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National Provider Call Transcript

Centers for Medicare & Medicaid Services
Proposed Reform of Requirements for Long-Term Care Facilities
MLN Connects National Provider Call
Moderator: Amanda Barnes
August 11, 2015
2:30 p.m. ET

Contents

Operator: At this time, I'd like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I'll now turn the call over to Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you Holley. I'm Amanda Barnes from the Provider Communications Group here at CMS, and I'm your moderator today. I would like to welcome you to this MLN Connects National Provider Call on Proposed Reform of Requirements for Long-Term Care Facilities. MLN Connects Calls are part of the Medicare Learning Network®.

During this call, CMS subject matter experts will provide information on long-term care. This presentation will include an overview of the proposed rule to reform the requirements for long-term care facilities. These requirements are the Federal health and safety standards that long-term care facilities must meet in order to participate in the Medicare or Medicaid program.

Before we get started, I have a couple of announcements. You should have received a link to today's slide presentation email. If you've not already done so, you may view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials are available.

Lastly, registrants were given the opportunity to submit questions. We thank everyone who submitted questions.

At this time, I would like to turn the call over to Lisa Parker.

Presentation

Lisa Parker: Good afternoon. We're glad to have the opportunity to speak with you today about our recently published proposed rule. I am Lisa Parker, Director of the Division of Institutional Quality Standards in the Clinical Standards Group at CMS.

Before we get started, I'll just introduce the members of the long-term care regs team we have here today. Captain Sheila Blackstock is a registered nurse and an attorney and

also a member of the U.S. Public Health Service. Diane Corning is also a registered nurse and attorney. And Ronisha Blackstone has a background in regulatory affairs.

The Clinical Standards Group is situated in the Center for Clinical Standards and Quality here at CMS, and we are primarily responsible for the conditions of participation, which are the health and safety regulations that providers and suppliers must meet to participate in Medicare and Medicaid. These requirements apply to all individuals served by a facility, not only Medicare and Medicaid beneficiaries.

On July 16th, we published in the *Federal Register* a comprehensive revision of the requirements for long-term care facilities. These regulations apply to skilled nursing facilities and nursing facilities. Before we begin our discussion of the various provisions of the proposed rule, I'll speak briefly about our approach to making the revisions and give you a bit of background.

Background of the Proposed Rule

So we started with a review of the regulations at 42 CFR Part 483 Subpart B. The CFR is the *Code of Federal Regulations*, for those of you who aren't familiar. While we have made some changes to the long-term care regulations over the years as a result of legislation or a need to address a specific issue, they have not been comprehensively updated since 1991, despite substantial changes in the service delivery in nursing homes.

One of the examples that we cited is that the rules, as written, do not contemplate how electronics and computers are now integrated not only in the healthcare system but also into our daily lives. So this is an example of one of the issues we looked at in making these revisions.

As part of our preparation and review process, beginning in 2012, we reached out to stakeholders through CMS Open Door Forums, and we accepted emails from stakeholders regarding the existing provisions for long-term care facilities. We also conducted an extensive internal review and research to determine how to update and improve existing requirements for nursing homes to focus on person-centered care, safety, health, and quality of life. We also consulted with internal CMS experts, including former surveyors and nursing home administrators.

We believe that this proposal will not only modernize the requirements but will work together with other HHS and CMS initiatives to reinforce efforts to improve the quality of care and quality of life for nursing home residents, to reduce unnecessary readmissions to hospitals, and also to reduce healthcare-associated infections. In addition, these revisions will implement important safeguards required by the Affordable Care Act.

I will note that we did receive many thoughtful questions during the registration process, and we will try to address many of those as we go through our presentation.

I am moving on to slide 5, and I'll just speak really briefly about the regulatory process. Generally, once we publish a proposed rule, there is a 60-day comment period to allow the public to submit feedback on the proposed requirements. Anyone may submit comments, and we read every one. We consider all of the issues that are within the scope of the proposal.

To submit a comment, please go to regulations.gov. The appropriate links are included in the slides, and follow the instructions provided. The comment period closes at 5 p.m. on September 14th, 2015. After the comment period closes, we review all of the comments. We then summarize those comments and respond to them in the final rule. I'll speak more specifically about the comments — public comments — toward the end of the presentation.

We did receive a question about which provisions are actually open for public comment. And so, while we are making changes to a majority of the provisions in Part 483 Subpart B, and we're doing some major reorganizing, there are certain provisions where we did not make any changes, mainly because the statute did not permit discretion in those areas. So those provisions would not be open for comment.

OK. Moving on to slide number 6. Just an additional note about the approach we took in drafting what we consider a pretty massive revision. In developing the rule, we thought about the changes individually, but we also thought about how this revision would fit into the larger framework of initiatives and priorities at CMS. We did not develop the rule in a vacuum. Instead, as I mentioned earlier, we reached out to the long-term care community, and we also thought about how we can contribute to furthering existing agency initiatives.

So most of the changes in this rule relate to the following themes, if you will:

- Person-centered care,
- Quality,
- Facility assessment and the competency-based approach,
- Alignment with HHS priorities,
- Comprehensive review and modernization, and
- Implementation of legislation.

We will be discussing some of the provisions of the proposal in the context of these overarching themes. What we're doing today is providing some highlights of the proposed rule, and not a comprehensive briefing on all of the provisions, so we would encourage you to read the entire proposal before submitting your comments.

With that, I will turn it over to Ronisha Blackstone to discuss person-centered care.

Person-Centered Care

Ronisha Blackstone: Thanks Lisa. So I will be speaking about person-centered care, and we are on slide 7. So, in conducting our review of the current regulations, we found that there was a need to revise the regulations to reflect a more person-centered care approach. Like many other innovations and changes in healthcare that have developed since adopting the current regulations, the idea of person-centered care has evolved, and we believe our health and safety standards should ensure that the resident is the focus and remains in control of their care.

We believe that revising the regulations to be more person-centered could have a positive impact on the care that facilities provide, and as a result, ensure that residents live with dignity, respect, improved self-esteem, and self-determination. The proposed rule seeks to promote person-centered care by protecting a resident's choices, while also improving the quality of care and services that they receive. The proposed rule maintains all existing protections and does not take anything away. Instead, the regulation proposes revisions or additions to increase protection, promote resident choice, and support resident involvement and control.

Related proposals include adding a definition of person-centered care. In these regulations, we are proposing to define person-centered care 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.

We've also updated the Residents' Rights section. In the proposed rule, we have enhanced residents' rights regarding physician choice, their treatment preferences, choosing roommates, as well as their meal selection. For example, in the Residents' Rights section, we propose to emphasize that the resident has the right to participate in the care planning process, including the right to identify individuals or roles to be included in the planning process. We also propose to include that the resident has the right to request meetings and the right to request revisions to their plan of care.

