POTENTIAL IMPACT & OPPORTUNITIES

August 19, 2015 — 1:00 pm-2:00 pm ET
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PROPOSED REFORM OF REQUIREMENTS FOR LONG-TERM CARE FACILITIES

BACKGROUND
• Rules are the health and safety standards that LTC facilities must meet in order to participate in the Medicare or Medicaid Programs.
• The current requirements are found at 42 CFR 483 Subpart B.
• Last complete review and update was 1991.
• We are presenting “Highlights” not an exhaustive list of changes.

CMS THEMES
• Person-Centered Care
• Quality
• Facility Assessment, Competency-Based Approach
• Alignment with HHS priorities
• Comprehensive Review and Modernization
• Implementation of Legislation
DEFINITIONS (§483.5)

- Adds definitions for the following words/terms:
  - Adverse event
  - Resident representative
  - Abuse
  - Sexual abuse
  - Neglect
  - Exploitation
  - Misappropriation of resident property
  - Person centered care

ADVERSE EVENT (§483.5)

Defined as:
- An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.

LICENSED HEALTH PROFESSIONAL (§483.5)

Defined as:
- A physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.
NEGLECT (§483.5)

Defined as:
• The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness.

PERSON-CENTERED CARE (§483.5)

Defined as:
• To focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

RESIDENT RIGHTS (§483.10)

• Clarifies aspects of the regulation to reflect advances such as electronic communications including:
  – Eliminating language, such as “interested family member” and replacing the term “legal representative”
  – Resident right to access his/her own medical records and to be active in their own care planning
  – Adds language regarding physician credentialing
    • Physician chosen by the resident must be licensed to practice medicine. (Clarification of state license requirement needed)
    • Must meet professional credentialing requirements of the facility.
§ 483.11. FACILITY RESPONSIBILITIES

• New section
• Refocuses facility responsibilities for protecting the rights of their residents and enhancing a resident’s quality of life
• Revises visitation requirements to establish open visitation, similar to the hospital conditions of participation (CoPs)
• Recognizes the changes in patient care requirements

SNF PATIENT CARE ACCESS

Medicare beneficiaries who accessed care in a SNF increased 2.7 Xs Since 1989

✓ 636,000 (19 per 1,000 enrollees) in 1989

✓ 1,839,000 (52 per 1,000 enrollees) in 2010

(not including managed care)

Source: Federal Register

§ 483.11. FACILITY RESPONSIBILITIES

• The facility must provide equal access to quality care regardless of
  – Diagnosis, severity of condition or payment source
  – Facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all residents
• Facility must NOT require a resident to request any item or service as a condition of admission or continued stay
**Freedom from Abuse, Neglect, and Exploitation (§483.12)**

- Formerly “Resident behavior and facility practices”
  - Specifies that facilities cannot employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property.
  - Requires facilities to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and mistreatment of residents or misappropriation of their property.

**Transitions of Care (§483.15)**

- Previously “Admission, transfer and discharge rights,” (ADT)
  - Changed to reflect current terminology
  - Transitions between providers require demographic history of present illness including but not limited to:
    - active diagnoses, functional status, medications; reason for transfer and past medical/surgical history
    - to be exchanged with the receiving provider
  - No specific form, format, or methodology for communication
  - Only applies to non-hospital transfers between PAC providers

**Comprehensive Person-Centered Care Planning (§483.21) New Section**

- Care plan must focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives
- **Baseline** care plan must be completed within 48 hours of admission
**COMPREHENSIVE PERSON-CENTERED CARE PLANNING (§483.21) NEW SECTION**

- Must include measurable objectives
  - Include resident's medical, nursing, mental and psychosocial needs
  - Prepared by Interdisciplinary team including:
    - Physician, RN
  - Plus the addition of:
    - Nurse Aid, Nutrition staff, Social worker
  - Must include discharge plan

