



SUMMARY OF COMMENTS ON CMS PROPOSED REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

483.5 Definitions

AMDA recommends changes to the definition of person-centered care to state “individualized and appropriate care and services of any kind that directly and indirectly accommodate and support resident quality of life, input, and choice, to the extent practicable” to broaden the definition

AMDA recommends including pharmacists, respiratory therapists, dieticians, and psychologists in the definition of licensed health professional.

483.1 Resident rights

AMDA agrees that individuals should always be able to exercise their rights to the extent of his or her decision making capacity. They have the right to have others exercise those rights on their behalf if they lack capacity. Residents should be encouraged to participate in their care planning as much as possible.

AMDA supports the resident’s rights to choose their own physician who meets the professional credentialing requirements of the facility. We suggest that professional requirements should include practice and performance as well as credentialing requirements. Currently, credentialing only refers to background, education, training and licensing which is not enough to ensure physician performance and competent care. This supports the role of the medical director as identified in F501.

483.12 Freedom from abuse, neglect, and exploitation

AMDA strongly supports efforts to address abuse, neglect, and mistreatment. We are concerned that the proposed language could disqualify for life anyone including practitioners for reasons that are unrelated to the care of nursing home residents. We believe the circumstances and details of each situation need to be examined.

483.20 Resident assessment

AMDA supports the appropriate assessment and management of individuals with mental illness. We question the effectiveness of the current PASSR process and question the proposed requirements for additional PASRR discharge reporting. Many of our patients are admitted to our facilities with incorrect or missing diagnoses, confusing and problematic medication regimens, and active or barely controlled symptoms. We believe the requirements for discharge reporting will create an added burden without meaningful patient benefit.

483.21 Comprehensive care planning

AMDA supports patient-centered care planning but recognizes, as defined by IOM, that quality care has other important attributes that should be incorporated in the resident’s care plan including safe, effective, efficient, timely and equitable care for all.

AMDA supports a baseline care plan that consists of more than just the resident admission orders. In fact, these orders may need to be modified to reflect the resident’s changing condition.

AMDA agrees that the care plans should be tailored to cultural preferences and differences. We have concerns about using terms “culturally competent” and “trauma-informed” as that may be difficult for surveyors to evaluate. In fact, any individualized/patient-centered care plan should reflect all relevant underlying factors.

AMDA has concerns about the requirement to provide reportable facility data for patients transferred to another SNF, HHA, IRF, LTCH. We believe information regarding the facility’s experiences with actual care of residents that were referred previously is equally or more important, but was not mentioned in the proposed requirements.

AMDA agrees that discharge summaries from nursing facilities should contain enough information to be meaningful to the receiving provider. We are concerned that the proposed requirements do not mention the rationale for interventions. We believe these standards should apply to all care settings not just long-term and post acute care.

AMDA agrees that discharge medication reconciliation is important but must include the reason for changes in medications, and rationale for ongoing use. We believe this applies to all settings.

483.25 Quality of care and quality of life

AMDA notes that other documents besides advance directives, such as POLST orders may guide orders and actions related to life sustaining treatment.

AMDA agrees with limiting the use of bedrails unless they are of benefit to the individual.

AMDA supports efforts to restore continence when feasible, address fecal incontinence and to avoid urinary tract infections in residents who are incontinent.

AMDA believes that serum protein levels have significant limitations as a parameter of nutritional status and should not be listed as a measure of the same.

AMDA believes that hydration maintenance is about more than just providing fluids, and should consider electrolyte balance as well. We also believe and suggest that some dehydration is unavoidable such as occurs with residents on palliative care who are not eating and drinking.

