

SPECIAL TO SOCOMDS—21 February 2011

From Eileen Doll, RN, BS, AHCA Clinical Practice Committee Member from Maryland.

I wish to sincerely thank nurses from Connecticut (especially Lisa Morell) for contributing their knowledge, insights, and suggestions for improvement in clinical care and practices. When issues arise and information is needed, Connecticut has always “risen to the challenge” and helped me speak for and represent YOU as well as my “home” state.

The American Healthcare Association's Clinical Practice Committee held a full day meeting Wednesday, February 16, 2011, in San Antonio, TX, with representatives from as far away as Hawaii in attendance. Several committee members also stayed to attend Quality Symposium sessions.

1. Regulatory Update

- DEA re: drug prescribing—Several associations continue to make recommendations about proposed legislation. Current proposals include the following—only certain nurses will be agents of the physician, not all. Facility must make and keep list of nurses—send list to pharmacy. Prescribers can “opt out” for certain nurses who they do not want to give orders to. Drugs would include ALL controlled, including schd 2. Facility will not have to be DEA registered. If diversion occurs, the nurse is criminally responsible under the DEA. Still unsure what will be proposed and what will be made into law/regulation. AHCA has made formal comments and spoken directly with legislators about this problem and has recommended solutions.
- EPA re: drug disposal—AHCA met with EPA and submitted comments—they don't understand LTC; EPA asked to meet with AHCA again in March so they can better understand; pilot program in Maine—a mail back program, destroyed by another company; sent back and tracked per patient.
- ACA Section 3008 - Health Care Acquired Condition—payment incentive program for hospitals—hospital will not be reimbursed if acquired in hospital; looking to see if should also be effective in SNFs—RTI has contract. They have questions--(Sandy has list); quality issues in continuum—who does an emerging problem belong to???(per Hartung)--new regs proposed re: Provider Preventable conditions—comments will be accepted-from CMS—30 day comment period –in Federal Register; this all seems PUNITIVE. Where is role of patient him/herself and health status?? Is anyone doing active research about “best practices” on admission—AMDA guidelines could be combined, looked at, within timeframes; INTERact and Sbar is helpful, quickly assess that there IS a problem; “care path” for admission per se, not just per disease entity;
- ACA/CMS - Short Cycle Dispensing—on-generic drugs, Part D or Part B—7 day, not 30 day cycles—would be very costly for LTC, quadruples ordering costs
- CMS – Physician Signature on Lab Requisitions—did not pass; CMS understands concerns, did not push it
- Psychotropic Drugs—this is still a “hot topic” even WITH appropriate diagnoses; still viewed by many as restraints

2. Long Term Care Quality Alliance

- What is LTCA? --now called **Long Term Quality Alliance**
- PURPOSE—per Bill Hartung, AHCA—must have dialogue with other providers along continuum of care during transitions—must agree on goals and concerns, link between evidence based practices and outcomes; want to COMMUNICATE research findings, not make more; 3 workgroups; want to produce a usable product within 2 years, or else loses relevance

3. MDS 3 Issues and Next Steps

- AHCA's CP committee and Sandy Fitzler have submitted comments to CMS regarding MDS 3.0 for 2 + years. Comments included actual errors, recommendations for re-wording of form itself, recommendations for frequency of item completion, and much much more. Member facilities, state associations, and interested individuals have provided valuable examples, anecdotes, and insight into MDS 3.0 “real time” implementation.
- Key concerns—focus on discharge assessment and interviews/PHQ9
- AHCA **will continue** to express concerns and offer solutions to CMS—but individuals must also continue!!
- Training/Webinars—we will ask Deb Saliba to do a webinar re: appropriate response to “want to harm self—YES”
- Section Q—discussion re: pilot now being done of revised section Q; revisions made to skip patterns, who is asked about discharge, how often asked about discharge. Eileen will keep committee informed when pilot results are compiled. CMS had asked for some changes, so hopefully the suggested changes will prove to be useful in the pilot and be accepted by CMS in April for implementation in October 2011.

4. Workforce Clinical Practice project—we will prepare a white paper outlining issues & recommendations around appropriate SNF staffing—Irene Fleshner offered the following ideas from the project members. AHCA CP committee and Workorce committee feel that we should offer recommendations to member facilities and share with CMS **BEFORE** CMS mandates staffing levels.

Staffing Principles—not necessarily in order of value or importance

1. **All staff—Staff must be considered as an asset, not an expense**
2. **Actual # and competency of staff have a direct relationship to the nrsg care and quality of care—they are DIRECTLY linked**
3. **SNF populations are NOT homogenous**
4. **Staffing levels should not be based on payer types**
5. **All SNF's should have RN on duty 24/7—much discussion about this. Rural areas may not be able to recruit RNs. We may suggest “on duty or immediately available”. “Available” could be via webcam or other methodology. RATIONALE—skilled patients may require assessment by RN at any time.**

6. Newly admitted patients and patients with a change in condition must be assessed and evaluated by a RN within ___ timeframe. (still under discussion— recommendation?)
7. Intensity of services needed should drive staffing patterns
8. All clinical staff should practice at their highest level of licensure or certification
9. Mandated nurse staffing levels are inappropriate—for multiple reasons.
10. Staffing levels are not static
11. Routine staffing should take into account “average “and “outlier” patient need
12. Use all outcome measures for quality care
13. Consistent staffing for all staff—especially nursing staff
14. Staffing models developed with input from all members of nursing team

Eileen also recommended that committee make a statement (in tandem with #8 above) that facilities should hire and train non-nurse persons to perform non-clinical/non-nurse tasks. Non-nurse staff can manage nursing units, arrange staffing, make clinic appointments, call for supplies, etc. Only nurses can assess patients and perform skilled care. Consider converting nursing shift supervisor or other nursing “managerial only” positions to non-nurse managerial or support positions. The committee agreed and will incorporate.

5. Committee Goal Review & Update for 2011—discussion of type/content of statistics that AHCA prepares and presents to our legislators and the public. Will be discussed further in workgroup.