of operating policies and procedures to optimize resident choice

- If SNF has contract for dietary services, does contract require management company to accommodate resident choices and preferences? (See also Accountability - Action Item #1)
- Does the facility have “rules” about where the resident can eat or when they can eat that can be eliminated or modified?
- If “rules” about where residents can eat are changed, do sanitation policies or staffing need to change?
- How will the SNF document resident food intake if more flexible rules? Staff required?
### Think Person-Centered Care – Action Item #2

**AI #2:**
Does your SNF have policies that specifically address the needs of special populations such as trauma survivors?

- How will the SNF identify and address in a person-centered way, the unique needs of special populations?
- (See also evaluation of staff training under Collaboration.) Are staff able to identify special needs? Do intake documents for residents identify these needs in an appropriate way?
- Does the SNF need to consider outside resources to assist in development of processes to identify and assist residents with special/unique needs?

### Think Person-Centered Care – Action Item #3

**AI #3:**
Review of policies and procedures for resolving conflicts between resident choice and SNF accountability

- What are current policies or processes for addressing conflicts or grievances? Are they effective?
- Are there “choke points” for approval of alternatives to care to accommodate patient choice?
- How does SNF document patient choice issues, options tried, and risks? Does documentation reflect patient request and decisions made to accommodate patient choice? Family expectations?
### Person-Centered Care Policy requirements -

#### “Special Care Issues” including -

- **restraints**
- **bed rails**: (ensure correct installation, use and maintenance of bed rails, including attempting to use alternatives prior to installing a side or bed rail, assessing the resident for risk of entrapment from bed rails prior to installation, reviewing the risks and benefits of bed rails with the resident and obtaining informed consent prior to installation, ensuring that the resident’s size and weight are appropriate for the bed’s dimensions, and following the manufacturers’ recommendations and specifications for installing and maintaining bed rails)
- **vision and hearing**
- **skin integrity**: (care must be consistent with professional standards of practice and to clarify that foot care includes care to prevent complications from the resident’s medical conditions such as diabetes, peripheral vascular disease, or immobility, and also includes assistance in making and keeping necessary appointments with qualified healthcare providers such as podiatrists)
- **mobility**;
- **incontinence**: (residents with fecal incontinence receive the appropriate treatment and services to restore as much normal bowel function as possible)

### Person-Centered Care Policy requirements -

#### “Special Care Issues” including -

- **colostomy, ureterostomy, or ileostomy**
- **assisted nutrition and hydration**
- **parenteral fluids**
- **accidents**
- **respiratory care**
- **prostheses**
- **pain management**
- **dialysis**: (receive those services in accordance with professional standards of practice and the residents choices)
- **trauma-informed care**: (residents who are trauma survivors receive care and treatment that is trauma-informed, takes into consideration the resident’s experiences and preferences in order to avoid triggers that may cause re-traumatization, and meet professional standards of practice)
Person-Centered Care Policy requirements-

✓ Require facilities to have available suitable and 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 resident’s plan of care.

✓ Facility to provide not only adaptive eating equipment and utensils for residents who need these devices but also provide the appropriate staff assistance to ensure that these residents can use the assistive devices when consuming meals and snacks.

✓ A policy in place to address use and storage of foods brought to residents will help ensure consistent application of safe and sanitary food handling practices by staff when these foods are present in the facility.

✓ Specifically add respiratory therapy to the list of specialized rehabilitative services.

Person-Centered Care Process requirements-

✓ Comprehensive care assessment;

✓ the assessment is not merely for the purpose of understanding a resident needs, but also to understand their strengths, goals, life history, and preferences

✓ coordination with PASARR includes incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care

✓ referring all level II residents and all residents with newly evident or possible serious mental illness, intellectual disability, or related conditions for a level II resident review upon a significant change in status assessment (that is, a decline or improvement in a resident’s status)
Person-Centered Care Process requirements -

- Required to participate in the IDT care plan development are:
  - the attending physician,
  - a registered nurse with responsibility for the resident,
  - other appropriate staff in disciplines as determined by the resident’s needs
  - explicitly require a CNA with responsibility for the resident,
  - appropriate member of the food and nutrition services staff,
  - a social worker)
  - and to the extent possible the resident or the resident’s family/legal representative.

