

MANAGED CARE DIGEST SERIES[®]

SENIOR CARE DIGEST

2010-2011

INTERDISCIPLINARY REPORT
A SURVEY OF LONG-TERM CARE
HEALTH PROFESSIONALS



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Senior Care Digest Interdisciplinary Report

Dear Colleague:

We are proud to share with you this 2010-2011 edition of the *Senior Care Digest Interdisciplinary Report: A Survey of Long-Term Care Health Professionals*, part of the nationally renowned sanofi-aventis Managed Care Digest Series®, now in its 24th year of publication.

The long-term care field continues to evolve, and a wide range of innovations, developments, and changes in this field reflect efforts to address the changing needs of a rapidly growing senior population, a move toward more homelike and person-centered care, and technological developments and new evidence-based treatments. More than ever, it is essential to understand how long-term care practitioners are addressing the challenges they face, implementing clinical innovations, and working with patients, families, and each other in the long-term care setting. This publication reports the results of a national interdisciplinary survey of long-term care professionals, including medical directors, pharmacists, directors of nursing, and nurse practitioners, who provide care for the elderly residing in nursing facilities, assisted living facilities, and various other senior care environments.

The survey results and commentaries offer a unique and enlightening insight into the practices and attitudes of these dedicated health care professionals as well as their thoughts about the most pertinent trends, challenges, and issues. The commentaries highlight comparisons in responses from year to year, demonstrating how practitioners have changed their practices and attitudes as they gain experience and as new research and clinical/practice information comes their way. The overall result is an open and honest portrait of practitioners whose passion, knowledge, expertise, and energy make them unique and inspiring.

Your sanofi-aventis Senior Care account manager would be happy to provide you with additional information about our products and services. In the meantime, we hope this report will enlighten you about this vital health care field.

Thank you for your continuing commitment to quality care and quality of life for America's growing elder population. We look forward to continuing our role in this important mission.

Sincerely,



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Message from the Executive Editor



Dear Reader:

Welcome to the 2010-2011 *Senior Care Digest Interdisciplinary Report: A Survey of Long-Term Care Health Professionals*, presented by sanofi-aventis as part of its Managed Care Digest Series®.

In April and May 2010, health professionals from four key long-term care disciplines—medical directors, pharmacists, directors of nursing, and nurse practitioners—completed a survey designed to explore their perceptions on matters that are helping to shape the challenging and constantly evolving long-term care environment. The survey questions were developed with the participation of expert editorial advisory panelists representing their respective disciplines.

Now in its fourth year of publication, the *Senior Care Digest Interdisciplinary Report* has evolved into a unique tool for tracking trends, attitudes, and best practices in senior care. The 2010-2011 report begins with questions asked of all four disciplines, addressing topics such as controlled drugs, gradual dose reduction, social networking, and research. It is fascinating to see how respondents from the various disciplines agree and disagree on these issues, and the commentary following each section provides further insight.

The report next addresses issues pertaining to each discipline, including demographics, practice environments, and professional roles, to provide a current snapshot of each discipline's makeup and involvement in long-term care. The findings provide a unique opportunity for practitioners to learn more about what their interdisciplinary colleagues are thinking, feeling, and doing.

Many of the responses and open-ended comments were somewhat predictable, but even these offer useful information by validating what we had previously only assumed or expected. A number of unexpected findings emerged, and some eye-opening trends surfaced when this year's responses were compared with data from the 2007, 2008, and 2009 surveys.

While this report aims primarily to examine contemporary issues that affect the work of health professionals in the long-term care setting, it also helps educate professionals from each discipline about subjects of concern to their colleagues. Ideally, if all long-term care health professionals understand the challenges and issues faced by other disciplines in their common goal of providing quality care for our nation's seniors, they will be better able to work effectively as an interdisciplinary team.

It is my hope that the information in this publication will promote dialogue between professionals in the various disciplines, improve their understanding of their colleagues, and ultimately enable all interdisciplinary long-term care team members to collaborate more effectively and provide the highest quality of care for the seniors we serve.

Sincerely,

William Simonson, PharmD, FASCP, CGP
Executive Editor
Senior Care Digest Interdisciplinary Report

Methodology

More than 10,000 nursing facility medical directors, pharmacists active in practice with the elderly (long-term care and/or senior care), nursing facility directors of nursing, and geriatric nurse practitioners were invited to participate in a national survey through contact information provided by professional associations and a commercial firm specializing in targeted lists of health professionals.

Nationally prominent representatives from each of the four disciplines surveyed assisted in the development of the survey and also participated in data analysis and devel-

opment of discussion points pertinent to their respective disciplines.

Invitation letters sent by fax, U.S. mail, and e-mail provided instructions on how to access and complete the survey online. After undeliverable invitations were eliminated, the total number of respondents was 843, with the following response rates: medical directors, 10.3%; pharmacists, 12.1%; directors of nursing, 7.2%; and nurse practitioners, 8.3%.

Data in certain figures may not equal 100% due to rounding or may exceed 100% due to multiple responses.

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EXECUTIVE SUMMARY

The 2010-2011 sanofi-aventis *Senior Care Digest Interdisciplinary Report: A Survey of Long-Term Care Health Professionals* presents and interprets responses, gathered in April and May 2010, to a survey sent to more than 10,000 long-term care health professionals, including medical directors, pharmacists, directors of nursing (DONs), and nurse practitioners (NPs). A total of 843 respondents participated in the survey. This executive summary highlights selected key findings.

Interdisciplinary Issues

Social Networking

Facebook is the most popular social networking venue, with 46% of pharmacists, 41% of DONs, 40% of NPs, and 29% of physicians reporting that they use this site. At least half of the respondents from each discipline said they do not use any social networking sites. Of those who don't use any, the most frequent reason given by NPs (61%) and pharmacists and DONs (52%) was concerns about confidentiality/patient privacy. According to the survey responses, use of social networking sites for the purpose of communicating with patients and their family members is extremely rare.

Controlled Drugs

The vast majority of respondents agreed that innovative solutions must be developed to meet the needs of both the Drug Enforcement Administration (DEA) and nursing facility (NF) residents (DONs and NPs, 95%; pharmacists, 90%; and physicians, 85%). Large percentages of respondents also agreed that the nurse should be considered the physician's agent and verbal orders should be allowed (physicians, 94%; DONs, 88%; pharmacists, 85%; and NPs, 76%). And the majority of respondents agreed that the DEA's current position failing to recognize the nurse as an agent of the prescriber has resulted in residents experiencing pain unnecessarily (physicians, 85%; pharmacists, 79%; and DONs and NPs, 78%). On average, roughly one-fourth of respondents agreed that

controlled drug diversion by nursing staff is a serious problem in nursing facilities, but nearly twice as many disagreed that the DEA's policies reduce the likelihood of controlled medication diversion in this setting.

Gradual Dose Reduction

Ninety-three percent of DONs and 92% of physicians indicated that they are involved in some aspect of gradual dose reduction (GDR) of psychopharmacological medications in nursing facilities. A majority of respondents from each discipline agreed that GDR is effective in reducing the use of these medications (NPs, 81%; physicians, 78%; pharmacists, 76%; and DONs, 70%). Eighty percent of NPs, 73% of pharmacists, and 68% of DONs agreed that maintenance of comprehensive records with dosage reduction attempts scheduled well in advance can improve the GDR process.

Research Conducted in Nursing Facilities

Similar percentages of respondents from each discipline (approximately 20%) reported that some type of research is being conducted in their facilities. A large portion of survey participants indicated that they are not involved in research in their facilities (pharmacists, 86%; NPs, 81%; physicians, 78%; and DONs, 72%). Those who said they are involved in research most commonly reported that their role is collecting resident-specific data (DONs, 19%; physicians, 12%; pharmacists, 11%; and NPs, 8%). The type of research most frequently reported involves quality improvement (pharmacists and DONs, 77%; physicians, 56%; and NPs, 46%).

Physicians and Nurse Practitioners

Practice Responsibilities

Two-thirds of NPs (66%) and half of physicians (54%) agreed that there is a need for national regulations clearly defining supervision and collaboration and superseding state-generated definitions pertaining to non-physician caregivers. Twice as many NPs as physicians strongly agreed with that statement (NPs, 26%; physicians, 13%).

Responses about whether NPs should be allowed to serve as nursing facility medical directors were more polarized. Here, 93% of physicians disagreed (72% strongly disagreed), while half of NPs (46%) agreed. A similar response trend was noted with respect to whether NPs should be allowed to serve as co-medical director, with 76% of physicians disagreeing and 73% of NPs agreeing that they should be allowed to serve in this capacity. And 83% of NPs agreed that they should be able to serve as assistant medical director, compared to just 19% of physicians.

Physicians and NPs largely agreed that a shortage of health care professionals will increase NP presence in NFs (NPs, 84%; physicians, 81%).

Osteoporosis Management

A large portion of physicians (95%) and NPs (84%) said they prescribe oral bisphosphonates to manage osteoporosis in NF residents, compared to just 21% of physicians and 13% of NPs who said they commonly prescribe parenteral bisphosphonates. When those respondents who indicated that they prescribe bisphosphonates (either oral or parenteral)

were asked to report the total daily dosage of supplemental calcium they prescribe, the majority (physicians, 62%; NPs, 59%) said they typically prescribe 1200 mg per day.

Both disciplines selected the same top four contraindications for initiating therapy: 81% of NPs and 71% of physicians identified “resident not able to adhere to required administration techniques”; 63% of NPs and 62% of physicians selected “hospice care”; 58% of NPs and 61% of physicians indicated “limited life expectancy”; and 61% of NPs and 60% of physicians identified “presence of GERD/esophageal motility disorder.” Fifty percent of physicians and 42% of NPs identified severe dementia as a contraindication to initiating bisphosphonate therapy, while only 3% and 5%, respectively, identified mild dementia as a contraindication.

Pharmacists and Directors of Nursing

Compliance with Bisphosphonate Administration Requirements

Pharmacist and DON responses to a question about bisphosphonate administration were relatively similar. The most frequent response for both disciplines was that nursing staff members are able to comply with bisphosphonate administration requirements between 75% and 99% of the time. Nineteen percent of DONs said nursing staff always fully comply with bisphosphonate administration requirements, compared to 7% of pharmacists. Twenty-eight percent of pharmacists and 16% of DONs indicated that compliance occurs less than half of the time.

Discipline-Specific Questions

Medical Directors

Forty-one percent of medical directors indicated that they have served in this capacity for between 10 and 20 years, while 22% have worked as a medical director for four years or less. Nineteen percent said they have served as a medical director for more than 20 years. About a third of their time (36%) is spent in office-based practice and, on average, 8% of their time is allocated to “other” activities, including hospice care, academia, and administration.

One-fifth of medical directors (20%) said they are self-employed full time and see patients in nursing facilities, assisted living facilities (ALFs), and/or in their office. Seventeen percent indicated that they are employed by a managed care organization and/or health system. Ninety-three percent of medical directors said they also serve as an attending physician in one or more nursing facilities. More than a quarter of respondents (27%) said they serve in that capacity in only one facility, while 20% said they serve in two facilities. Seven percent said they serve as an attending physician in six or more nursing facilities. When medical directors were asked to report the total number of residents they serve at any one time as attending physician (in one or more facilities), they reported an average of 113, with a maximum of 600.

Lawsuits Involving Attending Physicians

One-fourth of respondents (24%) reported having been named as an attending physician in at least one lawsuit concerning a nursing facil-

ity resident. According to the survey responses, the majority of cases were dropped without settlement or were settled out of court. Few cases went to court, and only rarely was a decision rendered against the attending physician.

Lawsuits Involving Medical Directors

Few physicians reported being named in a lawsuit as medical director. As with the cases involving attending physicians, most of the suits involving medical directors were dropped without settlement or were settled out of court. According to the survey responses, decisions against the medical director were rare.

Pharmacists

Ninety-two percent of pharmacist respondents reported that they are members of the American Society of Consultant Pharmacists, and 25% said they belong to the American Pharmacists Association. More than a third of respondents (36%) said they have earned the certified geriatric pharmacist credential.

Two-thirds of pharmacists (68%) said they practice in one or more NFs, and a third said they practice in assisted living (38%) and/or serve as dispensing pharmacist for a long-term care pharmacy provider (34%). Pharmacists most frequently said they are paid by a pharmacy provider, whether by salary (30%), by the hour (15%), or by the bed (2%).

Senior Care Pharmacy Services

While more than half of respondents (59%) indicated that they currently do not see individual patients as a senior care pharmacist, 12% said they plan to offer senior care services at some point in the future. Fifteen percent of respondents said they con-

duct patient visits for comprehensive medication review in an office setting. Fourteen percent said they perform such reviews in the patient's residence, and 10% said they provide follow-up visits there.

Fifty-six percent of pharmacists who provide senior care pharmacy services in environments other than nursing facilities said they are reimbursed on a private-pay basis, either by the patient (31%) or by the patient's family or representative (25%).

Pharmacist Practice Activities

More than half of respondents (57%) said they are involved in a quality assessment and assurance committee. Other committee activities, reported by order of frequency, included involvement in a pharmacy and therapeutics committee (50%), quarterly review committee (48%), and behavior management/psychotropic drug committee (44%).

Medication Regimen Review

Nearly three-fourths of pharmacists (70%) said they perform medication regimen reviews (MRRs) in nursing facilities. About half (51%) reported that it takes them an average of 6 to 10 minutes to conduct an individual MRR for a long-stay resident, but when they were asked how long it takes to perform an MRR for a short-stay resident, the most frequent response—indicated by a third of pharmacists (36%)—was 11 to 15 minutes. Fifty-eight percent of pharmacists said they have contact, either occasional or routine, with residents for the purpose of observation/information gathering as part of their MRR. Respondents most commonly reported seeing residents on request of facility staff (86%) or when a staff member or another clinician suspects a medication-related problem (69%).

The majority of pharmacists (54%) reported that prescribers accept 81% to 100% of their MRR recommendations. A very small percentage (8%) reported an acceptance rate of 40% or less.

Directors of Nursing

Two-thirds of DONs (67%) said they have been serving in that capacity for five years or more. Slightly more than half (55%) said they have served as a DON in more than one facility during their career. A quarter of respondents (24%) said they plan to work in that capacity for fewer than five years.

Facility Staffing

DONs reported an average of 11.5 full-time equivalent RN staff positions in their facilities, with an average of 0.7 positions currently unfilled. The majority of respondents (76%) reported a turnover rate of 10% or less, with an average of 9.6%. Nearly half of DONs (47%) indicated that their facility's RN turnover rate was lower in 2009 than in 2008, compared to 12% who reported that the turnover rate was higher.

Health Insurance

Seventeen percent of survey respondents said their facilities provide fully paid health insurance for DONs, while 7% or less said their facilities provide fully paid health insurance for other full-time nursing staff (RNs, LPNs/LVNs, and nurse aides/assistants). A mere 1% of respondents said part-time staff receive this benefit. The majority of DONs said their facilities pay a portion of health insurance costs for family members of full-time staff, with one notable exception—only 33% of DONs said their facilities pay a portion of health insurance costs for family members of full-time RNs.

Five-Star Quality Rating System

A large portion of DONs (76%) agreed that the Five-Star Quality Rating System should be revised (55% strongly agreed; 21% mostly agreed). Similar percentages agreed that the system causes confusion for consumers selecting a nursing facility (32% strongly agreed; 30% mostly agreed). Fifty-seven percent indicated that they thoroughly understand the system. Relatively small numbers of DONs agreed that the system is having a positive impact in areas such as staff morale (17%) and census (11%).

