

The Power and Possibility of PASRR Webinar Series

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Networking with NAPP
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The next Networking Session with NAPP is:

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The Power of PASRR & YOU!

For more information about NAPP, please contact
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An overview of the regulatory compliance process for nursing homes, an update of the wide sweeping changes to the Conditions of Participation for nursing homes, and an in depth look the changes related to PASRR components.



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LEARNING OBJECTIVES

1. Participants will gain an understanding of how nursing homes are surveyed for regulatory compliance with regulations, remedial action that is taken by CMS for non-compliance with regulations, and how compliance results impact the provider as an organization, and implications to individual licensed professionals.
2. Participants will be provided with information on why the Conditions of Participation for nursing homes have been updated and understand the compliance domains that are being changed and the overall themes of the changes.
3. Participants will gain knowledge of how the changes will regulate actions by nursing home providers related to the delivery of care and services specific to PASRR functions.
4. Participants will have 'take away' points to consider how the changes to the Conditions of Participation for nursing homes can be built upon to affect desired outcomes of State Agencies , and how to align goals through the regulated changes that will be required of nursing homes.

The Nursing Home Survey Process

- The regulatory process is very comprehensive review of the delivery of care and services within a nursing home to ensure that the minimum conditions of participation are being met.
 - Background of the survey process
 - ✦ A 'survey' occurs every 9 – 15 months from the date of the prior survey
 - ✦ Surveyors do off-site work to identify clinical key indicators, review the past five years of survey compliance, and any received complaints and any reported occurrences
 - ✦ Every survey is unannounced and can commence on any day of the week, at any time
 - ✦ Surveys can be an initial certification, the 'annual' (every 9 – 15 months), or for a complaint investigation, MDS Focus survey, CHOW
 - ✦ Typically lasts 4 – 7 days, often spanning across a weekend
 - Domains and areas of practice that are reviewed for compliance include- clinical practice, patient safety, accuracy of assessments and records, administration of the organization, medical directorship oversight, resident satisfaction, environmental, resolution to grievances, quality assurance process improvement, quality of care, and quality of life
 - Compliance is determined by record review, observation, and staff / resident / family member interviews, software generated pathways...

The Nursing Home Survey Process, continued

- What happens if it is found that the nursing home is not meeting minimum requirements?
 - A 'deficiency' is cited
 - Each deficiency carries a weighted level of 'scope and severity' corresponding to the gravity of the non-compliance
 - Each cited deficiency (beyond a level 'A') requires remedial action by the nursing home.
 - Each scope and severity carries increased implications ranging from submitting a plan of correction to provider decertification and loss of professional licensure

The Nursing Home Survey Process, Continued..

- After the survey is completed the findings are submitted by the surveyors to the state office for internal review. A scope and severity rating is then assigned to each deficiency and sent to the provider.
- The provider then submits a 'plan of correction' for each deficiency - reviewed for acceptance by the state agency.
- Each plan of correction must contain at least five elements including how the specific incident(s) that formed the basis for the citation has been remedied, how the provider identified and corrected non-compliance from occurring elsewhere, annotate how policies and practice will be changed in order to systemically prevent reoccurrence and how compliance will be monitored, integration of changes into the QAPI process, and when compliance will be met.
- The provider is then re-surveyed for compliance which can take place by a desk review for very minor deficiencies, but most commonly by another unannounced survey called a 'revisit survey'.
- Further implications if the plan of correction is not effectively implemented at time of revisit.

Scope and Severity of Deficiencies

- Level 1, is a deficiency that has the potential for causing no more than a minor negative impact to the resident(s)
- Level 2, is noncompliance that results in no more than minimal physical, mental, and/or psychological discomfort to the resident and/or has the potential to compromise the resident's ability to maintain and/or reach his/her highest practical physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- Level 3 is noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practical physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.
- Level 4 is immediate jeopardy, a situation in which immediate corrective action is necessary because of the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in the facility.

Scope and Severity, continued..

- Scope

Isolated

Pattern

Widespread

Implications of Non Compliance

- Professional licensure
- Denial of Payment
- Operating licensure
- CMS Five Star Rating system

Questions Related To The Survey Process?