Think Person-Centered Care – Action Item #4

AI #4: Review of guardianship and POA policies and procedures

- Murky language in Mega-Rule as to resident’s personal representative
- Good time to review and tune-up policies and procedures for decision-making and documentation required if guardian or POA
### Think Person-Centered Care – Action Item #5

**AI #5:**
Review and update SNF nondiscrimination policies and procedures

- Person-centered requirements of Mega-Rule include enhanced nondiscrimination policies and procedures
- Obergefell decision: marital status changes
- Do nondiscrimination policies need to be changed for same sex marriage, transgender?
- If SNF is faith-based, should facilities start conversations now on these issues with relevant stakeholders?
- How does Mega-Rule impact distinct part units and relocations within SNF?

### Data mining and utilization – think “Golden Opportunity”
### You are only as good as your data!

**Mega-Rule has wide-ranging implications for what and how SNF collects, documents, analyzes, and utilizes data about resident care**

- Although not technically mandatory for SNFs, Mega-Rule will effectively require EHR
- Even if have implemented EHR, Mega-Rule will require heightened ability to manipulate and understand data
- Will impact reimbursement and all aspects of SNF compliance

**Regulations:**

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<td>resident assessment</td>
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<tr>
<td>42 CFR 483.21</td>
<td>person-centered care plan</td>
</tr>
<tr>
<td>42 CFR 483.45</td>
<td>pharmacy</td>
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### You are only as good as your data!

**Mega-Rule will require enhanced programs for certain kinds of data**

- Establishment and operation of QAPI program
  - How is data maintained? What are confidentiality protections?
- Establishment and operation of Compliance and Ethics program
  - How is data maintained? What are confidentiality protections?
- Establishment and implementation of Infection Prevention and Control program

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<td>42 CFR 483.80</td>
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You are only as good as your data!

Mega-Rule will require enhanced programs for certain kinds of data

- Conducting and utilizing facility assessment
  - How is this key document protected? Who will use it and how?
- Under bundled payments/ACOs, essential for SNFs to understand own costs and clinical data, including key indicators relevant to payment
- Staff and training needs, opportunities, programs related to data management
  - Do you have the “right people on the bus” for a more data-intensive environment?

Regulations:
- 42 CFR 483.85 (compliance and ethics)
- 42 CFR 483.95 (training)

Only as Good as Data: Action Item #1

AI #1:
Get a head start by obtaining an assessment of data capabilities and competencies – maybe by outside consultant/auditor

- Assessment should be “top to bottom” and address:
  - Key clinical indicators
  - Ability to access and utilize data as to payment
  - RUG categories, therapy minutes, overall acuity – verify accuracy
  - High-cost pharmaceutical use and other reimbursement issues
  - Staffing, billing, data mining
  - Privacy and compliance
  - QAPI, infection presentation and control
  - Resident/community demographics and needs
Attending to infection control data....

Infection prevention and control plan (IPCP) includes -

- The program must investigate, control, and prevent infections in the facility
  - issue and maintain protocols to guide decisions about what procedures, such as isolation and maintain a record of incidents and corrective actions related to infections
- A demonstrable and consistent system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility
- Is well known by all staff when and to whom possible incidents of communicable disease or infections should be reported

Attending to infection control data....

Infection prevention and control plan (IPCP) includes -

- Ensures standard and transmission-based precautions are followed to prevent spread of infections;
- Includes an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use
- F441 is and has been the most frequently cited regulation in Michigan for a loooonngg time! And failures can quickly threaten the health and safety of many.
- A annual review of IPCP and update the program as necessary due to changes in the issues and practice of infection prevention/control and changes in the facility itself, an annual update is important to ensuring the effectiveness of the IPCP
Attending to infection control data:

Infection prevention and control officer (IPCO)

- The facility must designate one individual as the infection prevention and control officer (IPCO) for whom the infection prevention and control plan (IPCP) at that facility is a major responsibility.
- A clinician who works at least part-time at the facility, and have specialized training in infection prevention and control beyond their initial professional degree.
- 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.

Only as Good as Data: Action Item #2

AI #2:
Post-assessment, develop roadmap of current data capabilities and competencies and path to augment functionality

- After the assessment, develop a road map of current data capabilities and competencies and the path to augment your current functionality
- Keep in mind the timing within your organization for approval of annual capital and operating budgets in terms of:
  - Likely effective date of Mega-Rule
  - Potential timing for IT upgrades
  - Timeline for determining supplemental staffing
  - Timing of governance approvals
Only as Good as Data: Action Item #3

AI #3: Assess the organizational structure of your data functions and access to information within your SNF

- Who has access to what information?
  - Quality Metrics – Nursing Home and Home Health outcome measures
  - Pepper reports
  - Resident satisfaction surveys

- Are all key stakeholders involved in compiling and receiving key data?

