Excerpted Summary of Key Items Related to How Social Workers Contribute to Improving Quality of Life of NH Residents

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 431, 447, et al.

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; Proposed Rule

Reorganization of Part 483 Subpart B

SUMMARY: This proposed rule would revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. These proposed changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These proposals are also an integral part of our efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 14, 2015.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
B. Statutory and Regulatory Authority of the Requirements for Long-Term Care Facilities Page 42173	LTC facilities include SNFs for Medicare and NFs for Medicaid. The federal participation requirements for SNFs, NFs, or dually certified facilities, are set forth in sections 1819 and 1919 of the Act and codified in the implementing regulations at 42 CFR part 483, subpart B. Sections 1819(b)(1)(A) and 1919(b)(1)(A) of the Act provide that a SNF or NF must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.	SNF and NF are very different populations and these regs ask for new very different skills for social workers (i.e., short stay SNF transitions of care and LTC NF behavioral/mental health, PSTD, person centered care for the cognitively impaired.
483 subpart B Cross Cutting Proposals Pages 421179-42180	1. Multi-faceted approach to reducing Unnecessary Hospitalizations (Pg. 42178-79) • Requiring that a facility notify the resident's physician when there is a change in a resident's status, including any pertinent information specified in § 483.15(b)(2)–(§ 483.11(e)(7)(ii)) • Addressing communication through a robust interdisciplinary team, comprehensive person-centered care planning process and through training requirements (§ 483.21). • Proposing a requirement for practitioner assessment prior to transfer to a hospital, except in an emergency situation (§ 483.30(e)). • Enhancing nursing care through a competency-based approach (§ 483.35). • Strengthening the clinical record requirements to ensure adequate and appropriate information is available to evaluating practitioners (§ 483.70(i)). • Ensuring ongoing evaluation of care process through implementation of a robust QAPI plan (§ 483.75)	Pages 42178-79 cites literature and ASPE (federal Studies) on re-hospitalization prevention and staffing and SW may have studies

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	2. Multifaceted approach Reduction in Inappropriate Use of Antipsychotic Medications (CMS believes that this approach would provide the best opportunity for a broad-based improvement in the areas of mental, behavioral, and psychosocial-related health care concerns, while also providing facilities with flexibility regarding how to address the type of staff and training or other resources and support they need to provide care and services in these areas) • Requiring that each nursing home conduct a comprehensive assessment, including its physical characteristics (that is, size, location, and number of residents), its resident population (including both a psychosocial and mental health assessment), the competencies and knowledge of its staff, and the identification of any resources or support, including training and additional staff, that the facility would need to ensure the appropriate care and treatment for all residents (§ 483.70) • Revising the current requirements that apply to antipsychotic drugs to also apply to any psychotropic drug; that is, any drug that affects brain activities associated with mental processes and behavior (§ 483.45) 3. Healthcare Associated Infections (HAIs) reduction – Non-social work	Pages 42179 Discusses comprehensive assessment including the areas of mental, behavioral, and psychosocial-related health care concerns, and psychosocial, which is part of the SW domain
§ 483.10 Resident Rights Page 42181-84	Current regulations at § 483.10 address a number of resident rights and facility requirements, including those establishing a resident's right to exercise his or her rights, including rights associated with a dignified existence, self-determination, planning and implementing care, access to information, privacy and confidentiality. We propose to revise § 483.10 to focus specifically on resident rights. • § 483.10(a)(2), we would clarify the resident's right to be supported in his or her exercise of rights • § 483.10(a)(3), we would clarify the resident's right to designate a representative, the resident representative's limitation to those rights delegated by the resident, and the resident's retention of those rights not delegated, including the right to revoke a delegation • In § 483.10(a)(4) we would address those residents who have been adjudged incompetent under the laws of a state. We would clarify the resident representative's limitation to exercising only the rights delegated, and the resident's retention of rights not delegated. Specifically, we would clarify that the resident who has been adjudged incompetent under the laws of a state retains the right to exercise those rights not addressed by a court order, that the resident representative can only exercise the rights that devolve to them as a result of the court order, that the resident's wishes and preferences should continue to be considered, and that the resident should continue to be involved in the care planning process to the extent practicable, as the resident is at the center of the care team • In proposed § 483.10(b), we have included resident rights related to planning and	This issue came up with Section Q return to community and yet it is very complex and requires greater time and social work skill

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	implementing care. We propose to re- designate and revise in this provision current § 483.10(b)(3), § 483.10(b)(4) and § 483.10(b)(8), relating to the resident's right to be informed of his or her total health status, including medical conditions; • We propose to add new requirements in § 483.10(b)(5) to specify 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, the right to request meetings and the right to request revisions to the person-centered plan of care. • We further specify in§ 483.10(b)(5)(iv) that the resident has the right to receive the services and items included in the plan of care. • We also propose to re-designate and revise existing § 483.10(d)(2) to specify that the resident has the right, in advance, to be informed of and to participate in, his or her care and treatment, including the right to be informed, in advance, of the care to be furnished and the disciplines that will furnish care. In addition, we propose to specify the resident's right to participate in the development of his or her comprehensive care plan. • We also propose at § 483.10(b)(6) to include the resident's right to self-administer medication if the interdisciplinary team has determined that doing so would be clinically appropriate. Finally, we propose to add a new section at • § 483.10(b)(7) to specify that these rights cannot be construed as a right to receive medical care that is not medically necessary or appropriate. • In § 483.10(d), we propose to re-designate a number of provisions relating to resident respect and dignity, based on existing • § 483.13(a) and § 483.15. We further propose to add a new § 483.10(d)(5) to specify that a resident has the right to share a room with his or her roommate of choice, when both residents live in the same facility, both residents consent to the arrangement, and the facility can reasonably accommodate the arrangement. We note that married couples, whether opposite or same sex, are addressed by § 483.10(d)(5). • In proposed § 483.10(e), we propose to revise a number of provisions relating to resident self-determination. We propose to revise § 483.10(e)(3) to ensure not only that specified individuals and/or org resident can receive h We propose to revise o Self-determination is a critical element in the care and treatment of nursing home residents. • § 483.10(e)(4) and (5), clarifying that it is the resident's right to participate in	Social work added to IDT and person centered care is added throughout the REG Social work added to IDT and person centered care is added throughout the REG Self-determination is a core tenant of social work

