



**Pennsylvania's Association
for Long-Term Care
Medicine**

Public Policy Updates

**David A. Nace, MD, MPH
Co-Chair Public Policy Committee**

PMDA

October 15, 2010

Public Policy Update Agenda

- ▶ Introduction and PMDA Policy Updates
 - ▶ David A. Nace, MD, MPH
- ▶ NF Healthcare Associated Infection Data Update
 - ▶ Phenelle Segal, RN, CIC
- ▶ Act I 2009: Preventable Serious Adverse Events Act
 - ▶ Michael T. Baer, MD
- ▶ Meet the Surveyor!
 - ▶ Linda Chamberlain, MS, BSN, RN
- ▶ Panel Discussion



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Public Policy Committee

Tom Lawrence	David Nace
John Benner	Steven Handler
Judith Black	Lou Piccoli
Kenneth Brubaker	Ann Shemo
Dan Haimowitz	Zach Simpson
Maryann Galietta	Joan Weinryb
James Hammett	Pan Fenstemacher

Thanks !



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The DEA



U.S. Department of Justice Drug Enforcement Administration

Office of Diversion Control

Update on the DEA

- ▶ In 2009, the DEA initiated a series of investigations & enforcement actions in LTC facilities nationally
 - ▶ Focus on compliance with the Controlled Substances Act of 1970
- ▶ The CSA requires that a controlled substance can only be dispensed pursuant to a valid written script:
 - ▶ 1) Full name & address of the patient
 - ▶ 2) Drug name, strength, dosage, quantity & directions
 - ▶ 3) Providers name, address & DEA number
 - ▶ 4) Providers original signature
 - ▶ 5) Actual date on which the medication is to be issued



Update on the DEA

- ▶ Facility order sheets do not meet DEA requirements
- ▶ Physicians must forward scripts for controlled substances to the pharmacist before they can be dispensed.
- ▶ Emergency prescriptions may only be given directly from physician to pharmacist
 - ▶ Only valid for 72 hour supply for C 2 meds, and
 - ▶ Requires written script to be subsequently forwarded



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Update on the DEA

- ▶ DEA has not recognized LTC nurses as *agents* of the prescriber
 - ▶ An *agent* may relay prescription details to the pharmacist on behalf of the physician
 - ▶ The agent doesn't perform the task of prescribing
- ▶ To date, LTC nurses and hospice nurses were not considered as potential *agents* as they were not employed by the physician



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Update on the DEA

- ▶ DEA interpretation of CSA has resulted in:
 - ▶ Delays in pain management
 - ▶ Medication errors and jeopardy
 - ▶ Decreases in patient safety
 - ▶ Facility citations for delays in medication delivery
- ▶ Current interpretation of CSA is unsafe, lowers quality, may increase risk of diversion, and not reflective of current standards of medical care



Update on the DEA

- ▶ PMDA has worked extensively with
 - ▶ US Senate Special Committee on Aging
 - ▶ AMDA
 - ▶ Other AMDA state chapters
 - ▶ Legislators
- ▶ PMDA has provided direct feedback to DEA
 - ▶ 14 page response to the DEA's Federal Register request for response



Current Status

- ▶ DEA reviewing comments
- ▶ PMDA continuing to work with AMDA
- ▶ PMDA response available for review
 - ▶ PMDA website
 - ▶ www.regulations.gov



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DEA Response

- ▶ DEA issued Statement of Policy 10/6/10
- ▶ Allows LTC and hospice nurses to be *agents*
 - ▶ If certain conditions are met
 - ▶ Only for Schedule III – IV meds



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DEA Response

- ▶ DEA requires non-employed registrants to be
 - ▶ Clearly identified
 - ▶ Personally agree to accepting the role as agent
- ▶ DEA states that outside “*affirmative actions* by the practitioner and proposed agent, a valid agency relationship generally will not exist outside of the employer-employee relationship”
 - ▶ This means you need to have the agreement in writing



DEA Response

- ▶ Practitioner will need ensure there is an “affirmative action” with every proposed agent (ie nurse)
 - ▶ Signed agreement with each nurse
- ▶ Practitioners may enter into such agent agreements with any number of agents
- ▶ Agents may enter into such agreements with any number of practitioners



Current Status

- ▶ AMDA and PMDA reviewing statement
 - ▶ Identify ways in which facilities may implement changes
- ▶ AMDA and PMDA continuing to work to reduce the delays associated with Schedule II meds
- ▶ >50% of physicians in LTC prescribe C II meds daily



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211.7 Countersignature of CRNP Documents



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211.7 Countersignature of CRNP Documentation

- ▶ (c) Physician assistants' and certified registered nurse practitioners' documentation on the resident's record shall be countersigned by the supervising physician within 7 days with an original signature and date by the licensed physician. This includes progress notes, physical examination reports, treatments, medications and any other notation made by the physician assistant or certified registered nurse practitioner.



211.7 Countersignature of CRNP Documentation

- ▶ PMDA has supported removal of 211.7 (c)
 - ▶ Not evidence based
 - ▶ No impact on patient safety
 - ▶ Reduced clinical care efficiency
 - ▶ Contradicted Act 48 2007

- ▶ Request for Exemption Campaign of 2010
 - ▶ Over 70 facilities requested exemption
 - ▶ All denied



211.7 Countersignature of CRNP Documentation

- ▶ In July 2010, PA DOH requested IRRC review for removal of 211.7 (c)
- ▶ Changed approved by IRRC on 9/16/2010 by 5-0 vote
- ▶ Approved and published in PA Bulletin 10/2/10



POLST Project



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Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name

First Name/ Middle Initial

Date of Birth

A **CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.

