

CMS Reform of Requirements for LTC Facilities 11/2016

Compliments of VAAP, presented by Kathy Hughes, ADC/COTA and
sponsored by Linked Senior

Federal Regulations for LTC

- Were first published in the Federal Register on February 2, 1989 (54 FR 5316). These regulations have been revised and added to since that time, principally as a result of legislation or a need to address a specific issue. However, they have not been comprehensively reviewed and updated since 1991 despite substantial changes in service delivery in this setting.
- Significant innovations in resident care and quality assessment practices have emerged. In addition, the population of LTC facilities has changed, and has become more diverse and more clinically complex. Over the last two to three decades, extensive, evidence-based research has been conducted and has enhanced our knowledge about *resident safety*, health outcomes, *individual choice*, and quality assurance and performance improvement.

“Therefore, we reviewed regulations in an effort to improve the quality of life, care, and services in LTC facilities, optimize resident safety, reflect current professional standards, and improve the logical flow of the regulations. Specifically, we are *adding new requirements where necessary*, eliminating duplicative or unnecessary provisions, and reorganizing the regulations as appropriate. Many of the revisions are aimed at aligning requirements with current clinical practice standards to improve resident safety along with the quality and effectiveness of care and services delivered to residents. Additionally, we believe that these revisions will eliminate or significantly reduce those instances where the requirements are duplicative, unnecessary, and/or burdensome.”

Resident rights (§483.10) • revised

We are retaining all existing residents' rights and updating the language and organization of the resident rights provisions to improve logical order and readability, clarify aspects of the regulation where necessary, and updating provisions to include advances such as electronic communications.

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

We are requiring facilities to develop and implement a baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care.

We are adding a nurse aide and a member of the food and nutrition services staff to the required members of the interdisciplinary team that develops the comprehensive care plan

Quality of care (§483.24) • no change

We are requiring that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

Quality of Life (§483.25) • no change

Based on the comprehensive assessment of a resident, we are requiring facilities to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Quality assurance and performance improvement (QAPI) (§483.75) • revised

We are requiring 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

Training requirements (§483.95) *New Section* ●

We are adding a new section to subpart B that 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.

****We are unable to quantify the benefits of the final rule; however, this final rule creates new efficiencies and flexibilities for facilities that are likely to reduce avoidable hospital readmissions, increase the rate of improvement in quality throughout facilities, and create positive business benefits for facilities.

****The federal participation requirements for SNFs, NFs, or dually certified facilities, of the Act provide that a SNF or NF must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

Behavioral Health

On March 29, 2012, CMS launched an initiative aimed at improving behavioral healthcare and safeguarding LTC facility residents from the use of unnecessary antipsychotic medications, the National Partnership to Improve Dementia Care in Nursing Homes. As part of the initiative, CMS has developed a national action plan that uses a multidimensional approach including public reporting, raising public awareness, regulatory oversight, and technical assistance/training and research. This plan is targeted at enhancing person-centered care for LTC facility residents, particularly those with dementia-related behaviors

*Trauma-Informed Care

HHS has also undertaken broad-based activities to support Americans that have specific needs to be considered in delivering health care and other services. Activities include raising awareness about the special care needs of trauma survivors, including a targeted effort to support the needs of Holocaust survivors living in the United States. Trauma survivors, including veterans, survivors of large-scale natural and human-caused disasters, Holocaust survivors and survivors of abuse, are among those who may be residents of long-term care facilities. For these individuals, the utilization of trauma-informed approaches is an essential part of person-centered care. Person-centered care that reflects the principles set forth in SAMSHA's "Concept of Trauma and Guidance for a Trauma-Informed Approach,"

Definitions (§483.5)

- Current regulations at §483.5 provide definitions for terms commonly used in the LTC requirements. We proposed to revise some of the existing terms for clarity and define new terms that we believe are widely used within the LTC setting, and that we believe will add value to the LTC requirements while promoting resident choice and safety.
- “We also proposed to define the term “resident representative” broadly to include both an individual of the resident’s choice who has access to information and participates in healthcare discussions as well as personal representative with legal standing, such as a power of attorney for healthcare, legal guardian, or health care surrogate or proxy appointed in accordance with state law to act in whole or in part on the resident’s behalf. We also noted that the same-sex spouse of a resident would be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. In addition, we proposed to add a definition 45 of “person-centered care” to be defined as focusing on the resident as the locus of control and supporting the resident in making their own choices and having control over their daily lives.

With regard to resident/family groups

Current wording - supports the intent of the proposed language that requires nursing facilities to provide a resident or family group, **if one exists** with private space – some suggestions that; There is no requirement for a facility to have a resident or family group if the residents or their representatives do not want one. However, if interest does exist, the facility should support the formation of such a group, as required by this section.

Friends be added to the wording, that facilities be required to hold such groups, that time frames be assigned to grievances – **NO changes** – simply clarified to commenter's

We have added a new §483.10(f)(5)(i) to specify that a facility must take **reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings** in a timely manner.

