An Overview of the new LTCF Requirements of Participation: Are You Ready?

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Boise ID

CMS Changes to SNF Regs

- New rule makes extensive changes to SNF Requirements of Participation (RoP)
  - Last major update was in 1991
  - Basis for SNF State Operating Manual and F-tags
  - Reorganized how existing requirements are labeled
- Updates to RoP include
  - Completely new language & new concepts
  - New requirements from ACA, IMPACT Act;
  - Existing requirements issued in S&C memos in the past several years;


RoP Sections with Changes

- Basis & Scope (§483.1)
- Definitions (§483.5)
- Resident Rights (§483.10)
- Abuse & neglect, (§483.12)
- Admission, transfer, and discharge rights (§483.15)
- Resident assessment (§483.20)
- Comprehensive person centered Care planning (§483.21)
- Quality of life (§483.24)
- Quality of care (§483.25)
- Physician services (§483.30)
- Nursing services (§483.35)
- Behavioral health services (§483.40)
- Pharmacy services (§483.45)
- Laboratory, radiology, and other diagnostic services (§483.50)
- Dental services (§483.55)
- Food & nutrition services (§483.60)
- Specialized rehabilitative services (§483.65)
- Administration (§483.70)
- Quality assurance and performance improvement (§483.75)
- Infection control (§483.80)
- Compliance and ethics (§483.85)
- Physical environment (§483.90)
- Training requirements (§483.95)

Red Txt = new sections or completely rewritten sections.
3-Phase Implementation

- **Phase 1:** Upon the *effective date* of the final rule (11-28-16)
- **Phase 2:** 1 year following the *effective date* of the final rule (Nov 2017)
- **Phase 3:** 3 years following the *effective date* of the final rule (Nov 2019)

Impact of New RoPs on Survey Process

- Surveyors need to complete training before Nov 28th 2016 in order to enforce Phase I
  - Training available to public as of Nov 18
- CMS developing a new survey process
  - Merges QIS with traditional survey
  - Incorporates new RoPs
  - Goes into effect in Nov 2017
- This will change the survey focus and types of tags issued

Themes of the Rule

- Person-Centered Care
  - Greater involvement of person (and their representative)
  - More notifications
- Monitoring
  - Staff competencies
  - Adverse events
  - Medication prescribing
- Alignment of resources with patient needs
  - Assessment/Staffing, Competency-Based Approach
  - Know Your Center, Know Your Patients, Know Your Staff
- Changing Patient Population
  - Acuity
  - Behavioral Health
Mindset Model*

Purpose & Intent Should Guide Your Implementation

- Mindset will drive how well you comply with the new requirements
- Two philosophical Approaches
  - practice to the regulation
  - practice to the purpose and intent

Added New Definitions

- “abuse”
- “adverse event”
- “exploitation”
- “misappropriation of resident property”
- “mistreatment”
- “neglect”
- “person-centered care”
- “resident representative”
- “sexual abuse”
Resident representative 483.5

- Resident representative means any of the following:
  1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
  2. A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
  3. Legal representative, as used in section 712 of the Older Americans Act; or
  4. The court-appointed guardian or conservator of a resident.

Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

Initial steps

Read the
- Final Rule Language (25 pg)
- AHCA Playbook
- RoP checklist Overview

Resources for New Requirements of Participation

https://educate.ahcancal.org/
Don’t Make Achieving Compliance Harder

Common Reasons for Deficiencies

- Over two-thirds of deficiencies are cited because a resident had an adverse event and the SNF did not do what they said they would do in their P&P, Care Plan, MAR or orders.

  - Common things that set you up for getting a deficiency:
    - Complex, detail oriented, absolute terms and deadlines
    - Doing something because you think it is required by regulations but may not help the resident
    - Broken, malfunctioning, failed batteries, etc making something inoperable
    - Recording same information in multiple locations, particularly information related to delivery of service or resident’s condition that should trigger change in plan of care

Evaluate the system

- Look at policies and procedures
  - Are you setting up staff to fail?
- Look at work flow
  - Ask staff why something is not working (why 5 times)
  - Ask what “frustrates” them about the problem
- Look at availability and functioning of equipment
- Look at environment
  - Design, lighting, noise, distance to travel
- Look at staffing type, level, and patterns
- Look at staff attitudes and beliefs
KSA

Is this a knowledge deficit?
• Is the reason implementation of a new program is not happening due to
  o Knowledge, Skill, or Attitude (KSA)
• Is the reason policies are not followed consistently due to
  o Knowledge, Skill, or Attitude (KSA)
• Are your in-services designed to address
  o Knowledge, Skill, or Attitude (KSA)