**DISCHARGE PLANNING (§483.21)
NEW SECTION**

Discharge plan must:
- Be part of the Comprehensive Care Plan
- Include resident and/or RP
- Consider availability of care giver support
- Reconcile all pre-discharge meds with post-discharge medications (both prescribed and over-the-counter)

**QUALITY OF CARE AND QUALITY OF LIFE (§483.25)**

- Relocates the provisions for unnecessary drugs, antipsychotic drugs, medication errors, and influenza and pneumococcal immunizations to §483.45 pharmacy services
- Special Need Issues: Adds a new requirement that facilities must ensure residents receive necessary and appropriate pain management
**Physician Services (§483.30)**

- Requires an in-person evaluation by a physician, PA, NP or clinical nurse specialist before an unscheduled transfer to a hospital.
- Allows physicians to delegate dietary & therapy orders to clinically qualified dietitians and therapists acting within the scope of practice defined by state law.

**Nursing Services (§483.35)**

- Sufficient Staffing:
  - Adds a competency requirement based on a facility assessment to include but not limited to:
    - Number of residents
    - Resident acuity
    - Range of diagnoses
    - Content of care plans

**Behavioral Health Services (§483.40)  New Section**

- Requires provision of necessary behavioral health care and services in accordance with patient comprehensive assessment and plan of care.
- Requires competencies and skills to provide behavioral health care and services for residents and implementation of non-pharmacological interventions.
**PHARMACY SERVICES (§483.45)**

Drug Regimen Review:
- **Adds the requirement** that a pharmacist review a resident's medical chart at least every 6 months and
  - When the resident is new to the facility,
  - Resident returns or is transferred from a hospital or other facility
  - During each monthly drug regimen review when the resident has been prescribed or is taking
    - Psychotropic drug
    - Antibiotic
    - Or any drug the QAA Committee has requested be included in the pharmacist's monthly drug review

**PSYCHOTROPIC DRUG (§483.45)**

- CMS is proposing to use the **definition used in the November 2001 OIG report:** "Psychotropic Drug Use in Nursing Homes" (OEI-02-00-00048), which is that they are drugs that affect brain activity associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
  - Anti-psychotic
  - Anti-depressant
  - Antianxiety
  - Hypnotic
  - Opioid analgesic
  - Any other drug that results in effects similar to the drugs listed above
  - Any other drug that results in effects similar to the drugs listed above, to address other medications.

- "We are also specifically soliciting comments on this definition and the types of drugs that should be included."

**PHARMACY SERVICES (§483.45)**

- Revises existing requirements regarding "antipsychotic" drugs to refer to "psychotropic"
  - Requires that facilities ensure residents who have not used psychotropic drugs not be given these drugs unless medically necessary.
  - Requires residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue use of these psychotropic drugs.
  - Requires PRN psychotropic drugs be limited to 48 hours unless the primary care provider (for example, the resident's physician) reviewed the need for the medications prior to renewal of the order and documented the rationale for the order in the resident's clinical record.
**PHARMACY SERVICES ($483.45)**

- Requires the pharmacist to document in a written report any irregularities noted during the DRR that lists at a minimum:
  - Resident's name
  - Relevant drug
  - Irregularity identified
  
To be sent to:
  - Attending physician
  - Facility's medical director
  - Director of nursing

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**IRREGULARITIES**

- Irregularities now include “unnecessary drugs”
- An unnecessary drug is any drug when used:
  1. In excessive dose (including duplicate drug therapy); or
  2. For excessive duration; or
  3. Without adequate monitoring; or
  4. Without adequate indications for its use; or
  5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
  6. Any combinations of the reasons stated in this section

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**PHARMACY SERVICES ($483.45)**

- Attending physician must document in the resident's medical record that he/she has reviewed the identified irregularity and what, if any, action they have taken to address it.

- If there is no change the attending physician should document his/her rationale in the resident's medical record.
WHAT’S MISSING?