OPEN DISCUSSION

Changes to the Conditions of Participation for Nursing Home Providers

- First comprehensive update since 1991
- Substantial advances in theory and evidenced based outcomes
- Changes reflect patient safety, quality of care, quality of life, and person centered planning
- Affordable Care Act included specific requirements for nursing homes including an enhanced Quality Assurance Process Improvement and having an Ethics Committee
- 22 practice domains are being impacted, some of the changes are meant to reduce duplication, be consistent with updated terminology and dignified wording, while other changes will require systemic overhaul by providers and associated stakeholders.
- The population within a nursing home has changed and new requirements are designed to meet the needs of a broader resident population.
- Higher percentage of short term residents (stay is less than 100 days), highly complex clinical needs, skilled therapy goals, and a variety of diagnosis including psycho-social, behavioral health, dementia related, neurological deficits, and a wider age range within the center.
- Designed to ensure that the regulatory environment stays relevant to the modern day population that is seen in nursing homes.

Conditions of Participation Sections with Changes

- Basis and Scope (483.1)
- Definitions (483.5)
- Resident Rights (483.10)
- Abuse and Neglect (483.12)
- Admission, transfer, and discharge rights (483.15)
- Resident assessment (483.20)
- Comprehensive person centered care planning (483.21)
- Quality of care (483.25)
- Nursing services (483.35)
- Behavioral health services (483.10)
- Pharmacy services (483.45)
- Laboratory, radiology, and other diagnostic services (483.50)
- Dental services (483.55)
- Food and nutrition services (483.60)
- Specialized rehabilitative services (483.65)
- Administration (483.70)
- Quality Assurance and Performance Improvement (483.75)
- Infection control (483.80)
- Compliance and ethics (483.85)
- Physical environment (483.90)
- Training requirements (483.95)

Themes in the Final Rule

- Person-Centered Care
- Staffing and Competency -Training and the need for competency specific skills and procedures
- Quality of Care and Quality of Life- Care planning, Emphasis on goals and their engagement
- Changing Resident Population – Behavioral health
- Focus on adverse events – Medication related, QAPI, infection prevention
- Increase monitoring of facility, staff and residents

3 Phase Implementation

- Phase 1:
Upon the effective date of the final rule (Nov 28, 2016)
- Phase 2:
1 year following the effective date of the final rule (Nov 2017)
- Phase 3:
3 years following the effective date of the final rule (Nov 2019)

Phase 1

- Resident rights and facility responsibilities
- Freedom from abuse and neglect and exploitation
- Admission, transfer and discharge
- Resident assessment
- Comprehensive person-centered care planning
- Quality of life
- Quality of care
- Physician services
- Nursing services
- Pharmacy services
- Laboratory, radiology, and other diagnostic services
- Dental services
- Food and nutrition
- Specialized rehabilitation
- Administration
- QAPI
- Infection control program
- Physical environment

Phase 2 and 3



Phase 2

- Behavioral Health Services
- QAPI
- Infection Control and Antibiotic stewardship
- Physical Environment

Phase 3

- QAPI
- Infection Control- IC Preventionist
- Compliance and Ethics
- Physical Environment
- Training

Added New Definitions

- Abuse
- Adverse event
- Exploitation
- Misappropriation of property
- Mistreatment
- Neglect
- Person-centered care (detail)
- Resident representative (detail)
- Sexual abuse

Definitions

- **Person-Centered Care**- focus on resident as locus of control and support in making own choices and having control over daily lives
- **Resident Representative** – individual chosen by resident to act on behalf of resident, person authorized by State or Federal law

Notable changes- Phase 1

- Expanded resident rights
- Expanded drug regimen review process to include more drugs
- Requires a discharge planning process and plan for all residents
- Require person-centered care plan- expanded resident assessment process
 - PASRR incorporated into assessment, care plan and discharge plan
- Behavioral health services
- Arbitration agreements

Notable changes – Phase 2 and 3

- Expanded the QAPI requirements
- Added compliance and ethics section
- Greater monitoring and documentation related to appropriateness of medications (psychotropic and antibiotic stewardship)
- Require infection control program and Infection Preventionist
- Added a staff competency requirement to determine nursing staffing levels – based on number of residents, resident acuity, range of diagnosis, and the content of care plans.
- Requires facility to provide behavioral health care and services training for residents with dementia and / or trauma such as PTSD, TBI etc.

Impact of new Conditions of Participation on the Survey Process

- CMS is developing a new survey process
- Incorporates the new conditions of participation
- Goes into effect 2017
- This will change the survey focus and the types of deficiencies

Questions Related to the Final Rule?



