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Assisted Living Column

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Nursing leadership in LTC

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The medical community is taking a comprehensive and critical look at the issue of whether or not long term care (LTC) facilities can safely manage the care of older adults who have higher levels of medical acuity and instability. Being able to accomplish this is crucial in being able to discharge patients from the hospital to the LTC facility with higher degrees of instability as well as reducing any risks associated with higher probability for rehospitalization. Certainly, one would like as much information as we can obtain regarding the ability of nursing to do this without raising the risk of harm. It is a no-brainer to make the assumption that for facilities to care for patients with high degrees of instability there would be need for higher staffing levels. Perhaps this explains why one of the key quality measures for LTC facilities looks at staffing ratios for nurses. One cannot forget that it is equally important that the competence and role of leadership abilities of the nurses in these facilities is elevated to a higher level.

Nursing role and responsibility in LTC has shifted to a leadership position as the environment has changed. As LTC has moved to providing care for much higher acuity patients, focus in value based care delivery at the same time there are fewer primary care physicians involved – nursing is needed to take on a leadership role. This leadership is especially critical in the areas of keeping the facility full so there is revenue to support the program, malpractice prevention both from a clinical and financial need, survey success and cost control – all are increasingly critical as pressures to perform with greater demands and less resources becomes the norm. In addition, beyond these areas there are also expanding roles where nursing is able to play more of what had historically been physician functions such as serving as attending and medical director. It truly is a world of opportunities for successful nurse leaders.

What specifically are we referring to when one says nursing leadership? The definition is wide. Historically, this refers to nursing leadership roles in long term care as having primary application to training of new staff and management of quality assurance activities. Having good outcomes for higher acuity patients in the long term care setting is going to rely heavily on effective teamwork. In turn, the team that is developed must have members that maintain good communications and provide a support network for each other.

Keeping the beds full

Occupancy is of course the life blood for any LTC program as the basis of revenue. Beyond being part of a preferred network there are new methods for filling beds. One of the newest is to have facilities accept direct admissions that come despite not being discharged from a qualifying 3 day hospitalization.

Specifically, the rules here state that the 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals.[1] In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. This requirement is meant to ensure, for Medicare, that the patient is critical enough to require medically necessary skilled services in a SNF and not be overused by inappropriate patients.

While managed care organizations, both Medicare and commercial, have always had the ability to waive the SNF 3-day requirement, Medicare FFS for accountable care organizations (ACOs) is now able to be granted a waiver for this requirement. For approved ACOs and their SNFs, a waiver for the 3-day rule is available in relation to an inpatient hospital, acute-care hospital, or critical access hospital with swing-beds prior to admission to a SNF. In other words, this benefit enhancement allows for beneficiary admission to approved preferred

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provider SNFs, either directly or with an inpatient hospital stay of fewer than 3 days.

The waiver is available if: (1) the beneficiary does not reside in a nursing home or SNF for long-term custodial care at the time of the decision to admit to a SNF; and (2) the beneficiary meets all other Centers for Medicare & Medicaid Services (CMS) criteria for SNF admission:

- is medically stable;
- has confirmed diagnoses (e.g., does not have conditions that require further testing for proper diagnosis);
- does not require inpatient hospital evaluation or treatment; and
- has an identified LTC or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

Preferred provider SNFs must also have, at the time of provider list submission, an overall rating of 3 or more stars for the past 7 of 12 months under the CMS Five-Star Nursing Home Quality Rating System. This is yet another reason that the star rating is so critical for SNFs. Star ratings are reviewed at the time of the preferred provider list submission. Once the SNF has been approved for inclusion on the list for a given performance year, it is not removed during the performance year if the star rating declines.

Beyond Medicare ACOs that are now able to promote direct admissions, direct admissions can also come through managed care plans as well as through those recently discharged from the hospital that still qualify for SNF admissions. There are also other relationships that utilize direct admissions such as hospice and private payers both in need of respite care.

Facilities should start by achieving a 3-star rating and developing an admission process from rapid assessment; then they should focus on initial and ongoing treatment—as well as assessment of those treatments in a timely manner—this requires careful planning.

Perhaps the easiest direct admission to SNFs are those coming from an ED, since a rapid comprehensive assessment can be completed as well as the initial treatment. In fact, our facilities, Forest and Chestnut Hill Healthcare Center in Newark and Passaic New Jersey, have developed programs where patients are sent for Rapid Assessment + Initial Treatment, a process which we affectionately refer to as RAbbIT. RAbbIT requires working with the ED ahead of time to establish a process where patients can be seen in the ED and be rapidly assessed with initial treatment started for continuation within the SNF. The reason this requires preparation is that EDs like to admit to the hospital patients who could just be sent to the SNF, so without setting the foundation for this process, EDs would just admit these patients, which is the opposite of reducing hospital admissions. Besides the ED, these services can also be accomplished through the ever-expanding urgent care centers. Together, EDs and urgent care can be used as the starting point for admission directly to the SNF.

