OFFICE OF THE CHIEF EXECUTIVE OFFICER
750 First Street NE, Suite 800, Washington, DC 20002-4241
202.408.8600 » FAX 202.336.8331 » amcclain@naswdc.org » SocialWorkers.org

NASW
National Association of Social Workers

Angelo McClain, PhD, LICSW
Chief Executive Officer

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Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3260-P
P.O. Box 8010
Baltimore, MD 21244

Transmitted via electronic submission

Dear Acting Administrator Slavitt:

The National Association of Social Workers (NASW) appreciates the opportunity to comment on the proposed rule, "Medicare and Medicaid Program; Reform of Requirements for Long-Term Care Facilities," 80 Fed. Reg. 42167 (proposed July 16, 2015). With 132,000 members, NASW is the largest membership organization of professional social workers in the United States. The association works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.

NASW commends the Centers for Medicare & Medicaid Services (CMS) on its reevaluation and proposed revision of the requirement for long-term care (LTC) facilities. We believe many of the proposed revisions reflect changes needed to improve the quality of life, care, and services in LTC facilities. NASW especially supports CMS's intent in emphasizing person-centeredness throughout the proposed rule. At the same time, we offer recommendations—especially those related to social work roles and staffing—that we believe would enhance resident choice, safety, and health outcomes.

§ 483.5, Definitions

NASW supports the proposed definitions for abuse, exploitation, misappropriation of resident property, neglect, and sexual abuse. We also support the "person-centered care" definition, which we believe could be strengthened by adding a concept from a recent National Quality Forum report: "The term also implies that the relationship between residents and providers is

one of a collaborative partnership" (National Quality Forum, 2014, p. 18). Furthermore, NASW supports the definition of "resident representative" and changes made throughout the regulations to integrate this term. Finally, we affirm CMS's highlighting of equal treatment for same-sex spouses who serve as resident representatives and the agency's corresponding changes supporting same-sex spouses throughout the proposed rule.

§ 483.10, Resident Rights

NASW is concerned that CMS's proposed restructuring of this section is not in the best interest of residents. Many important resident rights have been moved from the current Resident Rights section to the new Facility Responsibilities section (483.11). At the same time, many rights CMS proposes to move to § 483.11 are no longer listed in § 483.10. Residents, families, and advocates look to the resident rights language to understand residents' rights. Moreover, state laws governing nursing facilities often incorporate federally mandated resident rights. If the federal rights that have been added to the proposed § 483.11 are no longer denoted as resident rights, they might not be incorporated within state laws, which would undermine protections extended to nursing facility residents. Thus, it is essential that the section addressing resident rights be comprehensive. To achieve this aim, NASW recommends that CMS rewrite § 483.10 to include rights currently listed in § 483.11.

NASW's comments on specific provisions within § 483.10 follow.

- § 483.10(a), Exercise of rights. NASW supports new language proposed in subsections (a)(2) through (4). We especially support the resident's right to participate in the care planning and implementation process, as designated in subsection (a)(4)(iv).

- § 483.10(b), Planning and implementing care. NASW supports many of the revisions to this section. We suggest the following change to subsection (b)(5)(v): "The right to *read and obtain a printed or electronic* copy of the care plan . . ." Having a written copy of the care plan is as integral to resident participation in the planning process as it is to interdisciplinary team participation.

- § 483.10(d), Respect and dignity. NASW supports the changes in this section, especially the right to share a room with one's roommate of choice (subsection (d)(5)).

- § 483.10(e), Self-determination. Self-determination is the cornerstone of both social work practice and person-centered care. NASW supports the proposed revisions to subsections (e)(9) and (10). We also strongly support the visitation rights provision and agree with CMS that being able to receive visitors of the resident's choosing, at the time of the resident's choosing, is an essential element of self-determination. Because the facility is the resident's home, residents should have the same 24-hour access to visitors as do people who live in the community. Yet, NASW is concerned that this visitation right is eroded by CMS's proposal to allow limitations on visits from "other visitors" in

the Facilities Responsibility section. Please refer to our comments regarding § 483.11(d) for our recommendation on this issue.

- § 483.10(f), Access to information. NASW supports many of the changes in this section, especially to subsection (f)(2) and to subsections (f)(2)(iv) and (vi). We encourage retention of "State survey and certification agency" in subsection (f)(2)(ii).

  NASW also recommends a change to subsection (f)(3). Although current regulations give residents access to all their records, the proposed regulation would weaken residents' right to access their records by changing "all records" to "medical records." Moreover, the "cost-based fee" for the provision of copies—a fee that includes labor—could easily become prohibitively expensive, further limiting residents' right to their records. Thus, NASW recommends restoring the current rule language of "all records" and eliminating any fees for labor costs. NASW also recommends that residents have access to their records 24 hours a day, seven days a week. Residents may wish to review their records with family members, whose visits may occur more frequently on the weekend and holidays. NASW urges CMS to remove this requirement.

- § 483.10(g), Privacy and confidentiality. NASW supports the proposed revision to subsection (g)(1), which overlaps with subsection (h)(3).

- § 483.10(h), Communication, and § 483.10(j), Grievances. NASW support the changes in these sections.

§ 483.11, Facility Responsibilities

NASW supports the focus on respect for each resident's dignity, individuality, and rights within this section. At the same time, we are concerned that § 483.11 includes resident rights content that is not included in § 483.10. Please refer to our aforementioned comments on this issue.

- § 483.11(a), Exercise of rights. NASW supports the new concepts in subsections (a)(3) through (5).

- § 483.11(b), Planning and implementing care. NASW strongly supports CMS's proposal to involve the resident and resident representative in the care planning process. We recommend that subsection (b)(1)(i) be changed to read, "Facilitate the inclusion of the resident *and (with the resident's consent)* the resident representative(s)"; such inclusion should not be limited to the resident *or* the resident representative(s).

  NASW also strongly supports the involvement of the interdisciplinary team—including a social worker, nurse aide, and food and nutrition staff—in the care planning process, as specified in §§ 483.11(b)(2), 483.21(b)(2)(ii), and 483.21(c)(1)(iii). All three disciplines provide distinct services and bring valuable perspectives to the care planning process.

We are concerned, however, that CMS's estimate of one additional social work hour per week for care planning devoted to the facility's entire resident population is not realistic. Social workers can easily spend one hour a week on care planning with one resident.

- § 483.11(d), Self-determination. NASW supports the enhanced focus on resident self-determination. NASW notes an inconsistency between subsections (d)(1)(ii) and (d)(1)(iii): Relatives are not "subject to reasonable clinical and safety restrictions" in the way "others who are visiting with a resident" are. It is not clear if this distinction is intentional. If it is, we encourage CMS to reconsider this decision. Person-centered practice honors each resident's family of choice, regardless of legal relationship; such family may include not only the resident representative, a same-sex spouse, or a domestic partner (whether heterosexual or same-sex)—all of which are accounted for in the proposed regulation—but also friends and others who have a relationship with the resident. This distinction is inconsistent with the following provisions of the proposed rule:

    - 483.10(e)(3), which grants residents the right to receive the visitors of their choosing at the time of their choosing
    - 483.11(d)(2)(ii), which stipulates that residents be informed of the right to receive the visitors whom they designate
    - 483.11(d)(2)(iv), which requires facilities to "ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences."