One question that we received through registration was related to our proposal to add that the resident has the right to sign their care plan. The intent of this addition is to ensure that the resident is informed about and participates in their care planning process. This addition also ensures that their participation is evident to caregivers, surveyors, and other interested parties. Our proposal does not specify a method in which the signature must be obtained or a timeframe. However, existing requirements indicate that all residents must have a care plan that is developed in consultation with the resident.

We've also updated the care planning requirements within the proposed rule. We highlight the importance of care planning, and propose to make a new section entitled

Comprehensive Person-Centered Care Planning. This section relocates current care planning requirements, while revising and adding additional requirements aimed at improving resident satisfaction and increasing resident safety.

For example, we propose to require that documentation be included if a resident is not involved in the interdisciplinary team. We also propose to add additional mandatory members to the interdisciplinary team, including a nurse aide who has primary responsibility for the resident, a social worker, and a member of the food and nutrition staff. We believe that these individuals are necessary for the care of all residents. Specifically, nurse aides spend much of their staff time interacting directly with residents, providing them with day-to-day care. Dietary concerns and unplanned weight loss continue to be concerns for the long-term care population, especially for the elderly population. And social workers serve as a critical link with families in many ways, including arranging post-discharge services and addressing mental and behavioral healthcare needs.

We received a question through registration regarding the qualifications of a social worker. And I want to note that the existing requirements related to the qualifications of a social worker are proposed to be relocated to Section 483.70, which focuses on administration. We've maintained in the proposed rule that a qualified social worker must have a bachelor's degree in social work or a human services field, but propose to add gerontology to the list of studies that will meet this requirement.

Other examples of how we have highlighted the importance of care planning include proposing to require that a resident's goals of care, treatment preferences, and desired outcomes be assessed as part of developing their care plan and their discharge plan. And then lastly, we propose to implement Section 2 of the IMPACT Act, which supports the need for residents and their representatives to be informed and receive reliable and resourceful information to make decisions. The rule proposes to require facilities to assist residents and their resident representatives in selecting a post-acute care provider by using data that includes patient assessment data, data on quality measures, and data on resource use to the extent that the data is available.

In summary, the proposed rule aims to encourage facilities to acknowledge both the resident's needs and their right to make choices. We believe that such an approach will result in improved quality of life and care for long-term care residents.

And with that, I will pass it over to Sheila Blackstock, who will be speaking about the recurring theme of quality.

Quality of Care and Quality of Life

Sheila Blackstock: Good afternoon. We are now on slide 8, it's titled Quality, and I'm going to be addressing quality of care and quality of life. These are overarching principles for every service and so are considered throughout our proposals. And

overall, our proposals set a high standard for quality and safety in long-term care facilities.

Quality of care and quality of life are specifically addressed in a proposed 483.25. This section includes activities of daily living, activities program, and special care issues. We've also added a requirement relating to CPR subject to a resident's advance directive so that that decision is made based on an individual as opposed to a facilitywide policy. We solicit comments on the activities director, and I'll touch on that actually later in another section.

Many of the special care issues that are in this section are already identified in the regulations, but we update the language specifically around nasogastric tubes to include gastrostomy and jejunostomy tubes, as well as antral fluids. We also address both bladder and bowel incontinence, and we've added issues such as bedrail safety, pain management, dialysis, and trauma-informed care to the list of special care issues.

The other section that is very specific to quality is the section on quality assurance and performance improvement. It's new 483.75. And this section includes existing requirements for the QAA committee, as well as new requirements for a QAPI program, as required by the Affordable Care Act. We did receive a few questions on this particular section, so, hopefully, the information I'm about to give you will also answer those questions.

Under our proposal, each facility must develop, implement, and maintain an effective, comprehensive, and data-driven QAPI program. We propose that each facility will have to present its QAPI plan to the States — State agency surveyor at the first annual recertification survey that occurs after the regulation becomes effective, as well as annually and upon request to surveyors and to CMS after that initial presentation.

The requirements for the QAPI program are an outgrowth of the QAPI pilot that was conducted by CMS. And they're in alignment with the five elements set out in that pilot. So the proposed rule includes requirements for program scope and design, program feedback, data systems and monitoring, systematic analysis and systematic action, program activities, and governance and leadership. Nursing homes would be required to conduct at least one performance improvement project annually. And the tools that were developed in that pilot to help nursing home — nursing homes implement QAPI are available on the cms.gov website.

With regard to the QAA committee requirements, we retain the existing requirements with some modifications. We have added a requirement that the committee include the infection prevention and control officer. Under our proposal, the QAA committee would coordinate and evaluate the QAPI program and report to the governing body or designee on the QAPI program. We also address the need to disclose information in order to demonstrate compliance with the QAPI requirements.

In addition to these two specific sections, we incorporate quality principles and concerns with — throughout the proposed rule. So Ronisha has already discussed care planning and discharge planning. Diane will discuss infection prevention and control, as well as compliance and ethics. And another example is in the section of facility responsibilities, where we propose to require that facilities must have a grievance process and cannot prohibit or discourage residents from communicating with outside entities regarding any matter. This is so that residents or their representatives can communicate freely with, for example, the long-term care ombudsman, when they have a quality of care or quality of life concern.

So in summary, as I noted earlier, quality of life and quality of care are our overarching principles for every service, and so they have been considered throughout the development of our proposals.

A Competency-Based Approach to Facility Assessment

I'm going to move to the next slide, which is slide 9, and it is on facility assessment and a competency-based approach. The idea really is that facilities really need to know themselves, their staff, and their residents. We did not take a one-size-fits-all approach to revising these regulations since nursing facilities present a wide spectrum of sizes and resident population characteristics. Instead, our proposals reflect a facility assessment competency-based approach that accounts for and allows for diversity in populations and facilities. We recognize that facilities have — may have a largely post-acute care rehab population or a frail elder population or a large percentage of residents with Alzheimer's or other dementias or a ventilator-dependent population or a population of younger disabled residents or any combination of those populations.

So in keeping with statutory requirements, the focus is on caring for each resident so that he or she can maintain or obtain their highest practicable physical, mental, and psychosocial well-being. In 483.70, we have added a new requirement — that facility — that facilities conduct a comprehensive facilitywide assessment at least annually. This goes with a facility must know its own capabilities and capacities as well as the characteristics of its resident population, not just the number, but also the acuity and the range of diagnoses. This facility assessment is then used by the facility in making other decisions, including staffing decisions.