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	family groups and have his or her family members or resident representatives participate in family groups in the facility.is or her visitors of choice at the time of his or her choosing. • The ability to have access to information such as personal medical records and facility-specific information has changed significantly since the promulgation of the original requirements for long-term care facilities. • Qe propose to specify in § 483.10(f)(2) that the resident has the right to receive notices verbally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands • Next, we propose to add a new § 483.10(f)(2)(i) to reference required notices and a new § 483.10(f)(2)(iv) to ensure residents are aware of and can contact an Aging and Disability Resource Center or other No Wrong Door program. o ADRCs serve as single points of entry into the long- term supports and services system for older adults and people with disabilities. Sometimes referred to as a"one-stop shops" or "no wrong door" systems, ADRCs address many of the frustrations consumers and their families experience when trying to find needed information, services, and supports. Through integration or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective information, advice, counseling and assistance, empower people to make informed decisions about their long term supports, and help people more easily access public and private long term supports and services programs. Additional information on ADRC programs is available at http:// www.adrc-tae.acl.gov/tiki- • HIPPA already embedded in the regs. We propose to specify in paragraph (f)(3) that the resident has the right to access medical records pertaining to him or herself and to further specify in proposed (f)(3)(i) that the resident, upon oral or written request, has the right to receive requested medical records in the form and format requested by the resident, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual. • In proposed § 483.10(i), we propose to revise the language to state that the resident has a right to a safe, clean, comfortable, homelike environment, and a right to receive treatment safely. In proposed § 483.10(j), we propose to revise language relating to resident grievances to add that a resident cannot be deterred from voicing a grievance for fear of reprisal or discrimination	Social work role Section Q Return to Community Requirements not working as intended for CMS or NH social workers ADRCs are not strong in every state yet and focus mainly on the community.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
§ 483.11 Facility Responsibilities Pages 42184-91	introductory language for proposed § 483.11 would establish, based on existing requirements, that the facility must treat its residents with respect and dignity and provide care and services for its residents in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life and must protect and promote the resident's rights as specified in § 483.10. Further, the facility must recognize each resident's individuality and provide services in a person-centered manner. • In a new section proposed at § 483.11(a), "Exercise of Rights," we establish our expectation that the facility promote and protect the rights of the resident. • Proposed §483.11(a)(1) would provide that the facility ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. • We propose to re-designate current § 483.12(c)(1) as new § 483.11(a)(2) and move to this section the requirement that the facility provide equal access to quality care regardless of diagnosis, severity of condition, or payment source and establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all residents regardless of source of payment. • In proposed § 483.11(a)(3) and (4), we would specify that the facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or as delegated by the resident, with the condition that the facility could not extend greater authority to the resident representative than is permitted under applicable law. • In addition, we propose to add a new § 483.11(a)(5) that would clarify for facilities that if facility staff believed that a resident representative was making decisions or taking actions that are not in the best interest of the resident, we would expect the facility to comply with any state reporting requirements that might apply. We understand that there is the potential for abuse and neglect in this relationship and want to ensure that facilities recognize their role in appropriately identifying and reporting concerns that rise to the level of abuse, neglect or exploitation. • In proposed § 483.11(b), facility responsibilities include ensuring that the resident is informed of, and participates in, his or her treatment to the extent practicable, consistent with § 483.10(b), and that the resident participates in care planning, making informed decisions, and self- administering drugs when appropriate. In addition to the self-administration of drugs, residents may also self- administer or take part in other health care practices, such as dialysis. We also expect that the	

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	facility, through the IDT and the care planning process, would determine if, and under what circumstances, this is appropriate o We note that person-centered planning involves providing those services and supports that assist individuals to live with dignity and to support their goals (including, but not limited to, goals to potentially return to a community setting). The Department of Health and Human Services has issued guidance for implementing person-centered planning and self-direction in home and community-based services programs, as set forth in section 2402(a) of the Affordable Care Act. The principles in that guidance regarding dignity and self-direction apply equally to individuals who reside in a nursing facility. http://www.acl.gov/Programs/CDAP/ OIP/docs/2402-a-Guidance.pdf • We also propose new requirements in § 483.11(b)(1) to require that the facility ensures that the care planning process facilitates the inclusion of the resident or resident representative, includes an assessment of the resident's strengths and needs, and incorporates the resident's personal and cultural preferences in developing goals of care. • We propose a new § 483.11(d) to address the facility's responsibilities related to resident self-determination including immediate access to the resident by the resident representative, and to update the languages and references for the Office of the State long term care ombudsman and the protection and advocacy system. This would be an addition to the current requirement which provides a right of access to any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. • We propose to re-designate §483.15(c)(5) as §483.11(d)(3)(ii) and revise it to clarify that the facility- designated staff person who participates in a resident or family group must be approved by the resident or family group and the facility. • We propose a new § 483.11(d)(5), which would incorporate requirements from § 483.10(c) that focus on the facility's responsibility related to the protection of resident funds. • We propose to add a new § 483.11(d)(6)(i)(G) to indicate that the facility may not charge the resident for hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan, whether provided directly by the SNF/NF or by a hospice provider under agreement with the SNF/NF. Communication • We propose to establish a new § 483.11(e) to incorporate multiple provisions related to information and communication. With the exception of medical records, we propose in§	SW

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	483.11(e)(1) to specify that the facility is responsible for ensuring that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand. • Proposed (e)(2)(i) would require that facilities provide residents with access to his or her medical records in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if it is not readily producible in such form and format, in a readable hard copy form or other form and format as may be agreed to by the facility and the individual • To improve clarity, we propose to re- designate § 483.10(b)(7) as new § 483.11(e)(12) and revise current paragraph (b)(7)(iii) to require that the facility provide the resident with "a list of names, addresses (mailing and email), and telephone numbers of all pertinent state regulatory and informational agencies, resident advocacy groups such as the state survey and certification agency, the state licensure office, the state long-term care ombudsman program, the protection and advocacy agency, adult protective services, the state or local contact agencies for information about returning to the community and the Medicaid fraud control unit." • Additionally, we propose to revise current paragraph (b)(7)(iv) to require that the facility include in the written description of legal rights "a statement that the resident may file a complaint with the state survey and certification agency concerning any suspected violation of LTC requirements, including but not limited to resident abuse, neglect, misappropriation of resident property in the facility, non-compliance with the advance directives requirements, and requests for information regarding returning to the community." • We propose a new § 483.11(f) to include provisions related to privacy and confidentiality. • We propose to re-designate existing § 483.10(j)(3) as § 483.11(f)(3) and revise it to require that the facility allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.	SW
§ 483.12 Freedom From Abuse, Neglect, and Exploitation Page 42188-89	• The focus of this section is to ensure that residents of SNFs and NFs are not subjected to abuse, neglect, misappropriate of resident property, and exploitation when they reside in a facility, to specify the facility responsibilities to prevent abuse, neglect and exploitation, and to establish requirements for the facility response to allegations that any of these has occurred. Thus, we propose to re- designate and revise this section as§ 483.12, "Freedom from Abuse, Neglect and Exploitation," • We propose to re-designate existing § 483.13(c) as §483.12(b) and to revise it to also require that the facility develop and implement written policies and	SW

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	procedures that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property.	
§ 483.15 Transitions of Care Pages 42189-42191	• We propose to re-designate current § 483.12 "Admission, transfer, and discharge rights" as new § 483.15, and revise the general title to "Transitions of care" in order to reflect current terminology that applies to all instances where care of a resident is transitioned between care settings. o Extensive literature speaks to quality of care concerns related to the transitions. • We propose to re-designate § 483.12(a) as proposed § 483.15(b) and address transfers and discharges. § 483.15(b)(1)(ii)(C) would revise existing § 483.12(a)(2)(iii) and we would clarify that a resident could be discharged when the safety of other individuals is endangered due to the clinical or behavioral status of that resident. • In proposed § 483.15(b)(1)(ii)(E), we would revise existing § 483.12(a)(2)(v) and clarify that provisions for discharge as a result of non–payment of facility charges would not apply unless the resident did not submit the necessary paperwork for third party payment or until the third party, including Medicare or Medicaid, denied the claim and the resident refused to pay for his or her stay. This is consistent with existing guidance and would help to clarify the meaning of failure to pay. • In the proposed revision to paragraph § 483.15(b)(2), we would make a number of revisions based on the importance of effective communication between providers during transitions of care. o First, we propose to clarify that the transfer or discharge would be documented in the resident's clinical record and that appropriate information would be communicated to the receiving setting. While this type of documentation is presently required for hospitals with which the facility has a transfer agreement, such communication is important regardless of the setting to which the resident is being transferred or discharged. In addition, we propose to require that, when a facility transfers or discharges a resident because the transfer or discharge is necessary for the resident's safety and welfare, the facility would include in its documentation the specific resident needs that it cannot meet, facility attempts to meet the resident needs, and the service(s) available at the receiving facility that will meet the resident's needs • We propose to add a new requirement at § 483.15(b)(2)(i) that the transferring facility provide necessary information to the resident's receiving provider, whether it is an acute care hospital, a LTC hospital, a psychiatric facility, another	SW formally added and costed out to serve in this transitions role. CMS estimate that this requirement would cost $20,272,252 ($44 social worker hourly wage × 1 hour staff time × 460,733 residents discharged or transferred to another SNF annually)