OPEN DISCUSSION

Changes That Improve PASRR Related Delivery of Care and Services

- The changes within the ‘Resident Assessment’ domain contains new specific PASRR related regulatory requirements.
 - *Coordination of the resident assessment with the PASRR program*
 - ✦ This will ensure that all parties and the delivery of care and services are integrated with the PASRR recommendations so that there is continuity of care and reduces gaps and duplications in care and services.
 - *Adding exceptions to the preadmission process transitioning to/from an acute care facility for individuals that have MI / ID*
 - ✦ 30 day stay or less
 - *Immediate notification to the state authorities if a resident with MI / ID has a ‘significant change in status’ as defined by the RAI manual*
 - ✦ This will allow for a third party review of qualified personnel to determine of Specialized Services or other care and services specific to the PASRR recommendations are to be updated due to any changes in needs that may occur due to the event that caused a significant change in status.

Changes That Improve PASRR Related Delivery of Care and Services

- *Integration of the PASRR assessment into the Plan of Care indicating how the assessment recommendations will be delivered to the individual*
 - By integrating the PASRR assessment into the plan of care there will be a documented plan that indicates the resident needs as identified by the PASRR screen and recommendations. Within the plan of care each recommendation will identify the resident wishes, the discipline(s) within the team and outside agencies that will be responsible for overseeing that the plan is implemented, and provides guidance to all staff members on how to consistently deliver the recommendations.
- *New training requirements on behavioral health needs*
- There have been significant advances in how to effectively respond to individuals that experience behavioral health deficits. These advances have proven to be much more effective and sustainable than the use of antipsychotic medications. While at times there is still a place for such medications to be used it is now seen as the treatment of last resort due to the side effects that most medication have which cause more harm than any benefit.
- Proper training will allow for all staff members to effectively meet the needs of the residents by knowing how to respond to an individual, will improve the resident to resident relationships within the center, will provide consistency to the resident, will reduce hospital re-admissions and will improve patient safety and outcomes in an effective and humane manner.

PASRR Related changes in the Conditions of Participation

- The inclusion of PASRR processes into the Conditions of Participation are welcomed by many advocates as they are now rooted into regulatory requirements.
- This change will add consistency to the PASRR system, will improve the resource allocation and delivery of appropriate care and services to individuals that trigger a level II, and will ultimately result in improved nursing home compliance due to the regulatory implications that will result in a deficiency being cited for non-compliance.

Questions Related To PASRR?



OPEN DISCUSSION

The Big Picture

- New Conditions of Participation will result in an emphasis on quality of life, person centered care, and hard wiring of knowledge and skills
- Improves patient safety
- Promotes PASRR and Specialized Services

New Conditions of Participation May Align With Goals of State Agencies

- ***Person centered approach that promotes choice***
 - PASRR recommendations are very personal to the individual. By taking a person centered approach individual wishes, participation, acceptance, sustainability, dignity, and goal setting will be improved.
- ***Regulated integration of PASRR assessment into delivery of care and services***
 - The regulatory process carries a lot of weight including up to decertification and loss of individual professional licensure. Having the PASRR processes written into the Conditions of Participation will empower regulators with the backing to ensure proper administration of the components of PASRR assessment.
- ***Reduced cost of care***
 - By coordinating the PASRR functions into the plan of care and implementation of the required behavioral health training for all staff members in the nursing home there may be a reduction in resident transfers to a different provider, and less gaps and duplications in the delivery of care and services.
- ***Improved quality of life***
 - Person centered, maintains consistency in approach to care and services, promotes non medical supports and services

Questions Related to How the Changes May Align With Goals of State Agencies?



OPEN DISCUSSION

Resources and References

American Health Care Association and National Center for Assisted Living

www.ahcancal.org

Link to the Final Rule:

<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-Medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

Conclusions

- Review of material covered
- Opportunity for open dialogue
- Next steps
- Adjourn

Follow up OCR Guidance and Resources for Long Term Care Facilities: Using the Minimum Data Set to Facilitate Opportunities To Live In The Most Integrated Setting

How can you Participate in Networking with NAPP?

Join the Networking with NAPP presentation on October 25th at 1PM EST <https://attendee.gotowebinar.com/rt/7812027187665157889>

- Send NAPP your tools for PASRR evaluators & NF care planning
- Send NAPP your questions or suggested topics
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Email: nappfrontdesk@pasrr.org

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Questions and Answers Session

‘New Wide-Sweeping CMS Conditions of Participation for Nursing Homes to Support PASRR Requirements’

October 18, 2016

Steve Wallace regarding how behavioral health services have been defined. Steve also asked, “We have found that 95% of antipsychotic prescription for residents comes from outside the SNF. What will be done about that?”