Action Strategies to Avoid
• “In-service” as a correction strategy
  • Assumes a knowledge deficit –
    o Is this the real problem or are there systems issues getting in the way of staff acting on their knowledge?
• Adding “more” to an already complex system guarantees failure
• Punishing staff for errors due to the system
  • 80:20 rule – 80% due to system vs 20% to the individual

Care Plans with Person-centered Care Focus
48-Hour Baseline Care Plan

- New requirement - Phase 2
- Initial set of instructions to facilitate smooth transition of care and to provide effective, person-centered care starting at admission

Minimum of 6 key elements:
- Initial goals based on admission orders
- All physician orders, including medications and administration schedule
- Dietary orders
- Therapy services
- Social services
- PASARR recommendations, if PASARR completed

Could be replaced by the comprehensive care plan if done within 48 hours of admission

Comprehensive Care Plan

- Phase 1 requirement
- Develop and implement a comprehensive, person-centered care plan for each resident, consistent with the resident rights set forth in the RoPs (section 483.10(c))
  - Include measurable objectives and timeframes to meet resident’s needs (medical, nursing, mental and psychosocial) as identified in the comprehensive assessment
  - Describe at a high level services to be provided as well as resident’s goals and preferences
  - Include summary of resident’s strengths, goals, desired outcomes, life history, personal and cultural preferences, PASARR findings and specialized services needed
Comprehensive Care Plan

- Prepared and reviewed by IDT that now must include, in addition to attending physician and RN with responsibility for that resident, nurse aide and member of food and nutrition services (new)
  - Include resident and their representative(s) to the extent practicable; document an explanation if not practicable
- Reviewed or revised after comprehensive assessment and quarterly review assessment

Comprehensive Care Plan

- Rooted in resident’s rights (483.10(c))
  - Participate in developing the plan, be informed of the care to be provided, and participate in decision-making, in language he or she can understand
  - Identify individuals and roles to participate, request meetings, request revisions to plan
  - Participate in establishing goals and expected outcomes of care, including duration, frequency, type, and amount
  - Be informed of care options, risks, benefits, alternatives
  - Refuse or discontinue treatment
  - Self-administer meds if IDT determines clinically appropriate
  - Be informed in advance of changes to the plan
  - Receive the services in the plan
  - Review and sign off on significant changes

Discharge Planning Process
Intent & Purpose

Partner with the resident to maximize the likelihood that they may be able to return to the community, if they want to, without complications.

Flow of Medicare Beneficiaries

Discharge Planning Process #1

MAJOR required steps
1. Create an interdisciplinary team which includes the resident
2. Evaluate the resident’s discharge potential, goals, and needs
3. Document results of discharge plan
4. Create a discharge plan (see below for required content)
5. Update discharge plan
6. Share discharge plan with the resident
Discharge Planning Process #2
7. Prepare resident & their representative for discharge
8. Notify Ombudsman of all discharges and transfers
9. Document reason for discharge or transfer
10. Provide required information to receiving provider
11. Complete a discharge summary

Information Accompanying Resident at Discharge or Transfer
- Ensure specified information is copied and available to go with resident:
  - Contact information of practitioner responsible for care
  - Resident representative information
  - Advance Directive Information
  - Special instructions or precautions
  - Most recent comprehensive care plan goals
  - Resident’s discharge summary
  - Other documents as needed
  - Resident’s consent to share information
- Develop checklist to ensure all required information is sent
  – Phase 2 requirement

Discharge Summary Template
- Phase 1 requirement
- Key elements:
  - Recapitulation of stay (diagnoses, pertinent lab tests and results, course of illness/treatments/therapy)
  - Final summary of resident’s status (specified items from comprehensive resident assessment, including needs, strengths, goals, preferences)
  - Medication reconciliation
  - Post-discharge plan of care (where individual will reside, arrangements for follow-up care, consent to share discharge summary)
  - Other elements as determined by center
Self-Assessment Audit of Discharge Summary

- Take 10 of your most recent discharge summaries
- Review the Discharge Summaries against required content – go to AHCA NCAL ED “Accompanying Residents at Discharge or Transfer §483.15(c)(2) – page 2

Develop Transition of Care Program

- Home visit soon after SNF admission
- Establish goals of SNF admission*
- Provide information to receiving provider*
- Provide orientation to resident & representative on discharge instructions*
- Arrange follow-up and communicate with primary care MD*
- Do follow-up calls to discharges to community within 24 hours and 3-5 days later
- Do follow up home visits after discharge

* Required as part of New SNF requirements of Participation

QAPI
Intent & Purpose

Have a system that
a. monitors and investigates current practices to
   • prevent adverse events
   • increases consistent use of evidence based practices
b. Creates teams to make changes to achieve better outcomes

QAPI requirements phased in

- QAPI requirements will be enforced over three phases (I- Nov 2016, II- Nov 2017, and III- Nov 2019).
- Most of the requirements for the QAPI program will be implemented in Phase 3.

