CMS Updates the Requirements of Participation
What Pharmacists and Facilities Need to Know

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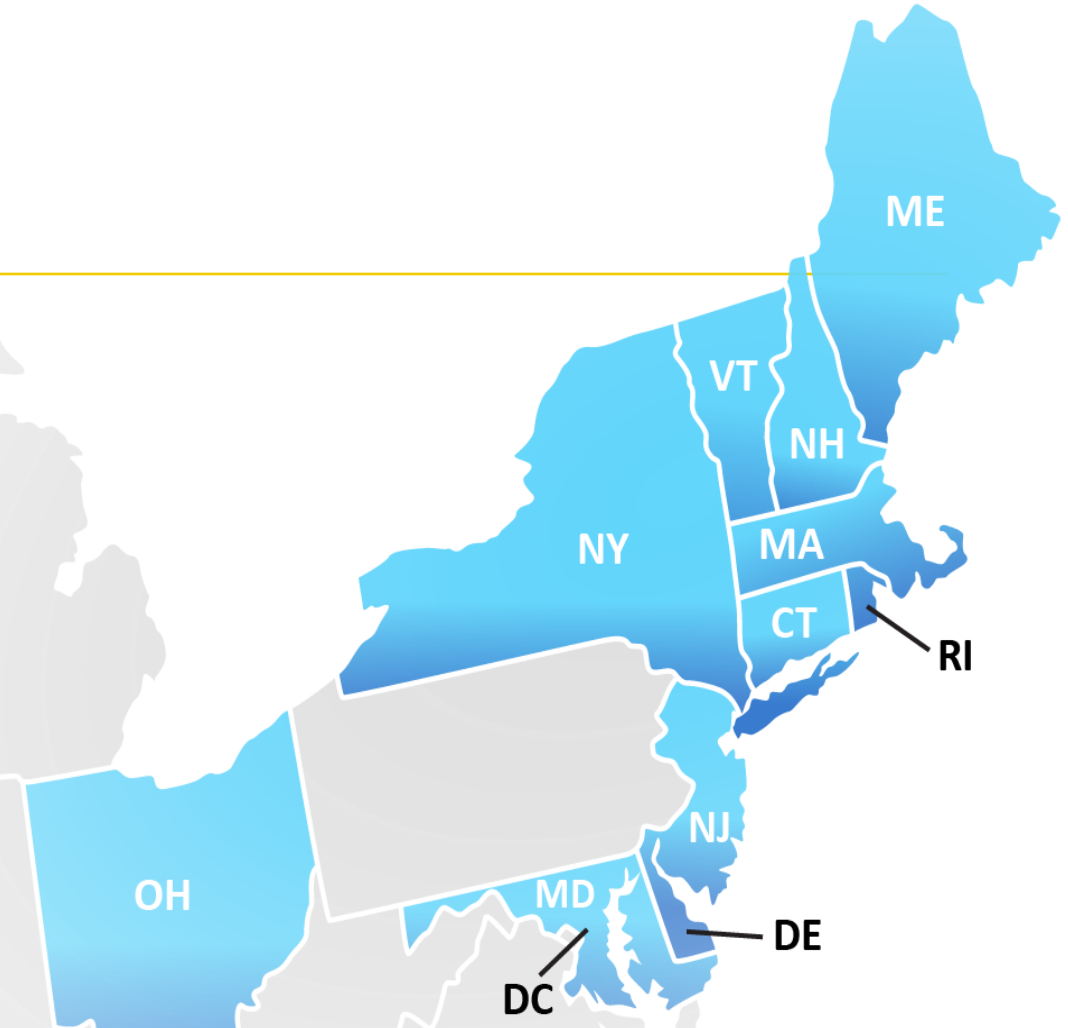

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Welcome!

- Today's session is being recorded
- Everyone is muted for this session – please use Chat or Q&A for questions or comments. We'll have a Q&A session with the speakers at the end of the presentation
- Slides and recording will be posted on our website

Speaker Disclosures and Resources

The speakers have nothing to disclose.

The primary resources used in preparation for this webinar were accessed August 17 through August 23,2022, and may be found at:

https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSLTCRegIG_PSG

The draft revision to Appendix PP, which becomes effective on October 24, 2022, may be found at:

https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/revised-long-term-care-surveyor-guidance-revisions-surveyor-guidance-phases-2-3-arbitration

Obtaining Continuing Pharmacy Education Credit

Thank you to the Connecticut Pharmacists Association for providing continuing pharmacy education credit

How to Claim Your CE Credits:

- As an ACPE-accredited provider, CPA is using an online platform called LecturePanda to provide your CE credits instantly. Please visit this link: LecturePanda CE to begin this process. You will be required to submit your information before proceeding to the evaluation.
- At the end of this presentation, we will announce a CE code, which you will be required to submit in the evaluation in order to receive CE credit.
- **The deadline to complete the evaluations is October 5.** If you have any questions or issues, please contact Lisa Capobianco at CPA: lcapobianco@ctpharmacists.org.