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	LTC facility, a hospice, home health agency, or another community- based provider or practitioner. • In recognition of this, in August of 2011, the State of New Jersey mandated the use of a universal transfer form. Rhode Island and Massachusetts also require a universal transfer form and the American Medical Directors Association has developed and recommends the use of a universal transfer form. Additionally, other tools and information are available from CMS (see http://www.medicare.gov/Pubs/pdf/ 11376.pdf) and AHRQ (see http:// www.innovations.ahrq.gov/ content.aspx?id=3285) as well as through a number of professional organizations, including but not limited to the National Transitions of Care Coalition (www.ntocc.org). Examples of resources include TeamSTEPPS® Long Term Care Version (http:// www.ahrq.gov/professionals/education/ curriculum-tools/teamstepps/ longtermcare/interact2.net/), and the On-Time Quality Improvement Program (http:// www.ahrq.gov/professionals/systems/ long-term-care/resources/ontime/ qualityimprov/index.html).	
§ 483.20 Resident Assessments Pages 42191-42196	Therefore, we propose to add new § 483.20(e)(1) and § 483.20(e)(2). In new § 483.20(e)(1), we propose to clarify that coordination with PASARR includes incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. • In new§ 483.20(e)(2), we propose to clarify that PASARR coordination also includes referring all level II residents and all residents with newly evident or possible serious mental illness, intellectual disability, or related conditions for level II resident review upon a significant change in status assessment (that is, a decline or improvement in a resident's status). Often facilities overlook the PASARR recommendations during a resident's assessment and the development of their care plan. • Add a new paragraph (k)(2). Sections 1919(e)(7)(A)(ii) and (iii) of the Act provide exceptions to the preadmission screening for individuals with mental illness and individuals with intellectual disability for admittance into a nursing facility. • Newly proposed § 483.20(k)(2) would add to the regulation these statutory exceptions that were inadvertently omitted when this regulation was initially written. Second, we propose to add a new paragraph at § 482.20(k)(4). Section 1919(e)(7)(B)(iii) of the Act requires a NF to notify the state mental health authority or state intellectual disability authority when there has been a significant change in the resident's physical or mental condition so that a resident review can be conducted.	PASARR is mental health oriented and this task involves social work. PASARR is broken in some states and not well coordinated in many/most.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
§ 483.21 Comprehensive Person-Centered Care Planning Pages 42142196	Through the care planning process a facility should establish and document the services that the facility will provide to residents to assist them in attaining or maintaining their highest quality of life. Care planning drives the type of care that a resident receives and is essentially the framework for the quality of care that a facility will provide. • According to a July 2012 report, "Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs" ((OEI–07–08– 00151), https://oig.hhs.gov/oei/reports/ oei-07-08-00151.asp), the OIG found that nearly all records (99 percent) reviewed in their study failed to meet one or more Medicare requirements for beneficiary assessments and/or care plans. o Furthermore, 9 percent of records contained care plans that were not developed or updated within the required 7 days from the completion of the Minimum Data Set (MDS), while 6 percent of records did not include care plans at all. The report also found that less than 5 percent of the records actually contained care plans that were developed by the required interdisciplinary team. • Similarly, a February 2013 OIG report, "Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements" ((OEI–02–09– 00201), https://oig.hhs.gov/oei/reports/ oei-02-09-00201.asp), studied the extent to which LTC facilities meet requirements for care planning. The OIG report found that for 37 percent of the stays, facilities did not meet Medicare requirements for care planning. • § 483.21, entitled "Comprehensive Person- Centered Care Planning." This new section would contain all of the existing requirements for care planning. We believe that relocating the requirements to a new section dedicated solely to care planning would emphasize the importance of care planning as well as provide clarity to the regulations • At § 483.21(a)(1)(ii), we propose to list the information that would, at a minimum, be necessary for inclusion in a baseline care plan, but would not limit the contents of the care plan to only this information. Information such as initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and PASARR recommendations as appropriate would be the type of information that would be necessary to provide appropriate immediate care for a reside • at § 483.21(a)(2), we propose to allow facilities to complete a comprehensive care plan instead of completing both a baseline care plan and then a comprehensive care plan. In this circumstance, the comprehensive care plan would then have to be completed within 48 hours of admission and comply with the requirements for	Person-centered care are important words and helping residents' "attaining or maintaining their highest quality of life" is important but the care delivery and training to do this well is not there yet. Increased documentation will be required to meet these deficits and take a lot of time with care planning documentation which is a theme in the Reg Section Q of the MDS and Transitions of care

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	a comprehensive care plan at proposed §483.21(b). • We also propose to add a new§ 483.21(b)(1)(iv) that would require discharge assessment and planning to be a part of developing the comprehensive care plan. We are proposing to require facilities to assess a resident's potential for future discharge, as appropriate, as early as upon admission, to ensure that residents are given every opportunity to attain their highest quality of life. o This proposal seeks to improve resident satisfaction and encourage facilities to operate in a person-centered fashion that addresses resident choice and preferences. Upon a resident's request, this discharge assessment may include referral to a community transition planning agency to explore community living options, resources, and available supports and services. • We propose to require at §483.21(b)(1)(iv) that facilities document whether a resident's desire for information regarding returning to the community is assessed and any referrals that are made for this purpose. o Furthermore, we also acknowledge that residents' preferences and goals of care may change throughout the length of their stay in a facility, so we also want to emphasize that there needs to be an ongoing discussion with the resident or their representatives of the goals of care • Also in the spirit of person-centered care, we are proposing to specify additional mandatory members of the interdisciplinary team (IDT). o we propose to also explicitly require a NA with responsibility for the resident, an appropriate member of the food and nutrition services staff, and a social worker to be a part of the IDT. Including these critical team members in the IDT and the care planning process would ensure that the individual needs of a particular resident are being assessed and appropriately addressed. • Additionally, we propose to revise § 483.21(b)(2)(ii)(F), to provide that to the extent practicable, the IDT must include the participation of the resident and the resident representatives. • Lastly, we have added a new requirement at § 483.21(b)(3)(iii) to require that the services provided or arranged by the facility be culturally- competent and trauma-informed. As discussed previously, culturally- competent (including language, culture preferences and other cultural concerns), trauma-informed approaches that help to minimize triggers and re-traumatization, and that address the unique care needs of Holocaust survivors and other trauma survivors, are an important aspect of person- centered care for these individuals. Discharge Planning	Resident choice a social work role The social worker has been required to serve on the IDT by this reg and is costed out. CMS estimates that this requirement would cost $97,911,840 ($120 hourly wage ($23 NA hourly wage +$53 dietitian hourly wage +$44 social worker hourly wage = $120) × 52 hours (1hour per week × 52 weeks) × 15,691 facilities). Culturally competent and trauma-informed requires skills (i.e., including language, culture preferences and other cultural concerns), trauma-informed approaches that help to minimize triggers and re- traumatization, and that address the unique care needs