Organizational QAPI System

- Review performance
- Assess system
- Formulate plan to change system
- Pilot test change
- Evaluate change
- Revise plan & Repilot test
- Disseminate within organization
QAPI is more about mindset than practices

The Arbinger Institute: Mindset Model

Biggest Challenges in CMS’s QAPI Pilot

- Root cause analysis
- System thinking
- Utilizing Performance Improvement Projects

The First Law of Improvement

*Every system is perfectly designed to achieve exactly the results it gets*

- Paul Batalden, MD, Dartmouth
Quality Award Program

- Based on Baldrige Performance Excellence for Health Care
- Three levels of distinction
  1. Bronze – Commitment to Quality (5 pages)
  2. Silver – Achievement in Quality (20 pages)
  3. Gold – Excellence in Quality (55 pages)
- Similar framework to CMS QAPI program
- Organizations must achieve the award at each level to continue to the next level

http://qa.ahcancal.org

Integrated Management System (Baldrige Domains)

Mission, Vision and Values

Leadership & Strategy

Workforce

Results

Operations

Measurement, Analysis and Knowledge Management

Percent of AHCA/NCAL Members Awarded a Quality Award, 2007-2015

2-15%  16-20%  21-30%  31-53%
Silver & Gold have more deficiency-free surveys

Percent of Facilities with Health Citation-Free Inspections

<table>
<thead>
<tr>
<th>% Facilities Deficiency-Free</th>
<th>2010Q1</th>
<th>2010Q2</th>
<th>2010Q3</th>
<th>2010Q4</th>
<th>2011Q1</th>
<th>2011Q2</th>
<th>2011Q3</th>
<th>2011Q4</th>
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<tbody>
<tr>
<td>AHCA Golden &amp; Silver</td>
<td>18%</td>
<td>15%</td>
<td>12%</td>
<td>9%</td>
<td>6%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>ALL Others</td>
<td>20%</td>
<td>17%</td>
<td>14%</td>
<td>11%</td>
<td>8%</td>
<td>5%</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Infection Control Program

Intent & Purpose
Prevent the spread of infections and increase the appropriate use of antibiotics
IPCO Requirements

- Infection control program must have
  - a plan
  - Antibiotic stewardship program
  - infection preventionist (phase III)
  - A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility

Infection Preventionist Certificate

- 24 hour on-line CEU program and Examination
- Start in January 2017
  - New RoPs require this by Nov 2019
  - Charging a fee
  - Starting to sign people up

Self-Assessment Questions:

1. How do you track infections in your Center?
   a. do you track antibiotic resistance patterns?
   b. what do you do with the data?
2. How do you track use of antibiotics to treat UTIs?
   a. do you use McGreer Criteria?
3. How do you monitor staff handwashing practices?
4. How do you decide which residents need contact isolation?
5. How do you monitor staff’s correct use of PPE?
6. How do you prevent staff who are potentially infectious from spreading to others?
Pharmacy Services
(Medication Prescribing & Adverse Events)

Intent & Purpose
Reduce medication prescribing and administration that increases the risk of adverse events in elderly

Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

ADVERSE EVENTS IN SKILLED NURSING FACILITIES:
NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES
Adverse and Temporary Harm (SNF)

**Medication Events**
- Medication-induced delirium or change in mental status
- Excessive bleeding due to anticoagulant medication
- Fall or other trauma with injury secondary to effects of medication

**Resident Care Events**
- Fall or other trauma with injury related to resident care
- Acute kidney injury (AKI) secondary to fluid maintenance
- Exacerbations of preexisting conditions resulting from an omission of care

**Infection Events**
- Aspiration pneumonia and other respiratory infections
- SSI associated with wound care
- CAUTI

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SNF Adverse Events Potentially Preventable (OIG Report)

**Table 6: Percentage of Preventable Adverse and Temporary Harm Events by Clinical Category**

<table>
<thead>
<tr>
<th>Types of Adverse and Temporary Harm Events</th>
<th>Percentage of Preventable Adverse and Temporary Harm Events (n = 155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Events Related to Medication</td>
<td>60%</td>
</tr>
<tr>
<td>Events Related to Resident Care</td>
<td>57%</td>
</tr>
<tr>
<td>Events Related to Infections</td>
<td>52%</td>
</tr>
</tbody>
</table>