We have added “**or other guests**” to the list of individuals who may only attend a resident or family group meeting at the group's invitation at finalized §483.10(f)(5)(ii)

With regard to activities outside the facility

Not all patients/residents are realistically able to participate in activities outside the facility. “Some residents may not, realistically, be able to participate in activities outside the facility. However, many may be able to do so, particularly with family or other assistance or planning. The facility has a responsibility to promote and facilitate resident self determination, rather than act as a hindrance or barrier. At the same time, we recognize that there may be safety and security concerns with unfettered access to outside spaces and in and out of the facility. These competing interests must be balanced, taking into consideration the needs and preferences of residents in the facility” – NO CHANGE

With regard to internet

“The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. “We have added language to that effect at finalized §483.10(g)(9)(iii). We acknowledge that for devices provided for the community, advance planning may be required. Further, one resident’s use of video communications must not infringe upon the rights of other residents These were considerations when we used the term “reasonable access.”

Comprehensive Person-Centered Care Planning

We proposed to revise this section to clarify that the assessment is not merely for the purpose of understanding a resident needs, but also to understand **their strengths, goals, life history, and preference**

In addition, **new Section GG of the MDS** addresses a resident's goals related to function and has a person-centered focus on items such as pain. We understand that the MDS is an evolving assessment tool, and we will consider the feedback from commenters for possible efforts to improve the assessment in the future.

Comprehensive Person-Centered Care Planning

- We proposed to add a new §483.21(a)(1) to the current care planning regulations **and require that facilities complete a baseline interim care plan for each resident upon their admission to the facility. We proposed to require that the baseline care plan be completed within 48 hours of a resident's admission.** At §483.21(a)(1)(ii), we proposed to list the information that would, at a minimum, be necessary for inclusion in a baseline care plan, but would not limit the contents of the care plan to only this information. In the proposed rule, we indicated that information such as initial goals based on **admission orders, physician orders, dietary orders, therapy services, social services,**

Comprehensive Person-Centered Care Planning

- we proposed to allow facilities to complete a comprehensive care plan instead of completing both a baseline care plan and then a comprehensive care plan. In this circumstance, the comprehensive care plan would be completed within 48 hours of admission
- Under current §483.20(k)(2)(ii), the attending physician, a registered nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and to the extent possible the resident or the resident's family/legal representative are all required to participate in the IDT. We proposed to add the term "**other appropriate staff**", which should be determined based on the specific needs of the resident or at the request of the resident. **We proposed to also explicitly require a NA with responsibility for the resident, an appropriate member of the food and nutrition services staff, and a social worker (removed during FINAL ruling)** to be a part of the IDT.

Comprehensive Person-Centered Care Planning

- **The purpose of the baseline care plan is to serve as an interim care plan** within the initial period of residency to avoid poor quality care and reduce the risk of hospital readmission as a result of missing information
- **We do not require that any of the members of the IDT participate in person.** Facilities have the flexibility to determine how to hold IDT meetings whether in person or by conference call. The facility may determine that participation by the nursing assistant or any member, may be best met through email participation or written notes
- **Activities on the IDT** -commenter suggested that an activity professional should also be required to participate in the IDT and that many activity professionals are already a part of the resident assessment and the IDT. Similarly, the activity professional is not precluded from participating on the IDT if it is determined to be necessary for a particular resident, even though 208 they are not specifically listed at §483.21(2)(ii). Those facilities that currently involve the activity professional may continue to include these individuals.

Quality of Care and Quality of Life (§483.25)

- **Commenters recommended** that we add board certified music therapist to the list of qualified professions who could serve as an activities program director stating that the educational requirements for a music therapist prepare them to become excellent activities directors. Others suggested that an individual with a Master's degree in gerontology or aging studies, or other degree-based qualifications, be added to the list of qualified professionals who could serve as an activities program director. Some commenters did not want us to change the requirements, fearing that this would eliminate qualified candidates. Some commenters wanted to ensure that we did not change the requirements to specify a specific recognized accrediting body, while others suggested specifying a specific recognized accrediting body

“We thank all the commenters for responding to our solicitation of comments regarding whether the requirements for the director of the activities program remain appropriate and what should serve as minimum requirements for this position. We have reviewed all of the comments and believe we need additional time to further evaluate the many suggestions we received. We are not making any changes at this time.”

Nutrition

Religious preferences -This requirement does not mandate that every facility be able to provide every possible religious, cultural, or ethnic diet. However, a facility should consider these factors with respect to the population it serves, as well as input from residents and resident groups, when developing its menus.

Nutrition

Approved sources - We proposed to clarify in new §483.60(i)(1)(i) that facilities could procure food directly from local producers, farmers or growers, in accordance with state and local laws or regulations. We further proposed to clarify in new §483.60(i)(1)(ii) that this provision would not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and handling practices, such as the use of pesticides in accordance with manufacturers' instructions. Consistent with §483.70(b), we proposed to specify in §483.60(i)(2) that facilities would be required to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. We proposed to add a new §483.60(i)(3) to require a facility to have a policy in place regarding use and storage of foods brought to residents by visitors to ensure safe and sanitary handling

Time lines.....

Implementation date: The regulations included in Phase 1 must be implemented by November 28, 2016. The regulations included in Phase 2 must be implemented by November 28, 2017. The regulations included in Phase 3 must be implemented by November 28, 2019

See complete document - <https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf>

Links for additional information

QAPI - <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf>

SAMSHA's "Concept of Trauma and Guidance for a Trauma-Informed Approach," - <http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>