In terms of competency, we want to be sure that the staff caring for a resident have the necessary skills and competencies to do so, for both the resident's benefit and for the staff person's benefit because we believe that staff generally want to do the best job that they can.

We address competency-based staffing in a number of places. In Residents' Rights, we state that a resident's attending physician must be licensed and meet facility credentialing requirements. And in facility responsibilities, we parallel that, requiring

that the facility respect the resident's choice if the resident's choice meets those requirements.

In nursing services, we require the facilities have sufficient nursing staff with the appropriate skill sets and competencies, in accordance with the facility assessment, to provide necessary care, with similar requirements for food and nutrition services and for behavioral health services. We include an extensive discussion of nurse staffing in the preamble. And we explicitly seek comment on our approach vs. imposing mandatory nurse–resident ratios or minimum nurse staffing requirements, so please take a look at that discussion. In food and nutrition services, we established qualifications for dieticians and food services managers, with a 5-year window for existing professionals to meet the new requirements.

In quality of life and quality of care, we solicited but didn't change the current qualification for an activities director. We did solicit comments on the question, and we're interesting in hearing from stakeholders on that issue. Currently, there are four options to meet the requirement, along with licensure or registration by the State, if the State requires licensure or registration.

The activities director is responsible for leading the facility's activities program, which is expected to support residents in their choice of activity, both facility-sponsored and individual activities and independent activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Hopefully this answers a couple of the questions that we received through registration regarding the activities director. To the extent that you have suggestions or concerns regarding these minimum qualifications for this or any of the positions that are identified in our proposal, we do ask that you submit those as official comments to the rule so that we can look at those.

And now, we're going to move on to slide 10, which is alignment with current HHS initiatives, and Diane Corning's going to go over that.

Alignment with Current HHS Initiatives

Diane Corning: OK, thank you. In this slide I'm going to address the recurring theme of advancing crosscutting priorities. As we reviewed the current requirements, we also kept in mind the HHS initiatives and looked at it with an eye of fostering these initiatives. Good example of that is the National Partnership to Improve Dementia Care in Nursing Homes. There they had — two of their goals were the reduction in the use of antipsychotics and hospitalizations. In fact, between the second quarter of 2011 and second quarter of 2014, they saw almost a nationwide reduction of about 19 percent in the use of antipsychotics. So this is an example of goals and initiatives that we wanted to foster.

The first one I want to address is reducing unnecessary hospital admissions. One of the revisions we proposed along with that initiative is comprehensive person-centered care planning, which Ronisha has already discussed with you. Another revision we proposed was that in care transitions, which Sheila will also discuss later. Care transitions is an area that we identified as a very vulnerable time for residents, in which sometimes there are missed opportunities for successful continuity of care.

In this section, we placed an emphasis on communications between the parties. For example, the transfers and discharge, the resident or the resident's representative must receive notice and be provided sufficient preparation orientation before either a transfer or discharge. In addition, we propose minimum requirements for documentation that must be provided to the receiving facility. Some of that documentation must include current and past medical history, active diagnosis, and current problems, medicines, allergies, but also functional analysis — functional status, excuse me, psychosocial assessment, behavioral health issues, social support, and the comprehensive care plan goal.

In addition, we looked at physician services. Currently, 483.40(d) requires that a facility provide or arrange for the provision of physician services 24 hours a day in case of emergency. We're proposing that the facilities also be required to provide an in-person evaluation of a resident by either a physician, physician assistant, nurse practitioner, or clinical nurse specialist, prior to transferring the resident to a hospital. This evaluation must occur expeditiously once the potential need for the transfer is identified, and this requirement does not apply in emergency situations where the health or safety of the resident would be endangered.

In advance — in reducing the incidence of healthcare-acquired infection, we look to the current infection-control requirements at 483.80, and we decided to make some revisions. First of all, we are going to refer to it as the Infection Prevention and Control Program because we want to emphasize prevention also in these requirements. And our intent here was we really wanted to bring the nursing home requirements up to current standards.

Our proposed revisions include requiring the infection prevention and control program include an antibiotics stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. We would also require the designation of an infection prevention and control officer. This individual must be a clinician with specialized training in infection prevention and control beyond their initial professional degree. And this individual must also be on a facility's policy assessment and assurance committee and report to the committee on the infection prevention and control program on a regular basis.

In the theme of improving behavioral healthcare, when we started to do our research, we heard many concerns that behavioral health just wasn't getting the resources and

attention devoted to it that the residents really required. Therefore, we went through and we pulled out the different requirements for behavioral health, and it is now its own section, 483.40. Facilities must provide each resident with the necessary behavioral healthcare and services to attain or maintain the highest practical physical, mental, and social well-being, in accordance with the comprehensive assessment and their plan of care. This goes back to what Sheila was talking about, about the facility assessing its residents' comp — resident population and then determining the competencies and the skill sets along with the number of staff that are needed to care for their population.

In safeguarding nursing home residents from the use of unnecessary psychotropic and antipsychotic medication, we already have certain specific requirements for antipsychotic medication. Those are that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition, as diagnosed and documented in the clinical record. And also that residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue those drugs.

We are proposing that these current requirements be revised to include psychotropic medication. We've proposed that psychotropic drugs be defined as drugs that affect brain activities associated with mental processes and behavior. We believe that other drugs, other than antipsychotics, could be used to provide similar effects to the antipsychotics. We want to make sure that those drugs also are included in the specific requirements.

We're also proposing that there be a limitation on PRN orders for psychotropic medications. Specifically, that they be limited to 48 hours, and if the medication PRN order is to continue beyond that point, that the primary care provider document a rationale for that continuation in the resident's clinical record.

We are also provide — proposing to revise the requirements concerning the monthly drug regimen review that is currently required. Currently the pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports have to be acted on. We are proposing that the report also be sent to the facility's medical director and that the attending physician must document in the resident's medical record if the identified irregularity has been reviewed and what action is taken. If no action is taken, the attending physician must document the rationale in the medical record.

We are also proposing that the reviewing pharmacist must review the medical record at least every 6 months and when the resident is a new admission, has returned or is transferred from another facility, and every month whenever the resident has been prescribed or is taking a psychotropic drug, an antibiotic, or any drug that the facility's quality assessment assurance committee has requested be included in the review.

One of the examples of that is sometimes there's a concern with anticoagulants. We believe that requiring a review of the medical records in these circumstances will help foster the goals of other sections of the rule, specifically when a resident is new or is transferred in, that will help foster the goals of care transitions. We also believe that requiring a month — that the medical record be reviewed every month will help with our behavioral health goals in the case of psychotropic drugs. For antibiotics, that will help foster the goals of the infection, prevention, and control program, especially the antibiotic stewardship program. And by enabling the Quality Assessment Assurance Committee to identify specific drugs that are of concern, that's also going to help them with their QAPI activities.