Nurse Practitioners

Twenty-eight percent of NPs are adult nurse practitioner certified, while 19% said they are family nurse practitioner certified. Approximately half (47%) have been NPs for less than 10 years. Forty-seven percent of those practicing in NFs said they

serve in one facility, and 13% percent said they serve in five or more facilities per month. NPs most frequently said they are employed by a managed care organization/health plan (24%). Three-fourths of respondents (74%) said they receive a salary and 17% said they receive hourly compensation. Seven percent reported an incentive-based payment model.

Doctor of Nursing Practice

NPs most frequently agreed that the doctor of nursing practice (DNP) degree should qualify a nursing faculty member for university promotion and tenure (59%). A similar percentage (56%) agreed that the DNP will create additional confusion within their profession. Half (51%) agreed that the DNP is the preferred doctorate for advanced practice nursing, with one in four expressing a neutral opinion. A third (34%) felt that all current NPs should be granted the DNP degree based on their experience.



INTERDISCIPLINARY ISSUES

Physicians, Pharmacists, Directors of Nursing, and Nurse Practitioners

Social Networking

Introduction

Social networking sites such as Twitter, Facebook, and LinkedIn attract millions of users each day. People of all ages, backgrounds, and interests sign on to these sites to share observations, seek answers, offer information and links, talk to friends and family, post photos and videos, and network with colleagues. The survey asked participants from all disciplines—medical directors, pharmacists, directors of nursing (DONs), and nurse practitioners (NPs)—whether and how they use social networking sites.

Description of Data

At least half of the respondents from each discipline said they do not use any social networking sites (physicians, 66%; NPs, 56%; DONs, 54%; and pharmacists, 50%) (Figure 1).

Facebook is the most popular social networking venue, with 46% of pharmacists, 41% of DONs, 40% of NPs, and 29% of physicians reporting that they use this site. Smaller percentages said they use LinkedIn (12% or less of each discipline). Reported use of Twitter was extremely low, with 4% of pharmacists, 3% of NPs, 2% of DONs, and no physicians saying they use this site. Very small percentages reported using “other” methods, including some obscure social networking sites and communication via professional organizations and/or e-mail.

Reasons for Not Using Social Networking Sites

Of those who don't use any social networking sites, the most frequent reason given by NPs (61%) and pharmacists and DONs (52%) was concerns about confidentiality/patient privacy (Figure 2).

Nearly half of physicians (43%) likewise expressed concerns about confidentiality/patient privacy, but their most frequent response (54%) was that they just don't have a need for social networking sites. And 49% said it takes too

FIGURE 1

Use of Social Networking Sites

Which of the following social networking sites, if any, do you use on a regular basis?

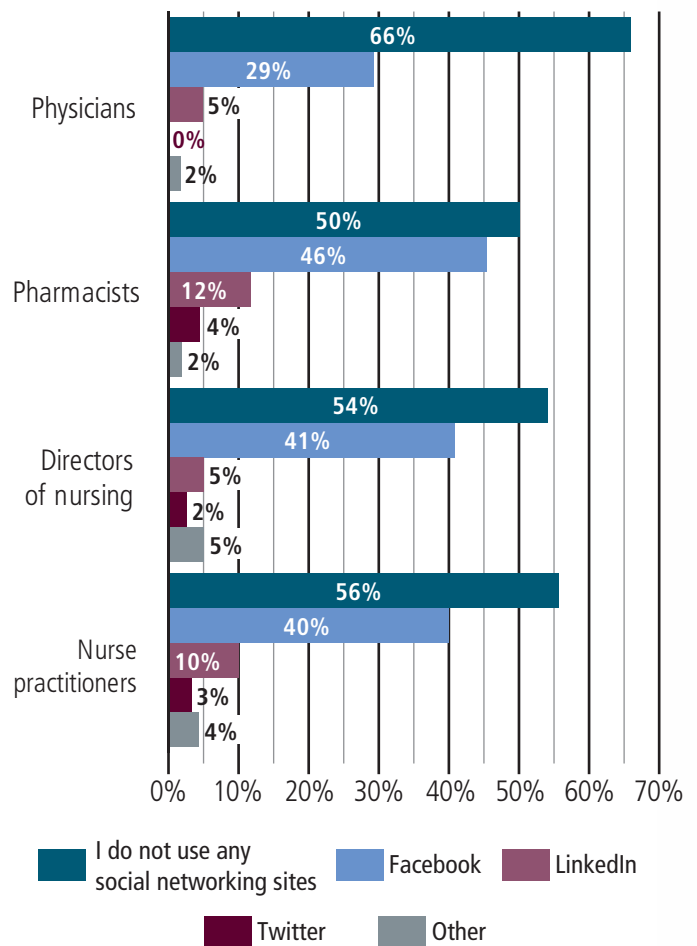
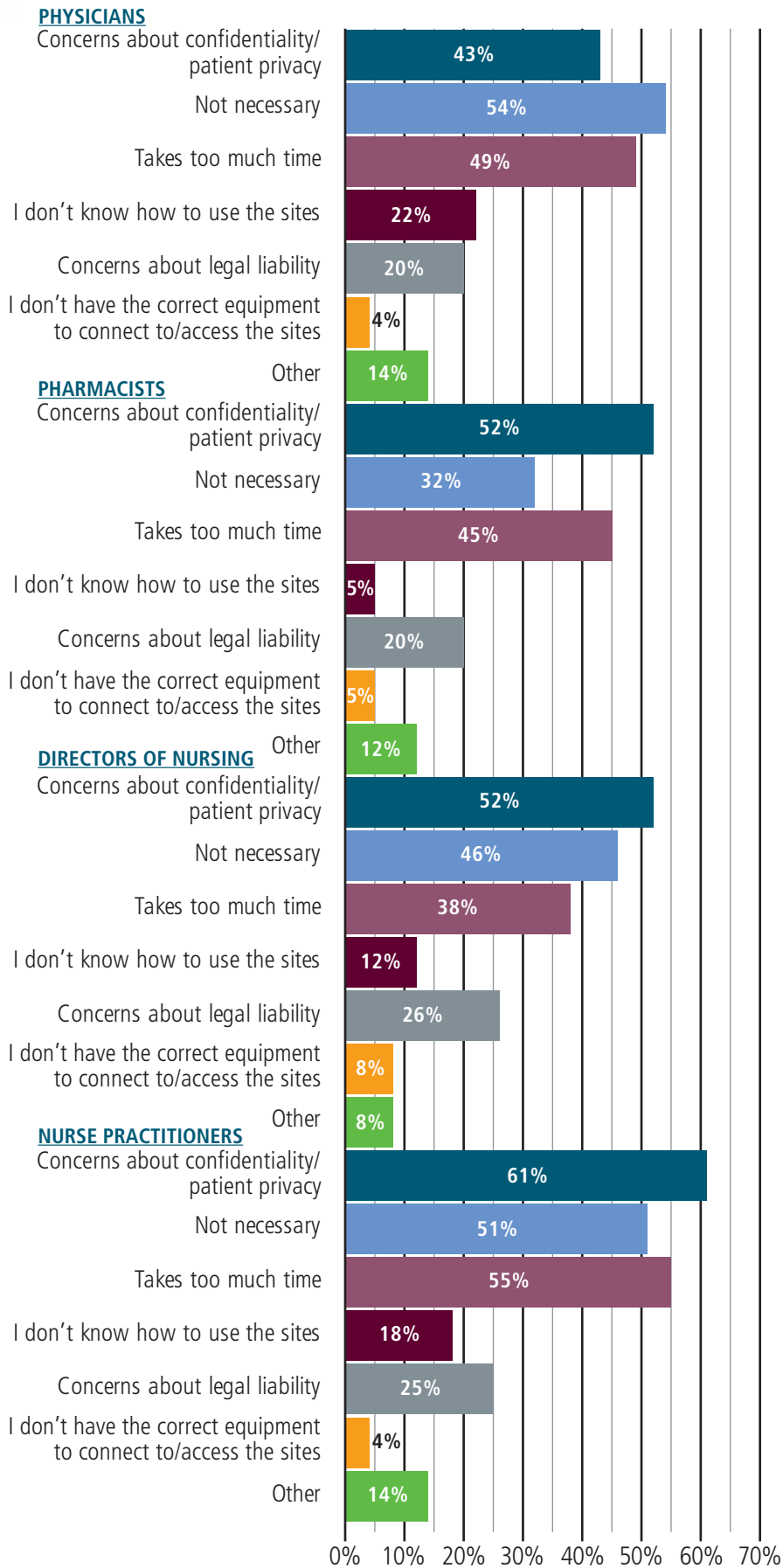


FIGURE 2

Reasons for Not Using Social Networking Sites



much time. These last two responses also were commonly identified by the respondents from the other three disciplines as reasons why they don't use social networking sites. Depending on the discipline, one-fourth to one-fifth of respondents don't use social networking sites because of concerns about legal liability.

Purposes for Using Social Networking Sites

The survey asked those who reported using social networking sites to identify their purposes in doing so. About half of NPs and DONs (54% and 49%, respectively) said they use the sites to communicate with professional colleagues, compared to 44% of pharmacists and 33% of physicians (Figure 3).

According to the survey responses, use of social networking sites for the purpose of communicating with patients and their family members is extremely rare.

The vast majority of those who indicated a reason for using social networking sites other than those listed as response options in the survey question said they use it for personal communication with family members and friends. Smaller percentages said they use such sites for a variety of other purposes, including seeking employment, marketing services, and maintaining a blog.

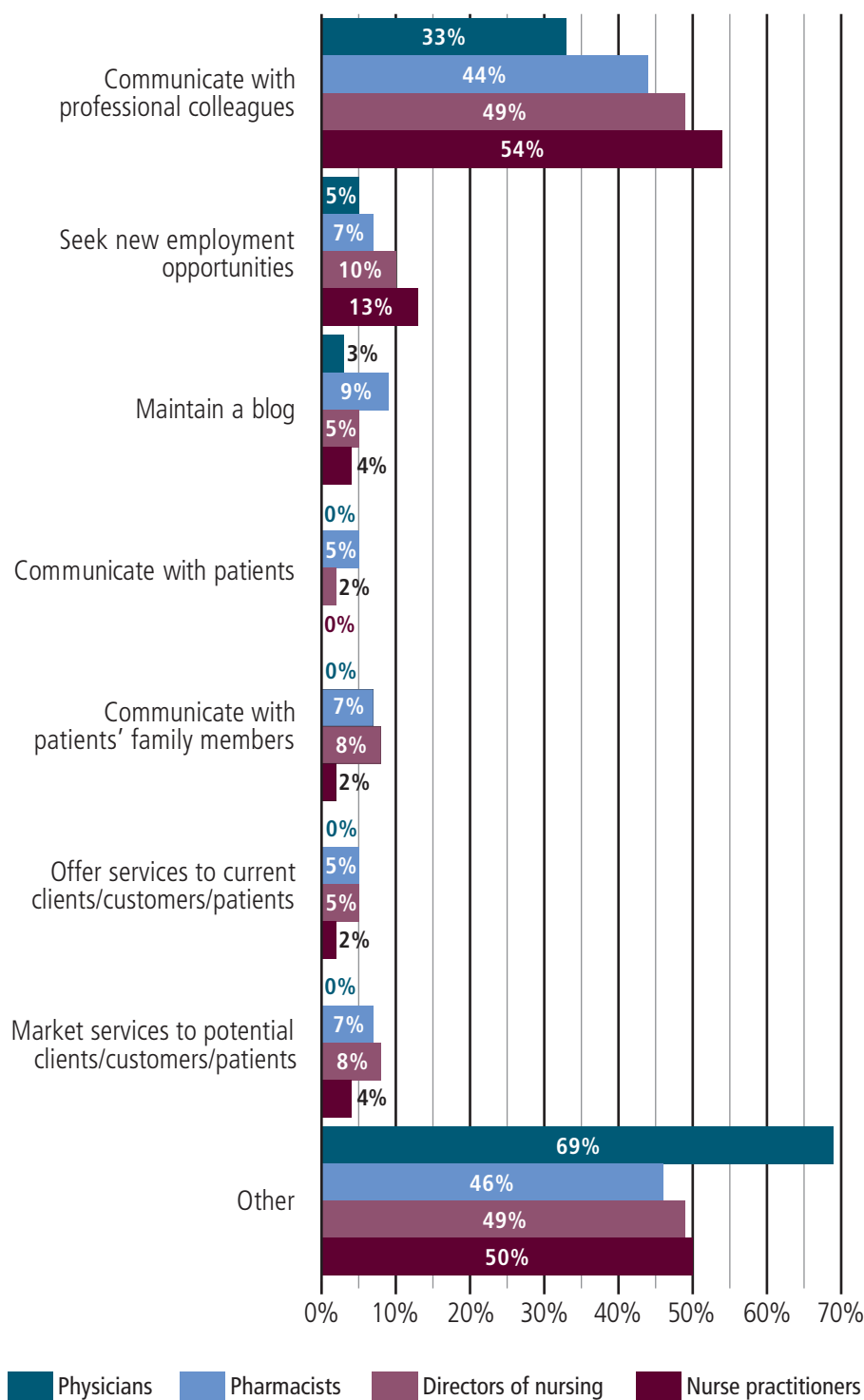
Commentary

Social networking sites allow a collaborative exchange of information, opinions, and comments. They enable real-time communication and sharing of ideas, links, articles, and news through "posting" (sending a message to a group or placing text on a Web site).¹

The survey responses indicate that

FIGURE 3

Purposes for Using Social Networking Sites



while a sizable percentage of respondents use social media sites—primarily Facebook—they have considerable reservations about using them in their role as health care professionals. Respondents from all four disciplines voiced concerns about privacy, which undoubtedly explains why they rarely use social networking sites to communicate with patients’ family members or even more rarely, with patients themselves. In fact, no physicians or NPs used them for communicating with patients.

The fact that a minority of respondents reported using one or more social networking sites for communication—either with family members and friends or professional colleagues—demonstrates the potential for wider use. However, only small percentages of respondents use them for other purposes, such as seeking employment, marketing, and blogging. These smaller numbers may represent the “early adopters” who will test the systems for these and other innovative purposes and perhaps find new ways to use them. It is important to note that as popular as social networking via the Internet is, it still is a relatively new concept. And as is true of many innovations before it, social networking may be seen as a fad by some people, strictly a social activity or simply a waste of time. How many of these people will come to see social networking sites as necessary or even useful is yet to be seen. However, it is reasonable to suggest that many health care professionals will avoid using them as long as they have privacy and legal liability concerns. Until these concerns are addressed, such individuals probably will avoid social networking sites or limit their use to personal communication with family and friends.

Open-ended comments about social media were revealing. Some were blunt, such as “*I hate computers.*” Others were more thoughtful, such as these comments: “*I do not want to give my personal information away to the rest of the world,*” or “*I am not interested because I like face-to-face contact when possible,*” or “*I would prefer a dedicated social networking site related to nursing and specialties (e.g., cardiology, epidemiology, etc.) and not a site for people to use for entertainment and gossiping.*”

With so many people believing that social networking sites are too time-consuming, it is possible that their use would increase—perhaps dramatically—if long-term care health professionals would see them as time savers rather than time wasters. This would require education on the part of professional organizations and widely touted success stories from colleagues—and these don’t appear to be forthcoming any time soon.

Reference

1. Kaldy JK. The social pharmacist: tweeting and posting the way to success. *Consult Pharm.* 2010; 34(1):26-34.

Controlled Drugs

Introduction

The Drug Enforcement Administration (DEA) currently does not recognize nurses as agents of the prescriber/physician in long-term care (LTC) facilities. This position conflicts with current treatment guidelines and standards of practice, leaving vulnerable, frail patients to struggle with pain for hours—or

even days—while physicians, nurses, and pharmacists rush to collect required DEA paperwork.¹

In the meantime, LTC pharmacies are subject to exorbitant fines for complying with practice standards and federal requirements for nursing homes, which conflict with DEA rules and often interfere with appropriate pain control.² The result: Pharmacies face the choice of meeting their obligation to patients or complying with the DEA’s arbitrary policy interpretation.

