Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

# THE HAT ADVANTAGE by Rebecca Adelman

## WHAT YOU NEED TO KNOW ABOUT THE MAJOR CHANGES TO THE REQUIREMENTS FOR LONG-TERM CARE FACILITIES

### *A SERIES GUIDE FOR PROVIDERS: PART 1 - OVERVIEW*

On September 28, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to make major changes to improve the care and safety of the nearly 1.5 million residents in the more than 15,000 long-term care facilities that participate in the Medicare and Medicaid programs. Beginning this month, the HAT Advantage will present a series of articles through 2017 addressing the changes beginning with an overview and implementation (this month) and Phase I regulations to be implemented by November 28, 2016 (next month). Monthly reports on Phase II regulations to be implemented by November 28, 2017 will start with the January 2017 HAT Advantage.

### NEW NURSING HOME SURVEY PROCESS – 2017

Also, as if the Final Rule changes aren't enough, a new survey process will debut in late 2017. This announcement came during a presentation by CMS at the first national meeting of the new American Association of Directors of Nursing Services on September 29, 2016. Currently, half the country uses a Quality Indicator Survey and the other half uses the traditional survey. According to CMS, the new survey process leverages best practices of both and will be computer-based. New F-tags will be effective in November 2017, along with changes in the State Operations Manual (SOM).

Also new will be surveyors who will start with the revamped process. Their job will include surveying facilities for everything in Phase 1 and Phase 2 of the final regulation. It will also include new F-tags. Dementia care surveys are scheduled to continue and remains a focus of CMS.

The HAT Advantage will be evaluating the changes in the SOM and providing recommendations related to survey compliance.

### SUMMARY OF MAJOR CHANGES

Following is a summary of the major changes that we be the focus for my assessments and recommendations in the next months and through 2017-2018. The regulation is noted with the summary.

**Basis and scope (§483.1)**
• Statutory language was added to include the compliance and ethics program, quality assurance and performance improvement (QAPI), and reporting of suspicion of a crime requirements to this section.

**Definitions (§483.5)**
• Definitions were added for "abuse", "adverse event", "exploitation", "misappropriation of resident property", "mistreatment", "neglect", "person-centered care", "resident representative", and "sexual abuse" to this section.

**Resident rights (§483.10)**
• All existing residents' rights have been retained and there is updated language and organization of the resident rights provisions to improve logical order and readability, clarify aspects of the regulation where necessary, and update provisions to include advances such as electronic communications.

**Freedom from abuse, neglect, and exploitation (§483.12)**
• Facilities are now required to investigate and report all allegations of abusive conduct. Specifically, facilities cannot employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property.

**Admission, transfer, and discharge rights (§483.15)**
• Transfer or discharge must be documented in the medical record and specific information be exchanged with the receiving provider or facility when a resident is transferred.

**Resident assessments (§483.20)**
• There is clarification of appropriate coordination of a resident's assessment with the Preadmission Screening and Resident Review (PASARR) program under Medicaid. Statutory requirements are also being added.

**Comprehensive Person-Centered Care Planning (§483.21) *New Section***
• Facilities are required to develop and implement a baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-

*Continued on page 4*

# Pathway to Rehabilitation Excellence

*By Kaleb Roudabush, NSCA-CPT*
*Wellness Coordinator*

## Our Ears

Some of you reading this can relate to hearing loss, however for those of you who can't, try the following to get a picture of what it is like to struggle with hearing loss. I want you to try placing your hands over your ears and listen to what is around you. Imagine what life would be like if this was an everyday struggle. Consider being in the dining room, everyone is talking and you hear lots of noises, struggling to understand, pretend to hear jokes by laughing along and feel left out at the end of the day with a throbbing headache. My goal of this article is not to the invite pity or poor me mantra, however I want to bring about awareness of how hearing greatly affects our health and wellbeing. September 19th – 25th is deaf awareness week.