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	• As mentioned above, we propose to re-designate this section as a new § 483.21(c). Transitions between settings of care are often complex for residents as well as for LTC facilities given that each facility differs greatly in its organization, practices and cultures o The February 2013 OIG report found that for the current discharge planning requirements (summary of a resident's stay and a post-discharge plan of care), many SNF stays that did not meet the discharge planning requirements did not have a post-discharge plan of care. o Another study found that one in five Medicare beneficiaries are re- hospitalized within 30 days, largely a result of medication errors, resident confusion about and subsequent failure to follow up on care instructions and the management of multiple chronic conditions (Parry, C., & Coleman, E. A. (2010).	of Holocaust survivors and other trauma survivors, are an important aspect of person- centered care for these individuals.
	IMPACT ACT • Our proposals also emphasize that discharge planning should focus on the necessary steps to achieve discharge consistent with a resident's goals and preferences. In addition, the IMPACT Act amended title XVIII of the Act by adding Section 1899B to require that post-acute care (PAC) providers, home health agencies (HHAs), SNFs, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs) report standardized patient assessment data, data on quality measures, and data on resource use and other measures. o The IMPACT Act also requires that this data be standardized and interoperable to allow for the exchange of data among PAC providers and other providers. The IMPACT Act requires the modification of PAC assessment instruments to allow for the submission of standardized patient assessment data and enable comparison of this assessment data across providers. Additionally, the IMPACT Act requires that standardized patient data, quality measures, and resource use measures along with patient treatment goals and preferences be taken into account in discharge planning.	IMPACT act is huge since LTC residents must be managed across settings by social work and facility
	• As required under section 1899B(i)(1) of the Act, to help inform the discharge planning process, we propose to require LTC facilities to take into account, consistent with the applicable reporting provisions**, standardized patient assessment data, quality measures and resource use measures that pertain to the IMPACT Act domains**, as well as other relevant measures specified by the Secretary.	Standardized data and quality measures will likely increase time and require more documentation
	• For those residents who are transferred to another LTC facility or who are discharged to a HHA, IRF, or LTCH, we propose at § 483.21(c)(1)(viii) to require that the facility assist residents and their resident representatives in selecting a	SW role and costed out at only 1

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data are available. o Further, under the proposed regulation, the facility would have to ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use are relevant and applicable to the resident's goals of care and treatment preferences • At § 483.21(c)(1) we propose to improve the discharge planning for LTC facilities by adding a requirement that facilities must develop and implement an effective discharge planning process. Relates to Section Q • The facility's discharge planning process must ensure that the discharge goals and needs of each resident are identified. This process should also result in the development of a discharge plan for each resident and any referrals to local contact agencies or other appropriate entities, should the resident have a desire to receive information about returning to the community. In addition, we propose to require that the facility's discharge planning process require the regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must also be updated, as needed, to reflect these changes. We also propose to require that the IDT responsible for the developing a resident's comprehensive care plan be involved in the ongoing process of developing the discharge plan. o Furthermore, we propose to require that the facility consider caregiver/ support person availability, and the resident's or caregiver support persons' capacity and capability to perform the required care, as part of the identification of discharge needs. In order to incorporate residents and their families in the discharge planning process, we also propose to require that the discharge plan address the resident's goals of care and treatment preferences. o Facilities would have to **document in the discharge plan** that a resident has been asked about their interest in receiving information regarding returning to the community. o If the resident indicated interest in returning to the community, the facility must **document any referrals to local contact agencies** or other appropriate entities made for this purpose and update a resident's comprehensive care plan and discharge plan in response to information received from such referrals. o Likewise, if discharge to the community were determined to not be feasible, the facility would **document who made the determination and why.**	hour per resident Therefore, CMS estimates that this requirement would cost $20,272,252 ($44 social worker hourly wage × 1 hour staff time × 460,733 residents discharged or transferred to another SNF annually). Section Q is not mentioned because this is a reg that only mentions comprehensive assessment. Statistically, it is not clear how many long-term residents can be discharged and many facilities have none. The local contact agency infers that there are community services and yet this varies by state. This might be a point of comment and if we can find some relevant statistics.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	• At § 483.21(c)(2)(i) we propose to revise the current requirements for the post-discharge plan of care to specify that a recapitulation of a resident's stay would include, but not be limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. We also propose to explicitly include a requirement for facilities to include what arrangements have been made with other providers for the resident's follow-up care and any post-discharge medical and non-medical services as needed. o These arrangements should include community care options, resources, and available supports and services presented and arranged by the community care provider as needed. Some local community transition agencies include Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), or Centers for Independent Living (CILs), which can provide information and assist the resident in arranging for available community supports and services prior to discharge. Adding this requirement would hold facilities accountable for their role in preparing residents for care transitions from one setting to another and assist in decreasing a resident's risk for complications and hospitalization. • In addition, the discharge planning process should ensure that residents receive adequate information that is understandable and prepares them to be active partners and advocates for their healthcare upon discharge. At § 483.21(c)(2)(i) we propose to revise the current requirements for the post-discharge plan of care to specify that a recapitulation of a resident's stay would include, but not be limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. • We also propose to explicitly include a requirement for facilities to include what arrangements have been made with other providers for the resident's follow-up care and any post-discharge medical and non-medical services as needed. o These arrangements should include community care options, resources, and available supports and services presented and arranged by the community care provider as needed. Some local community transition agencies include Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), or Centers for Independent Living (CILs), which can provide information and assist the resident in arranging for available community supports and services prior to discharge. Adding this requirement would hold facilities accountable for their role in preparing residents for care transitions from one setting to another and assist in decreasing a resident's risk for complications and hospitalization. • Lastly, in keeping with the theme of resident centered care, we also propose at § 483.21(c)(2)(iv) to require that the post-discharge plan be developed along with	Section Q Community options vary and ADRCs focus more on community