And with that, I'll turn it over to Amanda.

Keypad Polling

Amanda Barnes: Thank you Diane. And at this time we will pause for a few moments to complete keypad polling. Holley, we're ready to start.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please continue to hold as we complete the polling. And I will now turn the call back over to Amanda Barnes.

Presentation Continued

Amanda Barnes: Thank you Holley. Sheila, we're ready to resume our presentation.

Comprehensive Review and Modernization

Sheila Blackstock: OK, and for everybody on the line, we're going to be starting on slide 11, which covers comprehensive review and modernization. This is where we really talk about bringing the regulations into the 21st century, and Lisa actually touched on a lot of these in her initial comments.

So to recap a little bit, this was a comprehensive review and revision, so when we reviewed the existing regulations, we did it completely. We reorganized and updated the existing requirements, as well as added new statutory requirements that Diane is

going to discuss after this. We incorporated new technology like electronic communications and recordkeeping, which Lisa already mentioned. And we looked to research and to the existing evidence base, some of which didn't even exist when the regulations were originally written.

We did receive some questions on this section, and particularly somebody said, "What exactly is new in these proposals?"

So at a high level I'm going to try to address that, but there is a tremendous amount of detail obviously in the regulations, so we really encourage folks to read it. We did touch every section of the regulations, some more than others, and there is a crosswalk included in the proposed rule to help you find where existing provisions have been moved to in the proposal. We did not do anything to reduce existing resident protections though. We also didn't make significant changes to the resident's assessment section, so the MDS assessment provisions, except to elevate care planning, which Ronisha has already discussed.

We also did not make significant changes to dental services, although we highlight the importance of good oral hygiene and dental care in the preamble. We elevated several sections due to their importance and those — some of those have been discussed. Care planning is already mentioned — was one; also training in behavioral health.

And while some sections are updated to meet current standards, some requirements are completely new, such as the ethics and compliance requirements that Diane will discuss.

We renamed some sections, and that was to better reflect their content. So they're — currently there's a section titled, Resident Behavior and Facility Practices. We propose to retitle that Freedom from Abuse, Neglect, and Exploitation. In addition to more clearly reflecting what's actually in the section's content, this section also now addresses exploitation, which we define as the unfair treatment or use of a resident or the taking of a selfish or unfair advantage of a resident for personal gain through manipulation, intimidation, threats, or coercion.

We renamed Dietary Services to Food and Nutrition Services, and we renamed Admission, Transfer, and Discharge to Transitions of Care. And Transitions of Care now begins with the provisions on admission and it reflects our understanding that transitions of care create a period of higher risks for residents, and that's important from a resident's safety perspective.

We also reorganized some sections to better reflect their content, so residents' rights. There's still a section that's titled Residents' Rights, but its content now contains statements that begin with the statement, "The resident has a right to," and goes from there.

There is a new section titled Facility Responsibilities that contains the provisions that say, "The facility must," and they're related to certain things that the facility must do to support the residents' rights.

We updated standards throughout the requirements. For example, as already discussed, we've revised care planning and discharge planning requirements. We've also updated many of the food and nutrition standards, including the qualifications of dieticians and food service managers. For those two positions, in both cases, we require either compliance with State-established standards or with our proposed minimum standards.

We've also updated infection prevention and control program requirements, as Diane discussed, and include antibiotic stewardship in those provisions. And in addition, to the extent possible in keeping with the statute, we propose revisions that would allow professionals like nurse practitioners, physician's assistants, and clinical nurse specialists to practice to their full scope of practice as allowed by their State law, and we include this, for example, in examining residents prior to an unplanned, nonemergency transfer to a hospital. We also propose to allow physicians to delegate certain tasks to dieticians and therapist to the extent permitted under State law.

And so, all of those are recognizing the ability of professionals to practice to their full scope of practice, again, under State law. So these are some of the updates that are included in our review and modernization. We've discussed others throughout this presentation, and Diane will touch on a couple more as she goes over the implementation of legislation, which is the next slide. So I'll turn it over to Diane.

Implementation of Legislation

Diane Corning: OK, thank you. Some of our proposals in our rule were actually required by legislation, specifically the Affordable Care Act and the IMPACT Act.

Two of the sections of the Affordable Care Act specifically addressed enforcement of other requirements and protections of residents. One of those requirements is that all nursing home operating organizations must establish compliance and ethics programs. And these programs — the legislation actually requires specific elements in these programs, some of which are:

- That they establish written compliance and ethics standards, policies, and procedures, which are to follow, that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations and promote the quality of care;

- That high level personnel must be — have overall responsibility for the program;

- That the facility must devote sufficient resources for the program;

- That there must be consistent enforcement; and

- That once a violation is detected, there must be reasonable steps taken to respond to prevent any similar occurrences in the future.

If the operating organization has five or more facilities, there are also additional requirements — the mandatory annual training, a designated compliance officer, and designated compliance liaisons at each facility.

The Affordable Care Act also contained the Elder Justice Act, which requires that covered individuals, which include the staff and managers in nursing homes, must report any reasonable suspicion of a crime to the Secretary and one or more law enforcement entities in their political subdivision in which the nursing home is located. That suspicion must be reported within 2 hours if the suspicion resulted in serious bodily harm to the resident or not later than 24 hours if there is no serious bodily harm. These facilities must annually notify covered individuals of their obligation to report, and retaliation for people making such a report is prohibited.

Other sections of the Affordable Care Act address quality of care improvement, such as the quality assurance performance improvement, as discussed by Sheila, and the IMPACT Act, which was previously discussed by Ronisha. And the IMPACT Act really highlights the need for residents to have the information they need to make good decisions.

Now in addition to what's listed on the slide, it wasn't specifically required by legislation, but we have also added some requirements regarding binding arbitration agreements. During our research, we became aware of concerns that, in some cases, residents may either feel pressure to sign such agreements or they are being asked to sign these agreements without them being properly explained, so they really weren't aware of the right they were giving up. And we were also made aware of some concerns that, after signing these agreements, that some residents may feel that they weren't free to speak to surveyors, representatives from the ombudsman, and other people.

Thus, we have proposed that if a nursing home chooses to ask residents to sign one of these agreements, that admission to the facility must not be contingent upon signing the agreement. It must be entered into voluntarily after it has been explained to the resident or the resident's representative, and that person — the resident or the resident's representative acknowledges that they understand the agreement.

