Phase III Regulations: Effective Nov 2019

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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;

http://www.gpo.gov/fdsys/pkg/FR-2015-07-16/pdf/2015-17207.pdf

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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 = sections with Phase III

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Overview of Phase III Changes

- Infection Preventionist
- Trauma-informed care
- QAPI program (see other QAPI session slides)
- Compliance and Ethics Program
- Centralized Bedside Call System
- Comprehensive Training Requirements

Infection Preventionist

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Infection Preventionist 483.80(b)

Regulations	To Do
b. Infection preventionist. The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's IPCP. The IP must: 1. Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; 2. Be qualified by education, training, experience or certification; 3. Work at least part-time at the facility; and 4. Have completed specialized training in infection prevention and control.	1. Designate or hire a staff person (e.g. nurse or other clinician) who has or will obtain additional training in infection control. 2. Take advantage of AHCA's IPCO Qualification Training

Infection Preventionist

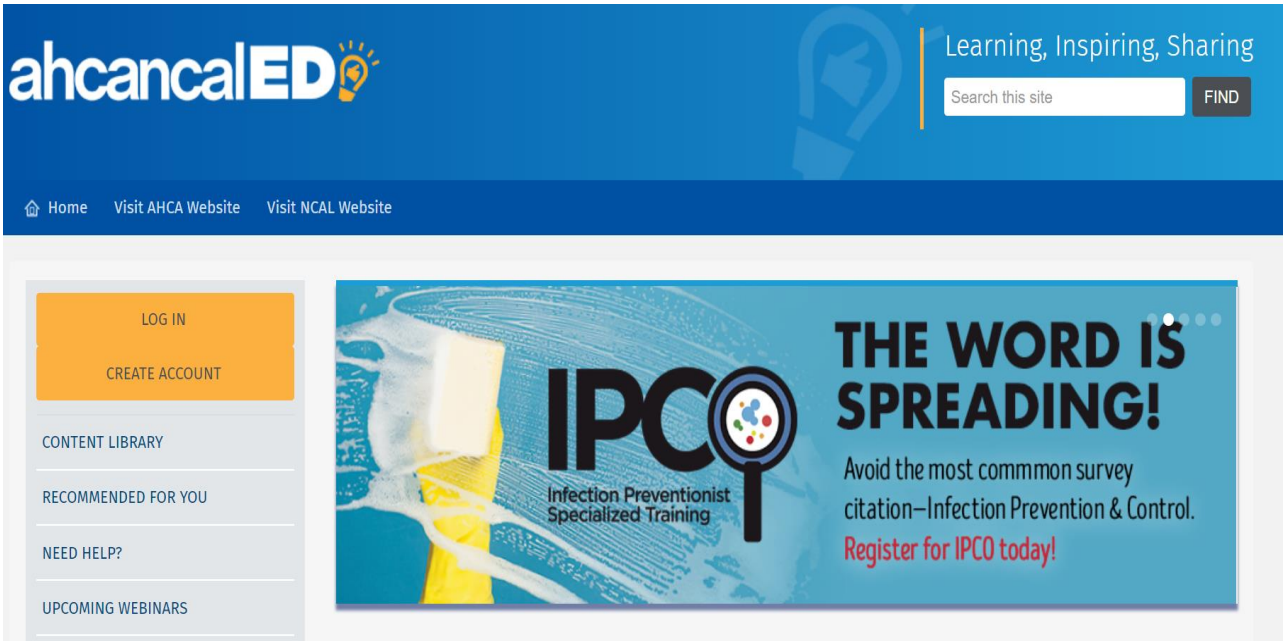
§483.80 (c) IP participation on the quality assessment and assurance committee.

- *The individual designated as the IP, or at least one of the individuals if there is more than one IP, 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.*

[§483.95(c) will be implemented beginning November 28, 2019 (Phase 3)]

So What Do I Do?

- Identify at least one staff person to serve as the Infection Preventionist (IP)
  - Have a back up person to help the IP and also to serve as the IP if the IP leaves.
    - so get the back up person trained.