The Connecticut Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. Pharmacists in attendance who complete an evaluation will receive 1 contact hour of CPE credit (0.1 CEU). Statements of credit will be uploaded to CPE monitor on the NABP website, where you can print your credits for your profile.

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Learning Objectives

1. Identify changes to the Requirements of Participation (RoP) and in particular the revisions to Appendix PP, State Operations Manual (SOM), Guidance to Surveyors
2. Describe the nuances in the provisions of care for residents of skilled facilities as compared to community or other congregate settings, especially related to infection control, psychotropic medication use, and mental health
3. Discuss the new emphasis surrounding the requirements to provide care for those with substance use disorders, including opioid use disorder
4. Outline strategies to mitigate risks associated with legal and illicit drugs and how to address drug storage, disposition, disposal, and drug overdoses in facilities
5. Review changes to the requirements for review of psychotropics and gradual dose reductions
6. Describe the new refinements to the infection preventionist requirements

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Learning Objective 1

Identify changes to the Requirements of Participation (RoP) and in particular the revisions to Appendix PP, Guidance to Surveyors

What is the history of the Final Rule, a/k/a the Mega Rule?

Why were changes made?

Is there a list of the sections which will be affected?

How will the revised guidance affect pharmacy or infection prevention?

The Mega Rule: November 28, 2016

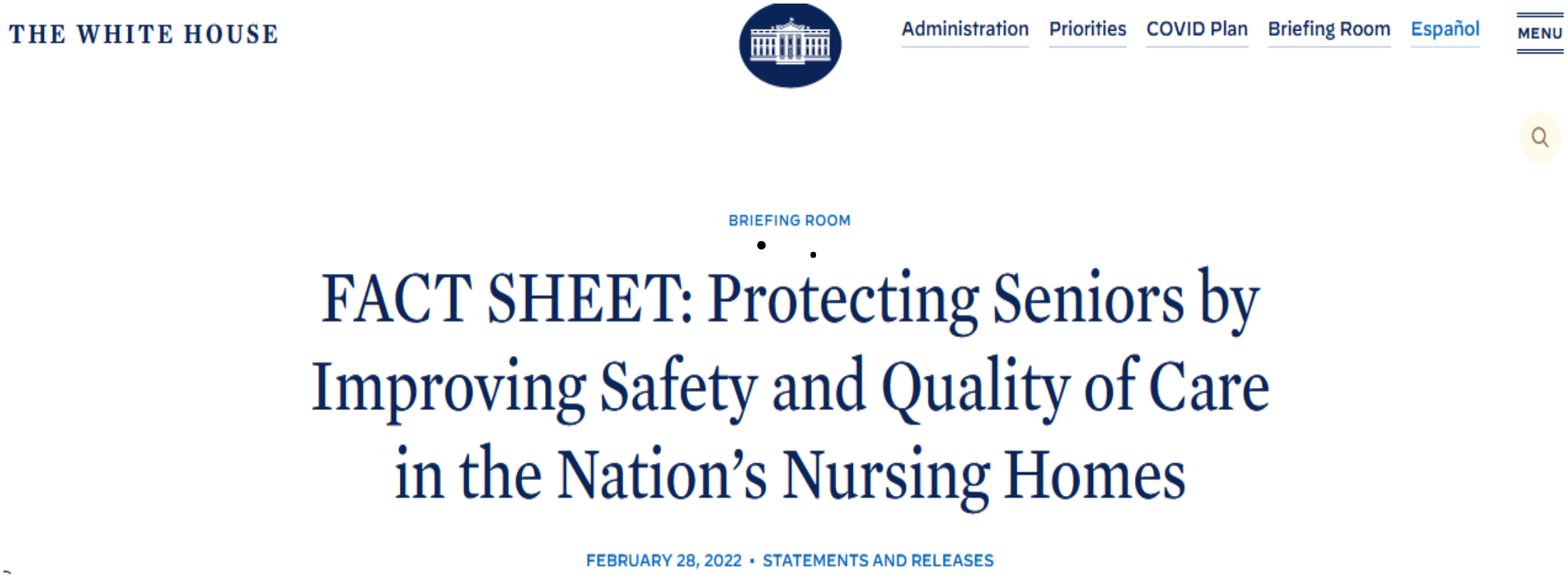
"This final rule will revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. These changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These revisions 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."

Implementation dates:

The regulations included in Phase 1 must be implemented by November 28, 2016.The regulations included in Phase 2 must be implemented by November 28, 2017.The regulations included in Phase 3 must be implemented by November 28, 2019.

https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

Biden-Harris White House Initiative: February 28, 2022



https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/

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Task for Centers for Medicare and Medicaid Services (CMS)

Ensuring Taxpayer Dollars Support Nursing Homes That Provide Safe, Adequate, and Dignified Care

CMS is launching four new initiatives to ensure that residents get the quality care they need—and that taxpayers pay for. These initiatives will help ensure adequate staffing, dignity and safety in their accommodations, and quality care.