483.30 Physician services

AMDA agrees it is desirable to reduce unplanned hospitalizations and re-hospitalizations. We do not believe that requiring on site visits by practitioners prior to transfer to a hospital is either desirable or safe. In many cases practitioners are not available to see the resident in a timely fashion, or during night or weekend hours, and further delay can lead to decline. We believe there are several other variables that can be addressed that also affect hospital transfer decisions. Improving nursing staff assessment skills, better and more timely communications regarding condition changes, obtaining and reviewing advance directives, better communication with families are just some of the other factors. A heightened focus on providing safer care and preventing harm which is significant cause of re-hospitalization may have more impact. This requires good care practices, attention to infection and infection prevention, environmental safety and quality prescribing and monitoring of medications. While we recognize the value of on-site practitioners, we do not believe this requirement is realistic in many circumstances. We also believe that the proposed regulations have not considered the value of telemedicine as a viable, cost-effective alternative to on-site and face-to-face practitioner visits.

AMDA believes that therapeutic diets should be ordered by the physician or the NP/PA. We support development of a facility-specific protocol by the medical director and/or medical staff to delegate some of these responsibilities based on close collaboration. Nutrition encompasses much more than just diet and requires more input than just that of the dietician.

AMDA believes similarly that rehabilitation services should be ordered by the physician, as impaired function necessitates more consideration of overall medical issues than just giving therapies. Again, facility specific protocols can be developed by the medical director with input of the medical staff to delegate some of the responsibility based on close collaboration.

483.35 Nursing services

AMDA recognizes the many diverse skills nurses need and the responsibility to have nursing staff with demonstrated competency to care for residents. Their skills need to match resident needs and the scope of services they are expected to provide.

483.40 Behavioral health services

AMDA agrees that facility staff and practitioners should know how to handle behavior and psychiatric issues. AMDA has been fully active and supportive of efforts to reduce unnecessary anti-psychotic medications and we believe that less medicine is often better. We are concerned about the misconceptions and biases about psychopharmacological medications. When used appropriately by knowledgeable individuals medications can be highly beneficial for many disorders. Although we recognize there are still many facilities where improvement in this area is needed, we believe that the choice of treatments must be individualized without a priori assumptions and exclusions of specific categories of medications. .

AMDA supports non-pharmacologic interventions as part of the management of behavior and psychiatric disorders but recognizes that the demonstrated efficacy is very limited.

483.45 Pharmacy services

AMDA supports safe and appropriate use of medications. We have concerns about some of the changes and suggested approaches. We believe Drug Regimen Review (DRR) by definition implies clinical review of the resident including chart review. We are aware of issues with pharmacy electronic records not interfacing with facility EHRs, but that does not change the expectation. We recognize interoperability issues and access to EHRs may create problems with pharmacists having the access they need to complete a thorough clinical review

We need clarification on the 6-month chart review as that should be part of the existing review. We support and expect that physicians work with their consultant pharmacists when they have issues with medications and we believe that this currently happens in most situations. We support pharmacist involvement at other times such as admission and readmission. Medication management and reconciliation is a significant responsibility of the prescriber in collaboration with nursing.

AMDA recognizes that the pharmacist DRR may identify some irregularities that are the responsibility of other disciplines such as nursing, e.g., vital sign monitoring or documentation, obtaining tests ordered or the results. Although the DON and medical director may have concerns about these and other issues that reflect system failures, they do not need to be reported to or

commented on by the attending physician or their designee. The reporting of irregularities to the medical director can be in a format decided by the medical director and pharmacist.

AMDA supports documentation of response to prescriber irregularities by the attending or their designee in the medical record. This should include that the irregularity has been reviewed, any action taken, or the rationale if they are not accepting the pharmacist recommendation. This could be written on the consultant pharmacist report that would be filed in the medical record, in a progress note, or via nursing documentation based on a discussion with the practitioner who is not in the facility.

AMDA supports maintaining the existing F329 definition of psychopharmacologic medications as those medications that are given with the specific purpose of affecting mood, cognition, and behavior. The fact that a medication affects the brain does not automatically make it a psychopharmacologic medication. Many commonly used drugs can potentially affect brain function. We do not support using the broader definition of psychotropic drugs given in these proposed regulatory changes. We believe it would be difficult to survey consistently with that definition and has potential for unintended adverse consequences for patients.

