The New Requirements of Participation (RoPs) – An Overview, Updates, and Strategies for Success

Arkansas Health Care Association Annual Convention
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Learning Objectives

• Summarize the implementation timetable for the three stages of the RoPs
• Distinguish key systems changes required as a result of the new RoPs
• Apply interventions within your building(s) that will produce positive outcomes
Themes of the Rule

- Person-Centered Care
- Facility-Based Responsibility
  - Assessment/Staffing, Competency-Based Approach
    - Know Your Center, Know Your Patients, Know Your Staff
- Quality of Care & Quality of life
  - New/changed evidence-based practice
  - Care Planning
    - Patient goals
    - Patient as the locus of control
- Changing Patient Population
  - Acuity
  - Behavioral Health
- Reflects dramatic cultural & technology changes over three decades
Alignment with HHS Priorities

Advancing Cross-Cutting priorities:

– Reducing unnecessary hospitalizations
– Reducing the incidences of healthcare acquired infections/adverse events
– Improving behavioral healthcare
– Safeguarding nursing home residents from the use of unnecessary psychotropic (antipsychotic) medications
– Care Planning
– Quality Assurance & Performance Improvement
– Health Information Technology/IT Interoperability
Current timetable (and possible changes)

• Phase 1 – November 28, 2016 (NOW)
• Phase 2 – November 28, 2017
• Phase 3 – November 28, 2019

* Possible changes in either timing and/or content from discussions with administration
Impact of New RoPs on Survey Process

• 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
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.
Added New Definitions

- “abuse”
- “adverse event”
- “exploitation”
- “misappropriation of resident property”
- “mistreatment”
- “neglect”
- “person-centered care”
- “resident representative”
- “sexual abuse”
Purpose & Intent Should Guide Your Implementation

• Mindset will drive how well you comply with the new requirements
• Two philosophical Approaches
  – practice to the regulation
    VS
  – practice to the purpose and intent
Person-Centered Care Defines the Essence of Each RoP

- Care is customized based on patient needs and values—patient values drive variability (personality, nationality, ethnicity and beliefs and expectations associated with religion and culture).

- Focus on the resident as the locus of control and supporting the resident in making their own choices and having control over their daily lives.
  - The patient is seen and cared for as a whole person, not compartmentalized into body parts or functions.
  - Engagement of the interdisciplinary team is essential to the care and services for the patient according to their individual needs.
  - Person-centered care is not task focused, rather it is focused on the person and their needs which are unique for each individual and cannot be accurately reflected in a categorical manner.
  - Quality outcomes are the result of a comprehensive, holistic and individualized dynamic relationship between the direct caregivers, interdisciplinary team, support staff, patient, and family.
  - Flexibility in provision of care and services is critical to desired outcomes and requires consideration of both quality of life and quality of care aspects.

AHCA Clinical Practice Committee July 2016
Resident/Patient Rights (§483.10) Comprehensive Restructuring

- Expanded & comprehensive restructuring, retain existing, update language and organization, includes “facility responsibilities
- Consider advances such as electronic communications
- Eliminate language such as interested family member, replace the term “legal representative with “resident representative”; in accordance with state and Federal law
- Addressing (written) roommate choice, including same-sex couples
- Add physician credentialing, to right to physician choice:
  - Must be licensed to practice medicine in the state
  - If physician does not meet facility requirements, may seek alternative coverage, discuss with resident
- Retain HIPAA protections, but clarify the patients right to access to medical record
Resident/Patient Rights (§483.10)

Resident/patient rights related to planning and **implementing** care:

- Be informed of total health status, including medical condition.
- Right to:
  - Participate in the planning process, including identifying individuals or roles included in the planning process;
  - Establish expected goals & outcomes of care, type, amount frequency & duration of treatment;
  - Request meetings and revisions to the care plan; and
  - Receive the services included in the plan, right to see the care plan, including review/signing after **significant** change.
Resident/Patient Rights (§483.10)

Resident/patient rights related to care planning:

- **The facility shall:**
  - Facilitate the inclusion of resident/patient representative;
  - Include an assessment of patient/resident’s strengths and weaknesses; and
  - Incorporate personal and cultural preferences in developing goals.