1 in 6 adults experience some degree of hearing loss. Hearing loss can happen in many ways, through over exposure to loud sounds, ear wax in the ear, head trauma, viruses, inner ear infections, allergies, tumors, fluid in the ear and malformation or failure of the ear structure etc. Hearing loss can be sudden or gradual. Ask yourself, are you always turning up the volume on the TV or radio? Do you tend to avoid social events because you're afraid you won't understand people? Are you having a hard time on the phone or do you ask people to repeat themselves often? If you answered yes to the previous questions or have any doubt about whether your hearing has change, contact your local audiologist and get a hearing test! What is so important about having your ears checked? Studies show that hearing loss raises the risk of social isolation, depression and mental decline which could possibly even lead to Alzheimer's. Because your brain plays a major role in understanding speech, it has to work harder when hearing loss occurs. Other areas of your brain begin to atrophy because it is working so hard to listen to sounds in your environment.


If you are a candidate for hearing aids, it the best investment you can make to improve your quality of life. Just like a balanced diet, exercising and regular wellness checks keep you healthy, so does taking care of your hearing. Taking care of your ears does take some work when you get new hearing aids; you begin to learn how the world sounds around you. For many this can be overwhelming, for you are used to hearing the world in low volume. However, work with your audiologist, talk to a few people you know who have hearing trouble for support and you will be glad you are taking care of your ears!

## Getting on the Same Page by Paige Hector, LMSW

# DON'T JUST DO SOMETHING, STAND THERE!

## Understand the Context of the Event for the Correct Root Cause Analysis

The root cause analysis (RCA) has long been accepted as a performance improvement tool. On the surface, it's seemingly easy to do and gives staff and management some satisfaction that they've "done something" about an event that "shouldn't" have happened.

However, there are pitfalls. While there is a place for root cause analysis (RCA), unfortunately this tool tends to be overused and misunderstood. It's especially tempting to resort to a RCA when there is a "never event" or a "near miss." Staff is shaken up, a resident or patient may have suffered injury and everyone's on high alert. The pressure to "do something" is stifling. Of course, the incident needs to be investigated, but perhaps not at the level of detail that is inherent in a typical RCA. There is another question that needs to be answered first.

The first task is to determine if the incident was due to common or special cause (re-read my article in August 2016 on this topic). Was this incident occurrence TRULY unique (therefore, special cause)? If so, then a RCA as currently practiced is appropriate.

However, if it's common cause, i.e., "systemic" (usually the rule rather than the exception) the RCA needs a totally different context. "Dissecting it to death" (asking "why" repeatedly) may be ineffective.

The issue (and mistake): most people tend to treat all variation as special cause.

Many RCAs inadvertently treat common cause variation as special cause. Common cause means that everyday organizational routines will inevitably conspire to create an "incident"…and occur unpredictably (think of driving to work and getting all the red lights – it happens, but you can't predict when). Never events and near misses are many times still common cause variation. The system is "perfectly designed" for them to happen. Tough to accept. Please don't tune out just because instinctually that idea doesn't sit well with you. It doesn't mean that you have to tolerate their occurrences – you are hardly powerless! Eradicating them just requires a different (common cause) strategy - a strategy most people aren't usually taught.

Take falls for example. Let's say that over 18 months there are 164 falls in your facility. Doing a RCA on each one would most probably be premature and incorrect. Only a time plot of the number of falls occurring over time, say, monthly or even weekly, can determine whether the variation in the number of falls is due to common cause or special cause. The danger is that looking at each fall individually only tells you what happened with that fall but, if it is common cause, it misses the bigger opportunity of applying the more powerful strategy of examining all the falls as a group to identify process and system problems that allow the falls to happen – sort of a root cause analysis of all of your root cause analyses! Talk about a powerful performance improvement strategy.

Think about all the RCAs done in your facility in the past six months – dozens? Think about all the staff time – investigating, interviewing, documenting, and explaining. And, what if I told you that much of that time was likely wasted? Gasp. Go ahead, take a deep breath. Take several. I'll wait.

Ready? Thanks for sticking with this and being willing to expand your knowledge of performance improvement. I promise your staff will thank you.

Davis Balestracci wrote a fantastic article on RCAs in May 2016 (https://www.linkedin.com/pulse/maybe-its-time-do-root-cause-analysis-obsession-davis-balestracci) I've summarized the main points below.

- Instead of treating each incident as a special cause, instead consider it "a hazardous situation that was unsuccessfully avoided." Call it what it is, common cause. Balestracci points out that RCAs have the luxury of hindsight which results in actions based on biases and a lack of critical thinking. Since the outcome is already known, "it is so easy to oversimplify the inherent situational complexity and ignore the uncertainties of the circumstances the person or people faced."