1. I don’t know that ‘behavioral health services’ has been defined by CMS at this time but it is seen as any interventions to address the needs of an individual with mental or behavioral health needs (other than those that would be considered dementia related) . , including those related to psychiatric disorders and substance use disorders One of the key themes of the new Conditions of Participation is that all staff members within a nursing home must know how to provide care and support services to every person in the nursing home according to their individualized plan of care. With this in mind nursing homes will be regulated on the delivery of behavioral health services from clinicians that specialize in behavioral health, physician services that are coordinated behavioral health aspect of the plan of care, and ultimately provision of services by the direct care staff.
2. Note that the concept of behavioral health intervention has been defined in the Guidance to Surveyors section of F329 / CFR 483.25(1) (Unnecessary drugs) to be “‘... individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychosocial environment, and are directed toward preventing, relieving, and/or accommodating a residents distressed behavior.’” This guidance is what regulators use when assessing the appropriate application of the CFR.

Within the continuum of care the nursing homes continue to be the most regulated aspect of health care. You are correct in the scenario that you presented that antipsychotic prescriptions (even more so now since the definition has been expanded to include more drugs) are prescribed outside of the nursing home. To directly answer your question of “what will be done about that” I do not sense that there will be increased regulations relevant to this category for entities such as home health providers, acute care hospitals, and geriatric-psych inpatient settings.

Some measures that can be taken by the nursing home to be compliant with the regulations include:

A) The nursing home will have had a conversation with the provider that prescribed the antipsychotic to determine if other interventions can be attempted prior to continuing the orders at time of admission to the nursing home.

B) The nursing home will not be scrutinized if a resident is admitted with such medications as long as a risk benefit statement has been entered into the medical record and there is a formal consent signed by the resident/representative acknowledging the potential side effects of the medication.

C) In cases when a consent is signed by the resident/representative the nursing home will continue to be required to show behavioral tracking documentation, monitoring for side effects, an annual risk / benefit statement by the physician (or if a risk/ benefit statement is not provided then an attempt at a dose reduction), and continual communication with the MD and pharmacist.

Dean Lerner inquired regarding which F-Tag is used for PASRR deficient practices and how often is this F-Tag cited by CMS state survey agencies? Dean also asked if you have a side-by-side of the old conditions of participation and the new conditions of participation.

Dean, there are several direct F-tags related to PASRR including F285, F274, F279, and F406. Although indirectly associated to PASRR, the following F-tags could also be cited depending on the nature of alleged deficient practice related to PASRR requirements - F278 (Accuracy of Assessment), F240 (Quality of Life), F241 (Dignity), F281 (Professional Standards of Quality).

It is unknown at this time if a specific F-Tag within the new Conditions of Participation will be assigned to the new regulatory language surrounding PASRR related requirements or if this area will be put into the guidance to surveyors under the existing F-tags related to care plans and assessments. CMS has stated that there may be new F-tags as a result of the new requirements but this will not be known until the spring of 2017 at the earliest.

A side-by-side 'red lined' document is being prepared by the American Health Care Association (AHCA) to examine what has remained the same, and what has changed between the previous and the most recently released Conditions of Participation. To my knowledge AHCA has not made it known when this will be published.

Question from Ken Jones. Ken asked, "When a person in a NF has to be sent to a psychiatric hospital for exacerbation of their mental illness and their medications are changed in order to stabilize them. Then the person goes back to the NF and regulations require that the medications be reduced. Then the person has another episode. Are there exceptions to keep a person on the medications that are keeping them stable?"

Ken, thank you for the question as this happens often. In my experience this issue has been less prominent over the last two years as evidenced based outcomes related to certain side effects is starting to gain attention from clinicians outside of the nursing home. There has also been a concerted effort by the nursing home community to partner with the inpatient psychiatric providers to educate them that introducing an antipsychotic medication may not be a sustainable plan of care due to the patient safety concerns related to the side effects and black box warnings

with the intent that such medications are not prescribed on readmission orders. CFR 483.125(1) addresses this as a patient safety measure. There are few exceptions to the use of antipsychotic medications outside of the CFR. However, my response to Steve Wallace's question applies here as well.

