Dear Dr. Jeff:
The administrator at our facility informed me that there are “hundreds of pages” of new “COPs” that have just been announced, and that I need to familiarize myself with them and adjust our practices accordingly. I am not sure what a COP is. I looked at the new rules through a computer link, but reading them doesn’t seem helpful, and eventually my eyes begin to cross. What do you suggest?

Dr. Jeff responds:
The Conditions of Participation (COP) are the federal requirements to participate in the Medicare and Medicaid programs. This is simply another way of referring to the regulations that govern virtually every skilled nursing facility, because without these reimbursement programs very few facilities could survive financially.

The answer to the mystery of why the major reorganization of regulations occurred as a feature of a budget bill (Omnibus Budget Reconciliation Act of 1987) is that federal control of nursing homes is exercised through its funding mechanisms, not by public health rules. State surveyors visit facilities to confirm for the federal government that those authorized to bill these federal insurance programs are in substantial compliance with the COP. Their salaries are funded by the federal government, and, as many have experienced, their surveys are periodically double-checked by federal surveyors who also can perform facility surveys and identify deficiencies.

In essence, federal and state oversight of nursing homes is one complex interlocking process governed by the COP. Their salaries are funded by the federal government, and, as many have experienced, their surveys are periodically double-checked by federal surveyors who also can perform facility surveys and identify deficiencies.

Arbitration and Liability
The change that has received the greatest attention from popular media is a new requirement in the ROP forbidding all pre-dispute binding arbitration agreements for nursing home admissions after November 2016. Arbitration agreements have been common albeit not universal, and they cover disputes between residents (and/or their representatives) and facilities. They require disputes be settled by professional arbitrators rather than through the courts. Arbitrators are theoretically neutral individuals, but their decisions have tended to be unfavorable to individuals, and their settlements are not available for public scrutiny. Nothing prevents parties from voluntarily submitting claims to arbitration, but the law courts will now be open as an alternative.

Welcome Changes
One particularly well-received clarification in the ROP concerns authorization for nurse practitioners and physician assistants to order radiology and laboratory tests. Most states include this function within their scope of practice, so this will remove an irrational barrier that has limited the ability of trained professionals to provide appropriate care and delayed patient access to needed diagnostic tests.

An important addition is the inclusion of respiratory therapy among restorative therapies for SNF residents. Recognition of the role respiratory therapists can play in the management and recovery of these patients is a significant advance.

As COPs change, so will the role of the consulting pharmacist. In facilities that use computerized chart review by the consulting pharmacist, prewritten orders to sign, particularly receiving recommendations that must be transcribed onto order sheets or even prewritten orders to sign, particularly for complex orders such as tube feedings or specific therapy modalities. Although the new regulation will eliminate the delay between the observed need for orders and their actual signature and implementation — and remove from practitioners an annoying paperwork task — they do raise a potential risk in the management of complex patients, such as unstable diabetics or those with uncontrolled pain symptoms. The facility should examine communication processes to ensure that practitioners are aware of any changes and that coordination occurs. Some of us may elect not to delegate these tasks.

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pharmacy orders but lack a formal electronic health record system, these reviews will now have to be performed on site. Moreover, reviews will need to be performed upon admission and when there is a change of condition or a possible adverse drug effect.

**Medication Management**

Psychoactive medications are defined as those affecting mood or behavior or cognition. New language in the ROP expands the prior regulations aimed at curbing the use of antipsychotic medications (often incorrectly called “psychotropic”) to all psychoactive medications, potentially including a wide variety of medications not previously reviewed. “Psychoactive” is not a recognized pharmacologic category, and indeed any drug that crosses the blood-brain barrier can potentially affect mood or cognition. For example, all centrally acting antihypertensives have potential effects on mood or cognition. The primary mechanism of action for opioids is to interrupt pathways between the sensation of pain and the emotional reaction to that sensation. In the proposed rule, opioids were considered under this definition of psychoactive medications, but CMS removed them based on comments from the Society and others. Every medication with anticholinergic properties, which includes half the medications in the pharmacopeia, has the potential to decrease memory and cognitive function. These include many medications used for the management of common illnesses in the elderly, such as furosemide, warfarin, nifedipine, amantadine, and ranitidine.

Clearly, there will need to be clarification as to the intention and implementation of these regulations. This will probably come through the **Guidance to Surveyors** (a handbook for surveyors that is publicly available). Under the best scenario, this will lead to a decrease in polypharmacy and the use of inappropriate medications for individuals with dementia. The Society has already tried to encourage improved prescribing practices (e.g., “prescribing wisely” recommendations can be found here: www.paltc.org/choosing-wisely). Certainly, residents with declining cognitive function or apparent excessive sedation will now be reviewed for the potential effects these medications may cause. The increased role for review of dementia care in the new survey process as well as the preexisting campaign to decrease the use of antipsychotics in residents with dementia will all tie into these new regulations. Residents with declining cognitive function or apparent excessive sedation will now be reviewed for the potential effects these medications may cause. The increased role for review of dementia care in the new survey process as well as the preexisting campaign to decrease the use of antipsychotics in residents with dementia will all tie into these new regulations. Clinicians who have attempted to circumvent antipsychotic regulations through the use of medications from other categories, such as sedating antidepressants, “mood stabilizers,” or reformulated cough suppressants, will have to subject their practices to greater scrutiny. Increased collaboration with consulting pharmacists will be required to avoid deficiency citations.

Medical directors will have to be notified of all potentially unnecessary drugs being used in the facility, which will probably play a greater role in appropriate prescribing. Unnecessary drugs are defined by CMS as those given in excessive doses (including duplicate therapy), for excessive duration, without adequate monitoring, without adequate indications for their use, or in the presence of adverse consequences.

There are other changes buried in these new requirements. These include requirements for the addition of certified nursing assistants as members of the interdisciplinary team, new regulations regarding food service directors, new educational qualifications for social workers, and further clarifications of the Quality Assurance/Performance Improvement requirements already in effect. If you have concerns or questions regarding the requirements, I would not advise you to try to resolve them by yourself. All the major national organizations—including provider organizations as well as organizations for long-term care professionals—will be monitoring the process from regulation to actual implementation on the ground.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.