  Even more significantly, such a restriction is not consistent with the Nursing Home Reform Act of 1986 (S. 2604, 1986), which passed as part of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). Thus, NASW recommends that CMS delete all references to "clinically necessary or reasonable restriction or limitation or safety restriction or limitation" and that the facility policies and procedures clearly state that residents have the right to 24-hour visitation by anyone they choose.

  NASW supports many of the new concepts and changes in § 483.11(d)(2) through (d)(6). In subsections (d)(6)(ii)(L)(1) and (L)(2), we encourage clarification of whether "health care provider" is intended to refer to the attending physician; the terms seem to be used interchangeably throughout the proposed rule.

- § 483.11(e), Information and communication. NASW supports the proposed changes to subsection (e)(4)(i). We note that the list does not match that listed in the corresponding § 483.10(f)(2)(ii), which omits Adult Protective Services (APS) and lists Aging and Disability Resource Centers rather than "home and community based service programs." We also note that the state survey and certification agency is included in § 483.11(e)(4)(i) and § 483.11(e)(12)(iii), but not in § 483.10(f)(2)(ii). We recommend consistency to facilitate facilities' adherence to all related requirements.

NASW recommends revision of § 483.11(e)(2) along the lines described in our comments addressing § 483.10(f)(3).

The association supports the addition of § 483.11(e)(7)(D)(ii), though we encourage clarification regarding whether "attending physician" is intended rather than any "physician." We also recommend that the phrase "or upon" be omitted from subsection (e)(9); it is essential for prospective residents and resident representatives to receive a notice of rights and services prior to admission, so that they can make informed decisions about choice of facility. NASW supports the addition of subsections (e)(11)(i) through (e)(11)(v), (e)(13), as well as the addition of APS to subsection (e)(12)(iii). We recommend adding "exploitation" to subsection (e)(12)(iv), consistent with incorporation of this concept in other proposed rule text addressing abuse and neglect.

NASW supports all the proposed revisions to subsection (e)(10). Timely information about Medicaid eligibility is essential to maximizing LTC affordability and residents' economic security. At the same time, we are concerned that CMS's estimate of 0.05 hour (three minutes) of social work time per resident to generate and convey post-admission (second) notices of Medicaid eligibility (subsection (e)(10)(i)) is too low. Other provisions of the rule emphasize the need to communicate information in a manner the resident understands. Meaningful communication of Medicaid eligibility, which includes explaining next steps and responding to inquiries, frequently requires additional time.

The association recommends that § 483.11(e)(11)(v) be changed to refer to all admission contracts, whether or not "required." Such a change would protect the federally guaranteed rights of residents who agree to any admissions contract, whether required or voluntary.

- § 483.11(f), Privacy and confidentiality. NASW supports the proposed changes to this provision. In subsection (f)(1), we suggest changing "verbal (meaning spoken)" to "oral," consistent with other provisions in both the current and proposed regulations.

- § 483.11(g), Safe environment. NASW supports the proposed additions to this provision.

- § 483.11(h), Grievances. NASW recommends that subsection (h)(1) be amended to read, "The facility must make information on how to file a grievance or complaint available to the resident *at the time of admission and upon request*, . . ." Similarly, we recommend that subsection (h)(3) be revised to read, "*At the time of admission and* upon request, the provider must give a copy of the grievance policy to the resident. *The policy must be communicated both orally and in writing, in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand.*" This language is consistent with § 483.11(e)(9)(i) and with other language used in the proposed rule.

The association also supports changes to subsection (h)(3). We recommend that the term "orally" be substituted for the phrase "verbally (meaning spoken)" in subsection (h)(3)(i). We also recommend that APS be added to subsection (h)(3)(i).

§ 483.12, Freedom From Abuse, Neglect, and Exploitation

NASW strongly supports the reframing of and lead-in to § 483.12, including the inclusion of "any physical or chemical restraint not required to treat the resident's medical symptoms," and other proposed revisions to this section. We recommend that "exploitation" be added to subsections (a)(2)(i) and (a)(2)(ii). We strongly recommend that subsections (a)(2)(ii) and (a)(2)(iii) be broadened to apply to abuse, neglect, exploitation, or misappropriation of property of any persons served in a nurse aide or other direct care worker role, not just to residents of the specific facility. We also recommend that this requirement be expanded to include all staff employed by the nursing facility. Thus, subsection (a)(2)(ii) would read, "Have had a finding entered into the State nurse aide registry or state licensure board concerning abuse, neglect, *exploitation,* mistreatment of *persons served*, or misappropriation of the property *of persons served*"; subsection (a)(2)(iii) would read, "Have had a disciplinary action taken against a professional license *or certification* by a state licensure body as a result of a finding of abuse, neglect, *exploitation,* mistreatment of *persons served*, or misappropriation of the property *of persons served*." Finally, we recommend that "his representative" be changed to "her or his resident representative" in subsection (b)(5)(iii)(c)(4).

§ 483.15, Transitions of Care

NASW strongly supports much of the content within this section and the reframing of "admissions, transfer, and discharge" as "transitions of care." At the same time, we are concerned that many of the provisions in this proposed section, provisions included in the current § 483.12, are no longer described as "rights." As described in our comments regarding § 483.10, such a change might limit residents, families, and advocates' understanding of and access to resident rights. We recommend that all content describing resident rights in § 483.15 be moved to § 483.10. Such a change would not preclude CMS cross referencing that content in § 483.15. Additionally, NASW offers the following comments on specific provisions within this section.

- § 483.15(a), Admissions policy. NASW strongly supports the addition of the word "request" in subsections (a)(2)(i), (ii), and (iii), as well as in subsections (a)(3). The provisions addressed in these subsections are objectionable whether they are phrased as a request or requirement, and residents might not be aware of the distinction and of their rights to refuse such "requests" when signing admissions contracts.

  The association also supports proposed subsection (a)(2)(iii), which prohibits waivers of a facility's liability for loss of personal property. Yet, we are concerned that such a

waiver is limited to residents' personal property. NASW recommends prohibition of all waivers of liability, whether they relate to loss of residents' property or inadequate care delivered by facility staff.

NASW is concerned about the phrase "at or" in subsection (a)(6). Disclosure of special characteristics or service limitations must occur prior to time of admission, or potential residents will not be able to make informed decisions regarding choice of facility. For example, some facilities don't accept residents who use pumps to administer pain medication—something a potential resident may need or may anticipate needing in the future. Others do not accept residents who use BiPAP machines on an ongoing basis, as is common in people with ALS. Yet, they may accept residents who use CPAP machines, and even those who use BiPAPs on an occasional, as-needed basis—and residents may not realize that they will need to move when they transition to regular BiPAP use. If potential residents do not learn of such limitations until time of admission, they may not have time to find an alternate facility, or the decision may be rushed.