The survey asked participants the extent to which they agree or disagree with a series of statements on this issue.

Description of Data

Overall, the largest percentage of respondents agreed that innovative solutions must be developed to meet the needs of both the DEA and nursing facility (NF) residents (DONs and NPs, 95%; pharmacists, 90%; and physicians, 85%) (Figure 4).

Large percentages of respondents also agreed that the nurse should be considered the physician’s agent and verbal orders should be allowed (physicians, 94%; DONs, 88%; pharmacists, 85%; and NPs, 76%). And the vast majority of respondents agreed that the DEA’s current position failing to recognize the nurse as an agent of the prescriber has resulted in residents experiencing pain unnecessarily (physicians, 85%; pharmacists, 79%; and DONs and NPs, 78%).

On average, roughly one-fourth of respondents agreed that controlled drug diversion by nursing staff is a serious problem in nursing facilities, but nearly twice as many disagreed that the DEA’s position reduces the

likelihood of controlled medication diversion in this setting.

Commentary

Long-term care health professionals have long requested relief from DEA regulations that keep patients waiting for needed pain medications and are incompatible with the practice model in this care setting.

The American Society of Consultant Pharmacists (ASCP), in collaboration with other stakeholders, has established the Quality Care Coalition for Patients in Pain (QCCPP) to ensure that nursing home residents, hospice patients, and others have access to appropriate and timely pain medication by (1) advocating the elimination of barriers to access resulting from laws, regulations, and policies governing the prescribing and dispensing of controlled substances, and (2) promoting compliance and best practices by educating providers, prescribers, consumers, and caregivers about appropriate prescribing and dispensing practices.³

The survey results left little doubt about long-term care health professionals’ dissatisfaction with the current situation. Physicians’ strong agreement that the DEA policy is having a negative impact on residents is supported by several comments such as these: “*The new DEA rules sometimes hang up the analgesics for three days for nonhospice patients*” and “*It has resulted in delay of treatment of frail older adults, including hospice patients.*”

A number of respondents agreed that controlled drug diversion is a serious problem in NFs; however, several comments noted that this issue can be resolved. For example, one DON said, “*Facility policy with strict guidelines for control of narcotics and random*

FIGURE 4

The Nurse as the Physician's Agent for Controlled Drug Prescribing

PHYSICIANS

The nurse should be considered the physician's agent and verbal orders should be allowed

It has resulted in residents experiencing pain unnecessarily

Innovative solutions must be developed to meet the needs of both the DEA and nursing facility residents

It reduces the likelihood of controlled medication diversion in nursing facilities

Controlled drug diversion by nursing staff is a serious problem in nursing facilities

PHARMACISTS

The nurse should be considered the physician's agent and verbal orders should be allowed

It has resulted in residents experiencing pain unnecessarily

Innovative solutions must be developed to meet the needs of both the DEA and nursing facility residents

It reduces the likelihood of controlled medication diversion in nursing facilities

Controlled drug diversion by nursing staff is a serious problem in nursing facilities

DIRECTORS OF NURSING

The nurse should be considered the physician's agent and verbal orders should be allowed

It has resulted in residents experiencing pain unnecessarily

Innovative solutions must be developed to meet the needs of both the DEA and nursing facility residents

It reduces the likelihood of controlled medication diversion in nursing facilities

Controlled drug diversion by nursing staff is a serious problem in nursing facilities

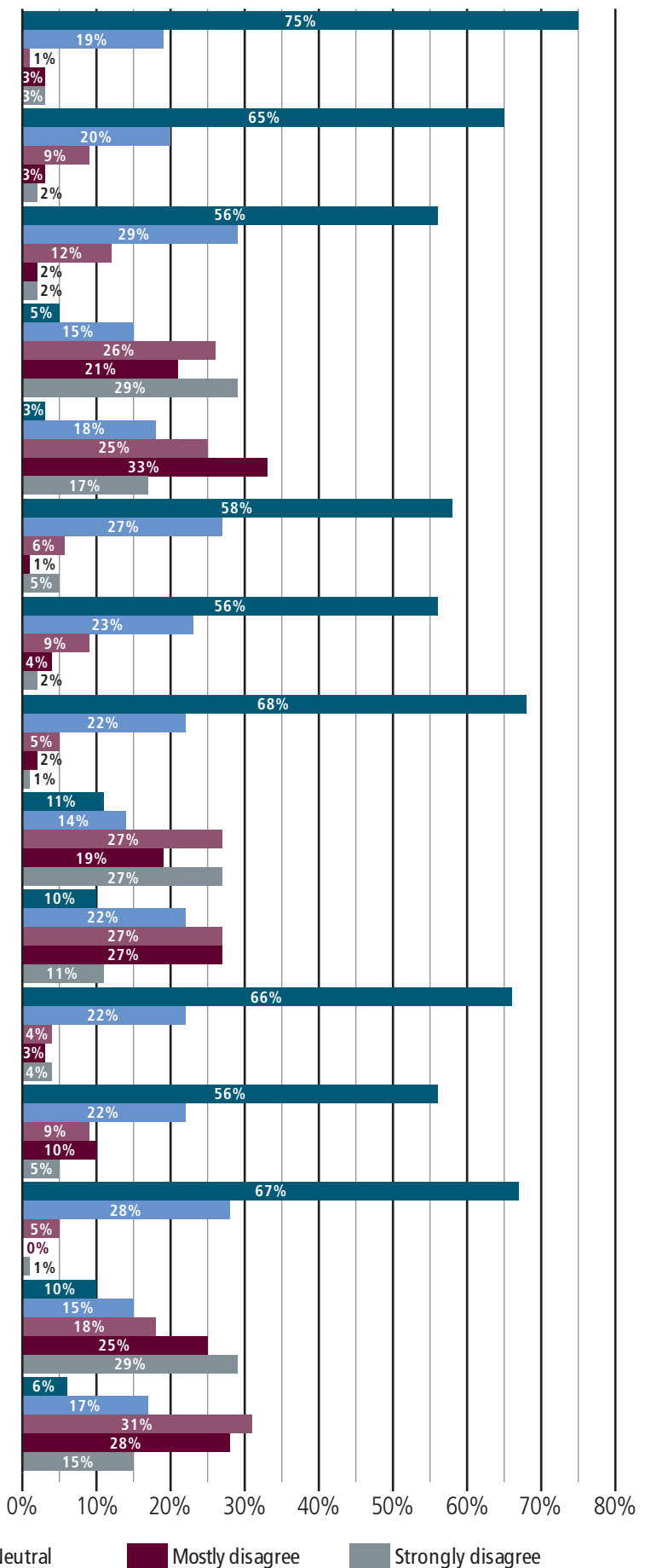


FIGURE 4 (continued)

The Nurse as the Physician's Agent for Controlled Drug Prescribing

NURSE PRACTITIONERS

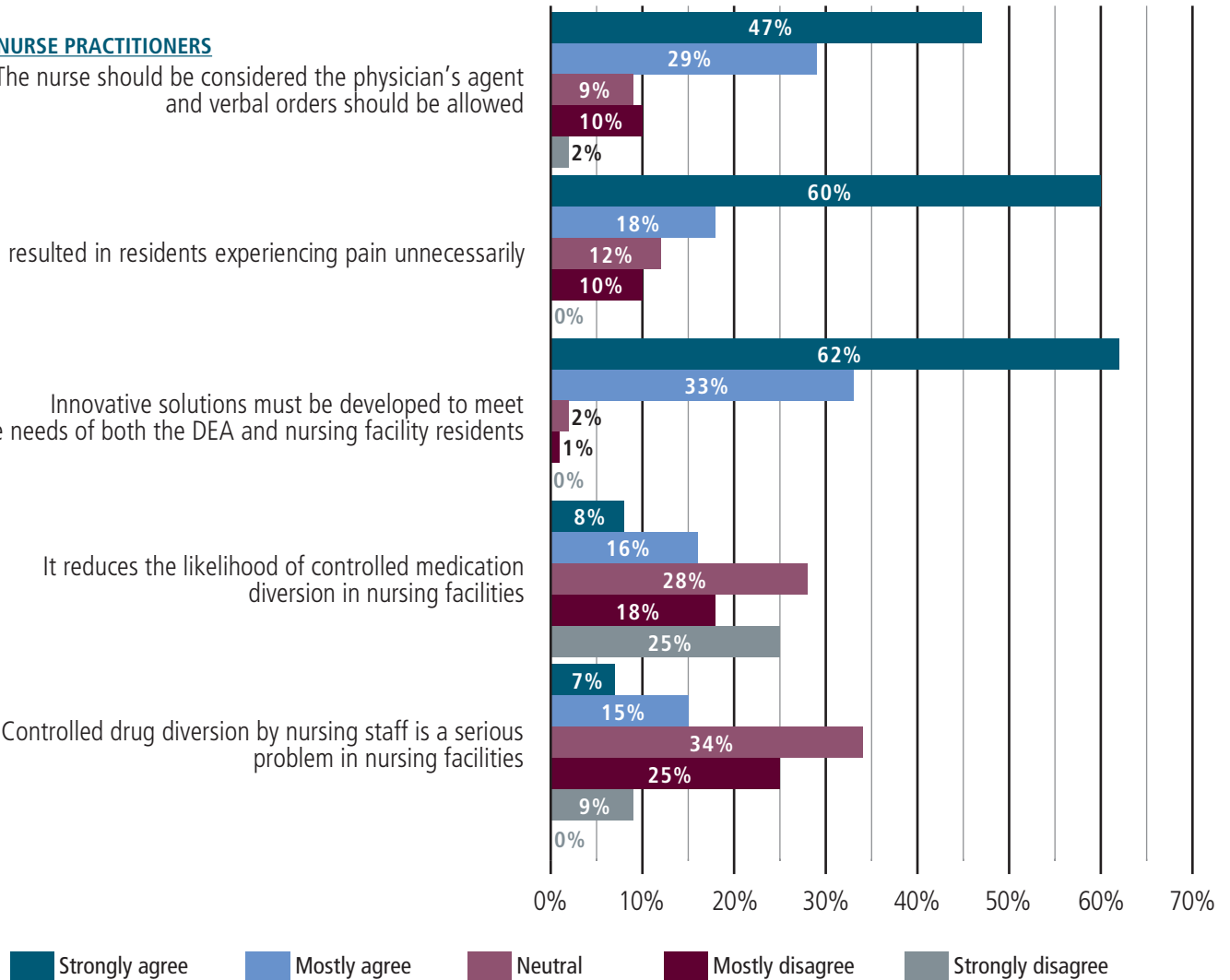
The nurse should be considered the physician's agent and verbal orders should be allowed

It has resulted in residents experiencing pain unnecessarily

Innovative solutions must be developed to meet the needs of both the DEA and nursing facility residents

It reduces the likelihood of controlled medication diversion in nursing facilities

Controlled drug diversion by nursing staff is a serious problem in nursing facilities



drug testing prevents diversion. Facilities need to readily report nurses to their Board of Nursing rather than just terminate for cause.” A pharmacist suggested that rather than controlling diversion, the DEA’s action actually has facilitated it: “The DEA has increased the potential for drug diversion by nursing home staff. To compensate for the FDA’s action, doctors are requesting larger quantities of controlled drugs to be sent to the homes. [The] nursing staff is having to make new areas for storage of the controlled medications due to increased quantities received.”

After resisting changes that would correct this situation, the DEA issued a notice in the June 2010 *Federal Register* requesting the public’s feedback on whether the agency should revise existing regulations to make it easier for nursing facility residents to gain access to controlled substance medications.⁴

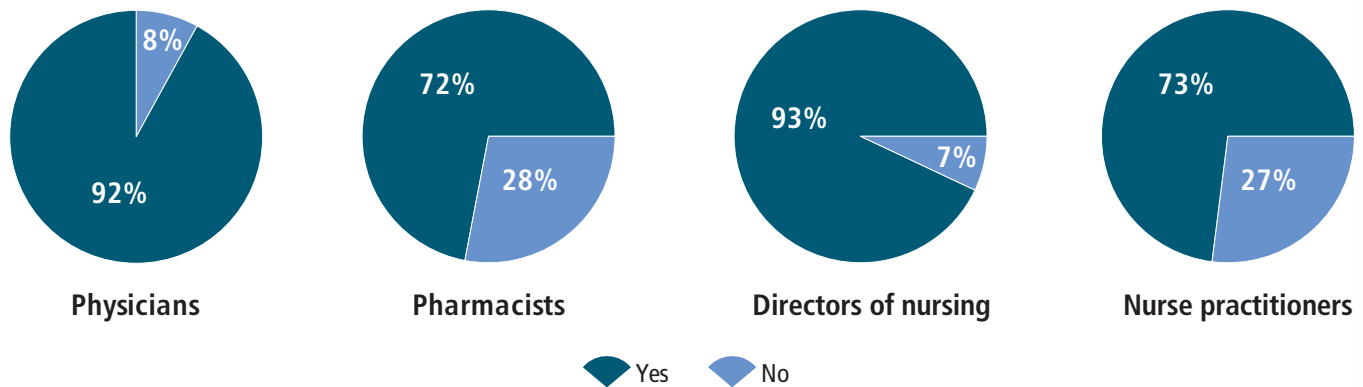
The agency is specifically seeking comments from long-term care practitioners, pharmacists, facility management, nurses, and residents and their families. This request for comments presents stakeholders

with an opportunity to seek changes to the Controlled Substances Act that would allow the NF nurse to be recognized as the agent of the prescribing physician and would allow chart orders to be recognized as valid prescriptions for controlled substance medications. Comments were accepted through August 30, 2010. While it certainly doesn’t represent a solution, this development provides hope that the controlled drugs situation will be remedied in a mutually agreeable way.

FIGURE 5

Involvement in GDR of Psychopharmacological Medications in NFs

Are you involved in any aspect of NF GDR?



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2. American Society of Consultant Pharmacists. ASCP fact sheet. Chart orders and nurse as agent of the prescriber. <http://www.ascp.com/advocacy/federal/upload/03%20DEA%20Fact%20Sheet.pdf>. Accessed July 8, 2010.
3. Quality Care Coalition for Patients in Pain Web site. <http://www.ascp.com/advocacy/qccpp/>. Accessed July 8, 2010.
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Gradual Dose Reduction

Introduction

Tag F329 – Unnecessary Drugs specifies that nursing facility residents who use antipsychotic drugs receive gradual dose reduction (GDR) and

behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.¹ The survey asked participants whether they are involved in any aspect of GDR and sought their opinion of various aspects of this intervention.

Description of Data

Involvement in GDR

Ninety-three percent of DONs and 92% of physicians indicated that they are involved in some aspect of GDR of psychopharmacological medications in nursing facilities (Figure 5).

Three quarters of NPs (73%) and pharmacists (72%) said they are involved in this type of intervention. Pharmacist involvement was lower than expected, so the survey data were examined more closely. Subsequently, it was determined that of those pharmacists who said they perform monthly medication regimen reviews (MRRs) in nursing facilities, more than 94% reported involvement in GDR.

Opinion/Impression of GDR

When respondents were asked whether they agree or disagree with a

series of statements about GDR, the responses from all four disciplines were relatively consistent. A majority of respondents from each discipline agreed that GDR is effective in reducing the use of psychopharmacological medications (NPs, 81%; physicians, 78%; pharmacists, 76%; and DONs, 70%). However, only a quarter of respondents from each discipline said they “strongly agree,” compared to half who said they “mostly agree” (Figure 6).