- Take hard look at metrics being used for operations and management
  - Still relevant? Would additional metrics be beneficial to decision makers?

- Who has “ownership” of key data compilation and reporting activities including distribution of that information to other stakeholders?
  - How often does reporting occur?
  - Are additional reports or “linkages” required to ensure relevant leaders have the right data at the right time?
You are Only as Good as your Data!

Mega-Rule will continue pressure by CMS to move toward more transparency and accountability with higher expectations as to QAPI

- More focused reports also provide a paper trail for litigation and pose other risks
- SNFs need to be prepared for more sophisticated approaches to litigation discovery
- Is your organization taking maximum advantage of state peer review privilege?
- State Agent access to information, but CMS/State Agent already have broad access

Regulations

- 42 CFR 483.75 (QAPI)
- 42 CFR 483.85 (compliance and ethics)

Only as Good as your Data: Action Item #4

AI #4: Review of peer review privilege and processes and other confidentiality protections for SNF data

- Consider the extent to which your compliance program and related activities may be protected under the state peer review statute and/or attorney-client privilege
- Need to set up privileges properly and in compliance with applicable statute
- Need to maintain documents and document management and labeling systems to differentiate privileged documents from non-privileged
**Only as Good as your Data: Action Item #5**

| At #5: Undertake compliance review of other data protection issues | - More sophisticated data management required for compliance with the Mega-Rule  
- Will require SNFs to pay even more attention to HIPAA compliance and avoidance of privacy breaches  
- Good time to review HIPAA policies and procedures and to beef up training as to HIPAA compliance  
- Consider the extent to which your compliance program and related activities may be protected under the state peer review statute and/or attorney-client privilege |
Resources

- The Office of the National Coordinator for Health Information Technology (ONC) has released the 2015 Interoperability Standards Advisory (available at [http://www.healthit.gov/standards-advisory](http://www.healthit.gov/standards-advisory)), which provides a list of the best available standards and implementation specifications to enable priority health information exchange functions.
- Information on the development of standards applicable to the long-term care setting can be found at: [http://wiki.siframework.org/LCC+LTPAC+Care+Transition+SWG](http://wiki.siframework.org/LCC+LTPAC+Care+Transition+SWG) and [http://wiki.siframework.org/Longitudinal+Coordination+of+Care](http://wiki.siframework.org/Longitudinal+Coordination+of+Care).
Resources


- The “Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs” on June 6, 2014 (see http://www.acl.gov/Programs/CDAP/DIP/docs/2402-a-Guidance.pdf).


- The National Transitions of Care Coalition (www.ntocc.org), Examples of resources include TeamSTEPPS® Long Term Care Version (http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/interact2.net/).


- Facilities may also wish to review the Discharge Summary document that is included in the HL7 Clinical Document Architecture (CDA) Release 2.0, now identified as the best available standard for the summary care record (see the Interoperability Standards Advisory at http://www.healthit.gov/standards-advisory).

- Additional information and resources regarding the use of bed rails is available at http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/default.htm.


Resources


- United States Department of Agriculture provides an online, interactive tool for healthcare professions to calculate daily nutrient recommendations for dietary planning based on the Dietary Reference Intakes (DRIs) at [http://fnic.nal.usda.gov/fnic/interactiveDRI/](http://fnic.nal.usda.gov/fnic/interactiveDRI/). The DRIs are the Food and Nutrition Board of the Institute of Medicine’s update to the Recommended Dietary Allowances, developed in partnership with Health Canada.


- Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment.” ([http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072662.htm](http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm072662.htm)).


Resources

- [http://www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)
- [http://www.ascp.com](http://www.ascp.com)
- [http://www.amda.com](http://www.amda.com)
- [http://www.ahcancal.org](http://www.ahcancal.org)
- [http://www.leadingage.org](http://www.leadingage.org)
- [http://www.americangeriatrics.org](http://www.americangeriatrics.org)
- [http://www.ntocc.org](http://www.ntocc.org)