- Establish a Minimum Nursing Home Staffing Requirement.
- Reduce Resident Room Crowding.
- Strengthen the Skilled Nursing Facility (“SNF”) Value-Based Purchasing (“VBP”) Program.

Task for Centers for Medicare and Medicaid Services (CMS)

Ensuring Taxpayer Dollars Support Nursing Homes That Provide Safe, Adequate, and Dignified Care

CMS is launching four new initiatives to ensure that residents get the quality care they need—and that taxpayers pay for. These initiatives will help ensure adequate staffing, dignity and safety in their accommodations, and quality care.

- **Reinforce Safeguards against Unnecessary Medications and Treatments.** Thanks to CMS' National Partnership to Improve Dementia Care in Nursing Homes, the nation has seen a dramatic decrease in the use of antipsychotic drugs in nursing homes in recent years**. However, inappropriate diagnoses and prescribing still occur at too many nursing homes. CMS will launch a new effort to identify problematic diagnoses and refocus efforts to continue to bring down the inappropriate use of antipsychotic medications.**

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CMS Responds with Updated Guidance

https://www.cms.gov/newsroom/fact-sheets/updated-guidance-nursing-home-resident-health-and-safety

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Changes to Appendix PP, Effective October 24, 2022

483.10 - Resident Rights

483.12 - Abuse, Neglect, and Exploitation

483.15 - Admission, Transfer, and Discharge

483.24 & 483.25 - Quality of Life & Quality of Care

483.25 - Trauma Informed Care

483.30 - Physician Services

483.35 - Nurse Staffing and Payroll Based Journal

483.40 - Behavioral Health

483.45 - Pharmacy Services

483.60 - Food and Nutrition

483.70 – Arbitration

483.75 - Quality Assurance and Performance

483.80 - Infection Control

483.85 - Compliance and Ethics

483.90 - Physical Environment

483.95 - Training Requirements

Psychosocial Outcome Severity Guide

Reference:

https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSLTCRegIG_PSG

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Select List, Summary of Changes

Summary of Significant Changes

Topic	Summary
Abuse and Neglect	• Clarifies compliance, abuse reporting, including sample reporting templates, and provides examples of abuse that, because of the action itself, would be assigned to certain severity levels.
Admission, Transfer, and Discharge:	• Clarifies requirements related to facility-initiated discharges.
Mental Health/Substance Use Disorder (SUD):	• Addresses rights and behavioral health services for individuals with mental health needs and SUDs.
Resident Rights:	• Imports guidance related to visitation from memos issued related to COVID-19, and makes changes for additional clarity and technical corrections.
Potential Inaccurate Diagnosis and/or Assessment	• Addresses situations where practitioners or facilities may have inaccurately diagnosed/coded a resident with schizophrenia in the resident assessment instrument.
Pharmacy:	• Addresses unnecessary use of non-psychotropic drugs in addition to antipsychotics, and gradual dose reduction.

https://www.cms.gov/newsroom/fact-sheets/updated-guidance-nursing-home-resident-health-and-safety

Significant Changes: Infection Control and Infection Preventionist (IP)

Infection Control:	• Requires facilities have a part-time Infection Preventionist. • While the requirement is to have *at least* a part-time IP, the IP must meet the needs of the facility. • The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. • IP role is critical to mitigating infectious diseases through an effective infection prevention and control program. • IP specialized Training is required and available.

https://www.cms.gov/newsroom/fact-sheets/updated-guidance-nursing-home-resident-health-and-safety

Self- Assessment Question 1

- The CMS Revised Appendix PP Requirements of Participation:

- a) is mandated by law every 4 years
- b) was mostly in response to political posturing
- c) addresses concerns which came to light during the COVID-19 pandemic
- d) updates many areas of care for the residents of skilled/nursing facilities

Self- Assessment Question 1

- The CMS Revised Appendix PP Requirements of Participation:

- a) is mandated by law every 4 years
- b) was mostly in response to political posturing
- c) addresses concerns which came to light during the COVID-19 pandemic
- d) updates many areas of care for the residents of skilled/nursing facilities

Learning Objective 2

2. Describe the nuances in the provisions of care for residents of skilled facilities as compared to community or other congregate settings, especially related to infection control, psychotropic medication use, and mental health.

Are there care requirements for those who live in these alternate settings?

YES, but the changes to Appendix PP ONLY APPLY TO SKILLED/ NURSING FACILITIES.

State specific requirements substitute when Federal regulations may not exist; check with your state department of health or boards.

Do the RoP changes affect your practice ?