AMDA does not support moving the current regulations regarding unnecessary medications (F329) to Pharmacy Services, as this implies that medications are primarily a pharmacy or pharmacist responsibility. Other disciplines (particularly prescribers and nursing) have primary accountability.

AMDA strongly supports the appropriate and judicious use of all medications including orders for PRN medications. We agree that PRN medications should be reviewed for effectiveness, indications and side effects. We believe that the proposed time frame of 48 hours does not allow for enough time to assess their effectiveness. PRN medications are often used as a therapeutic trial as well as part of a gradual dose reduction plan and a longer time frame may be needed. We agree that ongoing need and effectiveness should be documented. Another alternative approach is to require facilities to develop policies with the medical director and/or medical staff to define the review process for all PRN medications including timing of the review and documentation expectations.

483.50 Laboratory, radiology, and other diagnostic services

AMDA agrees that facilities and practitioners should address diagnostic test results in a timely fashion. However, it is reasonable to allow facilities, medical directors and other practitioners to establish parameters and use protocols to allow test results to be triaged and addressed in the proper context. For example, depending on the resident/patient's condition or situation, abnormal results could be handled routinely and so-called "normal" results may need urgent attention. "Promptly" (the current and proposed term) implies "immediately" and should be replaced with "timely" in the proposed regulations.

AMDA appreciates the clarification that other diagnostic services including radiology services can be ordered by a PA/NP where allowed by state law. Again, abnormal results should be communicated in a timely fashion.

483.55 Dental services

AMDA supports the need for oral care services for residents. We suggest that when dentures are lost, the facility needs to ensure that the resident is able to eat and drink adequately while a referral to a dental provider is made (AMDA disagrees with a three day requirement for this).

483.60 Food and nutrition services

AMDA agrees that therapeutic diets must be prescribed by a physician but does recognize that facility-specific protocols can be developed, as discussed in earlier comments

483.70 Administration

AMDA supports the proposed requirement for facility assessment done at least annually, and which should include input from the medical director and medical staff. The need for competent staff extends to the medical staff for specialty services such as dialysis and ventilator care.

483.74 Quality assurance and performance improvement

AMDA strongly supports the concept of an effective quality assurance and improvement program. We have some concerns about the excessive focus on data and outcomes and would like to see more support for qualitative processes. We believe the requirement for Performance Improvement Projects (PIPs) may be overly prescriptive and that methods should be determined by the facility, based on their scope of service and problem-prone areas that may benefit from more rigorous processes to improve care.

AMDA is pleased to see that the medical director or their designee is specifically listed as a member of the QA&A committee and not just (as previously) any physician. We also support medical director and other medical practitioner involvement in the development and assessment of the QAPI program.

483.8 Infection control

AMDA supports an effective and efficient infection control program coordinated by adequately trained individuals. We prefer the term “coordinator.” We believe that this individual should have oversight and should work closely with the medical director and medical staff. All facility staff, including the medical staff, have responsibility for good infection control practices. We agree that the infection control coordinator should be a member of the QAPI committee. We believe they may be in a better position to oversee an antibiotic stewardship program than the consultant pharmacist, since they are expected to have infection control as a major responsibility. They can collaborate with the consultant pharmacist and the medical practitioners.

AMDA is concerned that dates for influenza season may vary annually, so the regulations should not prescribe specific dates for vaccination. We also support facility staff and practitioner immunization.

483.45 Compliance and ethics

AMDA supports facility compliance and ethics program and believes that this information should be integrated into the facility QAPI program.

483.95 Training requirements

AMDA supports training to include the key areas proposed in the regulation for communication, resident’s rights and facility responsibilities, abuse, neglect, and exploitation, QAPI, infection control, as well as compliance and ethics. We would like to comment that there are more effective ways to train than traditional in-services. Computer based, self directed learning, mentoring and real time coaching are examples of alternative strategies that are often more effective and should be at least acknowledged, if not encouraged.