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AHCA IPCO Certificate Program

- 23 hour online, self-study

ahcancalED

IPC
Infection Preventionist Specialized Training

- 9 modules with guides, quizzes and final test
  - 80% test pass requirement
- Certificates
  - ANCC contact hours credit
  - Specialized training, 3 year expiration (renewal option)

AHCA American Health Care Association
NCAL National Center for Assisted Living

Improving Lives *by* Delivering Solutions *for* Quality Care

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Register Today!

ahcancalED

https://educate.ahcancal.org/p/ipco

IPC
Infection Preventionist Specialized Training

Email educate@ahca.org with any questions

AHCA
AMERICAN HEALTH CARE ASSOCIATION
NCAL
NATIONAL CENTER FOR ASSISTED LIVING

Improving Lives *by* Delivering Solutions *for* Quality Care

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Trauma Informed Care

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Trauma Informed Care

- Appears in multiple areas
- Requires providers to have be able to
  - Assess for past trauma
  - Develop care to address past trauma
  - Provide care to treat past trauma
  - Assure staff competency in recognizing and caring for trauma survivors

Trauma Informed Care

§483.25(m) Trauma-informed care.

- *The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.*

[§483.21(b)(iii) (3) *Comprehensive Care Plans.* The services provided or arranged by the facility, *as outlined by the comprehensive care plan,* must—

(i) Be provided by qualified persons in accordance with each resident's written plan of care.

(ii) Be culturally-competent and trauma–informed.

[§483.25(m) & [§483.21(b)(iii) will be implemented beginning November 28, 2019 (Phase 3)]

Trauma Informed Care

DEFINITIONS §483.21(b)

- ***""Trauma"*** *results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being ("Trauma." SAMHSA-HRSA Center for Integrated Health Solutions. Substance Abuse and Mental Health Services Administration. 30 Nov 2016. Accessed at: http://www.integration.samhsa.gov/clinical- practice/trauma)*
- ***"Trauma-informed care"*** *(TIC): Is an approach to delivering care that involves understanding, recognition and response to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into policies, procedures and practices to avoid re-traumatization. Adapted from: http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf*

Trauma Informed Care

§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who displays *or is diagnosed with* mental *disorder* or psychosocial adjustment difficulty*, or* ***who has a history of trauma and/or post-traumatic stress disorder*****, receives appropriate treatment and services** to correct the assessed problem *or to attain the highest practicable mental and psychosocial well-being (as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019);*

Screening for Trauma

Facilities should use a multi-pronged approach to identifying a resident's history of trauma, which may include:

- *Resident Assessment Instrument (RAI),*
- *Admission Assessment,*
- *History and physical,*
- *Social history/assessment,*
- *Review medical records*
- *Discussion with family and friends*
- *Observation of behaviors that may indicate past trauma*

There are many psychosocial screening and assessment tools available at the following SAMHSA website: https://www.integration.samhsa.gov/clinical-practice/screening-tools#TRAUMA

Trauma-Informed Care

§483.21(b)(3)(iii) *For many trauma survivors, transitioning into a nursing home can trigger re-traumatization. Some common triggers may include:*

- *Experiencing a lack of privacy or confinement in a crowded or small space;*
- *Being exposed to certain loud noises, or bright/flashing lights; or*
- *Having unknown people helping them with ADLs such as dressing, toileting, or bathing*

Seek input from family and friends of the survivor, and other human service agencies can help implement individualized interventions

Have an index of suspicion when residents have symptoms of past trauma such as substance abuse, eating disorders, depression, and anxiety

Trauma-Informed Care

Facilities must recognize the effects of past trauma on residents. Trauma survivors may include

- *Veterans*
- *Survivors of large-scale natural and human-caused disasters,*
- *Holocaust survivors*
- *Survivors of crimes*
- *Survivors of all forms of abuse (sexual, physical, and mental)*
- *Witnesses to horrific events*

Trauma informed care

§483.40(a) Behavioral health services. *The facility must have sufficient staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include:*

(1) Caring for residents with mental 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), and

(2) *Implementing non-pharmacological interventions.*

[§483.40(a)(1) will be implemented beginning November 28, 2019 (Phase 3)]

So What Do I Do?

- Assess for past trauma
  - Develop a screening tool to assess all admissions
- Develop care to address past trauma
  - Should be driven by triggers for trauma (per resident or family)
  - Include access to psychiatry and psychology services
- Provide care to treat past trauma
- Assure staff competency in recognizing and caring for trauma survivors
  - Develop a real-time reporting program on behaviors suggestive of past trauma (e.g. huddles at change of shift on any changes to resident)
  - Develop in-service (or access online programs) about
    - How does past trauma impact elderly?
    - How does past trauma manifest itself in trauma survivors?
    - How do you approach individuals with past trauma?

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Environmental: bedside call systems

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Call Systems

483.90(f). The facility must be adequately 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–

(1) Each resident's bedside*; and

(2) Toilet and bathing facilities.