Direct admissions will be coming from managed care organizations, hospice, private respite, and, most recently, Medicare FFS ACOs, but only to those SNFs that are prepared to handle this process—a process significantly different than the traditional admission, which is a transition from the hospital. Those SNFs appropriately equipped to handle direct admissions will benefit from improved clinical and financial outcomes.

Preferred network inclusion

As health systems increase their involvement with risk-based coordination, they will have an expanding need to control costs through managing their post-acute care more aggressively to maintain the highest possible level of efficiency, especially through selection of a preferred group of SNFs to work more closely with.[2] The value of health system-preferred SNF networks was illustrated in a study in Health Affairs.[1] In the article, researchers studied several hospitals that had developed formal SNF networks as part of their care management efforts. These hospitals saw a relative reduction from 2009 to 2013 in readmission rates for patients discharged to SNFs that was 4.5 percentage points greater than the reduction for hospitals without formal networks. Overall, researchers found that establishing preferred SNF provider networks is one approach hospital administrators are using to reduce excess 30-day readmissions and avoid Medicare penalties or to reduce beneficiaries' costs as part of value-based payment models. The measure of success of many health system's SNF network is based on clinical and financial outcomes. These accountability measures focus primarily on keeping patients safe in the SNF and community.

Health systems often strongly recommend that all unplanned ED/hospitalizations undergo a thoughtful analysis to identify opportunities to prevent future occurrences. This activity typically reveals care improvement opportunities related to end-of-life planning or access to medical evaluation. Key metrics that may be helpful to follow include day of transfer, time of transfer, symptoms that triggered transfer, interventions attempted prior to transfer, hospital readmission diagnosis, and length of stay prior to transfer with special attention to transfers back to the hospital that occurred within 72 h of admission to the LTC facility. Assessment should also be made of the baseline diagnoses of the patients that are transferred with focus on areas such as congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus. These disease processes are important as they are commonly encountered in this environment and generally require a solid and coordinated interdisciplinary approach to keep under control. Once an area is identified, a plan can then be put into place to address the perceived problem, such as maintaining physician orders for life-sustaining treatment forms for all residents, using virtual after-hour medical services, or having a dedicated advanced practical nurse available to care for all facility residents. All of these efforts require nursing leadership to be successful to assure success in being part of a preferred network.

Quality measure

CMS created the Five-Star Quality Rating System[3] to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which you may want to ask questions. The Nursing Home Compare Web site features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average. There is one Overall 5-star rating for each nursing home, and a separate rating for each of the following three sources of information:

Health inspections – The health inspection rating contains the 2 most recent health inspections that occurred before implementation of the new long-term care inspection process on November 28, 2017, and inspections due to complaints in the last 2 years occurring prior to November 28, 2017. This information is gathered by trained, objective inspectors who go onsite to the nursing home and follow a specific process to determine the extent to which a nursing home has met Medicaid and Medicare's minimum quality requirements. The most recent survey findings are weighted more than the prior year.

Staffing – The staffing rating has information about the number of hours of care provided on average to each resident each day by nursing staff. This rating considers differences in the levels of residents' care need in each nursing home. For example, a nursing home with residents who had more severe needs would be expected to have more nursing staff than a nursing home where the resident needs were not as high.

The importance of the staffing rating measure for long term care cannot be understated and deserved additional discussion. The necessity of having adequate staff in hospitals is a foregone conclusion that few will debate. The only open parameter that everyone seems to agree upon regarding hospital staffing is that there should be flexibility in response to changes in the environment of care such as patient stability, intensity of care needs, and the volume of admissions and discharges that must be managed.

There have been studies that have investigated the impact of staffing levels on the quality of care in LTC facilities, though there is not a usual wealth of data. Over the course of 3 years ending in 2001, 16 states implemented standards of staffing that exceeded federal requirements and resulted in findings that could be anticipated. They found that having staffing levels that exceeded federal requirements resulted in a reduction in restraint use and a reduction in the number of citations that were given to facilities in response to surveys from the Department of Health.