Estimated Cost to Comply with All the Requirements of the Proposed Rule

<table>
<thead>
<tr>
<th>Regulatory Area</th>
<th>Section</th>
<th>First Year Total Cost</th>
<th>Total Cost in Year 2 and Beyond</th>
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PHARMACY COSTS!

LABORATORY, RADIOLOGY, & OTHER DIAGNOSTIC SERVICES ($483.50)

NEW SECTION

- Ordering Services:
  - Clarifies that a physician assistant, nurse practitioner or clinical nurse specialist may order laboratory, radiology, and other diagnostic services for a resident in accordance with state law, including scope of practice laws.
- Laboratory Services:
  - Clarifies that the ordering physician, physician assistant; nurse practitioner or clinical nurse specialist, be notified of abnormal laboratory results when they fall outside of clinical reference ranges, in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician, physician assistant’s, nurse practitioner’s or clinical nurse specialist’s orders.

ADMINISTRATION ($483.70)

- Facility Assessment — Requires facilities to:
  - Conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.
  - Review and update this assessment to accommodate change.
  - Assessment must recognize resident population (# of residents, types of care and staff competencies and cultural aspects), resources and a facility-based and community-based risk assessment.
QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI)  
(§483.75) NEW SECTION

- Requires all LTC facilities to develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life.

INFECTION CONTROL (§483.80)

- Infection Prevention and Control Program (IPCP): 
  - Requires facilities to have a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under an arrangement based upon its facility and resident assessments that is reviewed and updated annually.

- Infection Prevention and Control Officer (IPCO):
  - Requires facilities to designate an 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.

PHYSICAL ENVIRONMENT (§483.90)

- Resident Rooms:
  - Requires facilities initially certified after the effective date of this regulation to accommodate no more than two residents in a bedroom.

- Toilet Facilities:
  - Requires facilities initially certified after the effective date of this regulation to have a bathroom equipped with at least a toilet, sink and shower in each room.

- Smoking:
  - Requires facilities to establish policies, in accordance with applicable federal, state and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety.
**TRAINING REQUIREMENTS (§483.95)**

**NEW SECTION**

- Sets forth all the requirements of an effective training program that facilities must develop, implement, and maintain for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. Training topics must include:
  - Communication
  - Resident Rights and Facility Responsibilities
  - Abuse, Neglect, and Exploitation
  - QAPI
  - Infection Control
  - Compliance and Ethics
  - Dementia training for Nurse Aids
  - Behavioral Health for all staff based on section 483.70(e) facility assessment

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**TRANSITIONS OF CARE**

- CMS is soliciting comment on both the information elements we are requiring and the time frame for transmission of the required information. While we are not proposing any specific form, format, or methodology for the communication of this information for all facilities, we strongly believe that those facilities that are electronically capturing this information should be doing so using certified health IT that will enable the real time electronic exchange with the receiving provider. By utilizing certified health IT, facilities can ensure that they are transmitting interoperable data that can be used by other settings, supporting more robust care coordination and higher quality care for patients.

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**REMINDER**

- The proposed rule published in the Federal Register on July 16, 2015.
- The comment period closes on September 14, 2015 at 5 p.m.
- Submit your comments on the proposed rule at [http://www.regulations.gov](http://www.regulations.gov) and follow the “Submit a comment” instructions.
- We will respond to timely comments submitted according to the instructions in the proposed rule when we publish a final rule.
HOW TO SUBMIT COMMENTS

- The proposed rule, CMS 3260-P Reform of Requirements for Long-Term Care Facilities, was published in the Federal Register on July 16, 2015.
- Anyone can submit a comment on the proposed rule.
- To submit a comment, visit www.regulations.gov, enter the file code CMS-3260-P and click on "Submit a Comment".
- The comment period closes at 5pm on September 14, 2015.
- For additional information on these and other Conditions of Participation, visit http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html?redirecturl=CFCsAndCoPs/16_ASC.asp.

QUESTIONS?