- **Skilled Nursing Facilities Yes**
- **Nursing Facilities Yes**
- Assisted Living Facilities No
- Independent Living Facilities No
- Adult Homes No
- ICF/IID* No, but see regulations specific to these settings
- *Intermediate Care Facilities for Individuals with Intellectual Disabilities

Examples of Oversight: Settings Other Than SNF/NF

State regulations provide requirements for Medication Regimen Review at specified intervals in different care settings

Example: New York State requires an Intermediate Care Facility (ICF) be reviewed every 3 months, while Individualized Residential Alternatives (IRA) every 6 months

A requirement to review psychotropic medications at least annually was instituted in 2021

Place of Residence and Appendix PP

	Infection Control	Psychotropics	Mental Health/ Substance Use Diorder
Skilled/NF	YES	YES	YES
General Community	Antibiotic Stewardship for anyone	NO	NO
Adult Homes	Antibiotic Stewardship Best Practices	NO	NO
Assisted Living	Antibiotic Stewardship Best Practices	NO	NO
ICF/IID	Antibiotic Stewardship Best Practices	NO	NO

How to Handle Concerns at Alternate Care Settings

What about handling of controlled substances such as used fentanyl patches? Who has oversight? DEA; EPA; State Laws

What about addressing substance use disorder?

Guidance on use of methadone, buprenorphine; naloxone for opioid overdose ?

Medication Assisted Treatment?

Naloxone encouraged in all 50 states and District of Columbia

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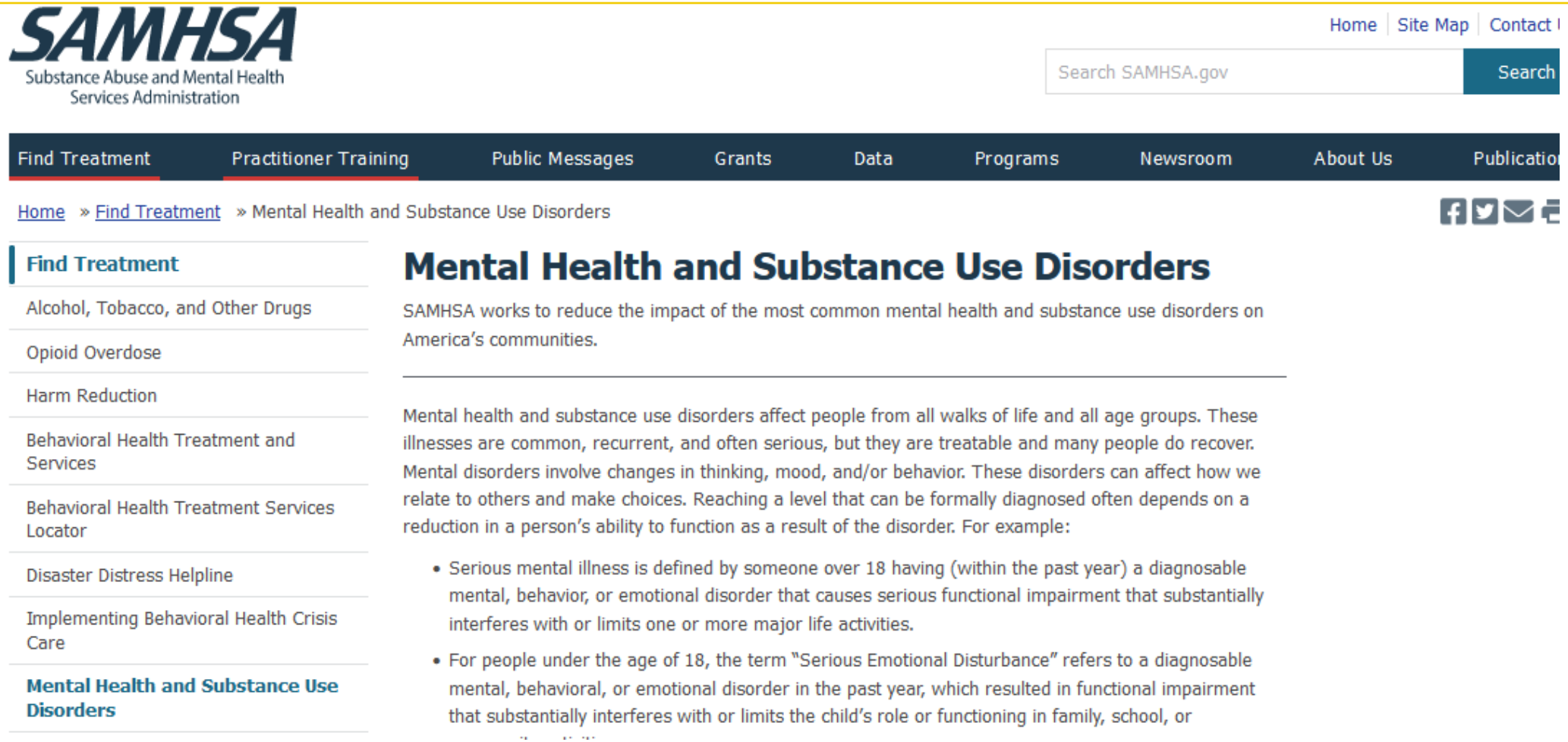
Learning Objective 3