Check One Resuscitate/CPR Do Not Attempt Resuscitation (DNR/ no CPR)

When not in cardiopulmonary arrest, follow orders in B, C and D.

B **MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.

Check One **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.*

Limited Additional Interventions Includes care described above. Use medical treatment, IV and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. *Transfer to hospital if indicated. Avoid intensive care.*

Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C **ANTIBIOTICS**

Check One No antibiotics. Use other measures to relieve symptoms.

Determine use or limitation of antibiotics when infection occurs.

Use antibiotics if life can be prolonged.

Additional Orders: _____

D **ARTIFICIALLY ADMINISTERED NUTRITION:** Always offer food by mouth if feasible.

Check One No artificial nutrition by tube.

Defined trial period of artificial nutrition by tube.

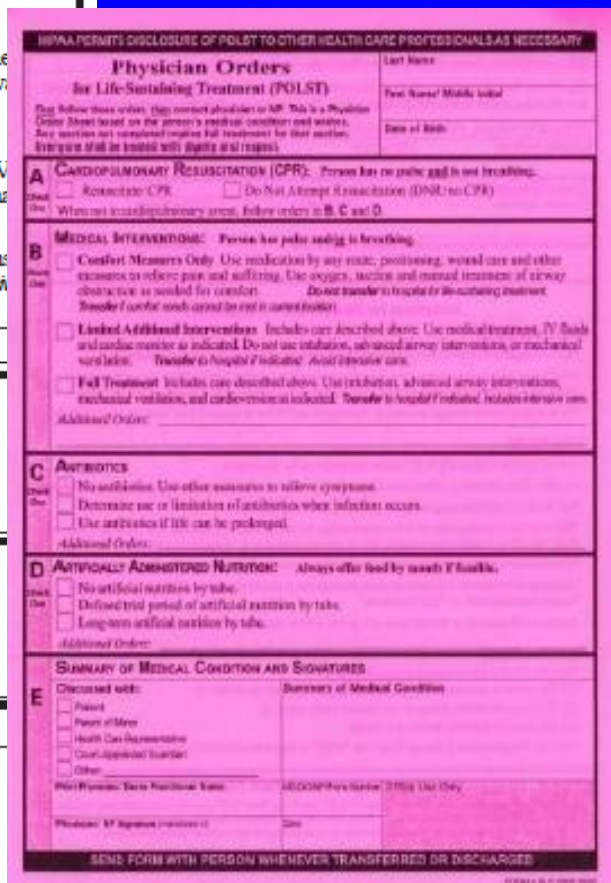
Long-term artificial nutrition by tube.

Additional Orders: _____

E **SUMMARY OF MEDICAL CONDITION AND SIGNATURES**

Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other: _____	Summary of Medical Condition 	
Print Physician / Nurse Practitioner Name	MDDONP Phone Number	Office Use Only
Physician / NP Signature (mandatory)	Date	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED



HAP Project

- ▶ Hospital and Healthcare System Assoc of PA (HAP) initiating project to disseminate POLST throughout PA
 - ▶ Have been pockets of state using already
 - ▶ Goal is to widen use of POLST

- ▶ PA-OLST
 - ▶ PA is finalizing form and will be ready for dissemination



POLST

- ▶ Facilities using POLST program had
 - ▶ More orders reflecting life sustaining treatment
 - ▶ 98% (POLST programs) versus 16% (usual care)
- ▶ Less likely to receive aggressive interventions including hospitalization & ED visits

F 334 Update



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F 334 Update

- ▶ PMDA notified that some surveyors have been stating that F 334 requires:
 - ▶ Written consent of resident or family for influenza vaccine
 - ▶ A specific physician order
 - ▶ Signature of resident or family attesting receipt of education

- ▶ **CMS Does Not Require Any of These**



F 334 Update

- ▶ PMDA working with CMS
 - ▶ Citations being reviewed
 - ▶ Written clarification being considered

- ▶ CMS allows influenza and pneumococcal vaccines to be given by a physician approved standing order policy and removed requirement for physician orders (Federal Register 2003)



F 334 Update

- ▶ No professional organization or expert recommends use of consent forms for influenza vaccine
 - ▶ AMDA recommends against consent forms
 - ▶ AMDA does recommend use of declination forms
 - ▶ Consent forms are a barrier to adequate immunization rates



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F 334 Update

- ▶ Written documentation of receipt of education is also a barrier and not recommended by CMS or any professional organization
- ▶ Per CMS, attention to the education process should only be reviewed in situations where immunization rates fall below acceptable levels
- ▶ PMDA provided national surveyor training last year on these issues for CMS



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CDC / NQF Participation



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NQF Quality Measure on Healthcare Worker Immunization

- ▶ CDC created HCW Influenza Immunization rate quality indicator
 - ▶ Accepted by NQF
 - ▶ Requires testing
- ▶ PMDA is participating in CDC Steering Committee to validate measure
- ▶ PA is one of 4 test states



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