And also, as Sheila discussed earlier, there's a general prohibition against the facility prohibiting or discouraging the resident from communicating with Federal, State, or local officials. These agreements also cannot contain any language that prohibits or discourages the resident or anyone else from communicating with Federal, State, or

local officials, including Federal and State surveyors or representatives from the Office of State Long Care Ombudsman's Office.

And with that, I'll turn it back over to Lisa.

Submitting Comments

Lisa Parker: Thanks Diane. So this ends the overview portion of our presentation. I am now on slide 13. Just a reminder that the comment period closes on September the 14th. All comments received by the deadline will be considered. Again, we do read all of the comments. And while none of these things are required when you're submitting comments, I would like to note that the comments that are most helpful to us in refining the proposed policies are those that are supported with data or evidence and those that, to the extent they may disagree with our proposed approach, present alternatives that achieve the same or similar policy goals as those outlined in the proposal.

Finally, comments that are relevant to and within the scope of the proposal are indeed helpful. As I noted earlier, we received many thoughtful questions that presented valid issues during the registration process, which we've tried to answer as we went through the slides. If we didn't answer your specific issue, please feel free to jump in the queue and we'll do our best to respond on this call.

I do want to reiterate that submitting a question during the registration is not considered an official public comment. To make a public comment, you must go on to regulations.gov and follow the instructions.

Just a few ground rules on the Q&A before we begin. I want to note that we will only be able to respond to questions on this call that are within the scope of our proposal. So, for example, we are not able to answer questions about the SNF PPS or the SNF quality measures. These are separate regulations, and they must be commented on separately and within the timeframes established in those rules.

We can't address billing questions or technical questions regarding the F tags and the survey process. We're also unable to address questions about other providers. This rule applies to skilled nursing facilities and nursing facilities only. We did receive a question during registration asking if the rule would be applicable to ICF/IID facilities. It is not applicable to those facilities.

And then, finally, there may be questions that will require more time, consideration, and perhaps a bit of research on our part. So again, for those types of questions, we would encourage you to submit those as public comments.

Questions Received in Advance

Of the questions we received during registration, the majority were focused on the following issues:

- Implementation of the requirements,
- The transfer evaluation, also referred to as the physician face-to-face, and
- The burden that the rule will impose on providers.

I will speak briefly about the implementation issues and then I'll turn it over to Sheila to discuss the other questions. After that, we will take questions.

We received two types of questions regarding implementation. Basically, when questions and how questions. With regard to the when questions, people inquired about timeframes for publishing the final rule and timeframes for compliance with the requirement.

By statute we have 3 years from the publication of a proposed rule to publish the final rule. However, our goal for this regulation is to publish the rule before the 3-year period. Regarding compliance with the requirement, we did not propose a specific timeframe in the rule. We do solicit comments, however, on what would be an appropriate timeframe for nursing facilities to implement these changes.

Many of the how questions regarding implementation were specific questions about the survey process and modification of the interpretive guidelines. The rule is not yet final, so we aren't able to speak to specific revisions that will be needed to the interpretive guidelines. However, the interpretive guidelines, or IGs, will be modified to reflect the provisions of the final rule. We will forward questions regarding the survey process to the appropriate CMS officials in Surveyor Certification Group.

So now Sheila will speak to you about the transfer evaluation and the burden of the proposed rule.

Sheila Blackstock: Thank you Lisa. So the transfer evaluation generated a significant number of questions, and as you all already know, transfers to a hospital represent a period of increased vulnerability for residents. This provision was one of the provisions included in our proposal in order to address unnecessary transfers to hospital. The idea is that this would be an opportunity to identify options that would allow the resident to be treated in house, if appropriate. We felt that this could be performed not only by physicians but also nurse practitioners, physician assistants, and clinical nurse specialists. There is an emergency exemption, and it is intended to prevent this provision from delaying a necessary transfer or putting the resident at increased risk.

Within the rule, we also included provisions on improved communications to the physician when they are being notified of a significant change in status of a resident so that the physician will have more information to operate on initially. And we also believe that our competency-based requirements would apply here, so that the people taking care of a resident would have the skill sets and competence needed to take care of them, consistent with their diagnosis and with their goals of care, so that all of that would come into play to identify changes in status more quickly, and really to be able to reduce the incidents of unnecessary transfers to hospitals.

The questions that were submitted raised many concerns, and we really welcome comments on this issue and all issues within the proposal that point out unintended cons — unintended consequences as a result of our proposal or that suggest alternatives to meet the objectives of, in this case, reducing unnecessary hospitalization and ensuring resident safety, quality of care, and quality of life.

The other question that we got in a number of ways are questions about the burden that would be imposed by these provisions. Just so you know, in general, we estimate burden based on estimates of how long certain activities generally would take, and we use salaries from the Bureau of Labor Statistics. And in this rule we added 48 percent overhead to reflect the cost. We discuss our estimates and the regulatory impact analysis of the proposed rule and explain our assumptions about how long we think something would take and how we estimated the cost. So you can look there for information in detail about specific provisions.

In some cases, we do discuss that we believe a practice is probably already in place by many providers as a standard business practice and, therefore, it doesn't really represent an added cost. But even if an activity is a standard business process, it may be appropriate for inclusion as a requirement in our regulations because they're important issues to the safety, quality of care, and quality of life of nursing home residents.

And this may apply whether the resident is in the facility for a short stay or whether the facility is actually the resident's home. As discussed earlier, we recognize that there is great diversity in the nursing home industry, both in terms of the facilities themselves and in terms of resident population. And so we incorporated flexibilities where we could. In a number of places we have asked — we specifically solicited comments on unintended consequences, as well as alternatives to our proposals. So we would encourage the folks who submitted questions on the burden issue, as well as anybody else who wants to provide us with input, to submit a comment on the rule to talk about what their concerns are or where they think maybe we didn't quite get it right.

With that said, I'm going to turn it back over to Amanda to get the queue for questions.

Question-and-Answer Session

Amanda Barnes: Thank you Sheila. Our subject matter experts will now take your questions about the proposed reform requirements for long-term care facilities. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your question to just one.

All right Holley, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you're asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question will come from the line of Ashleigh Allgood.

Jenny Jordan: Yes, this is Jenny Jordan with AQAF in Alabama, and our question is for clarification on the oversight of QAPI, if it will be done by QAA?

Amanda Barnes: One second.

Sheila Blackstock: This is Sheila, and responding to your question — and under our proposal, the QAA committee would coordinate and evaluate the QAPI program and report to the governing body or designee on the QAPI program.

Jenny Jordan: Thank you.

