Phase 3 Implementation: What You Need to Know

With Phase 3 implementation on November 28, 2019, providers are in a confusing and challenging situation given that the Centers for Medicare & Medicaid Services (CMS) will not be releasing Phase 3 interpretive guidance (IG) until the second quarter of 2020 and given the added variable that the proposed rule CMS released in July contained *potential*, but not yet adopted, changes to some Phase 3 regulations.

We want to ensure members are aware of several key points:

1. **All of the current Phase 3 regulations go into effect on November 28, 2019**. The Phase 3 regulations address the following areas:
   - Infection Preventionist (IP)*
   - Compliance and Ethics Program (C&E)*
   - Quality Assurance and Performance Improvement (QAPI) Program*
   - Trauma-informed Care
   - Bedside Call System
   - Comprehensive Training Program

2. The areas denoted with a (*) in item 1 above—Infection Preventionist, QAPI Program, and C&E Program—are those to which CMS has proposed changes in the proposed rule released on July 18, 2019.
   a. The changes in these three areas are *proposed,* not finalized. As a result, the IP, QAPI, and C&E regulations go into effect on November 28 as written in current regulations.
   b. **Because these changes are proposed and not adopted, CMS is not able to issue guidance until the rule is finalized.**
   c. This AHCA webinar provides a detailed overview of the proposed rule.

3. One of the *proposed* changes in the proposed rule is to delay implementation of **some** Phase 3 requirements for one year after the effective date of finalization of the rule. **The delay does not go into effect until CMS issues a final rule**.
   a. The requirements included in the proposed delay are:
      i. Elements of the Quality Assurance and Performance Improvement (QAPI) program and required QAPI staff training and Compliance and Ethics program requirements as well as required Compliance and Ethics staff training
      ii. Specifically, the sections included in the proposed delay are:
         1. QAPI Program, §483.75
            a. (a)(1), (4): QAPI program and documentation
            b. (b)(1)-(4): Program Design and Scope

c. (c)(1)-(4): Program Feedback, Data Systems, and Monitoring
d. (d)(1)-(2): Program Systematic Analysis and Systematic Action
e. (e)(1)-(3): Program Activities
f. (f)(1)-(6): Governance and Leadership
g. (g)(1)(iv), (g)(2)(iii): Quality Assessment and Assurance
2. Compliance and Ethics Program, §483.80
a. 483.85(a)-(e): Compliance and Ethics Program
3. Training Requirements, §483.95
a. (d): QAPI Training
b. (f)(1)(2): Compliance and Ethics Training

4. As announced on November 22, CMS will not release IGs for the existing Phase 3 requirements until 2020. In the absence of IGs, survey forms, and training, it will be difficult for state agencies to survey and enforce the Phase 3 regulations, just as it is challenging for providers to fully implement them. **However, members need to make a good faith effort to implement the current Phase 3 regulations as written, especially in those areas that do not contain proposed changes.** For example, members should ensure they have an appropriately trained IP overseeing their infection prevention and control program, have begun to incorporate trauma-informed care principles into their care planning processes, and have taken steps to implement functional training, QAPI, and C&E programs that address the core requirements outlined in the regulations. In addition, facility-specific training, QAPI, and C&E programs are best practices that can help with compliance and quality in all areas. CMS has acknowledged that once the guidance is released, it will be necessary to allow a period of time for surveyors and providers to effectively understand and implement the guidance.

5. AHCA has resources to help members in all these areas. For more information, members should visit the dedicated [RoP page](#) on ahcancalED.
a. Examples of AHCA resources to help, include:
i. Compliance and Ethics (including a member Toolkit and webinar series)
ii. Infection Preventionist (a comprehensive certificate program)
iii. Trauma-informed care (Action Briefs and Webinars)
iv. Checklists for General Compliance (under Phase 3 Overview Materials)
v. General Resources to Support Compliance (including tools for responding to adverse events and managing resident to resident mistreatment)

Arbitration Regulation: What You Need to Know

• An arbitration agreement cannot be a condition of admission or continuation of care. The agreement must explicitly state this.

• An arbitration agreement must be explained in a form, language and manner that resident or his or her representative can understand.

• An agreement must provide for neutral arbitrator and venue to be agreed upon by both parties.

• The resident, or his or her representative, must have right to cancel the agreement within 30 days of signing.

• The agreement must not discourage the resident from communicating with federal, state or local officials.

• If a dispute is settled by arbitration, a copy of the signed agreement and the arbitration award must be kept for 5 years and be available for inspection by CMS.

Infection Prevention and Control: What You Need to Know

With recent reports of healthcare-associated infections (HAIs) in nursing homes, including Candida auris and adenovirus, CMS in this memo is reminding facilities of their responsibility for effective infection prevention and control programs to mitigate the onset and spread of infection. Basic principles include: appropriate hand hygiene, appropriate use of personal protective equipment, environmental cleaning and disinfection, implementation of transmission-based precautions when indicated, providing adequate surveillance and identification of resident diagnoses of infection or multidrug-resistant organism (MDRO) colonization status, including types of infections and causative agents present, and identifying and communicating, at the time of transfer to/from the facility the infection and/or MDRO colonization status so appropriate measures can be taken.

CMS is strongly encouraging the use of available technical resources, especially when novel organisms appear or outbreak occurs, and cites the Centers for Disease Control and Prevention with links to their website resources. For example, infection prevention and control information for C. auris is currently located here. Facilities must comply with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks.

The CMS memo identifies that establishing an effective antibiotic stewardship program is essential for reducing MDRO development. CMS has created a training entitled, "Development of an Antibiotic Stewardship Program for Nursing Home Providers" to support compliance and improve appropriate antibiotic usage. The training is for providers and surveyors and can be found on the Integrated Surveyor Training website at https://surveyortraining.cms.hhs.gov starting December 2, 2019. Lastly, CMS has updated the "Nursing Home Infection Control Worksheet" (ICWS) which is a voluntary

self-assessment tool for facilities to use to improve infection control and prevention. The update includes specific questions about water management efforts to reduce the risk of Legionella infections. This training will also be available starting December 2, 2019 at https://surveyortraining.cms.hhs.gov.

We encourage members to take advantage of AHCA's Infection Preventionist Specialized Training (IPCO), which provides detailed, interactive training and certification on essential components of effective infection prevention and control, including antibiotic stewardship. All centers must have an Infection Preventionist to oversee their infection prevention and control program as of November 28, 2019. Recent HAI outbreaks underscore the critical importance of effective infection prevention and control systems and practices.

Should you have any questions, please contact regulatory@ahca.org.