Similar trends surfaced with respect to respondents’ satisfaction with GDR and the belief that it has a positive effect in their facilities. More than any other discipline, physicians agreed that GDR requests are generated too frequently. Much lower numbers of pharmacists, NPs, and DONs agreed with this statement.

Preparation of GDR Recommendations

Eighty-six percent of NPs, 84% of physicians, 82% of DONs, and 72% of pharmacists reported that GDR recommendations are most frequently developed by pharmacists (Figure 7).

More than half of DONs (53%) said

FIGURE 6

Opinion/Impression of GDR

PHYSICIANS

GDR is effective in reducing use of psychopharmacological medications

On average, GDR has a positive effect on a resident's condition

I am satisfied with the GDR process in my facility(ies)

GDR requests are generated too frequently

PHARMACISTS

GDR is effective in reducing use of psychopharmacological medications

On average, GDR has a positive effect on a resident's condition

I am satisfied with the GDR process in my facility(ies)

GDR requests are generated too frequently

DIRECTORS OF NURSING

GDR is effective in reducing use of psychopharmacological medications

On average, GDR has a positive effect on a resident's condition

I am satisfied with the GDR process in my facility(ies)

GDR requests are generated too frequently

NURSE PRACTITIONERS

GDR is effective in reducing use of psychopharmacological medications

On average, GDR has a positive effect on a resident's condition

I am satisfied with the GDR process in my facility(ies)

GDR requests are generated too frequently

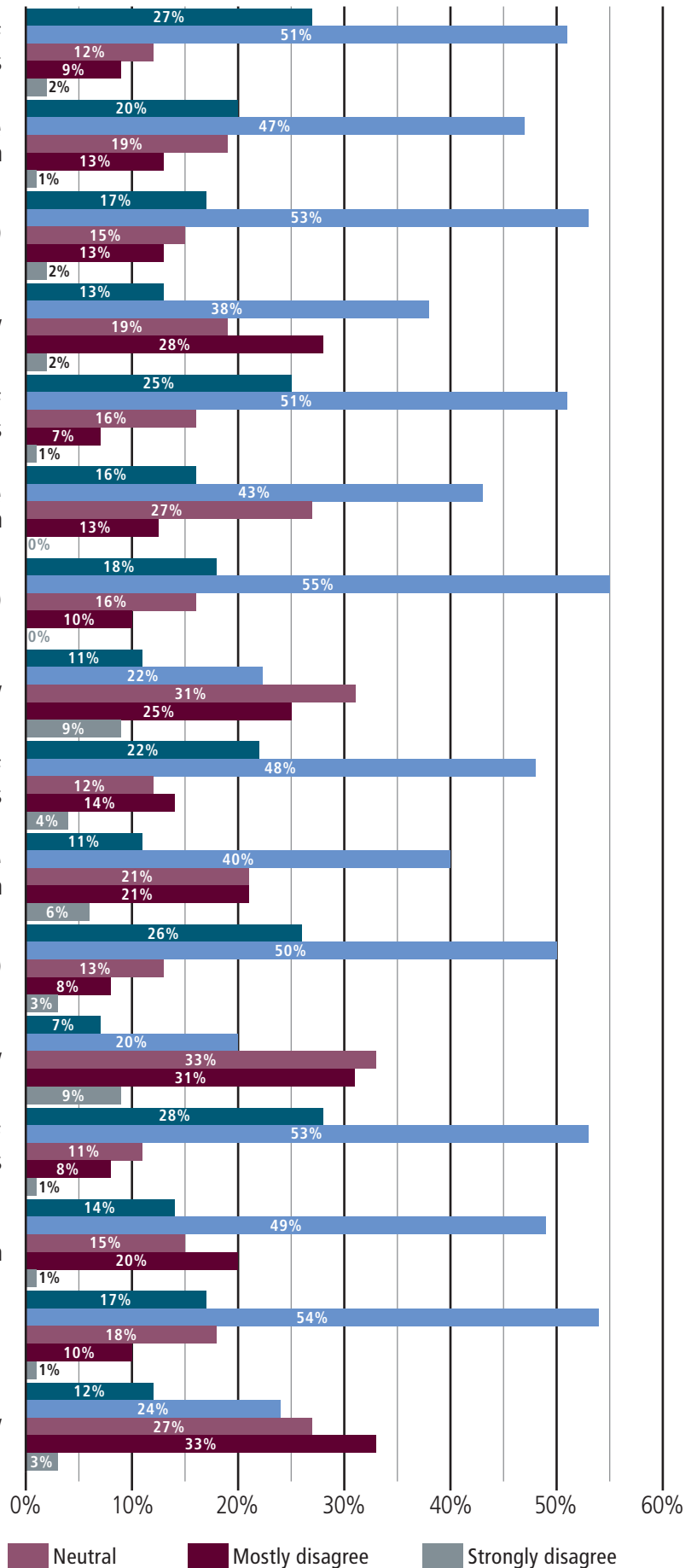
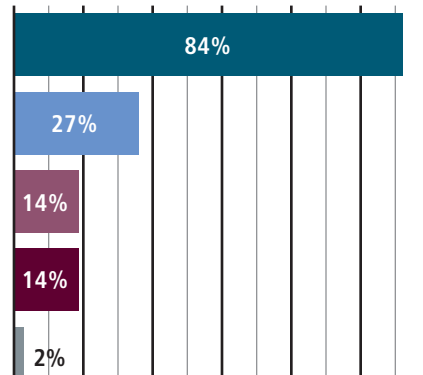


FIGURE 7

How GDR Recommendations Are Developed in NFs

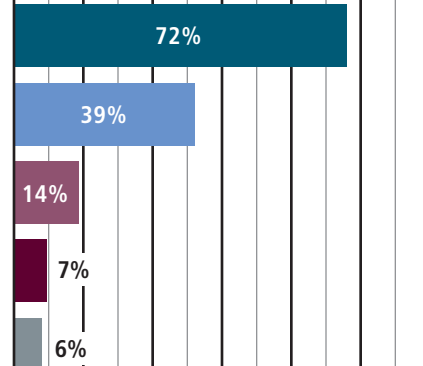
PHYSICIANS

- Developed by a pharmacist who focuses on the facility's problem areas
- Developed by an interdisciplinary committee that I participate in
- Developed by an interdisciplinary committee that I do not participate in
- Other
- I don't know



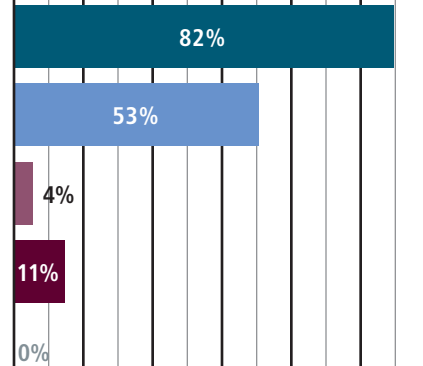
PHARMACISTS

- Developed by a pharmacist who focuses on the facility's problem areas
- Developed by an interdisciplinary committee that I participate in
- Developed by an interdisciplinary committee that I do not participate in
- Other
- I don't know



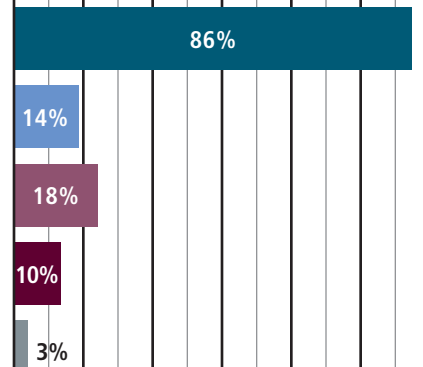
DIRECTORS OF NURSING

- Developed by a pharmacist who focuses on the facility's problem areas
- Developed by an interdisciplinary committee that I participate in
- Developed by an interdisciplinary committee that I do not participate in
- Other
- I don't know



NURSE PRACTITIONERS

- Developed by a pharmacist who focuses on the facility's problem areas
- Developed by an interdisciplinary committee that I participate in
- Developed by an interdisciplinary committee that I do not participate in
- Other
- I don't know



0% 30% 60% 90%

they participate in an interdisciplinary committee that develops the GDR recommendations, compared to 39% of pharmacists, 27% of physicians, and 14% of NPs. Respondents also described other means of communicating GDR data/recommendations; these are discussed in the commentary at the end of this section.

Factors Needed to Make GDR Most Effective

When survey participants were asked which factors are needed to make GDR most effective, physicians, pharmacists, and DONs selected “buy-in by attending physicians,” “support of the medical director,” and “cooperation of the interdisciplinary team” as the top three—though not necessarily in the same order (Figure 8).

Small percentages of respondents from each discipline said that GDR occurs automatically or that it is not needed because prescribers can use their clinical judgment. “Other” comments included the involvement of a psychiatrist and the state surveyor’s role in the GDR process; these are discussed at the end of this section.

Factors That Can Improve GDR

The final question on GDR was designed to identify which actions can improve GDR in the nursing home setting. The most common response from NPs (80%), pharmacists (73%), and DONs (68%) was agreement that maintenance of comprehensive records with GDR attempts scheduled well in advance can improve the process. Seventy percent of physicians, most of whom are also medical directors, agreed with this response, but a greater percentage (75%) agreed that the facility’s medical director should reinforce the importance of

FIGURE 8

Factors Needed to Make GDR Most Effective

	Physicians	Pharmacists	Directors of nursing	Nurse practitioners
Buy-in by attending physicians	86%	80%	73%	71%
Support of the medical director	73%	72%	71%	61%
Cooperation of the interdisciplinary team (physician, pharmacist, NP, nursing, etc.)	65%	74%	81%	83%
Ongoing communication between prescribers and pharmacist	64%	66%	64%	76%
Formal buy-in by facility staff and administration	62%	67%	54%	60%
Routine presentation of GDR results to facility's QA committee	39%	28%	44%	39%
Ongoing oversight and coordination handled by specific committee	28%	33%	41%	30%
GDR occurs automatically since it is mandated by the nursing facility survey process	8%	8%	13%	16%
GDR is not needed; prescribers can use their clinical judgment	5%	2%	5%	2%
Other	4%	1%	4%	2%

GDR to attending physicians and prescribers (Figure 9).

There was less agreement that GDR attempts and success should be compared between attending physicians. The strongest *disagreement* was that developing a policy for automatic stop order unless overridden by a prescriber's clinical review of the resident can improve GDR in nursing facilities. More than half of physicians and NPs (61%) disagreed with that statement—including 34% of nurse practitioners who strongly disagreed.

Commentary

GDR is a formal component of Tag F329 that is intended to reduce the use of psychopharmacological medications, which are defined in the Centers for Medicare and Medicaid

(CMS) State Operations Manual as any medications “used for managing behavior, stabilizing mood, or treating psychiatric disorders.”¹ Tag F329 specifies that the facility review the need for such medications at least quarterly and document the rationale for continuing the medication—including evidence that the resident's target symptoms and effect of the medication have been evaluated—as well as any changes in the resident's function or any incidence of any medication-related adverse consequences in the previous quarter.¹

Responses were quite similar between disciplines, which demonstrates a consistent understanding of the concept of GDR, its impact, and how to improve it. Respondents generally expressed satisfaction with

how the process works in their facilities and its effectiveness in improving medication usage.

It is understandable that high percentages of physicians and DONs are involved in GDR, since it is an important aspect of a facility's ability to comply with state survey requirements. Likewise, it is not surprising that consultant pharmacists are frequently involved in the process. However, it is interesting that others—including consultant psychiatrists or psychologists and other members of the interdisciplinary team (IT)—are also an integral part of the process and often meet on a scheduled basis. As one DON said, “*The pharmacy consultant makes the recommendations, the IT reviews the effects of the medication on the individual resident*

FIGURE 9

Factors That Can Improve GDR in NFs

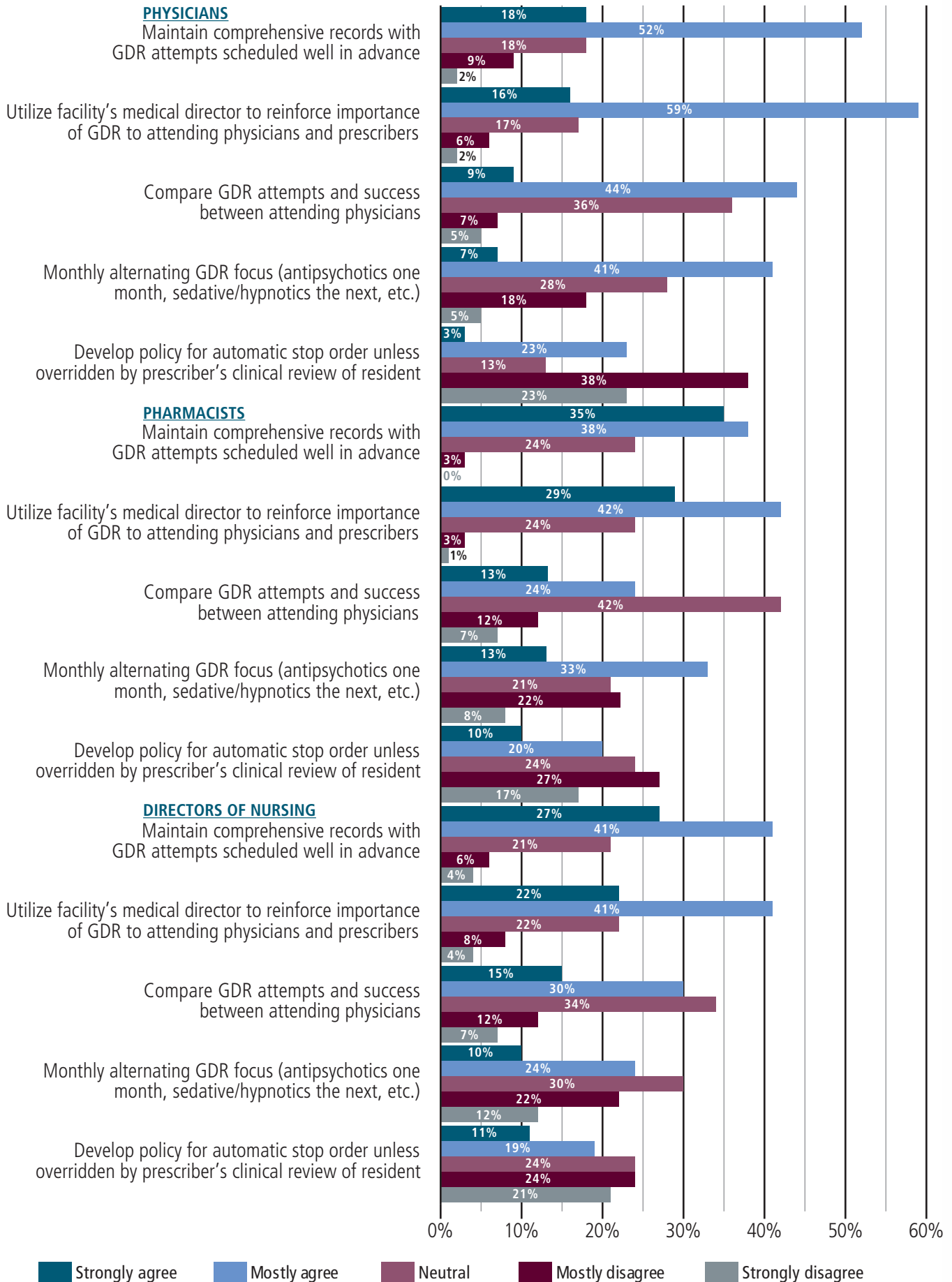
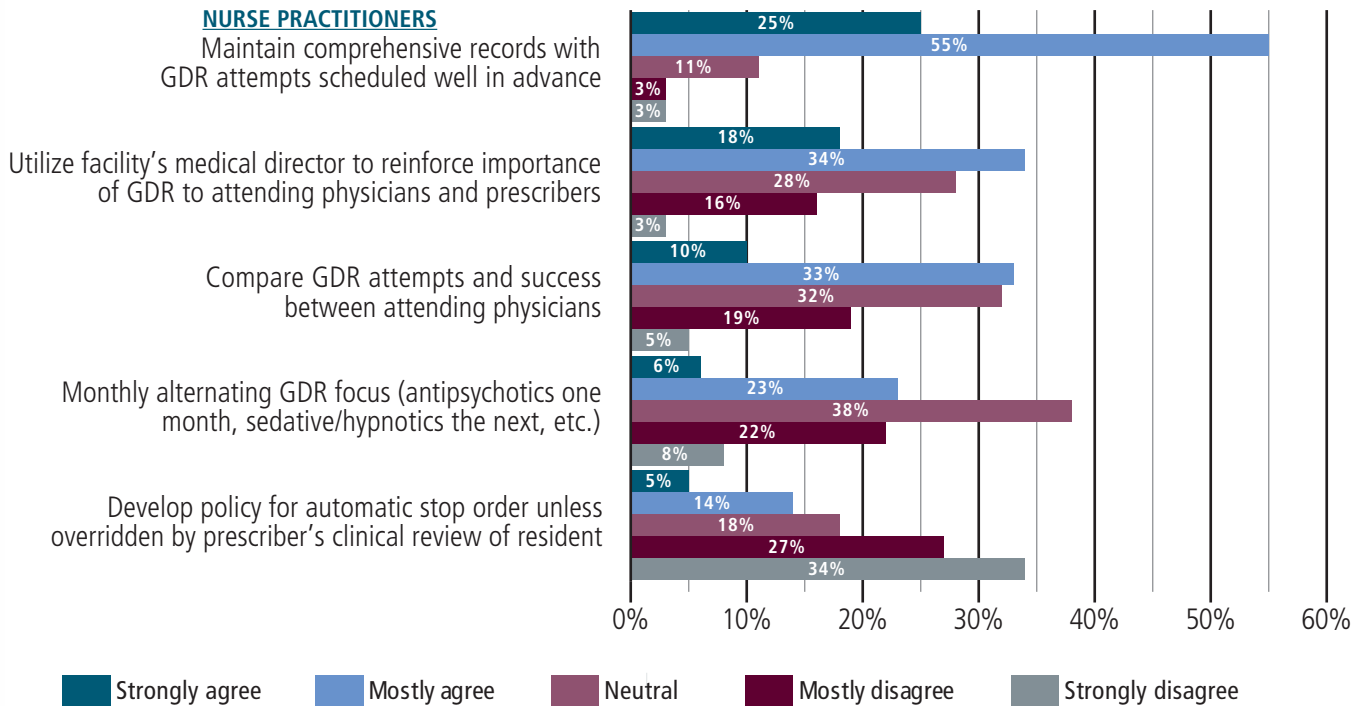