Amanda Barnes: Thank you.

Operator: Your next question comes from the line of Debby Harca.

Diane Marcello: Hi, this is Diane Marcello. And my question is in regard to the social worker. We have a 60-bed, skilled facility, and we are not required at this time to have a bachelor degree social worker. Is that now going to become the rule?

Amanda Barnes: One second.

Diane Corning: Hi, this Diane Corning. We did not change the requirement for — as we have here, "Any facility with more than 120 beds must employee a qualified social worker on a full-time basis." So we did not change that, it remains at 120 beds.

Diane Marcello: OK, thank you.

Amanda Barnes: You're welcome. Holley, next question.

Operator: Your next question will come from the line of Melody Malone.

Melody Malone: Yes, my question is in the QAPI regulation rollout, have you all determined how you're going to implement survey in looking at QAPI standards for that very first year of survey, considering when the facility's plan went into action?

Amanda Barnes: One second.

Sheila Blackstock: This is Sheila Blackstock. So from the survey process standpoint, those details have not been finalized yet and won't be until after we have a final rule.

Melody Malone: OK, will we have a chance to comment on that?

Sheila Blackstock: We expect so.

Melody Malone: Thank you.

Amanda Barnes: Thank you.

Operator: Your next question will come from the line of Theresa Edelstein.

Theresa Edelstein: Hello, thanks for taking my call. Can you hear me?

Amanda Barnes: Yes, we can.

Theresa Edelstein: OK, just a quick question, a clarification actually, on the discharge planning requirements that are part of the comprehensive person-centered care planning section. Are — is the expectation that that process will apply to both skilled nursing and nursing facility residents, or just to those receiving skilled nursing care with an expectation of leaving the facility after a short stay?

Amanda Barnes: One second.

Ronisha Blackstone: Hi, so this is Ronisha Blackstone. And so the overall section in regards to discharge planning that's at 483.21, that speaks to both skilled nursing facilities and nursing facilities with the exception of the requirements that are specific to the IMPACT Act. The IMPACT Act spoke directly to skilled nursing facilities.

Theresa Edelstein: OK, thank you very much.

Amanda Barnes: You're very welcome.

Operator: Your next question will come from the line of Anne Hummel.

Anne Marie Hummel: Yes, hi, this is Anne Marie Hummel with the American Association for Respiratory Care. CMS is proposing to add respiratory therapy under Section 483.65, Specialized Rehabilitative Services. And if the services are obtained from outside, an outside resource, it requires that it be a Medicare or Medicaid provider of specialized rehabilitated services. My question is, is there any reason to presume that respiratory therapists would not be considered specialized providers under that service?

Sheila Blackstock: Are you — is your reference to the requirements for when facilities contract with outside entities?

Anne Marie Hummel: Yes.

Sheila Blackstock: Those requirements regarding contracting with outside entities would always apply when a facility is obtaining services from an outside entity.

Anne Marie Hummel: I understand that, it's just that it says that they have to be a provider of specialized rehab services. So my question is, is a respiratory therapist considered a provider of that rehab service? They are covered under the port — the core provisions to provide respiratory therapy in that setting, and so my question is, is there any reason to presume they would not be allowed to provide the service if it was contracted outside?

Sheila Blackstock: Could you submit that as an official comment?

Anne Marie Hummel: Yes.

Sheila Blackstock: We really want to make sure that everybody has the common understanding, and I'm concerned there are complexities there that we may not want to answer on the fly.

Anne Marie Hummel: Yes, I propose to do that anyway, so I appreciate it. Thank you.

Sheila Blackstock: Thank you.
Amanda Barnes: Thank you.

Operator: Your next question will come from the line of Jim Mikes.

Jim Mikes: Yes, this is Jim Mikes with the Missouri Hospital Association, and I guess my — I just have a comment. I didn't notice any reference to utilizing telehealth services to

meet some of the standards that you'd like to reach. I was just wondering if that's by design or are you open to that, especially for services like behavioral health and even some of the pharmacy monitoring services?

Sheila Blackstock: I think we would be open to receiving a comment like that, and particularly to the extent that you have data that backs up its utility, that would be worthwhile.

Jim Mikes: OK, thanks.

Amanda Barnes: Thank you.

Operator: Your next question will come from the line of Chris Perry.

Chris Perry: Yes. You mentioned during the discussion, the additional disclosure requirements relative to QAPI in the proposed rule. And the proposed rule maintains the provision relative to the section regarding compliance solely to demonstrate compliance to the rule. But I guess, can you discuss whether there's a proposed change here in terms of surveyors' access to the QAPI information and the use of that for citing deficiencies, because it appears to provide a significant access to the information, and many providers are using those systems with PSOs and those types of things, which may create a conflict in terms of the access to that information.

Sheila Blackstock: You are correct that we retain the provisions that say disclosure is related to compliance with these sections, but you raised some good issues, and we would appreciate it if you would submit that as a formal comment.

Chris Perry: OK, thank you.

Operator: If you would like to ask a question, please press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Your next question will come from the line of Scott Allen.

Scott Allen: Yes, hi, good afternoon, my name is Scott Allen. I am in Florida. I represent Gulf Coast Health Care. My question for you is, if this is such a massive rewrite of these regulations, why the intent or the push to move this forward quicker than the normal process?

Lisa Parker: Well, our intent is to bring about improvement and change as — as soon as possible. We did note that the regs have not been revised, so we are on a normal process. There's normally a 60-day comment period for regulations. So there is no intent to push this through more quickly, just to bring about the change as soon as

possible because we believe that it will signify some significant improvements in the life of nursing home residents.

Amanda Barnes: Thank you.

Scott Allen: I believe you've stated earlier …

Lisa Parker: I'm sorry?

Amanda Barnes: Holley, next question please.

Operator: Your next question will come from the line of Sherri Johnson.

Sherri Johnson: Hi, thank you. I just want to know exactly how this is all going to affect the swing beds that are located inside an acute care facility?

Amanda Barnes: One moment.

Sheila Blackstock: So this is Sheila Blackstock, and one of the things we recognized as we were developing this rule is that there were cross references to this rule in multiple other places. So as a part of the rule, one of the things that you will see is that we've updated all of those cross references, and so – so, to the extent that the regulations that apply to swing beds include cross references to Subpart B, we have updated those cross references, and so you can look at that to see where it tracks. Does that answer your question?

Sherri Johnson: What part B of which one?

Sheila Blackstock: The revisions in this rule are to 42 CFR 483 Subpart B. Other parts of the regulations make reference to 42 CFR 483 Subpart B, and we have identified those cross references throughout 42 CFR and updated them as a part of the regulatory text in this rule.