Discuss the new emphasis surrounding the requirements to provide care for those with substance use disorders, including opioid use disorder

Mental Health and Substance Use Disorders



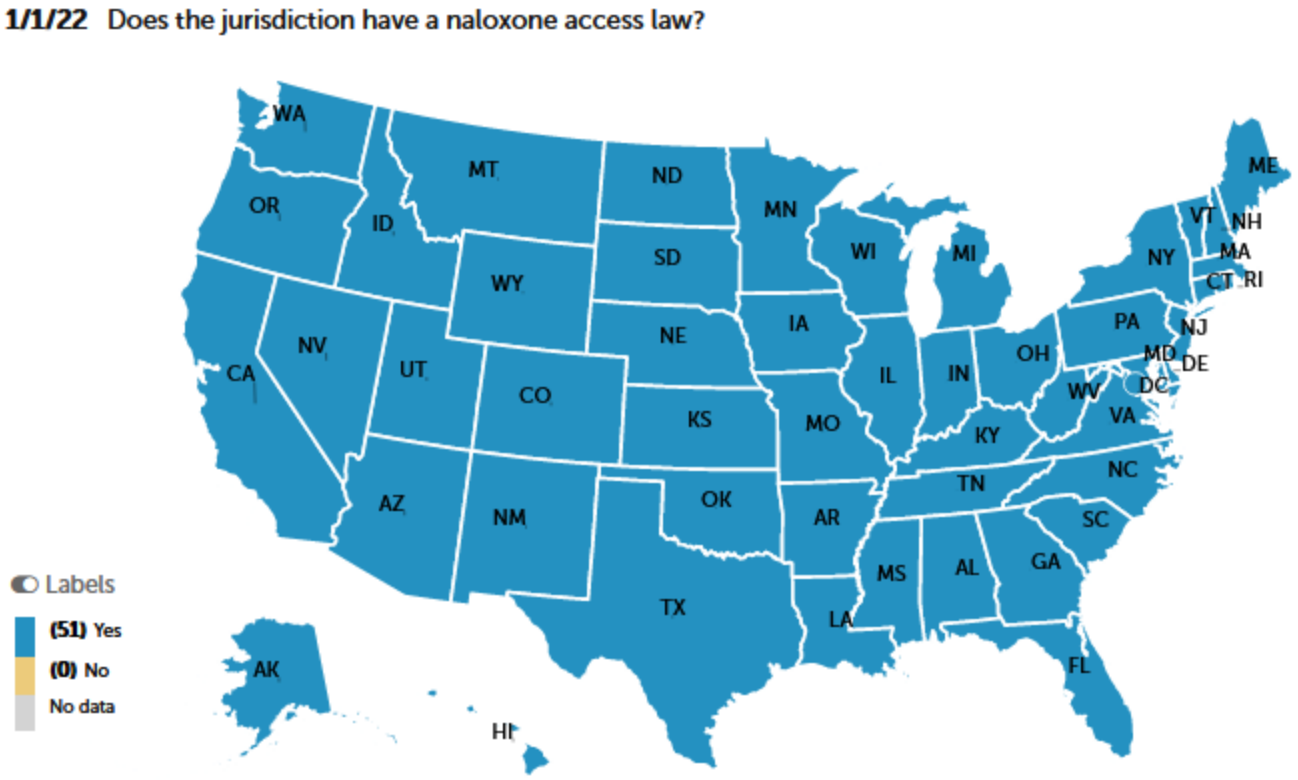
https://www.samhsa.gov/find-help/disorders

Medication Assisted Treatment (MAT) Resource

https://www.samhsa.gov/medication-assisted-treatment

Naloxone: Access Laws in all 50 States and District of Columbia

- https://pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139



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Self- Assessment Question 2

Appendix PP addresses substance use disorder and mental health for:

- a. community settings
- b. skilled/nursing facilities
- c. assisted living facilities
- d. homes for those with developmental disabilities

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Behavioral Health Services: This Requirement is Not New – The Emphasis is New

F740

483.40 Behavioral Health Services

- 483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and **substance use disorders.**
- "Substance use disorder" ("SUD") is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Substance Use Disorder (SUD) in Facilities

"Substance Use Disorder" is found in Appendix PP a total of 16 times.

483.25 Accidents

Guidance can be found under Wandering and Elopement section;

Significant revisions in guidance empowers surveyors to investigate facility education and policy/procedures to mitigate residents who leave the facility with drug-seeking behavior

Guidance Addresses Two Definitions: MAT and OUD

Found at: F697

483.25 (k) Pain Management.