- **Resident has the right to be informed in advance:**
  - Of the care to be furnished and the type of care giver or professional that will furnish care;
  - Of the risk/benefits of proposed care, of treatment and treatment alternatives and to make choices;

- **Does not include right to receive care that is not medically necessary.**
Resident/Patient Rights (§483.10)

- The facility must ensure:
  - Exercise rights without interference, coercion, discrimination, or reprisal.
  - Equal access to quality of care regardless of diagnosis, severity of condition, or payment source; once admitted.
  - Identical policies and practices regarding transfer, discharge, and provision of services regardless of payment source.

- Develop written policies and procedure regarding visitation:
  - Receive visitors including spouse regardless of sexual orientation.
  - Rights plus, no restriction or discrimination, unless clinically necessary or based on safety.

- Only allow the resident representative to make decisions or take actions that are allowed by the court or delegated by the resident.

- If the center believes decisions/actions are not in the best interest of the patient/resident, facility shall report as required by state law.
Resident/Patient Rights (§483.10)

• Make available and respect the right to privacy in his/her oral, written and electronic communications.
• The resident has the right to receive notices orally and in writing (including braille) in a format and language he/she can understand; how to contact an Aging & Disability resource, “No Wrong Door”
• Grievances, inform how to file; who may be contacted, to file;
  — Identify a grievance official responsible for the process, including:
    • Receiving & tracking;
    • Leading investigations;
    • Maintaining confidentiality;
    • Issuing official decisions to the resident;
    • Coordinating with State and Federal agencies;
    • Preventing further violations while investigations are taking place;
    • Documentation requirements; and
    • Meeting all applicable State and Federal, laws and regulations.
Freedom From Abuse, Neglect & Exploitation (§483.12)

- Establish policies and procedures to ensure the reporting of crimes in accordance with section 1150 B of the act, with associated penalties for failure to act (Elder Justice Act).
- Report violations to administrator immediately/not later than two hours if abuse or serious bodily injury—24 hours, if no abuse and does not result in bodily injury.
- Expand employment ban to professional who has current disciplinary action against their license.
Freedom From Abuse, Neglect & Exploitation (§483.12)

• Formally “Resident Behavior & Facility Practices”
• Notes improvement, but relies on number of abuse deficiencies cited to mandate greater attention
• Definition of abuse: actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
  – Definition means the individual must have acted deliberately, not that must have intended to inflict injury or harm.
  – Emphasis on exploitation: taking advantage for personal gain, through the use of manipulation, intimidation, threats, or coercion.
Admission, Transfer and Discharge Rights (§483.15)

• Transfer and discharge period represents a period of increased risk for complications and adverse events for the individual
  – Ultimate goal of “coordination of care”
  – Strengthens current transfer, discharge and disclosure requirements
  – Focus on voluntary and involuntary discharge—may discharge a patient while appeal is pending if failure to discharge or transfer would endanger the health or safety of the resent or other individuals. Facility must document the danger.
  – Requires policy on return to center following hospitalization or therapeutic leave; reflects CMS concern regarding facilities not taking patients back after transfer to the hospital.
  – Focus on orientation for discharge & post-discharge planning and follow-up.
  – Implements provisions of the IMPACT ACT
Resident Assessment (§483.20)

• Consistent with the goal of person-centered care.
• Go beyond collection of data to true understanding of strengths, goals, life history, and preferences.
• Clarify what it means to coordinate resident assessment with PASARR (preadmission screening & annual resident review)
  – Refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related conditions for level II review upon a significant change in status assessment;
  – Incorporate recommendations from the PASARR level II and PASARR evaluation into a resident’s assessment, care planning, and transitions of care.
• Establishes exceptions for PASARR screening.
• Mandates notification to state mental health authority or state intellectual disability authority promptly after a significant change in mental/physical health.
• *Cross Reference to New Section Behavioral Health (483.40)*
Comprehensive Person-Centered Care Planning, New Section: (§483.21)