Sherri Johnson: OK, yes. Thank you very much.

Sheila Blackstock: You're welcome.

Operator: Your next question will come from the line of Lisa Hall.

Jocelyn Montgomery: Hi, this is actually Jocelyn Montgomery with Lisa Hall. We have a question about the documentation that you listed as needing to go with a resident during transitions of care, and I'm wondering when an individual comes from a hospital to us and those specific laundry list of reports are not all complete, is that something

that skilled nursing would be penalized for? And if so, are you looking at increasing the requirements under the corresponding condition of participation for hospitals?

Sheila Blackstock: So, this rule that we're talking about today only applies to long-term care facilities. It doesn't apply to hospitals, which it sounds like is what you're asking about, will hospitals be required to do the same sort of thing? And we really can't address that in this. All this rule talks about is what we would require of long-term care facilities to send out when they transfer a resident out of a long-term care facility. It would be under another rule to be able to impose something like that on a hospital.

Jocelyn Montgomery: OK, thanks.

Amanda Barnes: You're welcome.

Operator: Your next question will come from the line of Tammy — excuse me Tony Mony.

Vera Cohen: Hi, Vera Cohen from King Harvard. The question that we have is about infection control and prevention. It's mentioned that the, that person, IPCP and IPCO, you know, will be spending a majority of the time — it will be major responsibility, right, the infection control, so can you please define what is it?

Female: What is the majority?

Vera Cohen: Right. Hello?

Amanda Barnes: One moment.

Diane Corning: OK. Hi, this is Diane Corning. In our proposal we do say it's a major responsibility for the infection prevention and control officer, we did not specify further. So that would be a – that would be a good comment to submit to us, and if you have any, as Lisa was saying, if you have any data or specific alternatives, that would be good, too, to submit.

Vera Cohen: Yes, we sure do have data and everything, because it's a part of our quality assurance program, so ….

Female: But, you know, it's concerning when you say majority and you don't define what majority means.

Lisa Parker: Right. Well, one of the – one of our goals in drafting the regulation is to where we can, try to provide flexibility for facilities to define, you know, what best meets the requirements for themselves.

Female: All right, thank you, that does the answer then.

Amanda Barnes: You're welcome.

Operator: Your next question will come from the line of Faye Zann.

Faye Zann: Hi, good afternoon, I'm calling from St. James, my name is Faye. I have a quick question. Are facilities required to have an ethics committee, or a program at all?

Diane Corning: Yes, this is Diane Corning. They are going to be required — the operating organization for a nursing home is going to be required to establish a compliance and ethics program. And then there are specific requirements in the proposed rule for that program. Now if there's five or more, they do have, have a designated compliance officer. And in the basic elements, they do require high-level personnel to have overall responsibility for the program. Does that answer your question?

Faye Tuson: Yes, thank you so much.

Diane Corning: Thank you.

Amanda Barnes: Holley, we're ready for our next question.

Operator: Your next question will come from the line of Catherine Dale.

Catherine Dale: Hi, this is Catherine Dale from the Los Angeles Jewish Home. I wanted to piggyback on that telehealth question earlier. On the physician, NP, physician assistant face-to-face, could that be done via telehealth?

Sheila Blackstock: That was not included in our proposal, but it would be something that you could submit as a comment through the formal comment process.

Catherine Dale: OK, thank you.

Amanda Barnes: You're welcome.
Operator: Your next question will come from the line of William Bell.

William Bell: Yes, this is William Bell from the Illinois Health Care Association, and we have several concerns, but one of them that I've heard from some of our members is the issue of the open visitation. Basically, trying to set up the nursing home similar to a visitation policy at a hospital, the fact that we don't have near the staff or the type of administrative people, security, and so forth in nursing homes, that that could be a huge problem for us with allowing for visitation at all hours.

Sheila Blackstock: That is something, particularly to the extent that you have additional details or specifics, that would be excellent to submit as a formal comment to the rule.

William Bell: OK.

Amanda Barnes: Thank you.

Operator: And your next question will come from the line of Kristopher Pattison.

Kristopher Pattinson: Hi, I'm Kris Pattinson from Arnett Carbis Toothman. I had a question about the delegation of orders. The physicians delegating their orders to dietary folks and to therapists, will they still be required to sign off on those orders?

Sheila Blackstock: So, some of that would depend on State law. So if a State required signature even once it's delegated, then that is a possibility. But I would say that that's not necessarily the case, and again, that is something that you could submit as a comment so that we can clarify it.

Kristopher Pattinson: Thank you.

Amanda Barnes: You're welcome.

Operator: Your next question will come from the line of Tammy Shimon.

Tammy Shimon: Hi, my question is in regards to the infection control education beyond regular education. Do you guys have a curriculum or a set number of hours that a person must have to show that they've had more education within infection control?

Diane Corning: Hi, this Diane Corning. We have required that they have some sort of specialized training beyond their initial degree since they — we're requiring that the person be a clinician. As Lisa pointed out before, when we draft we want to allow flexibility. So we haven't prescribed any specific amount or any specific type of education, just that it be beyond what, say, a nurse or PA or someone would have in their original professional degree program.

Tammy Shimon: So a CEU program would be — suffice, or what are you looking for?

Lisa Parker: We haven't been specific, so if you have recommendations we'd be happy to hear them.

Diane Corning: So that would be a good comment to submit to us.

Tammy Shimon: Thank you.

Amanda Barnes: You're welcome.

Operator: Your next question will come from the line of Shadoworee Betts.

Shadoworee Betts: Hi, this Shadoworee with Inverness Village in Tulsa. I just wanted to discuss the reducing unnecessary hospital readmissions where the requirement proposal is to have a face-to-face with a physician or a physician extender such as a nurse practitioner who would consider adding a registered nurse in consultation with the nurse practitioner or a physician when making a decision to send a person to the hospital?

Sheila Blackstock: Hi, this is Sheila Blackstock. We did not include that in our proposal, but it is certainly something that you could submit as a recommendation or a comment, particularly to the extent that you have perhaps evidence or suggestions of places where that has worked.

Amanda Barnes: Thank you. Holley, next question.

Operator: Your next question will come from the line of Philip Cyr.

Philip Cyr: Yes, I have a question regarding the patient's — or the resident's ability to choose their roommate. If there is no roommate available to that resident's liking, what is a facility to do?

Sheila Blackstock: I would need to look specifically at the language we proposed, but I believe it includes a statement that says, to the extent that a facility can reasonably accommodate the choice of roommate.

Philip Cyr: OK, thank you.

Amanda Barnes: Thank you.