FIGURE 9 (continued)

Factors That Can Improve GDR in NFs



and sends these recommendations to the medical provider.”

Numerous open-ended comments consistently focused on similar issues and concerns. Respondents frequently noted that GDR must consider the individual resident—it often can be detrimental and may result in the decline of a previously stable resident. They also expressed concern about the concept of stop orders for psychoactive medications. Again, they stressed that each resident must be evaluated individually.

Clearly, GDR can be a challenge in nursing facilities. It can be difficult to implement the process and to maintain adequate records of past attempts at GDR, since charts may occasionally be “thinned.” Another challenge is that long-term care facilities often attempt to minimize drug therapy changes in residents who appear to

be stable. That is, practitioners are of a mind that “if it ain’t broke, don’t fix it.”² This conflicts with the intent of GDR, which is to minimize the use of drugs that residents may no longer need. The intent is good, but practitioners are concerned that GDR isn’t always feasible—or best for the patient—in practice. Nonetheless, while GDR is difficult to implement appropriately, the benefits can be impressive. For example, a recent study found that a well-organized and coordinated nursing facility GDR program resulted in highly favorable outcomes, including a 25% decrease in falls in high-risk residents, a 66% decrease in pressure ulcers, and a 72% decrease in psychiatric discharges to hospital.³ If these dramatic outcomes can be replicated, we soon may see best-practice models of GDR being developed, embraced, and widely implemented in nursing facilities.

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Research in Nursing Facilities

Introduction

It is essential that long-term care (LTC) clinicians, staff, and consultants recognize how various treatments, practices, innovations, and attitudes impact diseases of aging in order to care for their elderly patients.¹

The survey respondents from each discipline answered a series of questions about their involvement in research within their nursing facilities.

Description of Data

Research Conducted in Nursing Facilities

Similar percentages of respondents from each discipline (approximately 20%) reported that some type of research is being conducted in their facilities (Figure 10).

More pharmacists (12%) and NPs (16%) said they don't know if research is taking place in the facilities where they practice than did physicians (5%) and DONs (2%).

Role in Research

A large percentage of respondents indicated that they are not involved in research in their facilities (pharmacists, 86%; NPs, 81%; physicians, 78%; and DONs, 72%). Of those who said they are involved in research in their facilities, the most common role is collecting resident-specific data (DONs, 19%; physicians, 12%; pharmacists, 11%; and NPs, 8%) (Figure 11).

More physicians (12%) than DONs (8%), pharmacists (7%), or NPs (6%) reported involvement as a project director or clinical investigator.

Respondents from each discipline identified research roles other than those listed as response options in the survey question. These included promoting facility involvement in research studies, serving as an Institutional Review Board (IRB) member, providing resources or guidance, performing literature reviews, and supervising staff involved in research.

Source of Research Funding

Funding sources identified by respondents varied greatly according

to discipline. Physicians and DONs most commonly reported that their research is unfunded (52% and 35%, respectively). In contrast, most pharmacists reported pharmaceutical industry funding (47%), and most NPs identified funding from a source other than those listed as response options in the survey question (29%) (Figure 12).

National Institutes of Health (NIH) funding was most commonly reported by physicians (28%). Small percentages of the other three disciplines reported NIH funding (NPs, 13%; pharmacists, 12%; and DONs, 11%).

Nature of Research

The respondents who said they participate in research in their nursing facilities most frequently indicated that the research involves quality improvement (QI) (pharmacists and DONs, 77%; physicians, 56%; and NPs, 46%) (Figure 13).

Commentary

Involvement in nursing facility research can be immensely valuable, and the findings from even a small research study can impact care and outcomes.¹ Organizations such as

FIGURE 10

Nursing Facility Research

Is any type of research conducted in one or more nursing facilities where you practice?

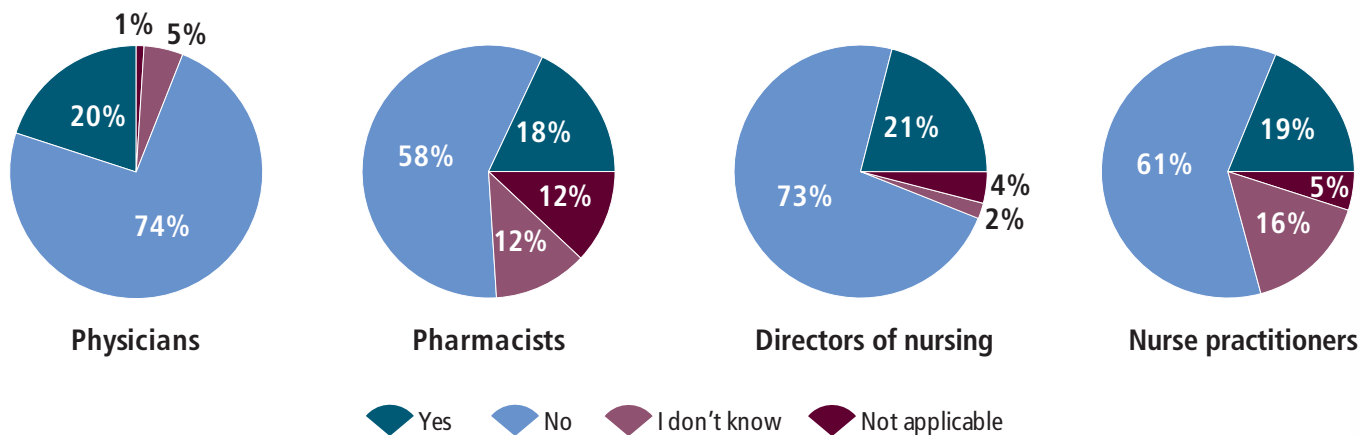
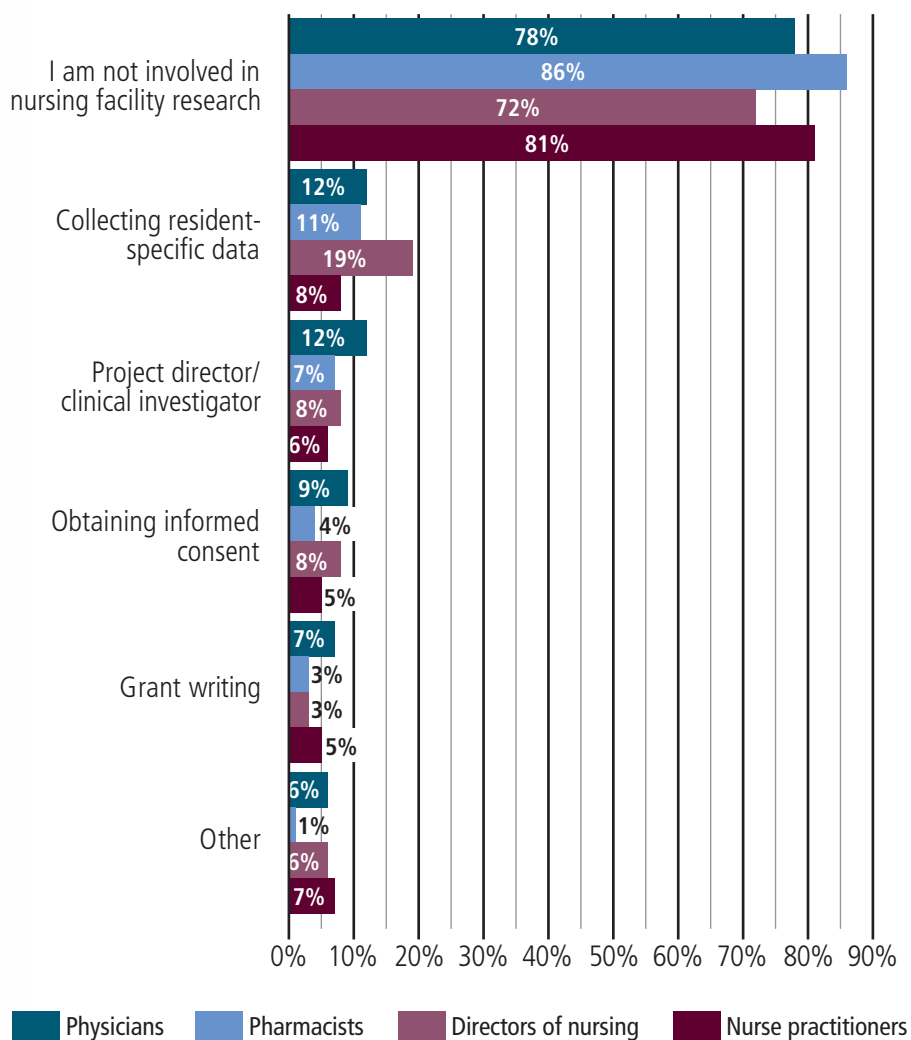


FIGURE 11

Research Role

What is your role in NF research?



the American Medical Directors Association (AMDA) and the American Society of Consultant Pharmacists have long promoted the need for more research involving LTC residents. Nonetheless, barriers remain. These include lack of funding, staff resistance, lack of staffing or staff time to collect data, unwillingness of families/guardians to let loved ones participate in research studies, the challenges of gathering data from voluminous records, and the difficulties of obtaining informed consent—especially for patients with cognitive

impairment or dementia.²

With the dearth of long-term care research, practitioners in this setting have had to depend on studies that involve younger and/or healthier patients and extrapolate the data to their frail elderly LTC residents. The difficulty is that LTC patients generally are sicker, take more medications, and have more comorbid illnesses and problems such as cognitive impairment, so practitioners often find themselves comparing apples to oranges.

The survey results revealed that relatively small percentages of respondents from each discipline are involved in research. However, we need to recognize that people’s definition of research may vary and thus affect their survey responses. For instance, some people may not consider a small QI study or questionnaire about practices and attitudes “research.” The reason for such differences is understandable since formal research is typically not a significant component of LTC health professionals’ formal education. This suggests an opportunity for research-related education and training in long-term care. If more practitioners understand research and what it entails, they would be more apt to promote, support, and participate in studies at their facilities.

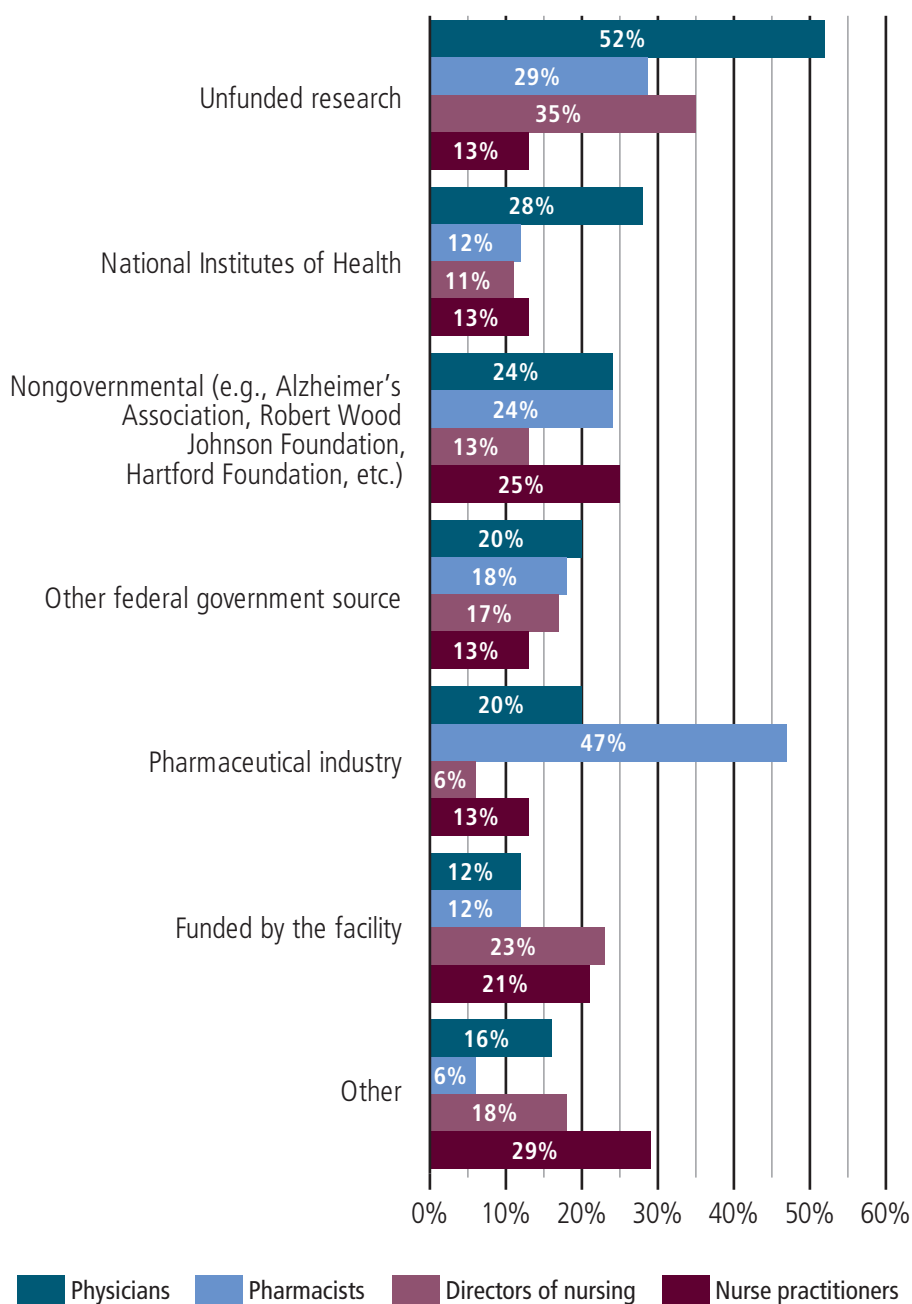
It isn’t surprising that more physicians and DONs are aware of research in their facilities than are pharmacists or NPs. After all, the medical director and DON are facility leaders responsible for administrative and clinical services; they spend more time in the facility and are more involved in its day-to-day activities. Pharmacists and NPs, on the other hand, serve as consultants and are less likely to know about studies unless they are directly involved.