- Think of it this way, when digging around for the "root cause", the human performance or error factors are treated superficially or overlooked altogether. It's easy to look at an incident in hindsight and say (or think), "Are you kidding me, why did he/she do that?!" or "How could she/he not have known that would happen?" Sadly, too often the outcome of a RCA is to "ask 'Why?' five times"…until the "who" is identified.

Lucian Leape, MD wrote a brilliant op-ed piece in the Boston Globe almost 20 years ago that is a perfect example of a RCA gone wrong, when the outcome was to blame 18 nurses in a tragic patient death rather than appropriately identify the medication system as the problem - http://www.ehcca.com/presentations/qualitycolloquium5/pc_article.pdf.

"The human tendency is an expectation of quickly getting to the bottom of things, get the forms filled out, fix the problem identified and get back to work. Invariably, this leads to solutions aimed at the people involved on the front line – retrain them, supervise them better or just fire them – rather than at the conditions that led to the event." Meredith Brown

Incidents have to be investigated. That's a given. But, let's stop the madness that leads down the dangerous path of blaming staff and grasping at the "simplest" of solutions. Let's really heed what Balestracci teaches, and the next time someone does something "unimaginable" (dare I say "stupid"?) in your facility ask, "Why did it make sense at the time for this person to make such a "stupid" decision?" Be honest, was it competence or culture? Competence you say? So then was it a matter of training or even hiring?

Keep the RCA in your arsenal but know when to use it!

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centered care that meets professional standards of quality care.

• A nurse aide and a member of the food and nutrition services staff are required members of the interdisciplinary team that develops the comprehensive care plan.

• Facilities are required to develop and implement a discharge planning process that focuses on the resident's discharge goals and prepares residents to be active partners in post-discharge care, in effective transitions, and in the reduction of factors leading to preventable re-admissions.

• The discharge planning requirements mandated by The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) are being implemented.

**Quality of care (§483.24)**
• Each resident is required to receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

**Quality of Life (§483.25)**
• Based on the comprehensive assessment of a resident, facilities are required 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.

**Physician services (§483.30)**
• Attending physicians will be allowed to delegate dietary orders to qualified dietitians or other clinically qualified nutrition professionals and therapy orders to therapists.

**Nursing services (§483.35)**
• A competency requirement is being added for determining the sufficiency of nursing staff, based on a facility assessment, which includes but is not limited to the number of residents, resident acuity, range of diagnoses, and the content of individual care plans.

**Behavioral health services (§483.40)**
• Anew section to subpart B is being added that focuses on the requirement to provide the necessary behavioral health care and services to residents, in accordance with their comprehensive assessment and plan of care.

• "Gerontology" is being added to the list of possible human services fields from which a bachelor degree could provide the minimum educational requirement for a social worker.

**Pharmacy services (§483.45)**
• Pharmacists will be required to review a resident's medical chart during each monthly drug regimen review.

• Existing requirements are being revised regarding "antipsychotic" drugs to refer to "psychotropic" drugs and define "psychotropic drug" as any drug that affects brain activities associated with mental processes and behavior. Several provisions are being required that are intended to reduce or eliminate the need for psychotropic drugs, if not clinically contraindicated, to safeguard the resident's health.

**Laboratory, radiology, and other diagnostic services (§483.50) *New Section***
• A physician assistant, nurse practitioner or clinical nurse specialist may order laboratory, radiology, and other diagnostic services for a resident in accordance with state law, including scope-of-practice laws.

**Dental services (§483.55)**
• SNFs and NFs are prohibited from charging a Medicare resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility, and a requirement is being added that the facility have a policy identifying those instances when the loss or damage of dentures is the facility's responsibility. NFs are required to assist residents who are eligible to apply for reimbursement of dental services under the Medicaid state plan, where applicable.

• With regard to a referral for lost or damaged dentures, "promptly" means that the referral must be made within 3 business days unless there is,documentation of extenuating circumstances.

**Food and nutrition services (§483.60)**
• Facilities are required to provide each resident with a nourishing, palatable, well balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

• Facilities must employ sufficient staff, including the designation of a director of food and nutrition service, with the appropriate competencies and skills sets to carry out the functions of dietary services while taking into consideration resident assessments and individual plans of care, including diagnoses and acuity, as well as the facility's resident census.