Even if the phrase "at or" were to be deleted from subsection (a)(6), however, NASW is concerned that retention of the proposed subsection might imply that a facility could use this notice to diminish the standard of care established by federal and state law and to justify involuntary transfers and discharges for a purported inability to meet a resident's needs. The preamble of the proposed rule refers to a "more predictable" transfer if "the need for specific types of care or services later become necessary" and gives the example of notice that a facility could not care for residents needing "psychiatric care" (p. 42189). Yet, many persons, both inside and outside of nursing facilities, have psychiatric diagnoses, and the nursing facility regulations explicitly establish a nursing facility's duty to provide specialized services for residents with mental illness. Moreover, the Patient Self-Determination Act of 1990 (H.R. 5067/S. 1766), which passed as part of the Omnibus Reconciliation Act of 1990 (P.L. 101-508), already sets standards for service limitations based on conscience, and transfers based on acute care needs are addressed elsewhere in the proposed § 483.15. Thus, NASW is concerned that the proposed § 483.15(a)(6) might enable facilities to arrange for involuntary transfer or discharge of residents with mental health issues, rather than providing the care otherwise required under the Nursing Home Reform Act.

- § 483.15(b), Transfer and discharge. NASW supports prohibition of involuntary transfer or discharge while the resident's appeal is pending (subsection (b)(1)(iii)) and the proposed provision requiring copies of transfer or discharge notices be sent to the Long-Term Care Ombudsman Program (subsection (b)(3)(i)). We encourage CMS to delete the phrases "of the residents" and "or other responsible parties" in subsection (b)(8); both phrases are redundant and may create confusion. Moreover, similar to our previous comments, NASW wonders whether CMS's estimate of less than five minutes of social work time to update the transfer notice and provide it to each resident is realistic. Although such updating may, indeed, already happen informally, meaningful

communication with residents on a topic as important as transfer may take longer than the 0.08 hour allotted.

- § 483.15(c), Notice of bed-hold policy and readmission. NASW supports the proposed requirement that, in readmitting a hospitalized resident to the next available nursing facility bed, the resident should be readmitted to the previous room, if that room is available (subsection (c)(3)(i)). We recommend that CMS revise subsection (c)(3)(ii) to include instances in which a facility refuses to honor a bed hold. We also recommend that the regulation be revised to specify that a facility can refuse a bed hold or a readmission right only if (1) the resident's needs cannot be met in the facility, or the resident's presence in the facility would endanger others' safety or health and (2) the resident's condition does not allow for the facility to follow the standard notice procedures for involuntary transfers and discharges. Finally, NASW strongly recommends that the regulation specify that a resident has a right to appeal when denied rights under a bed hold or under the provision that provides readmission to the next available room.

§ 483.20, Resident Assessment

NASW suggests that CMS reconsider the wording of subsection (b)(1)(xviii); the phrase "direct care/direct access staff members" is not clear and may create confusion. In many facilities, the term "direct care staff" refers to workers such as nurse aides. CMS's intent—which NASW fully supports—seems to be that any staff member who provides services directly to a resident be included in the assessment process. Thus, the association suggests replacing "direct care/direct access staff members" with "staff members of all shifts who provide services directly to the resident."

§ 483.21, Comprehensive person-centered care planning

NASW strongly supports the creation of this section, which promotes collaboration with residents and resident representatives in all aspects of care planning and implementation. An interdisciplinary, person-centered biopsychosocial assessment should be the cornerstone of care and services. An ongoing collaborative assessment process helps residents and resident representatives to identify and prioritize residents' values, goals, strengths, and needs. With this information and support, residents and resident representatives are better equipped to make decisions about care and services.

Residents' needs and goals often change over time, sometimes rapidly. Professional care coordination helps residents and resident representatives to navigate such changes and to determine the care and services that best meet their needs and goals. Care coordination also facilitates communication among all members of the team (residents, resident representatives, direct care workers, and professional staff) and fosters continuity of services, especially during

care transitions between practitioners, settings, and service sectors. With their person-in-environment, strengths-based perspective, social workers play an integral role in assessment and care coordination with residents and resident representatives. The *NASW Standards for Social Work Case Management* (2013) and the *NASW Standards for Social Work Practice with Family Caregivers of Older Adults* (2010) both elaborate on the aforementioned concepts.

- § 483.21(a), Baseline care plans. NASW recommends that information about the resident's customary routines and preferences also be required as part of the baseline care plan.

- § 483.21(b), Comprehensive care plans. The association recommends that CMS add "and goals" to subsection (b)(1), consistent with § 483.20(b)(1). Comprehensive care plans should focus not only on resident needs, but also on resident goals. We recommend that the same change be made to subsection (b)(2)(ii)(G). We support other proposed changes to this provision, especially—as noted in our comments on § 483.11(b)—the addition of the social worker, nurse aide, and food and nutrition services staff to the interdisciplinary team that prepares the comprehensive care plan (§ 483.21 (b)(2)(ii)). We believe that subsection (b)(2)(ii)(F) could be even stronger in facilitating resident and resident representative involvement in the care planning process and, to this end, we recommend the following additions:

    - Facilities should be required to provide advance written notice of the date and time of the care plan meeting.
    - In scheduling the care plan meeting, the facility must make reasonable accommodation of the schedules of the resident, resident representative, or others invited at the resident's request.
    - The facility must arrange for conference calls or video conferencing, if necessary, to enable resident representatives or others invited by the resident to participate.

  NASW supports CMS's efforts to require facilities to provide culturally competent and trauma-informed care (§ 483.21(b)(3)(iii)). We encourage CMS to refer facilities to two documents for materials addressing these topics:

    - The Council on Social Work Education's (CSWE's)competencies on trauma-informed care (2012)
    - NASW's standards (2001) and indicators (2007b) for cultural competence in social work practice (these documents have been revised recently; a combined version will be available soon at http://www.socialworkers.org/practice/standards/index.asp)
    - The *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*, developed by the U.S. Department of Health and Human Services Office of Minority Health (2013).

NASW also recommends creation of a new subsection addressing advance care planning within § 483.21(b). This subsection should require facilities to engage in an ongoing process of advance care planning with residents. Such a process should include not only identification and (if needed) completion of advance directives, but also

- discussion of existing and new advance directives in the interdisciplinary care planning meeting
- education of the resident and resident representative regarding programs based on the National Physician Orders for Life-Sustaining Treatment (POLST) Paradigm and, if desired by the resident or resident representative, completion and updating of such forms (please refer to http://www.polst.org for additional information)
- education of the resident and resident representative regarding Do-Not-Resuscitate (DNR) and similar state-specific forms and, if desired by the resident, completion of such forms.

Effective advance care planning requires an individualized approach that reflects each resident's values and biopsychosocial context. Professional social workers play an integral role in advance care planning and, in collaboration with their interdisciplinary colleagues, are already leading such efforts in a variety of settings (Bern-Klug, 2012; Bomba, Morrissey, & Leven, 2011; Herman, 2013).

- § 483.21(c), Discharge planning. NASW strongly supports this new section. We encourage CMS to add "goals" to subsection (c)(1)(i), to read as follows: "Ensure that the discharge needs *and goals* of each resident are identified and result in the development of a discharge plan . . ." This suggested change is consistent with the Section Q of the revised Resident Assessment Instrument Minimum Data Set (MDS 3.0), which focuses on residents' ability *and desire* to return to the community. Moreover, NASW concurs with CMS that involvement of the social worker in the ongoing process of developing the discharge plan (subsection (c)(1)(iii)) is appropriate. We also support the concept of devoting social work time to reviewing and compiling standardized data to align with each resident's preferences and goals (subsection (c)(1)(vii)). Yet, we believe that Regulatory Impact Analysis estimate of one hour of social work staff time for this task is too low and should be increased to two hours per resident.