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Drug Regime Review Process

**PD**
- Assess system
- Formulate plan to change system
- Pilot test change
- Evaluate change
- Revise plan & realign test
- YES Disseminate within organization
- NO Result

**DS**
- Assess system
- Formulate plan to change system
- Pilot test change
- Evaluate change
- Revise plan & realign test
- YES Disseminate within organization
- NO Result
Drug Regime Review Process

Phase I
- Need a Drug regime review P&P
- Change definition of psychotropic drug
- Change definition of medication “irregularity”
- Pharmacist findings of “irregularities” must be addressed
- Training to staff and physicians/prescribing practitioners on monthly drug regimen review P&P and new regulatory requirements
- Audit monthly DRR, medication error rates to be consistent with policies, procedures and regulatory requirements
- Incorporate identified areas for process improvement into QAPI

Change “Irregularity”

What is considered an irregularity (e.g. including, but not limited to, unnecessary drug criteria):
- Excessive dose (including duplicate drug therapy)
- Excessive duration
- Without adequate monitoring
- Without adequate indications for its use
- Use in presence of adverse consequences which indicate dose should be reduced or discontinued

Change Psychototropic Medication

A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
- (i) Anti-psychotic;
- (ii) Anti-depressant;
- (iii) Anti-anxiety; and
- (iv) Hypnotic.
Other Miscellaneous Changes

Physical Environmental (§483.90)

- Center must be equipped to allow residents to call for staff through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident’s bedside.
- Establish policies regarding smoking, smoking areas and smoking safety that also considers non-smoking residents.
- Conduct regular inspection of all bed frames, mattresses, and bed rails, to identify areas of possible entrapment.

Any facility newly certified or approved for construction (including remodeling) after November 28, 2016, must have bedrooms with no more than two residents AND must have a private bath including at least a toilet and sink for each resident room.

- A bathroom that is located between two patient rooms and is accessible from each does not meet this requirement.
- For purposes of this requirement, a “renovated or remodeled area” means an area that requires residents to be moved out of the area to complete work.
  - For example, if a facility is conducting a major renovation on a wing and all patients must be relocated, included in that renovation must be eliminating any 4-bed rooms and ensuring that each patient room is equipped with its own bathroom including at least a sink and a toilet.
Physician Services (§483.30)

- Retains existing requirements
- Allows physician to delegate writing of dietary orders to qualified dietitian or nutrition professional, and therapy orders to a qualified therapist, who are acting within scope of practices as defined by state law and supervised by a physician.

§483.50 Laboratory, radiology, and other diagnostic services

- Must develop policy & procedure for ensuring prompt notification of the ordering physician, PA, NP, or clinical nurse specialist of lab results (or radiology or other diagnostic services) that fall outside of clinical reference ranges.
- Note: The RoP does not specify any content for the P&P on notification of physicians, only that the facility must develop clinical reference ranges for laboratory, radiology and other diagnostic services for when a physician must be notified if not specified in the physician’s orders.

Training Requirements (§483.95)

- Most of the new Training Requirements, including the requirement for developing, implementing, and maintaining an effective training program for all staff on specified topics and based upon the needs identified in the Facility Assessment, are Phase III requirements.
- Some training requirements must be implemented in Phase I:
  - Abuse, neglect and exploitation, including:
    - Activities that constitute abuse, neglect, exploitation, or misappropriation of property
    - Procedures for reporting same
    - Dementia management and resident abuse prevention
  - Required Nurse Aide Training—Retains existing and adds:
    - Dementia management training & resident abuse prevention
    - Care of the cognitively impaired
  - Training of feeding assistants
Phase I Requirements for Existing Staff Positions

- Dieticians
  - Qualified dieticians must hold bachelor's degree or higher; have completed at least 500 hours of supervised dietetics practice; be licensed or certified by the State in which services are performed.
  - For dietitians hired or contracted with prior to November 28, 2016, have five years after that date to meet these requirements.

- Food Service Directors
  - If facility does not employ dietitian full-time, must designate a person to serve as director of food service who is certified dietary manager or certified food service manager, or has similar national certification, has an associate's degree or higher in food service management or similar discipline, meets State requirements, and receives consultations from a qualified dietitian or nutrition professional.
  - Food service directors hired before November 28, 2016 have five years to comply.

- Social Workers
  - Any facility with more than 120 beds must employ a social worker on a full-time basis.
  - Must have a minimum of bachelor's degree in social work or human services field, including but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology.
  - Must have one year supervised social work experience in a health care setting working directly with individuals.

RoP Sections with Changes

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