***[483.90(f)(1) will be implemented beginning November 28, 2019 (Phase 3)]**

SOM Guidance

- **GUIDANCE: §483.90(g)(1) and (g)(2)**

This requirement is met only if all portions of the system are functioning (e.g., system is not turned off at the nurses' station, the volume too low to be heard, the light above a room or rooms is not working, no staff at nurses' station), and calls are being answered. For wireless systems, compliance is met only if staff who answer resident calls, have functioning devices in their possession, and are answering resident calls.

Residents and their representatives should be interviewed about whether calls are being answered.

So What Do I Do?

- If you don't meet this requirement, begin now talking with vendors to install, test and train on systems that notify staff directly or a centralized area that is staffed
  - Note: having a call system to a centralized area that is frequently unattended will likely not meet this requirement, but CMS has not issued final guidance yet.
- Routinely ask residents if their "call lights" are being answered.
- Routinely test the call systems in bedrooms and bathrooms to assure they are functional and staff respond.

Compliance & Ethics

Compliance & Ethics

§483.85(b) General rule.

- *Each facility must have in operation a compliance and ethics program.*
- *Each facility must develop, implement, and maintain an effective compliance and ethics program*

Components of C&E Program

§483.85(c) Required components for all facilities must *contain, at a minimum, the following eight components:*

(1) *Established written compliance and ethics standards and policies*

(2) Assignment of specific individuals to oversee compliance with the program

(3) Sufficient resources and authority to reasonably assure compliance with the program.

*(*4) *Due care not to delegate substantial discretionary authority to individuals who you knew, or should have known had a propensity to engage in criminal, civil, and administrative violations.*

(5 *Steps to effectively communicate the C&E standards, policies, and procedures to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers.*

(6) *Takes reasonable steps to achieve compliance with the C&E program including monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations*

(7) *Consistent enforcement of the operating organization's standards, policies, and procedures*

(8) *After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations.*

C&E for Corporations ≥5 SNFs

§483.85(d) *In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, the CE must also include the following components in their compliance and ethics program:*

(1*) A mandatory annual training program on C&E program*

(2) *A designated compliance officer for whom C&E program is a major responsibility.*

- *This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer.*

(3) *Designated compliance liaisons located at each of the corporation's facilities.*

Annual Review

§483.85 (e) Annual review.

The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect

- *Changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations and in promoting quality of care*

So What Do I Do?

- Develop a written program on Compliance & Ethics that has eight sections consistent with CMS guidance
  - Keep the P&P short and written in 8th grade or less language
  - Create a system/process for staff to report concerns
    - Review reports on regular basis to see if C&E is being followed and if it needs to be revised
- Designate a person to be your compliance officer
  - Make sure they have the correct lines of reporting
- Develop a short in-service on the C&E P&P that includes what and how to report concerns
  - Develop a tracking program for all employees, contractors and volunteers who complete the in-service.
  - Consider having the in-service translated into different languages
- Add C&E program review to annual list of P&Ps that need to be reviewed.

Staff Training Requirements

§483.95 Training Requirements in Phase III

- A facility must develop, implement, and maintain an effective training program for all
  - new and existing staff;
  - individuals providing services under a contractual arrangement;
  - and volunteers,

  consistent with their expected roles.
- A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e).

Training topics must include but are not limited to—

- Communication;
- Resident rights;
- Abuse, neglect, and exploitation;
- QAPI;
- Infection control;
- Compliance & ethics
- Behavioral Health; and
- Any other topics guided by facility assessment

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So What Do I Do?

- Review your current in-service curriculum against required list
  - The duration of in-service is NOT specified.
  - Develop short in-services and put on you tube for your policy and procedures.
  - Develop a tracking mechanism for all your employees, contractors and volunteers.
- Ask you contractors to assure their employees have received and can provide documentation for in-services on required topics.

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§483.95(g) CNA Trainings

§483.95(g) Required in-service training for **nurse aides**. In-service training must—

(1) *Be* sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

(2) *Include dementia management training and resident abuse prevention training.*

(3) Address areas of weakness as determined in nurse aides' performance reviews *and facility assessment at § 483.70(e)* and may address the special needs of residents as determined by the facility staff.

[§483.95(g)(3) will be implemented beginning November 28, 2019 (Phase 3)]

(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

So What Do I Do?

- Review your current CNA in-service curriculum against GAP analysis from
  - Facility assessment for resident characteristics and treatment requirements
  - On-going monitoring of CNA practice
  - QAA committee findings and root cause analyses
- Develop an on-going peer monitoring for compliance with facility P&Ps
  - Add to QAA committee or other committee quarterly review of CNA practices.

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