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

- "Medication Assisted Treatment" (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. (From the Substance Abuse and Mental Health Services Administration (SAMHSA)).
- "Opioid Use Disorder" (OUD) is a problematic pattern of opioid use leading to clinically significant impairment or distress. Additional criteria used to assess and diagnose OUD can be found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Opioids and Use for Pain Management

Extensive section now in the guidance on the use of opioids for pain management:

- Discusses types of pain, risks for opioid addiction;
- Educates about the concomitant use of opioids and benzodiazepines;
- Notes use of this combination for end-of-life, palliative, or hospice care;
- Recommends several resources for best practices material

New in the Guidance: Side Effects of Opioids

"The CDC describes a number of side effects which prescription opioids can cause even when given as directed. Some side effects for which residents should be monitored include: • Tolerance, meaning more medication may be needed to achieve the same level of pain relief; • medication is stopped, or a dose is held or missed; • Increased sensitivity to pain; • Constipation; • Nausea, vomiting, and dry mouth; • Sleepiness, dizziness, and/or confusion; • Depression; and • Itching and sweating."

Possible Citation at F757, if not monitoring for these side effects

Learning Objective 4

Outline strategies to mitigate risks associated with legal and illicit drugs and how to address drug storage, disposition, disposal, and drug overdoses in facilities

Addressing Opioid Overdose Deaths in the Guidance

"According to the Substance Abuse and Mental Health Administration (SAMHSA), opioid overdose deaths can be prevented by administering naloxone, a medication approved by the Food and Drug Administration to reverse the effects of opioids. The United States Surgeon General has recommended that naloxone be kept on hand where there is a risk for an opioid overdose. Facilities should have a written policy to address opioid overdoses."

Pharmacist/Facility: Create Policy to Address Opioid Overdoses

Some State Specific Regulations already exist (MA)

SAMHSA References

- This document intended for prescribers which addresses appropriate prescribing, monitoring for adverse effects, and treating overdoses: SAMHSA Opioid Overdose Prevention Toolkit-2018
  [Opioid Overdose Prevention Toolkit | SAMHSA Publications and Digital Products]

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Risk Mitigation: Resident Rights and Personal Property

- 483.10 Resident Rights
  - F557 Respect, Dignity, Right to Have Personal Property

  - Staff searches not without consent; of the body and of the possessions;
  - Education for the staff about the signs, symptoms, and triggers of possible substance use;
  - If illegal substances found on the person/resident: refer to law enforcement;
  - Staff not to become an agent of law enforcement

Freedom from Abuse, Neglect, Exploitation

483.12

F609 Misappropriation of Resident Property and Exploitation

New guidance includes:

"Missing prescription medications or diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain"

Pearl: Consultants and facilities should review what drug diversion protocols are being implemented and periodically checked with the consultant pharmacist, especially for opioids.

Tags Related to Resident Rights and Precautions to Avoid Overdoses

F563 Right to Receive/Deny Visitors

- Denying access to visitors who have a history of bringing illegal substances into the facility
- Expectation that staff will observe and be educated on signs, symptoms of possible substance use after interaction with visitors or return from leave of absence

F689 Accidents (prevent possible accidental overdoses or exposure)

F740 Behavioral Health Services

- Interaction with visitors; look for signs, symptoms, possible triggers
- Education for direct care staff
- Inspection for medications in rooms; note that inspection of resident and belongings requires consent

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Safety for Residents with History of Substance Use Disorder (SUD): Guidance at Quality of Care

483.25 Quality of Care

- F689
  - "Safety for Residents with a history of Substance Use Disorder, residents who may leave the facility to obtain illegal drugs, prescriptions, or alcohol
  - Care planning: Facilities are responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address this risk.
  - Additionally, residents with SUD may try to continue using substances during their stay in the nursing home. Facility staff should assess the resident for the risk for substance use in the facility and have knowledge of signs and symptoms of possible substance use"

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F 755 Pharmacy Services

New guidance added for Fentanyl and disposal of patches over concern for flushing into the environment:

Therefore, nursing homes may use drug disposal products or systems for fentanyl patches and other controlled medications medications; or as long as the facility can show that the product or system minimizes accidental exposure or diversion. Disposal in common areas or resident room trashcans or sharps containers are methods that would not prevent accidental exposure or diversion. Concerns related to fentanyl patch disposal which could lead to accidental exposure should be investigated at F689.

Question to ask: what change if any would need to be made at your facilities?

Learning Objective 5

Review changes to the requirements for review of psychotropics and gradual dose reductions

Changes at: 483.45 Pharmacy Services

Changes at: 483.45(d) Unnecessary Drugs, General

Changes at: 483.45(e) Psychotropic Drugs

No Changes to Guidance at F 756

485.45 Drug Regimen Review

Extensive original section exists, yet no additional guidance …

What does this mean for your facilities ?