**Specialized rehabilitative services (§483.65)**
• Respiratory services are added to those services identified as specialized rehabilitative services.

**Administration (§483.70)**
• Facilities are required to conduct, document, and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Facilities are required to address in the facility assessment the facility's resident population (that is, number of residents, overall types of care and staff competencies required by the residents, and cultural aspects), resources (for example, equipment, and overall personnel), and a facility-based and community-based risk assessment.

• Binding Arbitration Agreements: Facilities cannot enter into an agreement for binding arbitration with a resident or their representative until after a dispute arises between the parties. The use of pre-dispute binding arbitration agreements is prohibited. SEE THE SECTION BELOW ON CHANGES TO ARBITRATION AGREEMENTS.

**Quality assurance and performance improvement (QAPI) (§483.75)**
• All LTC facilities must develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life.

**Infection control (§483.80)**
• Facilities must develop an Infection Prevention and Control Program (IPCP) that includes an Antibiotic Stewardship Program and designate at least one Infection Preventionist (IP).

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**Compliance and ethics program (§483.85) *New Section***
• The operating organization for each facility to have in effect a compliance and ethics program that has established written compliance and ethics standards, policies and procedures that are capable of reducing the prospect of criminal, civil, and administrative violations.

**Physical environment (§483.90)**
• Facilities that are constructed, re-constructed, or newly certified after the effective date of this regulation must accommodate no more than two residents in a bedroom. Facilities that are constructed, or newly certified after the effective date of this regulation must have a bathroom equipped with at least a commode and sink in each room.

**Training requirements (§483.95) *New Section***
• A new section to subpart B has been added that sets forth all the requirements of an effective training program that facilities must develop, implement, and maintain for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles.

## CHANGES TO ARBITRATION AGREEMENTS

LTC facilities can no longer enter into pre-dispute binding arbitration agreements with their residents or their representatives. The rule is not retroactive; however, we expect that pending Motions to Compel Arbitration will be scrutinized for unconscionability in light of the new rule with adverse rulings denying these motions. For providers with existing pre-dispute arbitration agreements, those agreements will not be impacted by this final rule. The comments to this section of the proposed rule read like Plaintiff briefings. Also, a new section was added to provide that when the facility and a resident resolve a dispute with arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years and be available for inspection upon request by CMS or its designee. The section on the arbitration agreement is 40 pages long and sides with the Plaintiff's bar on all arbitration issues. Below are a few excerpts of the DHS comments in the final rule which are expected to be persuasive on pending arbitration issues:

"We are convinced that requiring residents to sign pre-dispute arbitration agreements is fundamentally unfair because, among other things, it is almost impossible for residents or their decision-makers to give fully informed and voluntary consent to arbitration before a dispute has arisen. We believe that LTC residents should have a right to access the court system if dispute with a facility arises and that any agreement to arbitrate a claim should be knowing and voluntary."

Of note, throughout this comment section, DHS refers to mandatory arbitration agreements which are a condition of admission. This language is confusing as most arbitration agreements, especially those in Tennessee, will not be enforced if they are a condition of admission. Therefore, the comments can be distinguished on those grounds but the new rule does not ban only mandatory arbitration agreements but rather bans all arbitration agreements.

"The comments we received have confirmed our conclusion that pre-dispute arbitration clauses are, by their very nature, unconscionable."

"Many of the articles we reviewed provided evidence that pre-dispute arbitration agreements were detrimental to the health and safety of LTC facility residents."

"We agree with those commenters that asserted that there is unequal bargaining power between the residents and their representatives and the facilities."

"We are also concerned that the arbitration process, especially the secrecy it involves could result in some facilities evading responsibility for substandard law."

"We disagree with commenters who suggest that arbitration is merely a change of the forum and therefore, inconsequential…. arbitration can be very expensive for the resident, with some agreements requiring the resident to bear some of the costs of the arbitration and the limited discovery generally allowed puts the resident at a distinct disadvantage."