  Furthermore, NASW recommends that the capacity and willingness of caregivers/ support people not only be considered but also assessed when identifying discharge needs (subsection (c)(1)(iv)). Some caregivers may overestimate their ability to provide care; others, in contrast, may not wish to fulfill this role.

  NASW also recommends that the facility should be required to assist, if requested, with tasks necessary for relocation, such as making phone calls, packing, and obtaining prescriptions.

Finally, the association recommends that subsection (c)(1)(v) be revised to read, "Involve the resident and resident representative in the development of the discharge plan; inform the resident and resident representative*(s)* of the final plan *and provide a written copy of the document to them.*" We suggest that subsection (c)(1)(C)(ix) be revised to read, "Document, complete on a timely basis based on the resident's needs *and goals*, and include in the clinical record, the evaluation of the resident's needs, *goals,* and discharge plan. The results of the evaluation must be discussed with the resident *and* resident's representative*(s), who must be provided with a written copy of the document. . . .*" We also recommend that subsection (c)(2)(iv) be revised to read, "A post-discharge plan of care that is developed with the participation of the resident*, the resident representative(s)*, and, with the resident's consent, the resident's family *(as defined by the resident)*."

§ 483.25: Quality of Care and Quality of Life

NASW is concerned about CMS's proposal to combine the Quality of Care (current § 483.25) and Quality of Life (current § 483.15) sections. One of the groundbreaking aspects of the Nursing Home Reform Act has been that it entitles nursing home residents to quality of care *and* to quality of life. Never before—either in the pre–1987 nursing home regulations or in regulations for other health care settings—had quality of life featured so prominently in a law and been elevated to the same level of importance as quality of care.

Deleting the Quality of Life Requirement of Participation may send the message that resident quality of life is not essential. In the preamble, CMS argues that making care planning a stand-alone section raises its importance (p. 42192). It follows that the reverse is true: Eliminating a distinct section on Quality of Life reduces its importance. Such a move seems contrary to CMS's stated intent to promote person-centered care.

Also troubling is the fact that CMS has scattered the provisions included in the current Quality of Life section (483.15) throughout the proposed regulations. The requirement that a facility must maintain or enhance each resident's quality of life is under Facility Responsibilities (proposed § 483.11), and most of the other provisions are under Resident's Rights. The only provision remaining in the proposed Quality of Care and Quality of Life section is proposed § 483.25(c), activities. We recommend that Quality of Life be restored as its own section that includes language from self-determination (proposed § 483.11(e)), social services (proposed § 483.40(d)), and safe environment (proposed § 483.11(g)).

NASW also offers the following comments regarding specific provisions within § 483.25.

- § 483.25(a). We recommend that state-specific Do-Not-Resuscitate (DNR) forms, as well as forms based on the National POLST (Physician Orders for Life-Sustaining Treatment) Paradigm, be added to subsection (a)(3). As CMS has noted, adherence to a resident's advance directives is critical in emergency situations. Yet, advance directives may not

address DNR status and, if they do, are not recognized by the state in this regard the way DNR forms are. POLST forms (which are known by different names across states) may address specific care choices not included in advance directives and, unlike advance directives, are medical orders that must be followed.

- § 483.25(b), Activities of daily living. NASW supports the addition of oral care to subsection (b)(1).

- § 483.25(c), Activities. NASW supports the proposed revisions to subsection (c)(1).

- 483.25(d), Special care issues. NASW supports many of the proposed changes to this section, which promotes care consistent with professional standards of practice and residents' choices. The association recommends additional requirements related to restraints (subsection (d)(1)), especially the following resident protections before initiating restraint use with a resident:

    - The facility must conduct an environmental assessment.
    - The resident's physician must complete an in-person evaluation and determine that the benefits of restraint use—that is, the likelihood that restraint use will enable the resident to reach the highest practicable physical, mental, and psychosocial well-being—outweigh the risks to the resident. The physician must also write an order specifying the circumstances and duration for which the restraint is to be used. Restraint use may not be ordered on a standing or as-needed basis.
    - The facility must obtain written informed consent from the resident (or the resident representative).
    - The facility must establish a system for regular one-on-one monitoring of residents with whom restraints are used. Such a system must include discontinuation of restraints as quickly as possible.

  NASW also recommends that the proposed requirements related to bed rails (§ 483.25(d)(2)) be strengthened. CMS currently defines bed rails as physical restraints when they prevent a resident from getting out of bed voluntarily. Although some residents use bed rails to reposition themselves in bed or assist them when getting out of bed, for physically frail residents—especially those with dementia or delirium—the risks of serious injuries and death from falls or entrapment, entanglement, and asphyxiation contradict claims that bed rails enhance safety. Alternatives such as lowered beds and padding on the floor provide better protection from fall-related injuries than do bed rails. Thus, NASW supports CMS's proposed language to improve protection of residents from bed rail injuries through measures such as trying alternatives, assessing residents for entrapment risks, and regularly inspecting bed rail systems. We urge CMS to strengthen the proposed regulations by

    - specifying residents' right to be free of bed rails used as restraints

- mandating that bed rails can only be used if the resident requests them for mobility or other assistance
- requiring that a safety assessment be conducted before bed rails are used. Such an assessment must be conducted protocols that require an evaluation of residents and bed systems by an interdisciplinary team that includes a registered nurse, physician, licensed therapist, or other appropriate professional staff.

§ 483.35, Nursing Services

Consistent with NASW's support (Schakowsky, 2015) for the Put a Nurse in the Nursing Home Act (H.R. 952), we maintain that every facility should have a registered nurse (RN) on site for the purposes of providing direct resident care at all times. Thus, we strongly recommend that subsection (b)(1) be revised to read, "The facility must use the services of a registered nurse *24 hours a day*, 7 days a week." Similarly, we recommend that the phrase "Except when waived under paragraph (c) or (d) of this section" in subsections (a)(2) and (b)(2) be deleted, along with all of subsections (e) and (f). NASW also recommends that CMS incorporate minimum staffing standards for both nurses (RNs, licensed practical nurses, and licensed vocational nurses) and direct care workers; the proposed requirement calling for "sufficient nursing staff with the appropriate competencies and skills sets" (p. 42260) is both vague and ambiguous.

§ 483.40, Behavioral Health Services

Access to mental and behavioral health services is a major concern for facility residents. Consequently, NASW supports wholeheartedly the creation of this new section. We recommend that it be retitled "Mental and Behavioral Health Services"; although "behavioral health" is often used as a catch-all term, it is actually distinct from mental health and includes substance use disorders but not depression, anxiety, and so on. Moreover, because substance use disorders are an underaddressed and growing problem among older adults (and, potentially, other nursing home residents), we believe it is essential for CMS to specify such disorders within the regulations rather than using "mental illnesses and psychosocial disorders" as a catch-all term.