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	the participation of the resident and, with the resident's consent, his or her resident representative. o Furthermore, upon a resident's request, facilities should also include the community transition planning agency to assist the resident and facility with housing, personal care assistance, assistive technology, and other resources. • In addition, the discharge planning process should ensure that residents receive adequate information that is understandable and prepares them to be active partners and advocates for their healthcare upon discharge.	More discharge involvement with the resident
§ 483.25 Quality of Care and Quality of Life Pages 42196-42199	We propose to comprehensively revise and re-organize the current § 483.25 to ensure person-centered, quality care and quality of life for this vulnerable population. In this proposed revised section, we would focus on a limited set of concerns that do not clearly fit in other general sections of the regulation but which are of significant importance for each resident's health and safety and which contribute substantially to their quality of care, quality of life and person-centered issues such as dignity, respect, self-esteem and self- determination. • First, we propose to retitle this section "Quality of Care and Quality of Life", reflecting the overarching application of these principles. In our proposed revised introductory paragraph, we reiterate the requirement that each resident must receive and the facility must 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. We focus throughout this section, as we have in other areas, on establishing person-centered requirements that acknowledge both the resident's needs and the resident's right to make choices • Second, in § 483.25(a), we propose to address the residents' ability to perform ADLs and establish that, based on the comprehensive assessment of a resident and consistent with the resident's needs, choices, and preferences, the facility must provide the necessary care and services to maintain or improve, as practicable, the resident's abilities to perform his or her activities of daily living and to ensure that those abilities do not diminish unless the diminution is unavoidable as a result of the individual's clinical condition. •	Q oL Social work role
§ 483.35 Nursing Services	We are aware of long-standing interest in increasing the required hours of nurse staffing per day. We have heard suggestions that we impose a minimum number of hours per resident day or require a RN to be on site 24 hours a day 7 days a week.	Staffing discussion focuses on RNs. Check what the literature says about social work staffing.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
Pages 421199-421202	• There is abundant research that associates increased RN staffing with improved quality of care. Rather than specify how many nurses must be on duty, most focus on the number of hours of nursing care a resident must receive to achieve certain quality objectives • An alternative approach to mandating a specific number of hours per resident day is to mandate the presence of a registered nurse in a nursing home for more hours per day than is currently required, potentially 24 hours a day 7 days a week, subject to the statutory waiver. • We propose to include in the introductory language of proposed § 483.35 "Nursing Services" the requirement that, in addition to having sufficient staff to provide nursing care to each resident in accordance with his or her care plan and individual needs, the facility ensure that staff have appropriate competencies and skill sets to assure resident safety. • CMS wants comments on how to measure nurse staffing requirements since they cite literature and indicate that it is not conclusive.	
§ Behavioral Health Services 483.40 Pages 421202-421203	Currently, § 483.25 requires that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. We propose to add a new section § 483.40 to address this requirement as it relates to behavioral health services. • We propose to add a new section § 483.40 to include requirements for both behavioral health services and for **social workers** given the prevalence of mental health disorders and other cognitive impairments and in order to achieve the LTC requirements' goal of the highest practicable mental and psychosocial well-being for each resident, it is critical that LTC facilities ensure that behavioral health issues are addressed. These provisions work in conjunction with other provisions we propose, including those related to reducing the inappropriate use of psychotropic medications o Serious mental illness and cognitive and/or functional impairment are strong predictors of admission into a nursing home. Although estimates vary, the industry literature indicates that a large number of nursing home residents have a significant mental health disorder. In 2004, over 16 percent of nursing home residents received a primary diagnosis of a mental disorder upon admission (Jones, Figure 7). By the time residents were interviewed for the National Nursing Home Survey that percentage increased to almost 22 percent. The 1999 estimate was about 18 percent. In addition, nursing homes are caring for a significant	behavioral health services and for **social workers** given the prevalence of mental health disorders and other cognitive impairments and in order to achieve the LTC requirements' goal of the highest practicable mental and psychosocial well-being for each resident is a huge competency and current staff often were not prepared or trained This is especially important for mental illness, dementia, behavior and trauma related resident problems. Non-pharmacological treatments

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	number of patients with dementia and depression. By 2012, over 48 percent of nursing home residents had a diagnosis of Alzheimer's disease or another dementia and/or depression (Harris-Kojetin, p. 35, Figure 23). o In a 2003 report, the OIG concluded that not all residents of LTC facilities receive the behavioral health services they need. Additionally, there is evidence that there is not full compliance with the requirement to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident ("Psychosocial Services in Skilled Nursing Facilities," Department of Health and Human Services, Office of the Inspector General, OEI–02–01– 00610, March 2003). Social Work 120 Bed Rule • Currently, sections 1819(b)(7) and 1919(b)(7) of the Act require that a facility with more than 120 beds employ at least one social worker on a full-time basis or assure the provision of social services. **However, all facilities are required to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Meeting one requirement does not negate the need to meet other requirements.** • In keeping with our competency focus, we propose to include in new § 483.40 requirements to ensure that **there are sufficient direct care staff with the appropriate competencies and skills to provide the necessary care to residents with mental illness and cognitive impairment. The needed competencies and skill sets include knowledge and training, including non-pharmacologic interventions, necessary to provide the care for residents with mental illnesses and psychosocial disorders. Thus, LTC facilities would be required to have the staff, including social workers, necessary to provide the social services needed by their residents.** • We propose, in § 483.40(a) to require that the facility have sufficient direct care staff with the **appropriate competencies and skills sets to provide** nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at proposed § 483.70(e). o Necessary competencies and skills include knowledge of and appropriate training and supervision for caring for residents with the mental illness and psychosocial or adjustment problems as well as residents with a history of trauma and/or	should be an area of SW research 120 bed rule is not being addressed directly and probably should. Rationale is that social workers have the behavioral and mental health competency training at both the BSW and MSW level that often psychology or sociology social service hires do not. The end of the reg says "We also considered adding more requirements to the qualifications for a social worker in § 483.70(p). We considered requiring a masters of social work (MSW) for the social worker. We also considered requiring that the social worker also have a certification related to clinical work or gerontology. We did not propose these requirements because we are concerned that increasing the qualifications for social workers in nursing homes may result in access issues. We have received input that some nursing homes already have difficulty in hiring qualified social workers. We would welcome

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	post-traumatic stress disorder that have been identified in the facility assessment. o Furthermore, staff must be trained in implementing non-pharmacological interventions. • We propose to specify in new paragraph (b) that, based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays or is diagnosed with mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental health and psychosocial well- being. In addition, we propose to specify that a resident whose assessment does not reveal or who does not have a diagnosis of a mental illness or psychosocial adjustment difficulty will not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that the pattern was unavoidable.	comments related to qualification for the social worker, especially whether state licensure should remain the threshold requirement or if additional requirements are appropriate." Since there is limited current LTC MSW student interest in aging and insufficient MSW manpower to support 15,691 nursing homes, think about recommending BSW or MSW qualifications since both our competency based training. Most of the current social work staff need training and were not prepared for this level of intervention
§ 483.45 Pharmacy Services Pages 421203-421205	We believe that there are specific circumstances under which the pharmacist must at least periodically review the resident's medical record concurrently with the drug regimen review. Those circumstances include transitions in care, specifically when the resident is new to the facility or is returning or being transferred from another facility. We also believe it is critical when a resident is on a psychotropic or antimicrobial medication. In addition, we propose specific requirements related to the use of psychotropic drugs, § 483.45(e), and antibiotics, § 483.80(a)(2). We believe having the pharmacist review residents' medical charts when these medications are prescribed would not only assist the pharmacist in detecting irregularities related to these drugs but also enhance or contribute to the goal of ensuring that these medications are used only when medically appropriate for the resident. Psychotropic Medications • We want to emphasize that the proposed requirements concerning psychotropic medications are not intended to have a chilling effect or in any manner discourage the prescription or use of any medication intended for the benefit of a resident who has been diagnosed for a specific condition that requires these medications. Our proposed requirements are intended to protect nursing home residents from drugs that are not being prescribed for their benefit.	Non-pharmacological interventions with cognitively impaired and mentally ill residents huge role for social work and no additional hours added.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	• Our proposed requirements for gradual drug reductions, if not clinically contraindicated, and for behavioral interventions are intended to reduce or, if possible, eliminate the need for these medications. Likewise, our proposed requirement for a 48 hour limitation on PRN orders for psychotropic medications is intended to safeguard the resident's health. We are concerned about reports that PRN orders for these drugs may remain in effect for an extended time without being reviewed by the resident's physician or primary care provider. • These proposed requirements are completely in alignment with the concepts and requirements of person-center care and the resident maintaining her/his highest level of functioning. Therefore, we do not believe these proposed requirements should discourage the use of psychotropic medications when these drugs are required for the resident's benefit	
§ 483.55 Dental Services Page 421205-206	• We propose limited changes to update and clarify this section. First, we propose to add a new § 483.55(a)(3) to clarify that a facility may not charge a resident for the loss of or damage to dentures when the loss or damage is the responsibility of the facility. We welcome comment on this issue. Second, we propose to re-designate existing §483.55(a)(3) as §483.55(a)(4) and revise § 483.55(a)(4) by adding the phrase "or if requested" to clarify that if a resident asks for assistance in scheduling a dental appointment, the facility would be required to provide the assistance. • Third, we propose to modify the section by adding language at new § 483.55(a)(4)(ii) and § 483.55(a)(5) regarding transportation and referrals for dental services. We note that facilities could comply with these provisions by referring and transporting residents to a dental clinic or dental school rather than a dentist's office. We also understand that in some facilities, dental services are provided in the facility. • Finally, we propose to re-designate § 483.55(a)(4) as § 483.55(a)(5) and would require that referral for dental services occur in 3 business days or less from the time the loss or damage to dentures is identified unless the facility can provide documentation of extenuating circumstances that resulted in the delay. o We believe that it is imperative that the loss or damage is addressed and corrected quickly to avoid adverse consequences such as weight loss. o We propose to make the same changes at § 483.55(b)(2) and § 483.55(b)(3) to apply to nursing facilities and add a new § 483.55(b)(4) to require that facilities assist residents to apply for reimbursement of dental	Social work often looks for dental so might be interested in this proposed change