Let us think about this in more practical terms for a moment. Imagine the example of a patient who is in the hospital recovering from an exacerbation of congestive heart failure, hip replacement surgery, or the physical demands of an infection that requires being bedbound for a time while being treated with intravenous antibiotics and fluids. During the time that you are cared for in the hospital you are 1 of 5 or 6 patients that your nurse is responsible to provide care for. At some point, you are assessed as being able to tolerated transfer to a LTC facility to complete your episode of care and undergo rehabilitation services. In the blink of an eye you are in that long-term care facility and you are now 1 of 15 or 20 patients that the nurse is responsible to provide care for. At face value, it seems to be obvious that this patient is going to be at higher risk for having their potential for full recovery impaired.

Quality measures (QMs) – The quality measure rating has information on 16 different physical and clinical measures for nursing home residents. The QMs offer information about how well nursing homes are caring for their residents' physical and clinical needs.

No rating system can address all of the important considerations that go into a decision about which nursing home may be best for a particular person. Examples include the extent to which specialty care is provided (such as specialized rehabilitation or dementia care) or how easy it will be for family members to visit the nursing home resident. As such visits can improve both the residents' quality of life and quality of care, it may often be better to select a nursing home that is very close over one that may be, compared to a higher rated nursing home that would be far away. Consumers should therefore use the Web site only together with other sources of information for the nursing homes (including a visit to the nursing home) and State or local organizations (such as local advocacy groups and the State Ombudsman program).

Malpractice prevention

Nursing is also on the frontline when it comes to saving a LTC's facilities from malpractice suits. This comes from ensuring the delivery of quality medical care and improving communication including information that should be gathered prior to contacting the practitioner regarding a clinical issue/question or change in condition.

The two most critical areas involve recognizing acute changes with residents and making this known to the attending physician and family. Beyond this responsibility there is also the basic requirement to follow orders and the care plan. These are the very basic responsibilities but to avoid legal actions communicating with family such that expectations are management is perhaps the foundation for avoiding issues as many are the result of miscommunication rather than a true deviation from the standard of care. Communication is needed regarding management of expectations, especially during the end-of-life phase where hospice and palliative care services can be introduced.[7] These efforts lead by the nursing can greatly contribute to the avoidance of malpractice claims against a facility and by doing so save the facility not only through direct savings of payouts but also reputation, which impacts admissions.

Survey success

State surveys can impact not only the CMS Star Rating but also, for facilities having issues, can mean significant sanctions in the form of financial penalties or even closure of the facility to Medicare admissions. As a result, the nurse's involvement in preparing the staff for the survey process is extremely valuable.

LTC facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. To certify a SNF or NF, a state surveyor completes at least a life safety code (LSC) survey, and a Standard Survey.

SNF/NF surveys are not announced to the facility. States conduct standard surveys and complete them on consecutive workdays, whenever possible. They may be conducted at any time including weekends, 24 h a day. When standard surveys begin at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or begin on a Saturday or Sunday, the entrance conference and initial tour should is modified in recognition of the residents' activity (e.g., sleep, religious services) and types and numbers of staff available upon entry.

The State has the responsibility for certifying a LTC facility's or nursing facility's compliance or noncompliance, except in the case of State-operated facilities. However, the State's certification for a LTC facility is subject to CMS' approval. "Certification of compliance" means that a facility's compliance with Federal participation requirements is ascertained. In addition to certifying a facility's compliance or noncompliance, the State recommends appropriate enforcement actions to the State Medicaid agency for Medicaid and to the regional office for Medicare.[4] As a result, this process requires preparation such that the facility stands ready always.

Cost control

Nursing homes for their subacute stay/Medicare Part A received a fixed sum from Medicare or Commercial payers, which includes the cost of almost all the medications needed during this stay. As such reducing the costs of these medications directly contributes to the profitability for the nursing home. Management of these costs occurs even before admission through a pre-admission assessment that is often completed by the pharmacy provider who completes a financial assessment of the medication profile. In the case where expensive medications are needed the medical director can assist in working with discharging hospitals to optimize the discharge medications to the greatest extent possible.

Once admitted, nurse leaders can assure that expensive medications are only ordered in the face of no alternatives. Further the medical director can assure that medications that should be paid outside of the facility's payment such as vaccinations and ESRD-HD medications are billed directly. In the case of vaccinations this means that vaccines are billed through either Medicare Part B or D directly and that medications such as ESA and antibiotics are covered by the dialysis provider. These efforts can save nursing homes much needed funds, funds needed to better serve residents.