- § 483.40(a). Similar to our feedback on § 483.12(a)(2), "Direct care/direct access staff" may be interpreted only to mean direct care workers, which does not seem to be CMS's intent. Moreover, we recommend that social work is essential to realize the goal of subsection (a). Thus, NASW recommends that CMS reword the sentence to read, "The facility must have sufficient *staff who provide direct services to residents and* who have the appropriate competencies and skills to provide nursing*, social work, and other* services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being . . ." We recommend that subsection (a)(1) be revised to read, "Caring for residents with mental illnesses*, substance use disorders,* and *other* psychosocial *problems* . . ."

- NASW supports other proposed revisions to this section. In § 483.40(d), we recommend that the term "physical" be reinserted before "mental." Not only is the term included in § 483.40 and 483.40(a), but mental and psychosocial well-being affect physical well-being.

NASW also recommends that CMS strengthen requirements related to assessment of behavioral health and other psychosocial concerns. The Minimum Data Set (MDS) 3.0 evaluates only a fraction of residents' psychosocial and behavioral health concerns—behavior, cognition, mood, and preferences for routines and activities—but does not address many other concerns, such as emotional adjustment, financial needs, and social support. Thus, NASW recommends that CMS require that a comprehensive psychosocial assessment and social history be completed upon admission (§ 483.21(b)), with the assessment portion updated annually or when significant changes in the resident's health or behavioral health occur. NASW also recommends that CMS specify that care plans must directly address psychosocial and behavioral needs identified through interdisciplinary staff assessments, social histories, and applicable sections of the MDS and associated Care Area Assessments.

NASW is also concerned that limited SNF resident access to clinical social workers poses a significant barrier to facilities' ability to meet residents' mental and behavioral health needs as identified in proposed § 483.40. We recommend that CMS use the current rulemaking process to address this problem. Clinical social workers have a master's or doctoral degree in social work, at least two years' of post-degree supervised experience in a clinical setting, and a state-issued clinical social work license, certification, or registration. The Health Resources and Services Administration recognizes social work as one of five core mental health professions (Heisler & Bagalman, 2015). Some SNFs and NFs employ clinical social workers to provide medical social services to residents. This staffing pattern can certainly contribute to staff identification of and response to residents' mental and behavioral health concerns. Yet, psychotherapeutic diagnosis and treatment is not included in the services covered by the SNF Part A resource utilization group payment. Even if such services were included in the per-diem payment, many clinical social workers employed in a social services capacity would not have the time or flexibility to provide the mental health services some residents would require.

Thus, many LTC facilities contract with Medicare-certified independent practitioners to provide mental and behavioral health services to nursing home residents. Medicare Part B reimburses clinical social workers as licensed independent practitioners for the diagnosis and treatment of mental illness (Scope of Medicare Benefits, 1998). Before the year 2002, independent clinical social workers could be reimbursed under Part B for services provided to both SNF and NF residents. Since that time, however, clinical social work services have only been reimbursable under Medicare Part B if the nursing home resident is *not* receiving SNF benefits under Medicare Part A. NASW believes that CMS's implementation of the requirements established by the Balanced Budget Act of 1997 (P.L. 105-33), which bundled all social work services in the per-diem SNF payment (§ 4432), has failed to distinguish between medical social services provided to all SNF residents and discretionary psychotherapeutic services provided by clinical social workers to residents with specialized needs—a distinction NASW articulated to the

Health Care Finance Administration (HCFA) and to CMS from as early as 1990 (S. Harding, personal communication, April 17, 1990), following the passage of the Omnibus Reconciliation Act of 1989 (P.L. 101-239).

This revocation of clinical social workers' ability to bill Medicare Part B for psychotherapeutic services to SNF residents contrasts with privileges retained by psychiatrists and psychologists, whose services are not bundled in the SNF per-diem rate. Yet, clinical social workers are more plentiful than any other mental health professionals in the United States (Heisler & Bagalman, 2015). Thus, limiting SNF residents' access to clinical social workers limits SNF residents' access to essential mental health services. This limitation also disrupts continuity of care for Medicare beneficiaries who transfer from a setting, such as home or assisted living, where they receive mental health services from a clinical social worker, to a SNF, where they cannot receive such services. Such a gap in care can even occur within the same LTC facility when a beneficiary transitions from NF to SNF care.

In 2000, following repeated communication between NASW and HCFA, HCFA issued a proposed rule that would restore Medicare Part B reimbursement to clinical social workers for psychotherapy services provided to SNF residents (Medicare Program, 2000). In the proposed rule, CMS asserted "that it is appropriate to draw a distinction between a set of services that the SNF certification standards require social workers to furnish (and which, thus, fall outside the scope of the clinical social worker benefit) and other services (which remain coverable under the clinical social worker benefit)" (Medicare Program, 2000, p. 62682). This rule did not take effect. Two years later, CMS reprinted the HCFA proposal to allow clinical social workers to bill for psychotherapy services furnished to SNF residents (Medicare Program, 2002). Six months later, CMS stated, "Upon further review, we have determined that we will not include this issue in this final rule, but will address it in future rulemaking" (Medicare Program, 2003, p. 79987). Such follow-up has yet to occur.

For years, NASW has pursued legislation to correct the problem. (Please refer to the Improving Access to Mental Health Act of 2015 [H.R. 3712/S. 2173, 2015], recently introduced by Senator Debbie Stabenow (D-MI), Senator Barbara Mikulski (D-MD), and Representative Barbara Lee (D-CA), for additional information.) Recently, NASW leadership met again with CMS to discuss the issue. We believe the current rulemaking process affords CMS an ideal opportunity to rectify this limitation on clinical social worker reimbursement. Doing so would eliminate a long-standing access issue for Medicare beneficiaries and would contribute to the realization of the new requirements in the current proposed rule. Action on this issue may also reduce costs to both beneficiaries and the Medicare program by helping to prevent unnecessary transfers to the emergency department or psychiatric hospital, as well as to decrease avoidable rehospitalizations related to mental and behavioral health.

§ 483.45: Pharmacy Services

NASW supports the proposed changes to § 483.45(c)(2), (c)(3), and (c)(4). We also support the broadening of provision (e) to address all psychotropic drugs rather than antipsychotic drugs alone. We applaud CMS's recognition of the role of behavioral interventions as a complement to or replacement for pharmacy services in subsection (e)(2).

However, NASW is concerned that neither proposed § 483.45(d) nor § 483.10(d) includes sufficient protections against the use of antipsychotic medications as chemical restraints. The right to be free from chemical restraints is a central tenet of the Nursing Home Reform Act. Therefore, the association recommends that CMS establish new provisions that address the following issues:

- Establish a presumption that chemical restraint is harmful to residents.
- Require physicians to conduct an in-person evaluation of the resident before prescribing antipsychotic drugs and to justify that the potential benefits clearly outweigh the potential harmful effects.
- Require written informed consent from the resident or resident representative before initiating use of psychotropic drugs.
- Require consultant pharmacists to be free of conflicts that might compromise their ability to provide unbiased information.

Professional social workers play integral roles in such behavioral interventions. Please refer to NASW's preceding comments regarding clinical social worker access (§ 483.40) and our subsequent comments regarding social worker qualifications and staffing (§ 483.70) for additional recommendations related to § 483.45.

§ 483.60: Food and Nutrition Services

NASW supports the enhanced focus on resident preferences, assessment, and care planning throughout this section, as well as the addition of "drinks" to the requirements.