It is noteworthy that so many respondents indicated involvement in unfunded studies. In all probability, the majority of these studies involve QI, as QI is a priority for most facilities and the data available from the Minimum Data Set make it fairly easy to track outcomes and compare data. Moreover, the Centers for Medicare and Medicaid Services (CMS) has encouraged QI in nursing facilities. At the AMDA Foundation Long Term Care Research Network 2009 Fall Conference, CMS Deputy

FIGURE 12

Source of Research Funding

What is the source of funding for the research in which you are involved?



Chief Medical Officer Paul McGann said that QI is important to show what nursing home interventions benefit residents, and he encouraged QI studies in this setting.³

Many QI studies actually are small projects whose goal is to identify variables that affect resident outcomes, such as investigations of fall frequency compared to shift or diagnosis.²

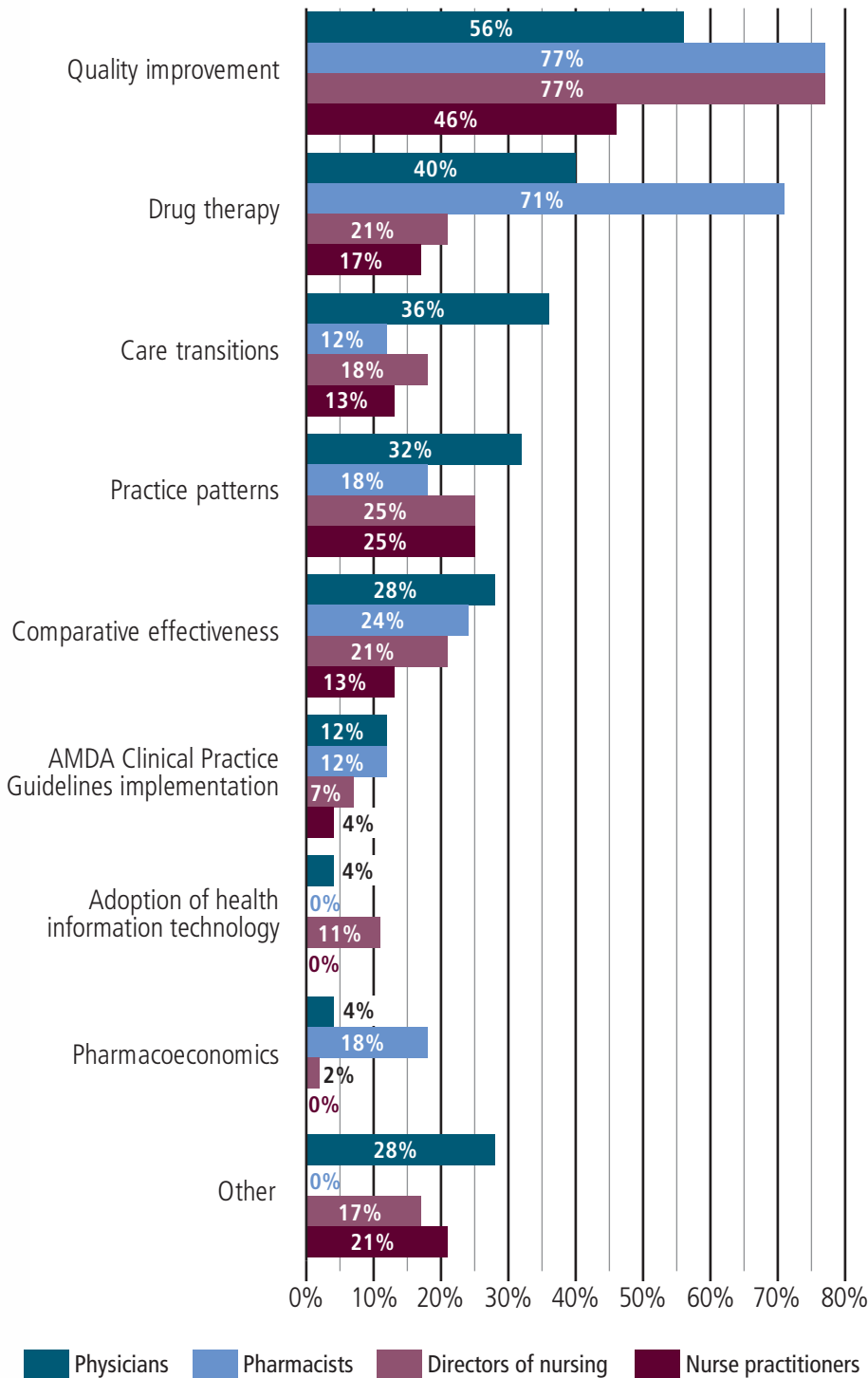
Resources are available for those interested in learning about or becoming involved in nursing facility research. The AMDA Foundation created the Long Term Care Research Network in 1999 to encourage clinician participation in research.² One of its initiatives is to encourage involvement in community-based participatory research (CBPR), which is cyclical, interactive research that involves many stakeholders, including researchers, clinicians, families, and members of the community.⁴

An open-ended question gave respondents an opportunity to suggest topics that warrant further LTC research, and they provided a wide range of responses. Physicians commonly identified the need for research on dementia and behaviors, falls, wound care, end-of-life issues, and appropriate use of medications. Pharmacists also listed dementia and behaviors as well as appropriate medication management. While DONs agreed with physicians about the need for falls and dementia research, they also voiced strong interest in studies on staffing issues as they relate to quality of care as well as staff training and education. NPs echoed DONs' interest in staff issues and frequently identified the need to address the relationship between proper staff training and quality of care.

FIGURE 13

Nature of Research

What is the nature of the research in which you are involved?



Clearly, there are significant opportunities for research in nursing facilities and a very broad assortment of issues to be studied. It also is clear that there are significant barriers to overcome. It will be interesting to see how involvement in—as well as funding for—long-term care research changes as the population ages and more baby boomers enter this care setting.

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INTERDISCIPLINARY ISSUES

Physicians and Nurse Practitioners

Practice Responsibilities

Introduction

The survey asked physicians and NPs their opinion of several statements regarding their practice roles and responsibilities.

Description of Data

Two-thirds of NPs (66%) and half of physicians (54%) agreed that there is a need for national regulations clearly defining supervision and collaboration and superseding state-generated definitions pertaining to non-physician caregivers. Twice as many NPs as physicians strongly agreed with that statement (NPs, 26%; physicians, 13%) (Figure 14).

Responses about whether NPs should be allowed to serve as nursing facility (NF) medical directors were more polarized. Here, 93% of physicians disagreed (72% strongly disagreed), while half of NPs (46%) agreed. A similar response trend was noted with respect to whether NPs should be allowed to serve as co-medical director, with 76% of physicians disagreeing and 73% of NPs agreeing that they should be allowed to serve in this capacity. And 83% of NPs agreed that they should be able to serve as assistant medical director compared to just 19% of physicians.

Physicians and NPs were unified in their assessment that a shortage of health care professionals will increase NP presence in NFs (NPs, 84%; physicians, 81%). However, only a small percentage of respondents from each discipline said that these shortages would increase physician presence in this environment.

Commentary

As documented in a separate section of this report, many physicians collaborate with NPs and undoubtedly rely on

that collaboration to maintain a higher patient load than would be possible if the physician practiced without that collaboration. (See the discussion of medical director collaboration with non-physician providers beginning on page 33.) The majority of NP and physician respondents concur that national regulations clearly defining supervision and collaboration and superseding state-generated definitions pertaining to non-physician caregivers are needed. However, survey responses demonstrated that physicians and NPs have dramatically different opinions as to whether NPs should serve as medical director, co-medical director, or assistant medical director.

A possible explanation for this difference is that while physicians are supportive of the role of NPs in their current capacities, they may feel NPs would be encroaching on responsibilities that physicians perceive as exclusively their own, and despite their willingness to collaborate, they traditionally view themselves as “captain” of the interdisciplinary health care team. Physicians also understand that the medical director coordinates and oversees medical care and intervenes with attending physicians, and that role requires that the medical director be a physician.

In a recent development, a Nebraska-based advanced practice nurse submitted a proposal to the Health Resources and Services Administration’s National Advisory Council on Nurse Education and Practice that would allow NPs to fulfill the role of medical director. A strongly worded letter from AMDA urged members to withhold support for changing federal regulations to allow this and stated that “Nursing home medical directors do not simply implement and approve resident care policies. Centers for Medicare and Medicaid Services regulations mandate that a physician supervises a resident’s medical care and medical directors coordinate the overall medical care in the facility.”¹

FIGURE 14

Physicians and NPs — Practice Responsibilities

PHYSICIANS

National regulations clearly defining “supervision” and “collaboration” and superseding state-generated definitions of non-physician caregivers are needed

Regulations should allow NPs to serve as assistant medical directors in nursing facilities

Regulations should allow NPs to serve as co-medical directors in nursing facilities

Regulations should allow NPs to serve as medical directors in nursing facilities

Workforce shortage of health care professionals will increase physician presence in nursing facilities

Workforce shortage of health care professionals will increase NP presence in nursing facilities

NURSE PRACTITIONERS

National regulations clearly defining “supervision” and “collaboration” and superseding state-generated definitions of non-physician caregivers are needed

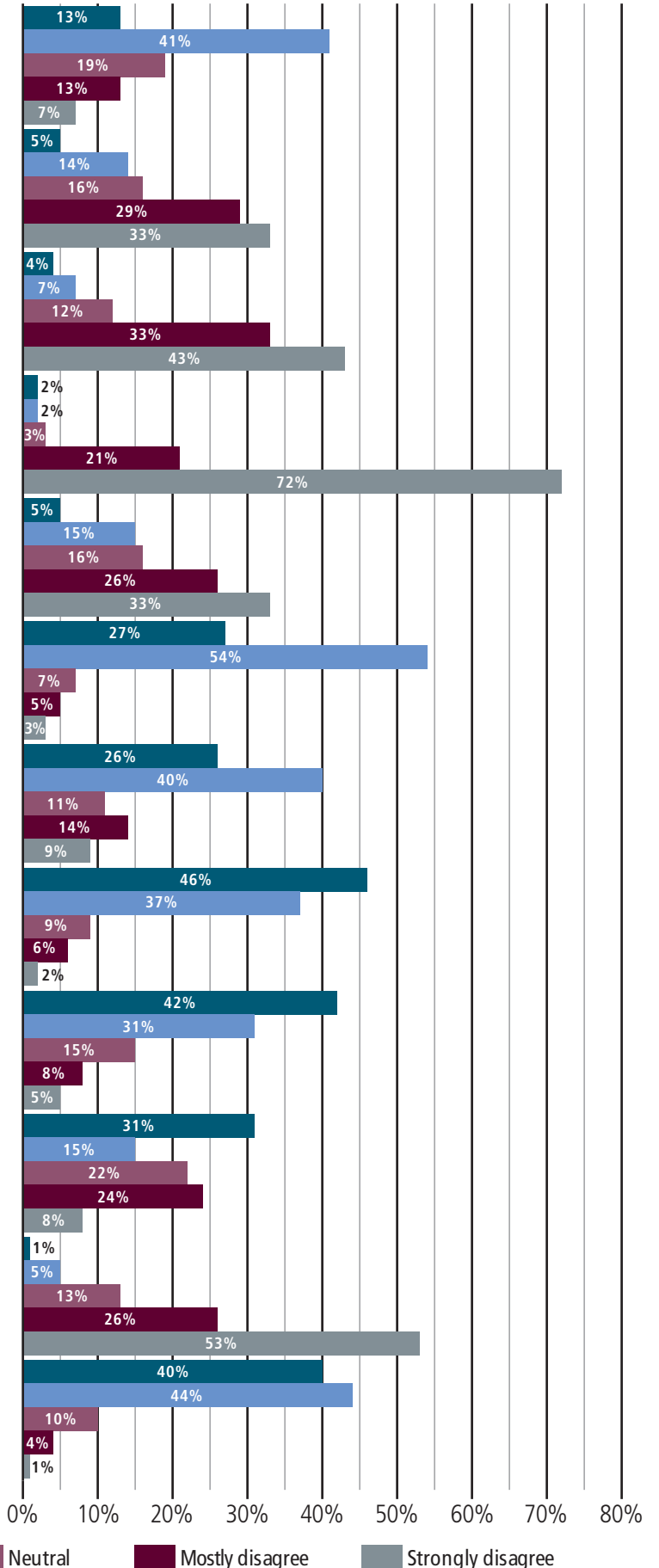
Regulations should allow NPs to serve as assistant medical directors in nursing facilities

Regulations should allow NPs to serve as co-medical directors in nursing facilities

Regulations should allow NPs to serve as medical directors in nursing facilities

Workforce shortage of health care professionals will increase physician presence in nursing facilities

Workforce shortage of health care professionals will increase NP presence in nursing facilities



The Gerontological Advanced Practice Nurses Association (GAPNA) does not support this proposal, and comments by AMDA's executive director reinforced the fact that "AMDA and GAPNA have developed a strong working relationship that is respectful and supportive of collaborative practice."¹

This collaboration will certainly continue, as will dialogue about ways physicians and NPs can offer their unique skills to assure that residents of long-term care facilities receive the quality of care they deserve.

Reference

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Osteoporosis Management

Introduction

Osteoporosis is a common condition in long-term care facility residents.¹

The survey asked physicians and NPs about their osteoporosis management strategies.

Description of Data

Osteoporosis Medications Prescribed for NF Residents

A large portion of physicians (95%) and NPs (84%) said they prescribe oral bisphosphonates to manage osteoporosis in NF residents, compared to just 21% of physicians and 13% of NPs who said they commonly prescribe parenteral bisphosphonates (Figure 15).

Of the non-bisphosphonate products, respondents most frequently said they prescribe salmon calcitonin (physicians, 46%; NPs, 45%). More NPs than physicians (13% versus 3%) said they do not prescribe any of the agents listed as response options in the survey question.

Supplemental Calcium Dosage

The survey asked those respondents who indicated that they prescribe bisphosphonates (either oral or parenteral) to report the total daily dosage of supplemental calcium they

prescribe. The majority of physicians (62%) and NPs (59%) said they typically prescribe 1200 mg per day (Figure 16).

Thirty-three percent of NPs and 26% of physicians reported prescribing less than 1200 mg per day.