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	services as an incurred medical expense under the state plan as appropriate.	
§ 483.60 Food and Nutrition Services Page 42206-42209	• It is not enough; however, to ensure that residents have choices in what they eat. Many nursing home residents have other barriers to eating, including dental issues, medical issues, medication- related issues, physical limitations and the need for proper positioning and assistance at mealtimes. o With so many issues facing nursing home residents, adequate nutrition requires both an understanding of the facility's population as a whole and an interdisciplinary approach for each resident. This includes ensuring that sufficient staff are available and have the appropriate skill sets, competencies, and training to assess and plan an overall facility dietary program as well as assess and assist individual residents at meals and with snacks. Thus, our proposed revisions include person-centered requirements that are outcome focused and intended to ensure each resident is provided, in a dignified manner, the nutritional and dietary care and services needed to meet the statutory goal of attaining or maintaining his or her highest practicable mental, physical and psychosocial well-being. o We propose a new § 483.60(b) to specify that a member of food and nutrition services also participate in the IDT. The registered dietitian or other clinically qualified nutrition professional is a critical member of the IDT; however, in some cases another member of food and nutrition services with the appropriate skill sets and competencies may be an acceptable alternative. Nutrition is an integral aspect of a resident's well-being, thus it is critical an individual knowledgeable about the facility capabilities as well as the resident's needs and preferences participate in the interdisciplinary team in order to ensure that resident can achieve or maintain his or her maximum practicable well-being o We propose to re-designate existing § 483.35(h) as new § 483.60(h) and retain, with some revisions, provisions for paid feeding assistants, as set out in the 2003 final rule (68 FR 55528). We believe the use of paid feeding assistants provides a valuable flexibility to nursing facilities and can serve to ensure that residents requiring dining assistance are able to receive it. o In proposed § 483.60(i), we clarify in new § 483.60(i)(1)(i) that facilities may procure food directly from local producers—farmers or growers, in accordance with state and local laws or regulations. We further propose to clarify in new § 483.60(i)(1)(ii) that this provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and handling practices, such as using pesticides in accordance with manufacturers' instructions.	Nutrition being added to the IDT and requirements may be of interest to SW
§ 483.70 Administratio	• We are proposing a new § 483.70(e) which would establish a new requirement for an annual facility assessment. This new requirement would be a central	Competencies and QAPI a new role

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
n Page 42210-42212	feature of our revisions to subpart B and is intended to be used by the facility for multiple purposes, including but not limited to activities such as determining staffing requirements, establishing a QAPI program, and conducting emergency preparedness planning. Multiple assessment areas are outlined including: o The facility's resident population, including the number of residents, the facility's resident capacity, the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity that are present within that population. o The staff competencies that are necessary to provide the level and types of care needed for the resident population.	
§ 483.75 Quality Assurance and Performance Improvement (QAPI) Pages 42212-42215	Section 6102 of the Affordable Care Act amended the Act by adding new section 1128I. Subsection (c) of section 1128I of the Act requires that the Secretary establish and implement a QAPI program requirement for SNFs and NFs, including those that are part of a multi-unit chain of facilities. Under the QAPI provision, the Secretary must establish standards relating to facilities' QAPI program and provide technical assistance to facilities on the development of best practices in order to meet these standards. No later than 1 year after the date on which the regulations are promulgated, a facility must submit to the Secretary a plan for the facility to meet these standards and implement the best practices, including a description of how it would coordinate the implementation of the plan with quality assessment and assurance activities currently conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B) of the Act. • The QAPI program should include standards for quality assurance, active feedback systems to monitor performance, and continuous efforts to optimize program design through quality improvement activities and proactive strategies. o The QAPI requirements we propose would not replace the QAA committee requirements but would enhance and be coordinated with these requirements. The QAA committee may also benefit from including individuals such as a resident council president, the director of social services or the activities director. • At proposed § 483.75(a), we would require that a facility develop, implement, and maintain an effective, comprehensive, data-driven QAPI program, reflected in its QAPI plan, that focuses on systems of care, outcomes and services for residents and staff. • In addition, we propose in new § 483.75(a)(4), to require the facility to present its documentation and evidence of an ongoing QAPI program upon request of a State Agency, federal surveyor, or CMS. The State Agency, pursuant to its agreement with the Secretary under section 1864 (a) of the Act, will consider such plan in making its certification recommendation and providing evidence to the	QAPI is huge and targets SW system's training. The reg only suggest social service could be added and perhaps we could recommend it be added especially if we can get BSW and MSW because it is in the scope of practice. Social work scholar Rosalie Kane has done much of the development work for QAPI which is required by the affordable care act. It seems to be required only for nursing home chains…?