§ 483.65: Specialized Rehabilitative Services

NASW supports the addition of respiratory therapy to this section.

§ 483.70: Administration

- NASW supports the proposed changes to § 483.70(d) and (e), addressing the governing body and facility assessment.

- § 483.70(f), Staff qualifications. NASW strongly supports retention of the requirement that professional staff be licensed, certified, or registered in accordance with applicable state laws (subsection (f)(2)). Such regulation helps to ensure competence and provides consumers with recourse if practitioners do not adhere to professional standards of practice (Association of Social Work Boards, 2013).

  At the same time, NASW notes that 14 states (CA, CO, CT, DE, FL, GA, IL, MT, NH, NY, RI, VT, WA, and WY) do not license social workers with bachelor's degrees (BSWs) (Association of Social Work Boards, 2015). We urge CMS to recognize this reality and to allow unlicensed BSWs who otherwise meet qualifications to be able to practice in SNFs and NFs in those 14 states only. In keeping with our comments on social worker qualifications, below, we recommend that this exemption *not* be extended to people with bachelor's degrees in gerontology, psychology, rehabilitation counseling, sociology, special education, or any discipline other than social work.

- § 483.70(j), Transfer agreement. NASW supports the proposed changes to this provision.

- § 483.70(n), Binding arbitration agreements. NASW is concerned that the proposed language could undermine residents' rights. Predispute arbitration agreements, even if signed voluntarily, preclude informed decision making by residents. Residents who sign predispute arbitration agreements often have no idea the critical, even fatal, problems that may arise in care. They also may not comprehend that by signing a predispute arbitration agreement, they forfeit their right to bring any claim against a facility in court. Thus, NASW strongly recommends that the proposed language of § 483.70(n) be deleted and replaced with this language: "*A facility may not enter into a pre-dispute agreement for binding arbitration with its residents."* Such language would allow facilities to offer arbitration as an option after a dispute arises, and for residents to choose this option.

- § 483.70(o), Hospice services. NASW's policy statement on hospice care calls for "availability of hospice care across health, home, and community-based settings" (NASW, 2015b, p. 169). Similarly, our policy statement on end-of-life decision making and care calls for "equitable access to affordable, comprehensive, person- and family centered services, including palliative and hospice care, to maximize physical, psychological, social, and spiritual quality of life . . . [and] continuity of care across service settings" (NASW, 2015a, p. 104). Thus, we are concerned that § 483.70(o)(1)(ii) enables LTC facilities to "not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice." We understand that a resident cannot use both the SNF and hospice benefits at once and that SNF discharge may be needed for a resident to access hospice. This situation does not seem to be the intent of the requirement, however. Moreover, although a facility may assist the resident in transferring to a facility that will arrange for the provision of hospice services, as stated in the requirement, such a transfer disrupts a resident's care at a critical juncture. Care cannot be person centered, and a LTC facility cannot be

considered a resident's home, if the resident is not able to access the services of a Medicare-certified hospice. Thus, NASW urges CMS to delete subsection (o)(1)(ii).

- § 483.70(p), Social worker. NASW's policy statement on long-term services and supports calls for "access to professional social work services in all settings, regardless of medical diagnosis, payer, or involvement of other disciplines throughout the long-term care spectrum" (NASW, 2015c, p. 210). NASW has long maintained that all nursing home residents deserve high-quality psychosocial care provided by a professional social worker—defined by the *NASW Standards for Social Work Services in Long-Term Care Facilities* (2003) as someone with a bachelor's (or advanced) degree in social work from a program accredited by the CSWE.[1]

  CSWE-accredited programs provide competency-based education that integrates and applies knowledge, skills, and values. The CSWE *Educational Policy and Accreditation Standards* (EPAS, 2015) are based on the following nine competencies and component behaviors:

  1. Demonstrate ethical and professional behavior
  2. Engage diversity and difference in practice
  3. Advance human rights and social, economic, and environmental justice
  4. Engage in practice-informed research and research-informed practice
  5. Engage in policy practice
  6. Engage with individuals, families, groups, organizations, and communities
  7. Assess individuals, families, groups, organizations, and communities
  8. Intervene with individuals, families, groups, organizations, and communities
  9. Evaluate practice with individuals, families, groups, organizations, and communities. (CSWE, 2015b, p. 8)

  These competencies are congruent with the competency-based emphasis of the proposed rule. Furthermore, each CSWE-accredited program includes field placement (one for BSW programs and two for MSW programs). These field placements, supervised by professional social workers, enable students to integrate knowledge, theory, and skills in practice (CSWE, 2015a). Field placements also provide a rich context for the assessment of student learning outcomes that is integral to competency-based education (CSWE, 2015b).

[1] Generally speaking, social workers are referred to as BSWs or MSWs, although some variation exists in social work degrees. For example, a BSW may hold a bachelor of social work, bachelor of arts with a major in social work, or bachelor of science with a major in social work (NASW, 2007a). Similarly, MSWs may hold a Master of Science in Social Work, Master of Social Service, or Master of Arts degree (CSWE, 2015a). In each case, however, the degree program must be accredited by CSWE to be considered a professional social work program.

NASW has long been concerned that CMS recognizes degrees in psychology, rehabilitation counseling, sociology, special education, and other "human services" fields as sufficient preparation for nursing home social work. We are equally concerned that some states do not even meet this federal requirement (Bern-Klug, 2008) and that federal requirements are not enforced consistently. For example, a national study of 1,071 social services directors employed in Medicaid- or Medicare-certified nursing homes found that 20 percent of social services directors did not even have a bachelor's degree, let alone one in social work (50 percent held a BSW)—and a study of social services staff who are not directors might reveal even more staff who do not meet federal requirements (Bern-Klug, Kramer, Chan, Kane, Dorfman, & Saunders, 2009). In contrast, another study found that 20 states exceeded federal regulations for nursing home social services staffing—defined "on the basis of requiring higher staffing levels (full time equivalents [FTEs] or ratios of qualified social services providers to residents), or by requiring higher credentials for any social services provider, qualified or not" (Zhang, Gammonley, Paek, & Frahm, 2008–2009, p. 10). Zhang et al. found the following association between psychosocial care quality and staffing exceeding federal regulations: "The greater the number of qualified social services and mental health services staff the higher the likelihood of quality psychosocial care" (p. 13).

The deprofessionalization of nursing home social work has become even more problematic since the introduction of the enhanced psychosocial screening requirements in MDS 3.0 (Simons et al., 2012; Zimmerman, Connolly, Zlotnik, Bern-Klug, & Cohen, 2012). All BSWs and MSWs, regardless of specialization, receive training in interviewing and psychosocial assessment, care planning, and intervention. As such, social workers possess the knowledge and skills to conduct psychosocial interviews (although they may require training to learn the specifics of how to use PHQ-9 or other tools required in MDS 3.0) and to determine when residents' responses warrant additional evaluation and services. On the other hand, paraprofessional social services staff members who lack social work education—including, from NASW's perspective, people with degrees in gerontology or with a bachelor's or master's degree in any discipline but social work—may not be adequately prepared to identify and address psychosocial issues (Bern-Klug et al., 2009; Simons, Bern-Klug, & An, 2012).