- Baseline Care Plan with 48 hours of admission develop/implement; six components and summary to resident and family代表
- Incorporate PASARR evaluation, specialized services
- Interdisciplinary Team (IDT) add nurse aide, member of food and nutrition
- Includes the resident’s goals for admission and desired outcomes
- Be culturally-competent and trauma-informed;
- The resident’s preference and potential for future discharge, included as part of care planning
- Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose
- Written justification if resident/resident representative does not participate
Quality of Life (§483.24)

• Retain all and enhance requirements; Highest Practicable.
• Quality of Life is a fundamental principle that applies to all care and services provided to facility residents.
• 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.
  ▪ Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to the resident’s advance directives and related physician orders.
  ▪ Conduct regular inspection of all bed frames, mattresses, and bed rails, to identify areas of possible entrapment.
  ▪ Support for ADLs, including walking.
Quality of Care (§483.25)

- Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents - Highest Practicable.
- Retains all current, but updates for change in evidence-based practice:
  - Modify requirements for nasogastric tubes to reflect current clinical practice, and include enteral fluids for assisted nutrition/hydration;
  - New requirements for enhanced services including: Foot care, Incontinence, Mobility, Pain Management, Dialysis; Trauma informed care;
  - Provide adequate supervision and assistance devices to prevent accident;
  - Meet professional standards—wide range of services;
  - Provide services according to person-centered plan of care.
- Re-designation of requirements:
  - Re-locate unnecessary drugs, antipsychotic drugs, medication errors, and influenza and pneumococcal immunizations to §483.45 Pharmacy services.
Physician Services (§483.30)

• Retain existing

• Delegation of Orders allowed for qualified therapist and quality dietitian who is acting within scope of practices as defined by state law and supervised by a physician.
Nursing Services (§483.35)

• Sufficient Staffing:
  – Adds a competencies/skill set requirement for determining sufficient staff based on a resident assessment, which includes but is not limited to census, acuity, range of diagnosis, and the content of care plans, in accordance with the facility assessment.

• Competency Approach:
  – Skills to care for residents' needs, as identified through resident assessments, and described in the plan of care.
  – Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident’s needs.
Behavioral Health (§483.40): New Requirement

• Provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, includes residents with dementia.
  – These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
    • Caring for residents with mental disorders and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), including implementing non-pharmacological interventions.
    • Mental health/disorder includes substance disorders.
  – Add “gerontology” to list which with a bachelor degree meets requirement for social worker.
Pharmacy Services (§483.45)

• Retains existing & modifies drug regimen review, definitions and reporting requirements, requires policies and procedures, including timeframes.
  – Review must include a review of the `resident’s medical chart` (distinguishes from just MAR review)
    • When the resident is new and has not previously been in the center;
    • When prior resident returns from the hospital and/or other center;
    • Monthly when resident is taking psychotropic drug, and antibiotic, and any drug the QAPI committee has requested be included in the review. R/T adverse events/medications.
      – Antimicrobial review is linked to antibiotic stewardship protocols
Pharmacy Services (483.45)

• Definition of Psychototropic drug: any drug that affects brain activities associated with mental processes and behavior; includes, but not limited to: anti-psychotic; anti-depressant; anti-anxiety; hypnotic.

  – Patients do not receive psychotic drugs pursuant to a order PRN unless diagnosis supports and condition is in the medical record, and;

  – PRN orders for psychototropic are limited to 14 days unless physician documents in the medical record the rational for continuation.
Pharmacy Services (§483.45)

• Documentation and Reporting of Irregularities: excessive dose or duration, without adequate monitoring or indication for use, in the presence of adverse outcome.
  – Pharmacist—On separate, written report sent to medical director, director of nursing and attending physician, list:
    • Resident/patient name
    • Relevant drug
    • Irregularity that pharmacist identified.
  – Physician—Document in the medical record the review of irregularity and what if any action has been taken to address it.
    • If no action is taken, document rationale in the medical record.
§483.50 Laboratory, radiology, and other diagnostic services

• Facility must promptly notify the ordering physician, PA, NP, or clinical nurse specialist of lab results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

• Physician extenders can order radiology and other diagnostic services and must be promptly notified of results falling outside of clinical reference ranges in accordance with facility policies and procedures.
Dental Services (§483.55)