NOTE: Effective November 28, 2016, your organization can no longer present arbitration agreements at admission for consideration. If a dispute arises, the long-term care facility may request that a resident enter into an independent agreement for binding arbitration. Failure to sign the agreement, however, may not be grounds for termination of a resident's right to remain in the facility. Residents must (1) be provided an explanation of the agreement in a form and manner that they understand, (2) acknowledge that they understand the agreement, and (3) voluntarily enter into the agreement. The post-dispute arbitration agreement itself must allow the parties to select a mutually-agreed upon neutral arbitrator and a venue that both parties deem convenient. It may not contain any language that discourages communication with federal, state, or local officials.

Challenges are being mounted against this arbitration ban based on the lack of DHS/CMS legal authority as well as other grounds. In the meanwhile, we recommend separate post-dispute arbitration agreements be utilized with accompanying guidelines for explaining agreements to residents and negotiating arbitration agreements with residents.

## SUMMARY OF COSTS AND BENEFITS

The total projected cost of this final rule is estimated at $831 million in the first year and $736 million per year for subsequent years. The average costs per facility are estimated to be about $62,900 in the first year and $55,000 per year for subsequent years. Although the overall magnitude of cost related to this regulation is economically significant, CMS would have us consider that these costs are significantly less than the amount of Medicare and Medicaid spending for LTC services.

CMS is unable to quantify the benefits of the final rule.

## SUMMARY OF ANTICPATED IMPACT OF THE FINAL RULE

In next month's newsletter, I will summarize the anticipated impact that this final rule will have on LTC facilities by regulatory section.

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# PHASE 1 IMPLEMENTATION – NOVEMBER 28, 2016

We prepared the following table outlining the rules that must be implemented by November 28, 2016. Next month, The Hat Advantage will review each of these sections and make recommendations for implementation and compliance. Please contact me with any questions, comments or need for more information. Stay tuned for the November HAT Advantage for the continued assessment on the final rule.

| | |
|---|---|
| 483.1 | Basis & Scope |
| 483.5 | Definitions |
| 483.10 | Resident Rights (except (g)(4)(ii)¬-(v)) |
| 483.12 | Freedom from abuse, neglect and exploitation (except 483.12(b)(4)-(5) |
| 483.15 | Admission, Transfer and discharge rights (except (c)(2)) |
| 483.20 | Resident Assessment |
| 483.21 | Comprehensive person-centered care planning (except (a) & (b)(3)(iii)) |
| 483.24 | Quality of Life |
| 483.25 | Quality of Care (except (m)) |
| 483.30 | Physician Services |
| 483.35 | Nursing Services (Except specific usage of facility assessment at 483.70(e)) |
| 483.40 | Behavioral Health Services (ONLY(b)(1), (b)(2) and (d)) |
| 483.45 | Pharmacy services (Except (c)(2) & (e)) |
| 483.50 | Laboratory, radiology and other diagnostic services |
| 483.55 | Dental Services (except (a)(3);(a)(5);(b)(3); (b)(4)) |
| 483.60 | Food and nutrition services (except (a) as linked to facility assessment at 483.70(e); (a)(1)(iv); (a)(2)(i)) |
| 483.65 | Specialized rehabilitative services |
| 483.70 | Administration (except (d)(3) and (e)) |
| 483.75 | Quality assurance and performance improvement (ONLY (h) and (i); (g)(1) QAA committee all requirements in phase 1 except subsection (iv) –addition of ICPO |
| 483.80 | Infection Control (except (a) as linked to facility assessment at 483.70(e); (a)(3); (b) and (c)) |
| 483.90 | Physical Environment (except (f)(1) and (h)(5)) |
| 483.95 | Training Requirements (ONLY (c); (g)(1)-(2); (g)(4); (h)) |

LAISSEZ LES BONS TEMPS ROULER AND SAVE THE DATE FOR THE 2017 CONFERENCE! Join us in New Orleans as we celebrate the 5th year anniversary of the Litigation Risk and Defense Strategies for Long-Term Care & Assisted Living Providers, Insurers and Brokers March 29-30. This year we will offer separate clinical and corporate mini-conferences! Details to follow. Please email me if you're interested.

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We want to make sure you are personally getting this newsletter each month, not just have it forwarded to you because you're now holding down the position of a predecessor! Let us know you now are on the job. E-mail your name, facility/company name and address to chip@ecpnews.net & we'll update our records. Just put NAL Professional on the e-mail subject line and we'll take care of the rest.

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