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	CMS Regional Office for a compliance determination. • We propose in new § 483.75(c) to establish requirements for QAPI program feedback, data systems and monitoring. • We propose at new§ 483.75(c)(1) that, as part of its QAPI process, the facility would have to maintain effective systems to obtain and use feedback and input from direct care/ direct access workers, other staff, and residents, resident representatives and families to identify opportunities for improvement. • In new § 483.75(c)(2), we propose to require that the systems, governed by appropriate policies and procedures, also include how the facility would identify, collect, and use data from all departments, including how the information would be used to identify high risk, high volume or problem-prone areas. • In new § 483.75(c)(3), we would require that the policies and procedures include a description of the methodology and frequency for developing, monitoring, and evaluating performance indicators. Finally, in new § 483.75(c)(4), we propose to require that the system, policies and procedures include the process for identification, reporting, analysis, and prevention of adverse events and potential adverse events or near misses. QAPI Technical Assistance Provided • In addition to establishing the standards for a QAPI program in this proposed rule, we would provide technical assistance to nursing homes on the development of best practices relating to QAPI o CMS QAPI Demonstration produced QAPI materials developed through this process are available at no cost to all facilities at http://www.cms.gov/ Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/QAPI.html. o QIOs and Advancing Excellence Campaign a resource o The State Medicaid Agencies (SMAs) and HHS's Administration for Community Living (ACL) provide online information resources for community care and transition programs, options, supports and services, community care transition planning entities, and contacts and links: www.medicaid.gov; www.mfp- tac.com; and www.acl.gov. Finally, CMS provides links to resources in its existing Interpretive Guidelines that provide information on how to develop and enhance quality improvement programs.	
§ 483.85 Compliance	In this proposed rule, we seek to address how nursing facilities can best establish internal controls, prevent fraudulent activities, and promote quality of care through these	SNF and NF care is very different, which the social worker is one of

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
and Ethics Program Pages 42218-42221	elements as implementing written procedures and standards of conduct, designating a compliance officer, and other specific requirements. This proposed rule would require SNFs, NFs, and dually- participating SNF/NFs to have in place an effective compliance and ethics program that would require facilities to use internal controls to more efficiently monitor adherence to applicable statutes, regulations, and program requirements to deter, reduce, and detect violations and promote quality of care for nursing home residents. SNFs and NFs must meet the requirements in part 483 to participate in the Medicare and Medicaid programs and therefore, we are proposing that the requirements for effective compliance and ethics programs as set forth in section 1128I of the Act be incorporated into the SNF and NF Requirements in Part 483. Specifically, we are proposing to add a new § 483.85 entitled, "Compliance and ethics program". • In § 483.85(c), we propose that the operating organization for each facility be required to develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, several components, which we discuss below.	the only disciplines to go both ways. Although a problem to balance, social work can help with ethics, internal controls, prevent fraudulent activities, and promote quality of care although there is probably no time. It is part of SW values
§ 483.90 Physical Environment Pages 42221-42222	• Therefore, we propose to require in new § 483.90(d)(1)(i) that, bedrooms in facilities accommodate not more than two residents unless the facility is currently certified to participate in Medicare and/or Medicaid or has received approval of construction or reconstruction plans by state and local authorities prior to the effective date of this regulation. • Currently, in existing § 483.70(d), the regulations allow for bedrooms that accommodate up to four residents. o We believe that this number of residents per room is inconsistent with current common practice, is not person- centered nor supportive of achieving the resident's highest practicable mental, physical and psychosocial well-being and is not an environment that promotes maintenance or enhancement of each resident's quality of life. o Reconstruction means that the facility undergoes reconfiguration of the space such that the space is not permitted to be occupied, or the entire building or an entire occupancy within the building, such as a wing of the building, is modified. We believe that semi-private rooms are far more supportive of privacy and dignity	Change to 2 residents per room is an improvement and may be of interest to social workers.
§ 483.95 Training Requirements Pages 42222-	We are proposing to add a new § 483.95 to subpart B that would set forth training requirements. We propose that a facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles.	Overall training is needed and what is proposed is not enough to bring current NH staff to be able to begin to address proposed changes

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
42225	We also propose that a facility be required to determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). • Communication Training o We propose at § 483.95(a) to include effective communications as a required training topic for direct care personnel. • Resident's Rights Training o We propose at § 483.95(b) to require that facilities train staff members on the rights of the resident and the responsibilities of a LTC facility to properly care for its residents as set forth at § 483.10 and § 483.11, respectively. We believe that it is necessary to ensure that direct care workers are trained to recognize when treatment is abusive or constitutes neglect or exploitation. ▪ Training all nursing home staff, particularly direct care staff, to be on the lookout for changes in a resident's condition and to effectively communicate those changes is one tool LTC facilities can employ to improve patient safety, create a more person-centered environment, and reduce the number of adverse events or other resident complications. • Abuse, Neglect, and Exploitation Training o At § 483.95(c) we propose to require that a facility provide training to its staff on the freedom from abuse, neglect, and exploitation requirements found in o § 483.12. We propose to specify that facilities must provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property. • Quality Assurance and Performance Improvement Training • Infection Control Training • Compliance and Ethics Training o According to the OIG in a 2002 report entitled, "Nurse Aide Training," (OEI– 05–01–00030), 63 percent of the nursing home supervisors interviewed said that training has not kept pace with the care demands imposed by current resident diagnoses. Many of these supervisors pointed out that they are seeing more combative and violent residents. Many supervisors and nurse aides stated that nurse aides need more	Social work role Social work role and complex

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	training in caring for residents with behavioral and cognitive disorders, such as Alzheimer's disease. o Also, six state Nurse Aide Training Competency Evaluation Program (NATCEP) directors specifically emphasized the need for more training in caring for residents with cognitive disorders • Required In-Service Training for Nurse Aides o Dementia among nursing home residents is prevalent and increasing. According to the Certification and Survey Provider Enhanced Reports (CASPER) data, in June 2009, 47 percent of all nursing home residents had a diagnosis of Alzheimer's or other dementia in their nursing home record. o According to a September, 2008 report prepared for CMS entitled, "Improving Nurse Aide Training," by Abt Associates, Inc. (Contract #500–95– 0062/TO#3), studies have shown that educational programs are more likely to be successful when the education is ongoing. Students are also more receptive to new information that is relevant to their current work environment, rather than information that is presented during the initial training. This report suggests that ongoing training in dementia management and abuse prevention, in addition to the already-required initial training, would be valuable. • The Need for Nurse Aide Training in Abuse Prevention - Section 6121 of the Affordable Care Act added sections 1819(f)(2)(A)(i)(1) and 1919(f)(2)(A)(i)(1) of the Act. These sections require all NAs to receive on- going training in both dementia management and patient abuse prevention training, "if the Secretary determines appropriate." o Based on CASPER data for 2007– 2009, nursing homes received 3,124 citations for abuse and mistreatment of residents. In 2003, State Long-Term Care Ombudsman programs nationally investigated 20,673 complaints of abuse, gross neglect, and exploitation on behalf of nursing home and board and care residents. o The Center for Advocacy Rights and Interests (CARIE) reports on their Web site (http://www.carie.org/programs- services/for-provider-professionals/ abuse-prevention/) reports the following results in 10 Philadelphia-area nursing homes self- reported abusive behaviors over a one- month period. ▪ 51 percent reported yelling at a resident in anger;	Social workers could be instrumental in providing the psychosocial care training, and training related to dementia behaviors, grief and loss, crisis, family communications, etc.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	▪ 23 percent insulted or swore at a resident; ▪ 8 percent threatened to hit or throw something at a resident; ▪ 17 percent excessively restrained a resident; ▪ 2 percent had slapped a resident; and ▪ 1 percent had kicked or hit a resident with a fist o We are proposing to amend the LTC requirements by requiring the current mandatory on-going training requirements for NAs include dementia management and resident abuse training. LTC facilities are required at existing § 483.75(e)(8) to complete a performance review of every NA at least once every 12 months, and facilities must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of NAs, and must be no less than 12 hours per year. • Training for Feeding Assistants o Current regulations at § 483.75(q) require facilities to only employ as a paid feeding assistant those individuals who have successfully completed a state approved training program, as specified in § 483.160. • Behavioral Health Training o We propose at § 483.95(i) to require that facilities provide behavioral health training to its entire staff, based on the facility assessment at § 483.70(e). As required at § 483.70(e), the facility would be responsible for using their facility assessment to determine the behavioral health related needs of their residents.	Shows the complexity of dementia care and need for strong psychosocial and person-centered care and professionals need to participate in training to make it team oriented. Focuses on NAs which is important but should involve partnership with professional and SW staffs. This is a huge need and seems underfunded and not totally thought through. Perhaps an area of comment
Regulatory Impact Analysis (RIA) There are about 15,691 SNFs and NFs that are certified by Medicare and Medicaid. We use these figures to estimate the potential impacts of the proposed rule. In addition, we have used the same data source for the RIA that we used to develop the PRA burden estimates. As stated in the COI section, we obtained all salary information from the May 2014 National Occupational Employment and Wage Estimates, United States by the BLS at *http://www.bls.gov/oes/current/oes_nat.htm* and all salary estimates include benefits and overhead package worth 48 percent of the base salary. The analysis below overlaps with the COI section for some requirements and much of the economic impact of the rule would be due to the cost for facilities to comply with the information collection requirements. The COI section contains more technical and legal detail, therefore readers may wish to consult both sections on some topics.		
Comprehensive Resident Centered Care Planning (§ 483.21)	• We would require that a NA, member of nutrition services, and social worker participate on the IDT. o When assessing the amount of burden associated with this requirement, we believe that this requirement would only produce an incremental increase in the staff time necessary to participate on the IDT.	IDT participation seems to suggest a sit down meeting and not walking rounds and 52 hours (1 hour per week) is low for most facilities