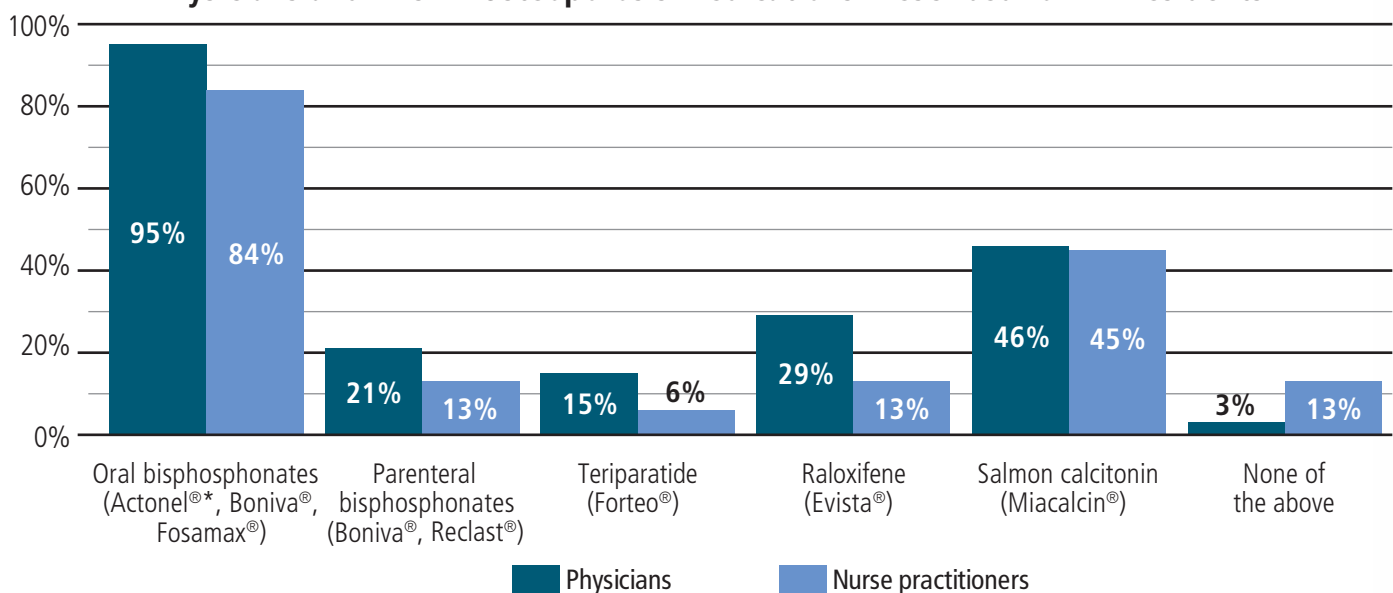
Supplemental Vitamin D Dosage

The survey asked physicians and NPs about the total daily dosage of vitamin D they prescribe for their NF residents who are receiving a bisphosphonate. (The question specified that this does not refer to therapeutic replacement doses for documented vitamin D deficiency.) The most frequent response of physicians and NPs was 800 IU per day (33% each) (Figure 17).

Twelve percent of physicians and 7% of NPs said they prescribe either 2000 or 4000 IU daily, and 24% of NPs and 16% of physicians said they routinely prescribe less than 800 IU per day.

FIGURE 15

Physicians and NPs — Osteoporosis Medications Prescribed for NF Residents



*Marketed by Warner Chilcott Pharmaceuticals Inc.

FIGURE 16

Physicians and NPs — Daily Calcium Supplementation Prescribed with Bisphosphonates

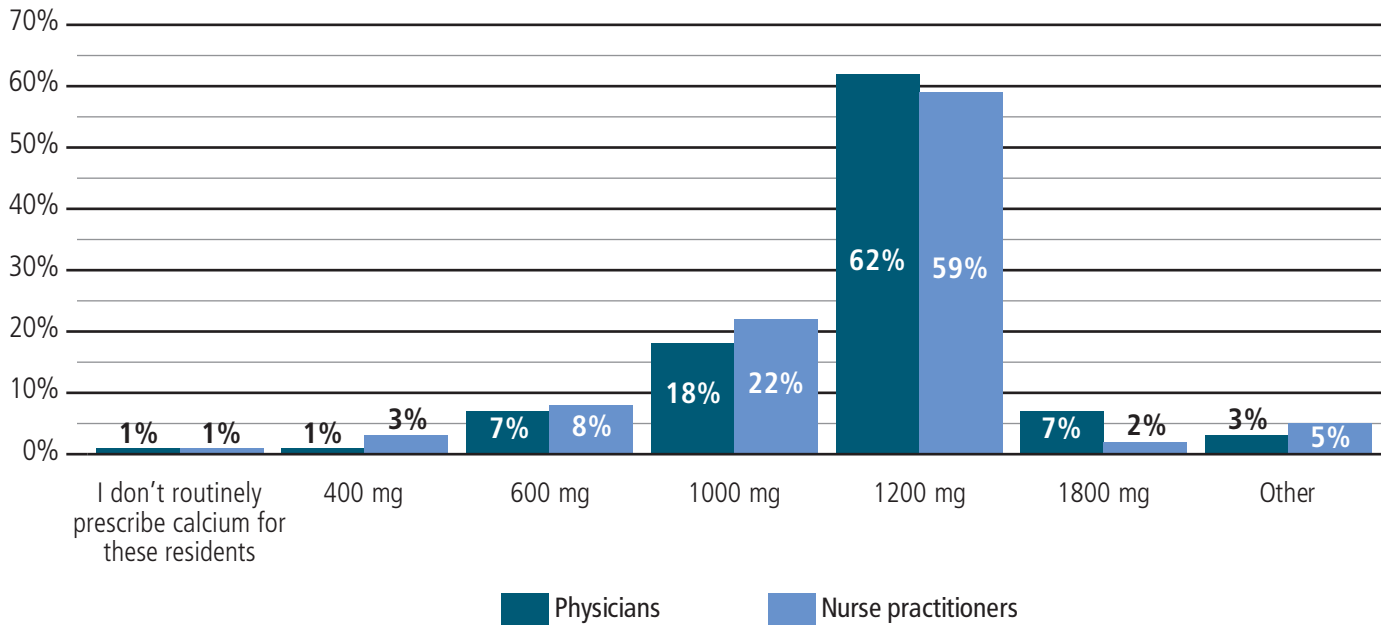


FIGURE 17

Physicians and NPs — Daily Vitamin D Supplementation Prescribed with Bisphosphonates

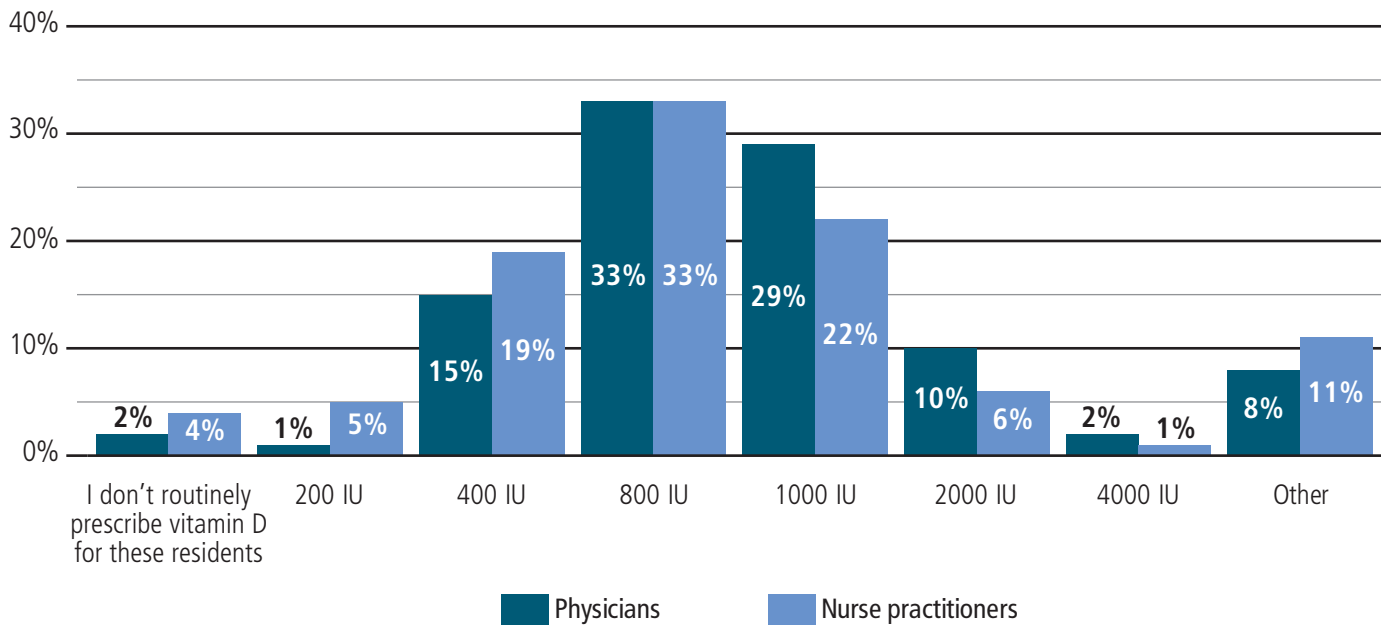


FIGURE 18

Physicians and NPs — Contraindications for Initiating and Reasons for Discontinuing Bisphosphonate Therapy

	Physicians		Nurse practitioners	
	Contraindication for initiating bisphosphonate therapy	Reason for discontinuing bisphosphonate therapy	Contraindication for initiating bisphosphonate therapy	Reason for discontinuing bisphosphonate therapy
Diagnosis of mild dementia	3%	5%	5%	4%
Diagnosis of moderate dementia	13%	17%	8%	15%
Diagnosis of severe dementia	50%	61%	42%	52%
Nonambulatory status	31%	49%	21%	28%
Presence of GERD/esophageal motility disorder	60%	59%	61%	57%
Significant periodontal disease	32%	32%	36%	29%
Hospice care	62%	80%	63%	71%
Age >70 years	3%	3%	3%	0%
Age >80 years	6%	6%	7%	5%
Age >90 years	18%	21%	26%	22%
Age >100 years	39%	37%	35%	36%
Resident not able to adhere to required administration techniques	71%	81%	81%	86%
Limited life expectancy	61%	76%	58%	63%
Length of previous bisphosphonate therapy	23%	42%	13%	20%

Contraindications and Discontinuation of Bisphosphonate Therapy

Physicians and NPs were asked about contraindications for initiating bisphosphonate therapy in their NF residents and reasons for discontinuing therapy. Both disciplines selected the same top four contraindications for initiating therapy: 81% percent of NPs and 71% of physicians identified “resident not able to adhere to required administration

techniques”; 63% of NPs and 62% of physicians selected “hospice care”; 58% of NPs and 61% of physicians indicated “limited life expectancy”; and 61% of NPs and 60% of physicians identified “presence of GERD/esophageal motility disorder” (Figure 18).

A third of respondents from each discipline (NPs, 36%; physicians, 32%) also noted significant periodontal disease as a contraindication. Fifty percent of physicians and 42%

of NPs identified severe dementia as a contraindication, while only 3% of physicians and 5% of NPs indicated mild dementia as a reason for not initiating bisphosphonate therapy.

More than a third of physicians and NPs (39% and 35%, respectively) said they consider age over 100 to be a contraindication. Much smaller numbers (3% of each discipline) identified age greater than 70 as a concern.

Respondents identified the same top

four criteria as reasons for discontinuing bisphosphonate therapy, with percentages similar to those noted as contraindications for initiating bisphosphonates.

Duration of Bisphosphonate Therapy

The survey asked those respondents who indicated that length of previous bisphosphonate therapy is a contraindication for reinitiating or continuing therapy to identify the duration of therapy that they consider to be the maximum. On average, physicians said seven years in either case, while NPs said five years (**Figure 19**).

Commentary

Given the availability of effective treatments for osteoporosis, more long-term care facility residents may benefit from evaluation for this condition and from therapy when it is diagnosed.¹

Bisphosphonates generally are con-

sidered first-line agents for the treatment of osteoporosis.² Physician and NP responses support the choice of this medication class, albeit more frequently in oral rather than parenteral dosage forms.

Use of parenteral products in NFs is influenced by cost and access issues (e.g., prior authorizations, administration reimbursement concerns, and infusion center transportation problems). This dosage form may be appropriate for those residents who are not able to tolerate oral agents or to comply with their strict administration requirements, but clinicians choose oral bisphosphonates far more commonly, which is not surprising. These products have been in existence longer, and prescribers are more comfortable and familiar with the oral preparations. While quarterly or annual parenteral dosing may seem like a distinct advantage, oral products that can be administered

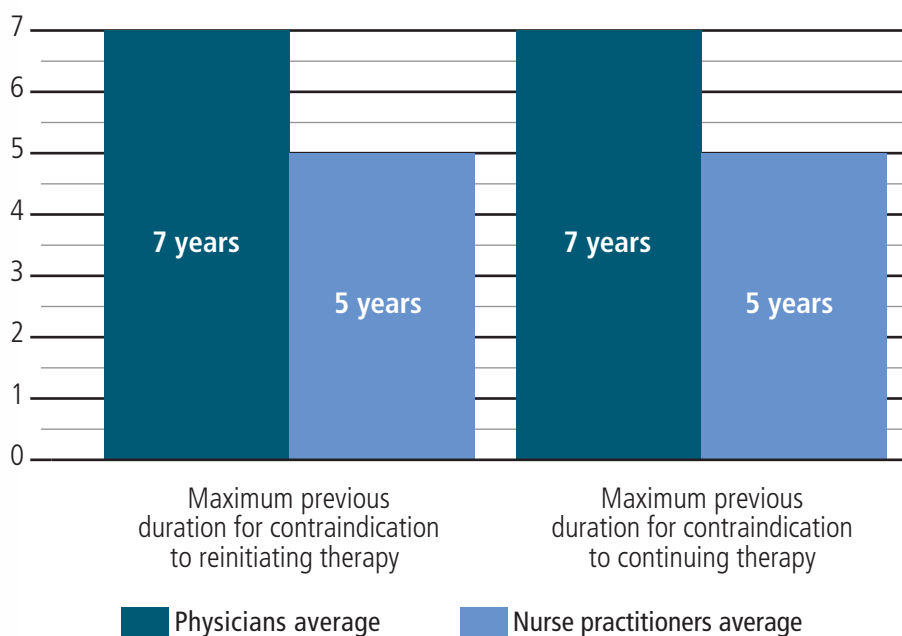
once weekly or monthly are simpler than daily dosing. And when practitioners weigh the cost, travel, and time considerations associated with parenteral administration against the strict administration requirements of oral preparations (e.g., taking the medication with a full glass of water, remaining upright for 30 or 60 minutes after administration, and refraining from intake of any other medications, food, or liquid other than water during that time), physicians and NPs typically prescribe oral products.

More physicians than NPs said they prescribe all classes of osteoporosis medications. NPs, on the other hand, more frequently reported not prescribing any medications for this condition. Although this survey is not powered for statistical significance, these data imply that physicians are more supportive of pharmacotherapy and/or they are more aggressive in osteoporosis treatment than NPs.