What does this say about Drug Regimen Review?

F757 and F758

483.45(d) Unnecessary Drugs, General

483.45(c)(3) *and* 483.45(e) Psychotropic Drugs

Definitions added for:

"Dose"; "Duplicate Therapy"; and "Excessive Dose";

Reminder of an Existing Definition:

"Psychotropic drug" is defined in the regulations at §483.45(c)(3), as "any drug that affects brain activities associated with mental processes and behavior." Psychotropic drugs include, but are not limited to the following categories: anti-psychotics, antidepressants, anti-anxiety, and hypnotics.

Medication Management, F757 and F758

Revised the guidance in 2 places:

at “Duration”, specifically concerning PRNs:

A medication, which is prescribed on a PRN basis, is requested by the resident and/ or/administered by staff on a regular basis, indicating a more regular schedule or other change in medication regimen may be needed.

At Adverse Consequences: May Address as a QAPI (Quality Assurance Performance Improvement)

Additionally, as part of a facility’s QAPI program, a facility may track its use of certain classes of medications, such as antipsychotics, through reports from the long-term care pharmacist which could identify trends and reduce adverse events.

Psychotropic Medications and Antipsychotics F758 Guidance Only

Revised Guidance:

Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented. Risks associated with psychotropic medications still exist regardless of the indication for their use (e.g., nausea, insomnia, itching), therefore the requirements pertaining to psychotropic medications in §483.45(e) apply to the four categories of drugs (anti-psychotic, anti-depressant, anti-anxiety and hypnotic) listed in §483.45(c)(3) **without exception.**

Guidance on Psychotropic Medications and Use

Addressing off-label use:

"Other medications not classified as anti-psychotic, anti-depressant, anti-anxiety, or hypnotic medications can also affect brain activity and should not be used as a substitution for another psychotropic medication listed in §483.45(c)(3), unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice and in accordance with §483.45(d)(4). Categories of medications which affect brain activity include antihistamines, anti-cholinergic medications and central nervous system agents used to treat conditions such as seizures, mood disorders, pseudodobulbar affect, and muscle spasms or stiffness**.** **The requirements pertaining to psychotropic medications apply to these types of medications when their documented use appears to be a substitution for another psychotropic medication rather than for the original or approved indication."**

Follow the Documentation

Why is the non-psychotropic medication being prescribed?

"For example, if a resident is prescribed valproic acid and the medical record shows no history of seizures but there is documentation that the medication is being used to treat agitation or other expressions of distress, then the use of valproic acid should be consistent with the psychotropic medication requirements under §483.45(e)."

Misdiagnosing Schizophrenia

Note: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, please refer to the following regulations:

- §483.21(b)(3)(i), F658, to determine if the practitioner's diagnostic practices meet professional standards.
- §483.20(g), F641 to determine if the facility completed an assessment which accurately reflects the resident's status.

The Gradual Dose Reduction Redux

"Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence. Compliance with the requirement to perform a GDR may be met if, for example, within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, a facility attempts a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated."

Inappropriate Antibiotic Prescribing

Antibiotics and Unnecessary Medication Citation at F 757 and/or F 881

NOTE: Instances of prescribing antibiotics unnecessarily should be cited at §483.45(d), F757. The findings may support citing F881 as well, in which case the surveyor must also show that the facility is not implementing part or all of the Antibiotic Stewardship Program (e.g., antibiotic use protocols that utilize an infection assessment tool, monitoring of antibiotic use, or feedback and education to prescribing providers).

Self Assessment Question 3

Which of the following is True?

Medications that are prescribed in lieu of psychotropics:

a. are safer to use since they are not dangerous

b. should not be considered psychotropics even if they are used for behaviors

c. will be scrutinized based on the way the medication use is documented

d. should not have gradual dose reductions

Self Assessment Question 3

Which of the following is True?

Medications that are prescribed in lieu of psychotropics:

a. are safer to use since they are not dangerous

b. should not be considered psychotropics even if they are used for behaviors

c. will be scrutinized based on the way the medication use is documented

d. should not have gradual dose reductions

Strengthened Requirements of the Infection Preventionist (IP)

Learning Objective 6

Describe the new refinements to the infection preventionist requirements

F882

§483.80(b) Infection preventionist

- The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must:
- §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;
- §483.80(b)(2) Be qualified by education, training, experience or certification;
- §483.80(b)(3) Work at least part-time at the facility; and
- §483.80(b)(4) Have completed specialized training in infection prevention and control.

So…What's New for the Infection Preventionist (IP) ?