• Retains existing and expands requirements.
• Recognized that Medicare does not pay for dental service, and defers to state plans regarding payment by Medicaid.
• Changes are limited and simply clarify existing with a few additions:
  – May not charge a patients for the loss or damage of dentures determined in accordance with facility policy to be the facility’s responsibility;
  – Added language to clarify that a centers must assist a patient with dental services: if necessary or is requested;
  – Promptly, within three days, refer patients with lost or damaged dentures for dental services; if referral does not occur within three days, the center must provide documentation of what they did to ensure that the resident could eat and drink adequately while waiting and of the extenuating circumstance that led to the delay;
  – Must assist patients who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the state plan.
Food & Nutrition Service (§483.60)

- Retain existing and modify
- Name change from dietary services indicative of broader scope of center responsibility
- Qualification Dietician:
  - Meets state requirements including licensure or certification
  - Absence of state requirements: Registered by Commission on Dietetic of the Academy of Nutrition & Dietetics (phase-in within meeting requirements within five years)
- Procure food from sources approved/satisfactory by Federal, State, or local authorities
  - May include food from local producers, subject to state law;
  - May use food grown in center garden;
  - Does not preclude patents from consuming food not procured by the center.
- Requires a policy for use and storage of food brought by family/visitors to ensure safe/sanitary storage, handling and consumption.
Food & Nutrition Service (§483.60)

• Designee if dietician is not employed full-time
  – A certified dietary manager, **required five years** from final rule;
    • A certified food service manager;
    • National certification for food and service management and safety;
    • Associate or bachelor degree in food service management;
    • State certified.
  – Receives frequent scheduled consultations from a qualified dietitian.

• Member of food and nutrition department **must serve** on IDT
  – Frequency of meals: replace 14 hours between with three meals per day, at regular times comparable to mealtimes in the community or in accordance with patient needs, preferences, requests, and plan of care.
  – Suitable, nourishing alternative meals and snacks must be available for patients who want to eat at non-traditional times or outside of scheduled meal service times and in accordance with the plan of care.
Specialized Rehabilitative Services (§483.65)

• Relocated & revised
  – Must provide, if patients need, physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and mental health rehabilitative services for mental disorder.
  • Adds respiratory therapy to reflect current needs of patients
  • Clarifies the meaning of specialized rehab services R/T PASARR to specify (cross-reference to 483.120(c) that with respect to mental health services or intellectual disability services a HCC must be provided to all patients who need these services.
Administration (§483.70)  
Annual Center Assessment *(staffing)*  

- Retain/relocate existing & modify: *(assessment written & reproducible)*  
- New requirement for annual center assessment which serves as a central feature of the revisions to subpart B and intended to be used for multiple purposes, including activities such as:
  - Determining staffing requirements  
  - Establishing a QAPI program  
  - Conducting emergency preparedness planning  
- The center-wide assessment would determine what resources a center would need to care for its patients competently both in day-to-day operations and in emergencies.  
- Assessment must be updated as necessary, but at least annually—and whenever any change would require a substantial modification to any part of the assessment.
Arbitration Agreements (§483.70)

• CMS has banned pre-dispute arbitration agreements in SNFs
• Pre-dispute arbitration agreements entered into before 11/27/16 are not prohibited
• AHCA has been granted an injunction
• Currently not being enforced
Quality Assurance Performance Improvement (483.75)

- New requirement, retain QAA requirement
- Develop, implement and maintain an effective, comprehensive, data-driven QAPI programs that focuses on indicators of the outcomes of care and quality of life. The center must:
  - Maintain documentation & demonstrate ongoing program;
  - **Present plan to survey team at first annual recertification survey that occurs following final regulations and annually thereafter**;
  - Present documentation & evidence of its ongoing program’s implementation to State Agency, Federal Surveyor or CMS on request:
    - Design & Scope, address full range of care & services provided;
    - All systems of care & management practices;
    - Include clinical care, quality of life, and patient choice;
    - Use best evidence to define & measure goals that reflect predictive processes of care to achieve expected outcomes;
    - Reflect the complexities, unique care, and services that the center provides.
Infection Prevention & Control (§483.80)

• Health care-associated infections (HAIs) lead to suffering for patients, as well as increased cost for the healthcare system
  – Between 1.6 and 3.8 million HAIs in nursing centers yearly
  – Results in an estimated 150,000 hospitalizations each year and 388,000 deaths, and
  – Between 673 million to 2 billion dollars in additional cost.