The enhanced requirements within the proposed rule further underscore Medicaid and Medicare beneficiaries' need for professional social work services. BSWs and MSWs are well prepared to fulfill the proposed requirements for LTC facilities:

- promoting quality of life for all residents (§ 483.25)
- advocating for residents' rights and helping facilities to uphold those rights (§§ 483.10 and 483.11)
- preventing and addressing abuse, neglect, and exploitation of older adults and other nursing home residents (§ 483.12) (Bern-Klug & Sabri, 2012; Bonifas, 2015)
- conducting biopsychosocial assessments and contributing to ongoing care planning (§§ 483.20 and 483.21)

- facilitating transitions of care and discharge planning (§§ 483.15 and 483.20) (Altfeld et al., 2013)
- assessing the need for, supporting, or providing mental and behavioral health interventions, including personalized practices to complement or replace psychotropic drugs (§§ 483.40 and 483.45) (roles may vary based on level of social work education and licensure; however, one national study demonstrated that social services departments headed by directors with BSWs or MSWs were significantly more likely to screen residents for depression than were social services departments headed by staff without BSWs or MSWs [Bern-Klug, Kramer, & Sharr, 2010])
- helping to identify cultural and other psychosocial factors that may influence resident choices related to daily living, including food and nutrition (§ 483.60)
- participating in quality assurance and performance improvement efforts (§ 483.75)
- identifying and responding to ethical issues (§ 483.85)
- recognizing and addressing environmental concerns (§ 483.90)
- helping to train their colleagues in a variety of topics (§ 483.95).

Professional social workers are also equipped to fulfill other responsibilities that complement the LTC facility requirements:

- providing individual, family, and group education and counseling related to illness, disability, treatment, interpersonal relationships, grief, loss, dying, and death
- facilitating financial and medical decision making, including advance care planning
- strengthening communication among residents, families, and facility staff
- participating in facility planning and policy development to promote optimal quality of life
- promoting facility–community interaction. (NASW, 2003)

Thus, NASW strongly recommends that CMS modify the definition of a "qualified social worker" (§ 483.70(p)(1)) in the following manner: "An individual with a minimum of a *bachelor's or master's degree in social work*." We oppose the inclusion of other "human service" fields, including gerontology, as sufficient preparation for nursing home social work, and we oppose use of the term "social worker" to apply to anyone who does not have a baccalaureate, master's, or doctoral degree in social work. (Erroneous use of the term on the federal level is especially problematic in states in which the term "social worker" is defined by title protection laws, thereby creating confusion for consumers and facilities alike.) Furthermore, NASW supports retention of the requirement of at least one year of supervised social work experience working directly with individuals in a health care setting (§ 483.70(p)(2)). Both recommendations are consistent with the association's 2012 letter to CMS regarding the LTC Conditions of Participation (Clark, 2012).

At the same time, NASW recognizes that experience varies among BSWs and MSWs and within each group and that professional development is an ongoing process for every discipline and all nursing home staff. At least one study suggests that "practitioners with more experience providing SNF social services may have a stronger capacity to provide quality psychosocial care in collaboration with their facility colleagues" than practitioners with less experience (Bonifas, 2011). Thus, we recommend that LTC facilities provide expert social work consultation to social work directors, especially those who are recently graduated BSWs and MSWs, to ensure that residents receive high-quality psychosocial care. Such consultation should address practice, administrative, and organizational issues, along with program planning and professional development. The consultant may also provide consultation to facility administration and staff regarding program planning, policy development, and priority setting related to social work services; case consultation regarding the psychosocial needs of residents and families; and in-service education on selected topics, as described in NASW's comments on proposed § 483.95.

NASW also recognizes that some LTC facilities may decide to retain or hire such paraprofessional social services staff to help fulfill administrative functions (such as completing financial paperwork) and to meet instrumental needs of residents (such as arranging appointments or locating lost items) (Simons, Bern-Klug, & An, 2012). NASW strongly recommends that such personnel be referred to as "social services assistants" and that they be supervised directly by staff with a BSW or MSW. Moreover, because such social services assistants do not meet NASW's recommended definition of "qualified social workers," they should not count toward a facility's minimum social work staffing ratios, which we address next.

Meeting the goals of both MDS 3.0 and the proposed rule requires not only professional social workers, but also an adequate ratio of social workers to residents. Long before the advent of MDS 3.0, practitioners, researchers, and policymakers had raised the question of caseload manageability for nursing home social services staff. An investigation by the Office of the Inspector General (OIG) found that more than one-third of nursing home residents with identified psychosocial needs had inadequate care plans, and almost half of those with care plans did not receive all planned services (U.S. Department of Health & Human Services Office of Inspector General, 2003). Moreover, although almost all facilities reviewed in the OIG investigation had complied with or exceeded federal staffing regulations, 45 percent of social services staff reported that barriers such as lack of time, burdensome paperwork, and insufficient staffing decreased their ability to provide comprehensive psychosocial services. A more recent OIG report found that skilled nursing facilities often failed to meet Medicare requirements for care planning and discharge planning; failure to address psychosocial needs was among the problems cited in the report (U.S. Department of Health & Human Services Office of Inspector General, 2013). Research has indicated that the 121:1 social services staff-to-resident ratio is insufficient to meet the psychosocial needs of nursing home residents (Bern-Klug, Kramer, Sharr, & Cruz, 2010; Bonifas, 2011); two other

studies indicate that large social services caseloads were associated with survey inspection deficiencies in psychosocial care (Bonifas, 2008–2009; Zhang et al., 2008–2009).

The implementation of MDS 3.0 increased the urgency of the staffing ratio question. Although the national trial indicated that MDS 3.0 took much less time to complete than MDS 2.0 (Saliba & Buchanan, 2008), NASW members have reported anecdotally that the new MDS requirements have increased their workload and affected the quantity and quality of other psychosocial services they are able to provide—a reality anticipated in professionally facilitated focus groups of nursing home administrators and social services staff at the launch of MDS 3.0 (Connolly, Downes, Fogler, & Reuter, 2010) and borne out in follow-up interviews with social service staff and nurses more than a year after MDS 3.0 implementation (Connolly, Downes, & Reuter, 2012). Implementing the Section Q "return to community" requirements has required additional social work staff time, as anticipated during the 2010 focus groups (Connolly et al., 2010). Moreover, MDS 3.0's incorporation of resident interviews and more reliable, valid assessment measures has resulted in increased identification of residents' mental health concerns, such as suicidal ideation (Connolly et al., 2012). This finding is consistent with the pre–MDS 3.0 assertion that "staff and family observations of depressed mood and pain significantly *underestimate* the presence of these treatable conditions" (Saliba & Buchanan, 2008, p. 4). Responding to those needs, whether through direct intervention or external referral for clinical mental and behavioral health services, is generally the responsibility of nursing home social services staff. Yet, high caseloads often preclude meeting residents' identified psychosocial needs identified in the MDS 3.0 (Simons et al., 2012).