- INTENT §483.80(b) The intent of this regulation is to ensure that the facility designates a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections.
- **Primary Professional Training.** The IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field. Examples of other related fields of training that are appropriate for the role of an IP include physicians, pharmacists, and physician's assistants
- **Qualifications.** The IP must be qualified by education, training, experience or certification. An example of certification is the Certification in Infection Prevention and Control (CIC®) which is conducted by the Certification Board of Infection Control and Epidemiology, Inc. (CBIC®) and accredited by the National Commission for Certifying Agencies (NCCA).

So…What's New for the Infection Preventionist (IP)?

- INTENT §483.80(b) The intent of this regulation is to ensure that the facility designates a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections.
- **IP Hours of Work.** At least part-time; varies based on the facility and its population, census, and specialized units. Must physically work on site at the facility, not off-site at a corporate office.
- **Specialized Training in Infection Prevention and Control.** An IP must have obtained specialized training in IPC prior to assuming the role; CMS in collaboration with CDC provides a free training site: The Nursing Home Infection Preventionist Training Course https://www.train.org/cdctrain/training_plan/3814

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Additional Infection Control Updates

F880: Water Management: extensive new guidance on minimizing outbreaks (Legionellosis)

F881: Providing feedback to providers on prescribing practices in the facility is no longer required as an element of compliance

F883: Influenza and Pneumococcal immunizations; revised the guidance to removed outdated language about 13-valent vaccine

Facilities *should* follow the CDC and ACIP recommendations for vaccines. For up-to-date information on indications and timing of pneumococcal vaccines, please refer to CDC's ACIP Vaccine Recommendations and Guidelines website located at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf and https://www.cdc.gov/vaccines/schedules/hcp/index.html

https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html

IP Alignment with the Quality Assessment and Assurance (QAA) Committee

- The IP must be a member of the QAA Committee;
- The IP must report to the Committee;
- Must be in attendance at the Committee Meetings: In order to be considered an active participant, the IP should attend each QAA meeting. If the IP cannot attend, another staff member should report on the IP's behalf
- Failure to do so will be cited as an element of non-compliance at F868 QAA Committee

Thank you!

Questions? Comments?

How to Claim Your CE Credits:

- As an ACPE-accredited provider, CPA is using an online platform called LecturePanda to provide your CE credits instantly. Please visit this link: LecturePanda CE and use the following CE code: care
- **The deadline to complete the evaluations is October 5.** If you have any questions or issues, please contact Lisa Capobianco at CPA: lcapobianco@ctpharmacists.org.

Need more information?

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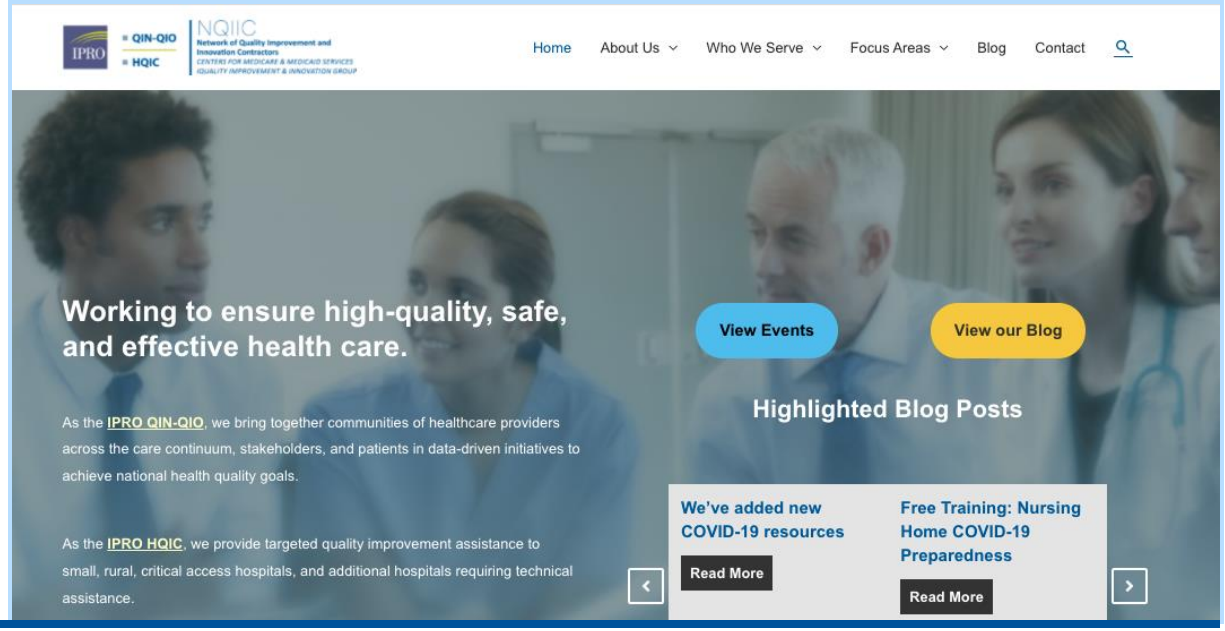

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