• Antibiotics are one of the most frequently prescribed medications in HCC; it is estimated that between 25% to 75% may be inappropriate.
Compliance & Ethics Program
Multi-Facility Requirements (483.85)

• Chief Compliance Officer responsible for operating the C&E program including assuring the OIG seven required elements and all requirements for “each center requirements” are met:

• Seven required components:
  – Development of standards and procedures;
  – Assignment of responsibility;
  – Due care in delegation of authority;
  – Communication standards;
  – Adoption of monitoring and auditing systems;
  – Enforcement/disciplinary;
  – Correction and continued evaluation of the program.
  – Additional requirements for companies with 5 or more facilities.
Physical Environmental (§483.90)

- Maintain all existing, and additions:
- Conduct regular inspection of all bed frames, mattresses, and bed rails, to identify areas of possible entrapment.
- Be equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each residents bedside.
- Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas and smoking safety that also take into account non-smoking residents.
- New construction or reconstruction: each room accommodate no more than two residents and each room have its own bathroom.
Training Requirements (§483.95)

• Retain existing training requirement, relocate training for feeding assistants, add significant new requirements:
  – The center must develop, implement and maintain an effective training program for:
    • All new and existing staff
    • Individuals providing services under contractual arrangements
    • Volunteers, consistent with their existing roles
  – A center must determine the amount and types of training necessary based on a facility assessment as specified at §483.70 (e)
  – *Don’t forget competency verification!*
Training Requirements (§483.95)

– Training for designated individuals as specified by category (new, existing, annually) and intervals must include (All existing retained):
  1. Residents Rights and facility responsibilities;
  2. Abuse, neglect and exploitation, including:
     – Activities that constitute abuse, neglect, exploitation, or misappropriation of property
     – Procedures for reporting same
  3. QAPI, that outlines and informs staff of the elements and goals of the center’s program set forth at 483.75
  4. Infection Control as specified at 483.80 (a)(2) (portions)
  5. Compliance & Ethics (annual if operating more than 5 centers)
  6. Required Nurse Aide Training—Retains existing and adds:
     – Dementia management training & resident abuse prevention
     – Address areas of weaknesses in CNA performance reviews and facility assessment
     – Behavioral Health—consistent with 483.30 and as determined by the facility assessment at 483.70(e)
Key Processes, Systems, and Assessments Needed

Grievance process (1)
System for accounting of each resident’s personal funds (1)
Discharge planning process (1)
Monthly drug regimen review process (1)
Facility wide assessment (2)
System to track, report, identify, and prevent adverse events (3)
System to obtain feedback from staff, residents, and families (3)
Key Processes, Systems, and Assessments Needed

System to collect data from all departments, including establishment and monitoring of performance indicators (3)
System to prevent, identify, report, investigate, and control infections and communicable diseases for residents, staff, etc. (2)
System to monitor antibiotic use (2)
System to detect ethical and compliance violations and allow staff to report incidents (3)
Process to ensure the integrity of reported data (3)
Key Processes, Systems, and Assessments Needed

System that allows residents to call staff directly for assistance (3)
System to track the location of on-duty staff and sheltered residents during and after an emergency (11/15/17)
Process for cooperation and collaboration with local, tribal, regional, State or Federal emergency preparedness officials (11/15/17)
So, What to DO?

- Check P & Ps for congruity with new requirements
- Review/create forms/documents to meet requirements
- Assure required programs/plans are in place
- Assure required staff positions and certification requirements are met
- Assure required in-servicing and staff training is incorporated into on-boarding and ongoing education
- Assess notifications and resident rights information and update to RoPs
- Address changes to physical environment
QUESTIONS?
THANK YOU!
FOR MORE INFORMATION

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