Role expansion

With a projection short fall of over 100,000 physicians by 2030, who will fill this gap?[5] One answer could be nurse practitioners. Nurse practitioners are Advanced Practice Registered Nurses (APRNs)

who are helping to mitigate the effects of the national physician shortage by serving as primary care providers. They hold advanced degrees, either an MSN (Master of Science in Nursing) or DNP (Doctor of Nursing Practice), national certification in a patient population focus, and state APRN licensure. Nurse practitioners are advanced practice registered professional nurses who are prepared through advanced graduate education and clinical training to provide a range of health services, including the diagnosis and management of common as well as complex medical conditions to people of all ages.

In 2010, approximately 56,000 nurse practitioners practicing primary care in the United States, according to research commissioned by the Agency for Healthcare Research and Quality. This is 52% of the total number of nurse practitioners in the United States.[6] The number of NPs has more than doubled today with the majority still involved in primary care. Part of this growth is the result of the demand and salary. The average Nurse Practitioner salary in the United States is $105,953 as of January 31, 2019, but the range typically falls between $98,315 and $115,100. Salary ranges can vary widely depending on many important factors, including education, certifications, additional skills, the number of years spent in your profession.[7]

The role of the nurse practitioner can differ somewhat depending on the state in which the nurse is practicing. Certain states allow them to work completely independently, whereas others require them to work under either direct supervision or a collaborative agreement with a doctor.[8] Their scope of services varies among three areas for nurse practitioners: practice authority, prescriptive authority and nurse practitioners as primary care providers.

Practice authority can be defined as nurse practitioners' ability to practice independently without physician oversight. This often requires having a relationship with a physician that outlines procedures the nurse practitioner may perform and procedures for consulting with the physician. In some states, policy specifies whether a nurse practitioner must complete a transition to practice period before practicing independently. In other states, nurse practitioners have full independent practice authority, meaning they practice independently with no physician oversight.

Prescriptive authority refers to a nurse practitioner's authority to prescribe medications. Some states require a relationship with a physician that outlines the nurse practitioner's prescribing abilities. Some states specify whether a nurse practitioner must complete a transition to practice period before being able to prescribe independently. State law in some places allows nurse practitioners to prescribe medications independently without physician oversight.

Some states explicitly identify a *nurse practitioner as a primary care provider*. This could include primary care being defined as a population focus for a nurse practitioner. Other states do not explicitly identify nurse practitioners as primary care providers.

Depending on the state's designation of the NPs scope of practice some can now serve as an attending PCP within the SNF. However, in most situations Medicare requires that the initial visit (history and physical), for the purpose of certifying that the patient requires skilled care, must be performed by a physician. An NP may, however, make a "medically necessary" visit without an initial physician visit; this could occur when a newly admitted Medicare patient in a LTC facility develops a problem that requires medical evaluation and intervention, before being seen by the physician. All subsequent visits may be performed by an NP (or other nonphysician), alternating with the physician.

NPs may perform the initial history and physical for new long-term care (nonskilled) admissions. NPs may also make additional visits, which must be substantiated based on the patient's need (ie, acute illness). Medicare provisions permit 1.5 visits per month; more than this frequency may invite increased scrutiny in the form of an audit.[9]

SNFs have the ability to directly employ NPs to better serve their SNF residents and facility. Given the importance of increasing the level of services provided by SNFs to maintain inclusion in hospital preferred networks and participate in direct admissions by being a 3 Star facility; NPs employed by the SNF directly can be highly valued. Given their sole or primary dedication to the SNF they are more available than most attendings to quickly assess and care for any urgent matter that may arise and by doing so reduce hospitalizations and potential liability issues. In addition, they can serve in an educational role for the entire facility. By providing staff education, the entire skill set of the SNF can be raised.

To help support their time within a SNF many are opening separate outpatient geriatric clinic located in the SNF. This not only provides revenue but also gets the community's older adults to form a positive relationship with the SNF so when they need one they are will think first of that SNF and thus also serve as a new referral source. Also in this type of clinic they can still bill incident to a physician when a physician is present in the building to provide direct oversight in keeping with the rules previously mentioned.

The role of NPs in LTC is incredibly bright as the shift to value based care will increase the need to greater primary care services in SNFs, a role NPs are well suited to fill. Once secure in the position as attending PCP in SNFs it is almost certain that there will be a move to expand their ability to serve as Medical Director's for SNFs. Although this significant change may take an act of Congress rather than a simply administrative fix. Given that high bar and the political pressure by many not to change, this final expansion of the NP role in SNF may take some time but it will surely come at some point perhaps starting in assisted living facilities where that strict requirement does not exist. Whether it is leading as a medical director or in other leadership roles, nursing is well positioned to lead LTC into this brave new world.

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