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
Additional Members of the IDT (§ 483.21(b)(2)(ii)) Page 42237	o In addition, we do not specify the type of communication the IDT must use. IDT members may use electronic communication as well as informal discussions to participate in IDT meetings. We estimate that participation on the IDT would add an additional one hour of staff time to the duties of a NA, member of food services, and social worker. We estimate that this requirement would cost $97,911,840 ($120 hourly wage ($23 NA hourly wage +$53 dietitian hourly wage +$44 social worker hourly wage = $120) × 52 hours (1hour per week × 52 weeks) × 15,691 facilities).	
Discharge Planning (§ 483.21(c)(1)(vii)) Page 42237	• We would require that, for residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, facilities assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use. o We estimate that it would take a social worker approximately one hour of staff time to compile and review the data in order to align the data with each resident's preferences/goals. This staff time would only be required for those residents who are transferred to another SNF or discharged from the nursing home. We are unable to determine the average number of residents who are transferred to another SNF or discharged from a nursing home annually. We believe that a conservative estimate would be that if there are an estimated 1,382,201 residents per year in nursing homes, possibly a third of these residents are discharged or transferred to another SNF on an annual basis. Therefore, we estimate that this requirement would cost $20,272,252 ($44 social worker hourly wage × 1 hour staff time × 460,733 residents discharged or transferred to another SNF annually).	A patient transitioning would require more that 1 hour for calls, coordination, patient/family contact and coordinating with the receiving or sending facility. It would be interesting if anyone had data to show how many NH residents transition to HHA, IRF, or LTCH to seek a stronger estimate of impact.
Medicaid Eligibility (§ 483.11(e)(11)(i)) Page 42236	The facility must provide notice to each Medicaid-eligible resident, in writing, at the time of admission and when the resident becomes eligible for Medicaid. This means some residents will require a second notice. The per facility cost will vary significantly according to facility size and resident mix and will be about $2.20 per resident who requires notification, or $608,168 for all such residents across all 15,691 facilities. (($44 hourly wage for social worker . .05 of an hour) . (.20 estimate percent of all nursing home residents who will require a second notice . 1,382,201 nursing home residents) = $608,168).	Medicaid second notices are important and yet "social worker × .05 of an hour" is very low.
Nursing Services (§ 483.35)	Our focus on competency requirements requires identification of and documentation of training, certification, and similar records in an existing personnel file or training record for direct care personnel. This specifically includes nursing services and food and nutrition	Competency requirements for mental and behavioral health a huge expense and not mentioned

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
Competency Requirements (§ 483.35, § 483.60) Page 42238	services but may apply to any direct care provider. We estimate the incremental burden of adding the additional information to existing files (paper or electronic) at 8 hours per year per facility, or $232. The cost for all facilities is estimated at $3,640,312. ($29 office clerk hourly wage × 8 hours per facility × 15,691 facilities = $3,640,312)	
QAPI (§ 483.75) Page 42238	We have proposed to require that each facility develop a QAPI program. In addition to the QAPI requirement related ICR costs discussed in the COI section, we expect that facilities would incur additional costs that would be dependent upon the projects they selected for their quality improvement activities. A facility that chose, as one of its projects, to improve residents' psychosocial well- being could incur costs for conversion of double rooms to single rooms, and additional social worker, and/or increased social activities for residents. Because the number, degree, and costs of these activities are difficult, if not impossible, to quantify, we have calculated only the cost of the QAPI ICRs ($118,419,977 upfront) that would be associated with the QAPI requirements (discussed in the COI section of the preamble). However, we encourage the public to comment on the potential costs for facilities of their quality improvement projects. We estimate that the ongoing annual cost for each facility to comply with the QAPI requirements would be $3,021 for each facility and for all facilities would be $47,402,511 ($3,021 × 15,691). (This discussion is detailed in the COI section.)	QAPI is important for person-centered care, resident rights, behavioral health, etc.
Alternatives Considered – 5.Additional Changes Pages 42242-	We also considered adding more requirements to the qualifications for a social worker in § 483.70(p). We considered requiring a masters of social work (MSW) for the social worker. We also considered requiring that the social worker also have a certification related to clinical work or gerontology. We did not propose these requirements because we are concerned that increasing the qualifications for social workers in nursing homes may result in access issues. We have received input that some nursing homes already have difficulty in hiring qualified social workers. We would welcome comments related to qualification for the social worker, especially whether state licensure should remain the threshold requirement or if additional requirements are appropriate.	Social Workers and their organizations need to weigh in on this to show how social work BSW and MSW preparation is competency based with standards and direct supervision to change the 120 bed rule. Outcome statistics or evidence-based competency models from non-nursing home settings would be helpful since CMS won't do anything without data
F. Benefits of Proposed Rule Pages 42242-43	In addition, these changes will support improved resident quality of life and quality of care. Quality of life in particular can be difficult to translate into dollars saved. However, there is a body of evidence suggesting the factors that improve quality of life may also increase the rate of improvement in quality and can have positive business benefits for facilities. Many of the quality of life improvements we propose are grounded in the concepts of person- centered care and culture change. These changes not only result in improved quality of life for the resident, they can result in improvements in the	Quality of live and social work is a no brainer and the QoL cost benefit of social work through research or clinical examples is a way again to justify changing the 120 bed rule.

CFR Code	REG Explanations/Questions	Relevance to SW Research/Practice
	caregiver's quality of work life and in savings to the facility. Savings can be accrued through reduced turnover, decreased use of agency labor and decreased worker compensation costs. Although these savings are difficult to quantify, we believe that they must be lower in magnitude than the costs borne by facilities; otherwise, facilities would change their policies even in the absence of this rulemaking	