NASW wholeheartedly applauds the strengthened psychosocial requirements within the proposed rule (especially those related to transitions of care, resident assessment, comprehensive person-centered care planning, quality of care and quality of life, behavioral health services, and pharmacy services). These proposed changes expand upon the progress of MDS 3.0 and make reconsideration of the social services staffing ratio even more crucial. We are concerned that facilities will not be able to meet the proposed requirements without increasing the social worker–resident ratio. Thus, the association reiterates its long-standing recommendation (included in Clark, 2012, and NASW, 2015d, 2015e) that CMS decrease the 121:1 ratio. Specifically, we recommend that CMS require at least one full-time social worker (as defined previously) in every LTC facility, regardless of size. Thus, § 483.70(p) would read, "*Every* facility must employ a qualified social worker on a full-time basis. . . ." We also encourage CMS to set additional social work staffing ratios, with consideration of the aforementioned research findings and current recommendations from leading nursing home social workers and social work consultants (such as the National Nursing Home Social Work Network) that enable social workers to provide high-quality psychosocial care. Consideration of high acuity and turnover in SNFs will be especially important in the development of such ratios, while recognizing that the needs of NF residents are equally important and often

overlooked because of SNF demands. For example, in Bern-Klug et al.'s 2010 study of a nationally representative sample of more than 1,000 nursing home social services directors, almost three-fourths commented that an appropriate ratio would be one full-time worker for 60 long-stay residents, and more than half suggested a ratio of one full-time worker per fewer than 20 subacute residents. It is worth bearing in mind, though, that these figures predated both MDS 3.0 implementation and the added requirements of the current proposed rule. In 2012, for example, the National Consumer Voice for Quality Long-Term Care proposed to CMS that facility employ at least one full-time social worker for every 50 long-stay residents and at least one full-time social worker for every 15 short-stay residents (Wells & Grant, 2012).

Finally, NASW recognizes that some facilities have reported difficulties in locating adequate numbers of BSWs or MSWs. We offer the following recruitment and retention to facilities in this situation:

- Partner with social work degree programs, especially those that have participated in CSWE GeroEd programs (and including distance-learning programs), to provide incentives for paraprofessional social services staff to obtain their social work degrees.
- Partner with NASW chapters (http://www.socialworkers.org/chapters/default.asp) and advertise job openings in the NASW Career Center (http://careers.socialworkers.org/employers.asp).
- Partner with state associations such as those affiliated with the American Health Care Association and LeadingAge to recruit qualified social workers.
- Foster partnerships among state associations, NASW chapters, and social work degree programs.

NASW also believes that facilities' can enhance their recruit and retention efforts by making nursing home social work jobs more appealing. Several findings from the association's benchmark study of licensed social workers in the United States (Whitaker, Weismiller, & Clark, 2006) highlight challenges that decrease job satisfaction and retention among gerontological social workers—challenges echoed anecdotally by many nursing home social workers:

- MSWs employed in nursing homes received the lowest wages of all MSWs in aging, and the median salary of gerontological social workers across settings is slightly less than median salary for all social workers.
- Nursing home social workers (both BSWs and MSWs) were more likely to have caseloads of 50 or more than gerontological social workers in any other setting.
- Gerontological social workers were more likely to report engaging in tasks below their skill level than were social workers in other specialty practice areas.
- Gerontological social workers were more likely to be isolated professionally than were social workers in other specialty practice areas; more than one-quarter reporting they were the only social worker employed in their organization.

- Gerontological social workers were slightly more likely than were social workers in other specialty practice areas to list ethical challenges as a factor in influencing a decision to change jobs.

Other research has found that the following factors influence job satisfaction among nursing home social services staff:

- sufficient time to identify and meet the social and emotional needs of residents
- being treated as an integral part of the team
- job autonomy
- level of stress and variety on the job
- equity in pay and benefits
- promotional opportunities
- support by coworkers and supervisors. (Liu & Bern-Klug, 2013; Simons & Jankowski, 2008)

NASW also recommends that CMS provide extra resources to support social work recruitment and retention efforts by nursing facilities in documented workforce shortage areas, such as in frontier areas and certain rural counties.

§ 483.75, Quality Assurance and Performance Improvement (QAPI)

NASW supports the creation of this new section on QAPI. We are especially pleased that the section promotes a comprehensive, data-driven program that includes quality of life among its outcomes (§ 483.75(a)). The introductory material within the proposed rule suggests that the director of social services might be appropriate for the quality assessment and assurance (QAA) committee. NASW affirms that professional social workers are well suited to serve as one of three staff members on the QAA committee (subsection (g)(iii)) and to participate in all QAPI-related activities. With their person-in-environment focus, social workers intervene on the micro (resident), mezzo (facility), and macro levels. We support CMS's focus on "high-risk, high-volume, or problem-prone areas," while encouraging CMS to forgo specification of the areas that each facility must address. Should CMS decide to propose such a list, inclusion of topics addressing psychosocial well-being, mental and behavioral health, and quality of life are crucial. A positive approach that focuses on improving long-term residents' everyday experience, promotion of short-term residents' decision making, and improving both palliative care (throughout the lifespan) and end-of-life services would be particularly useful.

§ 483.85, Compliance and Ethics Program

NASW strongly supports the creation of this new section. Professional social workers, who are guided by the NASW *Code of Ethics* (2008), are well equipped to contribute to and help to lead such programs.

§ 483.90, Physical Environment

NASW supports the proposed revisions to subsections (c), (d), and (e), as well as the new requirement in subsection (h)(5).

§ 483.95, Training Requirements

NASW strongly supports the creation of this new section. However, the intent of the section is not clear:

- § 483.95 and the introductory text preceding it state that the training program must be "for all new and existing staff"; yet, the information collection requirements (ICRs) refer only to the cost of training nurse aides. NASW urges CMS to make clear that the training is intended for all new and existing staff and to develop cost estimates accordingly.

- 483.95(a) stipulates that all "direct care/direct access personnel" be trained in communications. Per our comments on preceding sections, we believe this wording is confusing and may be interpreted to apply only to nurse aides and other direct care workers. Moreover, we believe that *all* staff—not only those who provide services directly to residents—need training in communications for a facility to function effectively.

NASW supports the training topics named in the proposed rule. At the same time, we strongly recommend that the following training topics be required for all facility staff members who provide services directly to residents:

- advance care planning
- cultural competence
- end-of-life care
- geriatrics and gerontology
- working with young and middle-aged adults
- grief and loss
- interdisciplinary collaboration
- person-centered care
- intellectual disability.

NASW also recommends that the term "dementia management" (subsection (g)(2)) be changed to "appropriate care of residents living with dementia," which is a more person-centered term. Furthermore, we recommend that all facilities be required to provide training on compliance and ethics annually, rather than limiting this requirement to organizations that operate five or more facilities.

Many professional social workers are well qualified to provide training on these topics, as well as on several topics proposed by CMS:

- communication
- resident rights and facility responsibilities
- abuse, neglect, and exploitation
- resident abuse prevention
- dementia management
- behavioral (and mental) health.

Finally, we are concerned that CMS has not proposed to increase the minimum number of hours of in-service training per year. We encourage CMS to study this issue in order to determine an appropriate minimum requirement that will promote thorough in-service training and enhance staff competence.

Thank you, again, for the opportunity to comment on CMS-3260-P. If you have questions about NASW's comments, please contact my office at naswceo@naswdc.org or (202) 408-8200.

Sincerely,

Angelo McClain, PhD, LICSW
Chief Executive Officer

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