If a nursing facility is identified as allowing entry to some of their residents before a Preadmission Screening Form is completed, is this an automatic Level One deficiency? Or should it be a higher level deficiency considering the fact that the preadmission screening form is a critical piece of PASRR's foundation. I had a conversation with a couple of stakeholders. Some felt that not having level I screenings completed prior to admission was a minor problem and did not warrant a deficiency at all, that it would only be considered serious, "if" it was later discovered that the individual had a major MI or ID decline or harmed themselves or others. Others felt that one of the reasons for the 87' PASRR legislation was to mandate the screening of applicants prior to admission into a NF to ensure eligibility, safety, appropriateness, quality of care, and that total care needs could be met. And, if you fail to screen prior to admission, the deficiency should be higher based on the intent of the PASRR regs and the potential risk of disastrous consequences if nursing facilities do not screen individuals. Would this be a scenario where surveyors would consider if it is an isolated incident, a pattern, or widespread? Or would the issue of not screening applicants prior to admission into a Medicaid Certified Facility be considered "substantial and egregious?" What is your understanding?

Thank you for your question. The way that a deficiency level is cited for not completing a Level I prior to admission is based on the 'scope and severity' approach that surveyors refer to when citing deficient practice. In other words, other factors would be considered when assessing the scope and severity / level of the deficiency such as whether the non-compliance was wide spread and a systemic failure, whether a negative outcome occurred to the resident due to the provider not meeting minimum requirements, or whether this concern was isolated and there was not a negative outcome, etc. This would be based on the investigation to include record review of a sampling of residents, staff interviews (primarily with the social worker, director of nursing, and/or the administrator), resident observation and interviews, review of internal policies, and what guidance is produced by the QIS survey system. After the survey investigation has been completed a citation level will be assigned based on if it was an isolated incident with no negative outcome, if there is a pattern of not having a Level I prior to admission, and if negative outcome was realized, or had the potential to be realized to the resident due to the facility admitting the resident(s) without a Level I prior to admission.

In the power point, it referenced adding an exception to the process for MI/ID/RC individuals where the stay will be 30 days or less. Doesn't the regulation already cover this exception, the exempted hospital discharge? Or was the slide referencing something different?

Thank you. You are correct that that the hospital exempted discharge is the one true exemption from PASRR. CFR 483.106(b)(2) speaks to this directly. Within F-tag 285/ CFR 483.20(m) the 'Guidance to Surveyors, Intent' it is stated "Residents readmitted and individuals who initially

apply to a nursing facility directly following a discharge from an acute care stay are exempt if: They are certified by a physician prior to admission to require a nursing facility stay of less than 30 days; and they require care at the nursing facility for the same condition for which they were hospitalized.”

It is believed that where this exemption is placed within the new Conditions of Participation is a reorganization of content, not a new regulation. This will be clarified once the Guidance to Surveyors is released by CMS which is expected to be in December, 2016. PTAC will be a resource that will provide this information once it is available.

Do you have any tips/suggestions/best practices on what the Mental Health and the Medicaid Agency can do in order to support and facilitate the new nursing home requirements?

Good question. The first recommendation is for the Mental Health and Medicaid Agencies to be highly educated on the new Conditions of Participation and that their understanding is parallel to that of the survey agencies and of the providers. Secondly, it is recommended that the new regulations for nursing homes be incorporated into the service contracts of third party vendors selected by the state agencies. Third I would suggest that the Mental Health and Medicaid Agencies hold joint training sessions with the nursing home provider communities. This can be accomplished by contacting the state chapters of Leading Age and of the American Health Care Association. I have such contact information for each state, if you would like to have this information please contact me and I will be happy to make a telephone introduction to your specific entity.

Does the PASRR program have any specific requirements with the new changes? Or is the major focus on the nursing homes and the inclusion of the PASRR process into their Conditions of Participation?

Thank you for the question. No, the new Nursing Home Conditions of Participation do not change any requirements of the state PASRR program. The update is directed solely to the nursing home providers.

Will there be another webinar in the near future regarding this topic?

One of PTAC’s goals is to provide webinars that are of value to CMS and the state agencies. If there is a request for a follow up to this topic PTAC will be responsive in providing such training. PTAC is also available to offer state/region specific training at any time and at no charge. Please contact the PTAC team if additional training is requested. Also please note the October 25th Networking with NAAP webinar will include specific training based on this PTAC webinar presentation, this is open to anyone and is free of charge. Please see the PTAC website for registration information!

Thank you, if I or anyone from the PTAC team can be of assistance please don't hesitate to contact us, we are here for you!

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