Operator: Your next question will come from the line of Jeff Kagan.

Jeff Kagan: Hi, this is Jeff Kagan from Excelerate Healthcare Services. I wanted to know what the actual theory is behind — to institute a formal — at least one performance improvement plan per year.

Sheila Blackstock: There was actually significant discussion on that issue. What I would suggest is, if you have a recommendation for something different from one a year, that you submit it as a formal comment, because we recognize that there were alternatives.

Jeff Kagan: OK, will do.

Amanda Barnes: Thank you.

Operator: Your next question will come from the line of Manda Mountain.

Manda Mountain: On the provision for the infection control, would you have a timeframe where someone could be grandfathered in?

Diane Corning: Hi, this is Diane Corning. We did not address that in our proposed revisions, but you would certainly be free to submit that as a comment.

Manda Mountain: OK, thank you.

Operator: Your next question will come from the line of Deborah Hoeckelberg.

John Barber: This is John Barber on Deborah's line. I see you're going for resident and patient rights extremely. We have a large elderly population. How are they going to be able to contribute in a care plan and sign off when they're dementia and really have no cognitive ability?

Amanda Barnes: One moment.

Sheila Blackstock: Hi, this is Sheila Blackstock. Actually, that was one of the things we considered, and all of the provisions include the option of a resident representative representing the resident in participation on the interdisciplinary care team, but there's also a provision that says if the resident or resident representative can't or doesn't participate, to document the reasons why.

Amanda Barnes: Thank you. Holley, next question please.

Operator: Your next question will come from the line of Frank Grosso.
Frank Grosso: Hello, this is Frank Grosso, I'm with the American Society of Consultant Pharmacists. The question I have is related to pharmacy services section 483.45, where it states as the requirement that a pharmacist review a resident medical chart at least every 6 months when a resident is new to the facility, prior resident's return, or is transferred, and with the other conditions. Can you clarify for me how that differs from the current requirement under the State Operating Manual for a consultant pharmacist to review the charts at least monthly?

Diane Corning: Yes, this is Diane Corning. When we were doing our research there was some concern that they were not — all pharmacists were not always reviewing the medical charts in conjunction with the medical review. Some of them were only looking at the medication administration record. So we wanted to clarify in the regulations that there are certain times that as it — we have proposed that the medical record must be reviewed in conjunction with the drug regimen review.

Frank Grosso: So this is not in addition to the current requirement, because the current requirement is a full chart review.

Amanda Barnes: One moment.

Diane Corning: Oh, hi, we were just kind of discussing that. We don't believe that the current SOM does require a medical chart review in conjunction with the medical administration — the drug regimen review every month, but that is something we can check.

Frank Grosso: OK, I would appreciate that because I believe it does. Thank you.

Diane Corning: OK.

Amanda Barnes: Please just submit that comment to the proposed rule.

Frank Grosso: We will. Thank you.

Amanda Barnes: Thank you. Holley, next question.

Operator: Your next question will come from the line of Angie Denoir.

Chuck Wheeler: Hello, this is Chuck Wheeler using — I'm sitting here with Angie Denoir, and I think most – for the most part my question has been asked. Just a real quick rider, when you said that the infection control person needs to work at least part-time at that facility, is part-time, is that going to be — is a consultant role acceptable in that role, or do you think that will be acceptable, or is it something that should be submitted? Part of my question was also about that training, which was already answered, so I appreciate the individual that asked that question earlier.

Diane Corning: So, you're asking if the infection control — prevention and control officer can be a part-time person?

Chuck Wheeler: Can it be a consultant that you're working with, or does it have to be a no kidding part-time, at each one of those — at each community if you – if we are a larger organization. Or can I use consultants to set, look at my infection control programs, my infection control data, what's going on, antibiotic stewardship, and function on the QAA committee?

Diane Corning: Our regs do not specifically address that, but that would probably be a good comment to submit through the official comment process.

Chuck Wheeler: OK, well thank you very much for your time.

Diane Corning: Thank you.

Amanda Barnes: Thank you.

Operator: And your next question will come from the line of Chris Wolf.

Chris Wolf: Yes, thank you for taking my question. On the slide of unnecessary re-hospitalizations or hospitalizations, I'm living in a small, rural community in Iowa where doctors are not very accessible. Will there be a point whereas people are going to question whether transfer to a hospital was in fact an emergency or whether we should have went and tried to find the doctor first?

Sheila Blackstock: Hi, this is Sheila Blackstock. To the extent that that provision creates unintended consequences, particularly in rural facilities, that is an excellent comment to submit though the formal process so that we can really think through that.

Chris Wolf: OK, thank you.

Amanda Barnes: Thank you so much.

Operator: Your next question will come from the line of Evelyn Harmon. Evelyn, your line is open.

Evelyn Harmon: Thank you. I had a question in regards to the regulations, and maybe you can't answer this. But we're a critical access hospital in Kansas and we recently closed voluntarily our long-term care and we're doing lowest level of acuity in swing beds. Do you think these regulations will eventually fall over to the patient's rights in that hospital setting?

Sheila Blackstock: We really — these regulations are specific to SNFs and NFs, the requirements for long-term care facilities, so we really can't speak to whether or not similar requirements would be established for other provider type.

Evelyn Harmon: I appreciate that. I just think probably it would be a good thing if it happened.

Sheila Blackstock: Thank you.

Evelyn Harmon: Thank you.

Operator: Your next question will come from the line of Teresa Wallace. Teresa, your line is open.

Teresa Wallace: I …

Your next question will come from the line of Debby Harca.

Debby Harca: Hi, this is Debby. And one of the questions that I have is on competencies. Do you have a list of competencies for nurses, CNAs, and other staff in — of the nursing home, if that is the requirement?

Sheila Blackstock: Hi, this is Sheila Blackstock. No, we do not in this regulation establish specific requirements by position or specific competencies by position. We do refer readers to a number of resources throughout the rule to get more information on a variety of issues. But if you have suggestions specifically regarding competencies, again, I know we're kind of sounding like a broken record, but it really would be helpful for you to submit those as official comments to the rule.

Debby Harca: OK, thank you very much.

Amanda Barnes: Thank you. Holley, we have a time for one final question.

Operator: At this time, we have no further questions.

Amanda Barnes: Thank you so much Holley.

Additional Information

If we could not get to answer your question or ask you to submit it to the comment — proposed comment period, you can submit those on — using slide number 5, excuse me.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On seventh — slide 17 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary.

We hope you would take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Amanda Barnes, and I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on Proposed Reform of Requirements for Long-Term Care Facility. Have a great day everyone.

Operator: This concludes today's call. Presenters, please hold.

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