Bisphosphonates, as well as other osteoporosis medications, should be administered with adequate amounts of calcium and vitamin D if dietary intake is inadequate.³⁻⁵ This is the case for most NF residents. While specific dosing information is not provided in the product labeling, it is reasonable to assume that those taking bisphosphonates should be taking at least the currently recommended dose of these supplements. The National Osteoporosis Foundation (NOF) currently recommends a daily intake of 1200 mg of elemental calcium, including supplements if necessary. NOF also recommends an intake of 800 to 1000 IU of vitamin D per day for adults age 50 and older.⁶

FIGURE 19

Physicians and NPs — Duration of Bisphosphonate Therapy



A great deal of attention is being paid to vitamin D in NF residents due to its multiple benefits, including protection against a broad range of diseases such as cancers, dementia, autoimmune disorders, and cardiovascular disease,⁷ and the recommended dosing is increasing. The Institute of Medicine's Food and Nutrition Board describes adequate vitamin D intake as 600 IU per day for people over age 70; however, this is expected to be increased to 800 to 1000 IU per day.⁸

With new data on vitamin D being published regularly and with recommended dosing changing, it is important for clinicians to be aware of the latest recommendations. However, it cannot be assumed that those practitioners prescribing less than the recommended daily dose are unaware of current recommendations. Rather, they may simply be exercising prudence because of concerns about adverse effects such as possible calcium accumulation in atherosclerotic plaque.⁷ Those prescribing the higher doses of 2000 IU or even 4000 IU are doubtless aware of new studies and discussions regarding the merits of vitamin D.

As with all medications, consideration must be given to a risk-benefit analysis both prior to prescribing bisphosphonates and during therapy

to determine if the patient will continue to benefit from the medication. The survey responses indicate that prescribers consider the same criteria for both initiation and continuation of therapy. That some—but not all—respondents agree with these criteria is a reflection of different conclusions about risk versus benefit. For example, it seems obvious that patients who cannot remain upright for the required time after oral bisphosphonate administration should not receive this treatment; however, not all prescribers see this as a contraindication to therapy.

Duration of bisphosphonate therapy has been a topic of discussion due to concerns that long-term administration may increase the likelihood of rare, unusually located femur fractures. This association may or may not be real.⁹ The survey results demonstrate that, on average, physicians support a somewhat longer duration of therapy than do NPs, but prescribers' comfort with duration of therapy may be influenced as additional studies evaluate the risks and benefits of prolonged bisphosphonate therapy.

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INTERDISCIPLINARY ISSUES

Pharmacists and Directors of Nursing

Compliance with Bisphosphonate Administration Requirements

Introduction

Osteoporosis is a common condition that is underdiagnosed and undertreated in nursing facilities.¹ Several therapies are available to treat this condition, with one of the most popular being oral bisphosphonates. While these products can reduce fractures, they have specific requirements for safe and effective administration. To avoid esophageal irritation and to allow for sufficient systemic absorption, bisphosphonate tablets (Fosamax®, Actonel®, Boniva®) must be administered with a full glass of water and the patient must remain upright without consuming any other beverage or food for at least 30 to 60 minutes, depending on the product.²⁻⁴ Strict adherence to these criteria may be difficult to achieve in nursing home residents who are taking multiple medications and/or have difficulty remaining upright for 30 minutes or more.

The survey asked pharmacists and DONs to indicate how frequently nursing staff fully comply with these requirements for correct bisphosphonate administration in their facilities.

Description of Data

Pharmacist and DON responses to this question were relatively similar. The most frequent response for both disciplines was that nursing staff members are able to comply with bisphosphonate administration requirements between 75% and 99% of the time (**Figure 20**).

Nineteen percent of DONs said nursing staff always fully comply with bisphosphonate administration requirements, compared to 7% of pharmacists.

A quarter of pharmacists (28%) and 16% of DONs indicated that compliance occurs less than half of the time. Few respondents from either discipline said that compliance is never achieved (pharmacists, 2%; DONs, 1%).

Commentary

While bisphosphonates as a class have been shown to be effective for the prevention and treatment of osteoporosis, specific administration techniques are necessary to reduce the risk of potentially serious adverse gastrointestinal side effects, including esophagitis and esophageal erosion, and to maximize the potential efficacy of these agents by assuring maximal systemic absorption.

The likelihood of esophageal irritation or erosion can be reduced by administering the medication with a full glass of water and by having the patient remain upright for at least 30 to 60 minutes afterward (depending on the particular drug). These measures facilitate passage of the tablet through the esophagus and into the stomach.

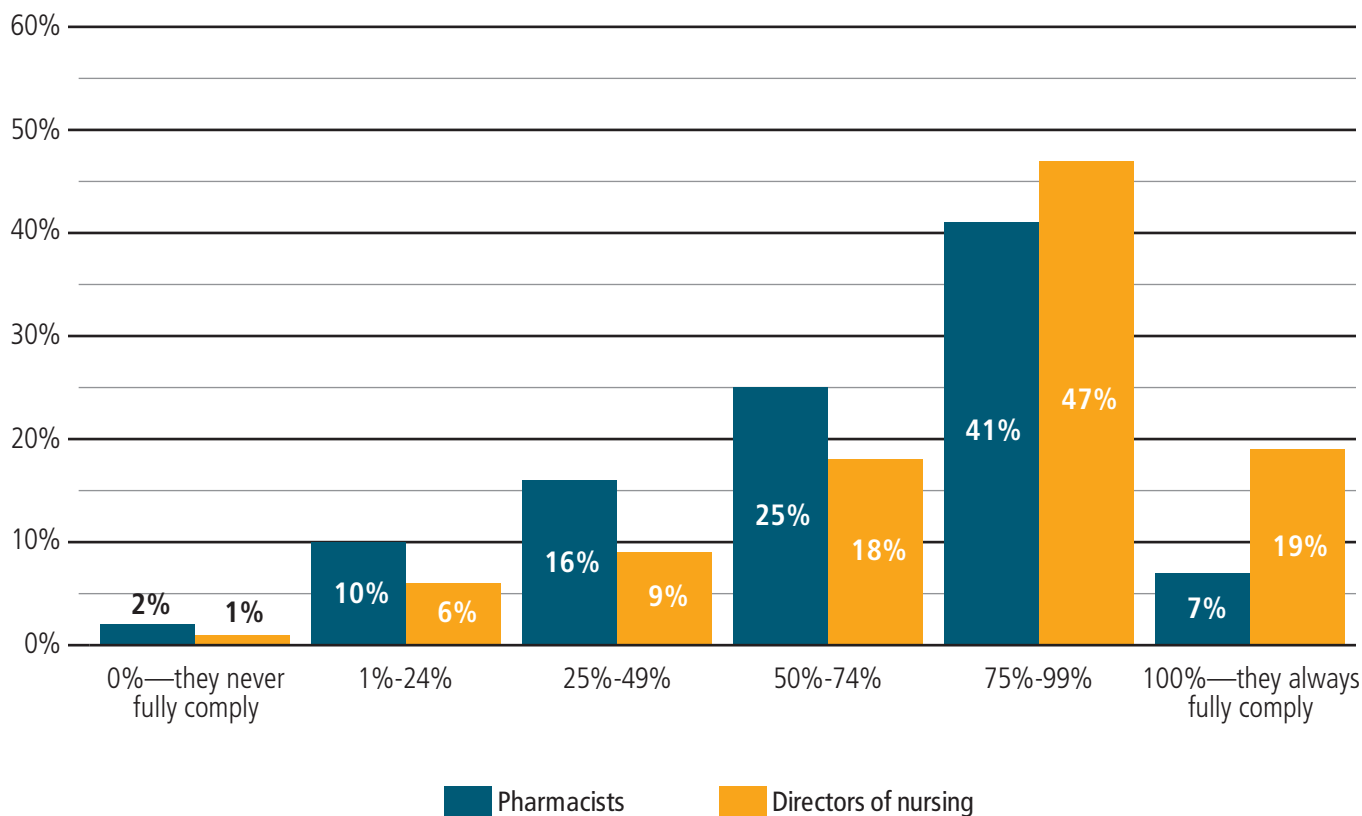
Even under optimal conditions, the systemic bioavailability of bisphosphonates after oral administration is less than 1%.²⁻⁴ Still, sufficient drug is absorbed to exert its clinical effect. However, failing to adhere to the administration directions specified in the product labeling—such as not taking a bisphosphonate with other medications, with any amount or type of food, or with any liquid other than a full glass of plain water—is liable to further decrease absorption to the point where the bisphosphonate will not have any pharmacologic effect.

While these administration requirements may be rather

FIGURE 20

Pharmacists and DONs — Frequency of Compliance with Bisphosphonate Administration Requirements

What is your perception of how frequently NF nursing staff comply fully with the requirements for correct bisphosphonate administration?



simple for healthy persons living at home, the frailty of many nursing facility residents suggests that they may be unable to comply adequately. Inadequate or busy nursing staff may present additional challenges to the appropriate and timely administration of bisphosphonates, or some nursing staff members may not be fully aware of these requirements. Survey respondents addressed this issue in some of their open-ended responses. In fact, several DONs said that nursing staff are well aware of the administration requirements, but residents may not comply. After the nurse administers the medication, residents may forget or be un-

willing to remain upright and/or to avoid food or liquid intake (other than plain water) for the required time. At the same time, some residents may have difficulty drinking a full glass of water with the medication.

As one DON explained, *“It is the residents who are often noncompliant with the recommendations for these medications. It is impossible for the nursing staff to provide one-on-one monitoring after the medications are taken for the 30 [minute] to 1 [hour] time requirement. Residents are often noncompliant even when they fully understand the potential for problems.”*

Several comments addressed actions

that can be taken if staff members determine that the resident is not taking the medication correctly. These include contacting the prescribing physician and/or having the medication discontinued.

Noncompliance isn't problematic just for residents. Bisphosphonate administration and monitoring are specifically addressed by Tag F329 (“Unnecessary Drugs”) in the CMS State Operations Manual “Guidance to Surveyors for Long Term Care Facilities,” so any variance from the specified instructions puts the facility at risk for survey noncompliance and possible citation.

The fact that such a large portion of respondents from both disciplines reported noncompliance with bisphosphonate administration requirements categorically points to the need for team leaders to emphasize proper use of these agents. Policies and procedures encouraging ongoing education of the nursing staff about the proper administration of these products, as well as monitoring of residents to assess compliance with these techniques, would be reasonable steps to minimize the risks and maximize the benefits of these medications. Pharmacists

could speak with the nursing staff about bisphosphonate administration when performing medication regimen reviews, and nursing staff members should be encouraged to discuss concerns about compliance or individual instances of noncompliance with the DON or other clinicians.

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DISCIPLINE-SPECIFIC QUESTIONS

Medical Directors

Demographics

Introduction

Every licensed nursing facility (NF) is required to have a physician who serves as medical director. This individual is responsible for coordinating medical care and implementing resident care policies in the facility.¹ The typical medical director serves in that capacity on a contractual basis, although a growing number serve as full-time physician leaders employed by the facility. Most medical directors also provide direct patient care in their facilities as an attending physician.

The medical director determines the educational needs of the facility staff, establishes protocols for medication and practitioner monitoring, and promotes accountability, teamwork, and quality of care. In brief, the medical director is a troubleshooter, patient advocate, and technical advisor.¹

Some medical directors choose to become certified through the American Medical Directors Association (AMDA). The certified medical director (CMD) program is based on an experiential model that recognizes the dual clinical and managerial roles of the medical director and requires indicators of competence in long-term care clinical medicine and medical management.

Description of Data

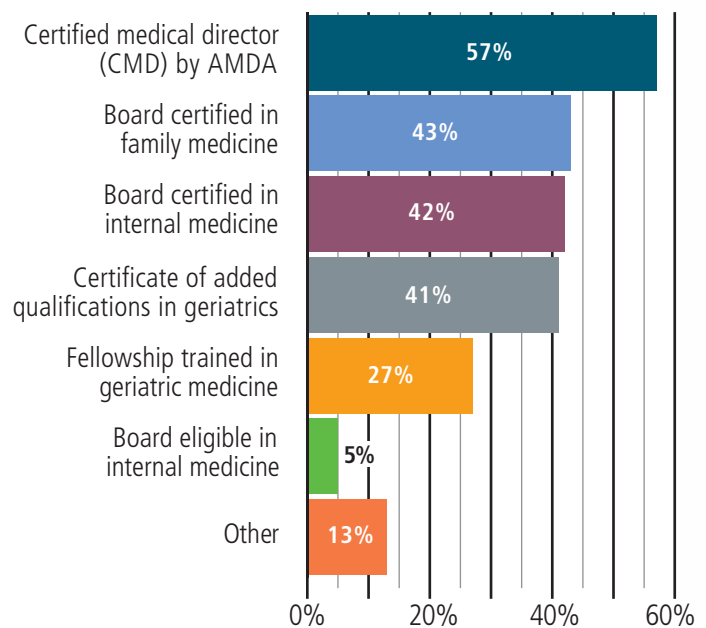
Credentials and Specialization

Fifty-seven percent of medical directors said they have obtained CMD status through AMDA (**Figure 21**).

Nearly equal percentages said they are board certified in family medicine (43%) or internal medicine (42%). Forty-one percent have earned a certificate of added qualifications in geriatrics, and 27% have completed fellowship

FIGURE 21

Medical Directors — Credentials and Specialization



training in geriatric medicine. Thirteen percent reported credentials other than those listed as response options in the survey question, including board certification in a wide range of specialties—most commonly palliative care.

Experience as a Medical Director

Forty-one percent of medical directors indicated that they have served in this capacity for between 10 and 20 years, while 22% have worked as a medical director for four years or less (**Figure 22**).

Nineteen percent said they have served as a medical director for more than 20 years.

Practice Description

When asked to identify how they allocate their time, medical directors said they spend the largest percentage

FIGURE 22

Medical Directors — Years of Experience

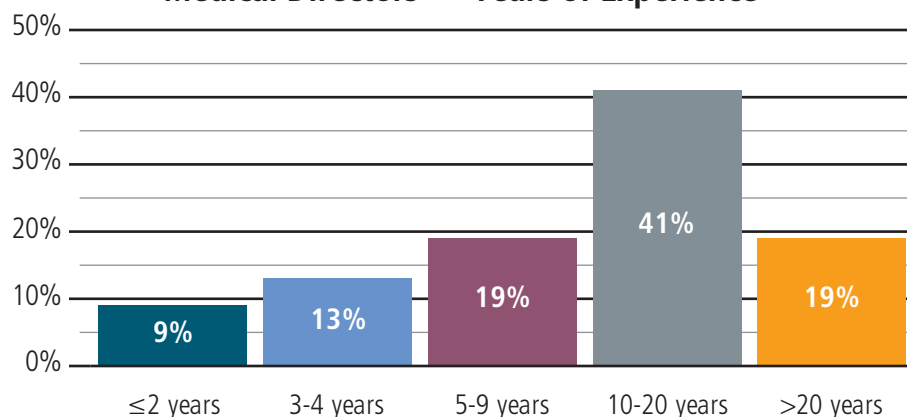


FIGURE 23

Medical Directors — Allocation of Time

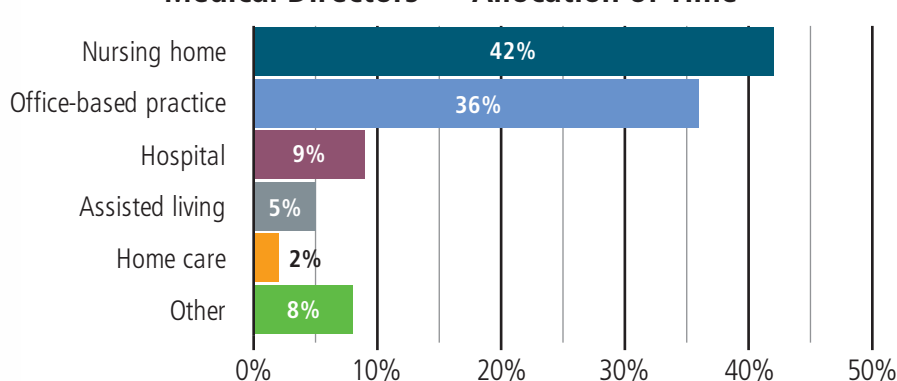
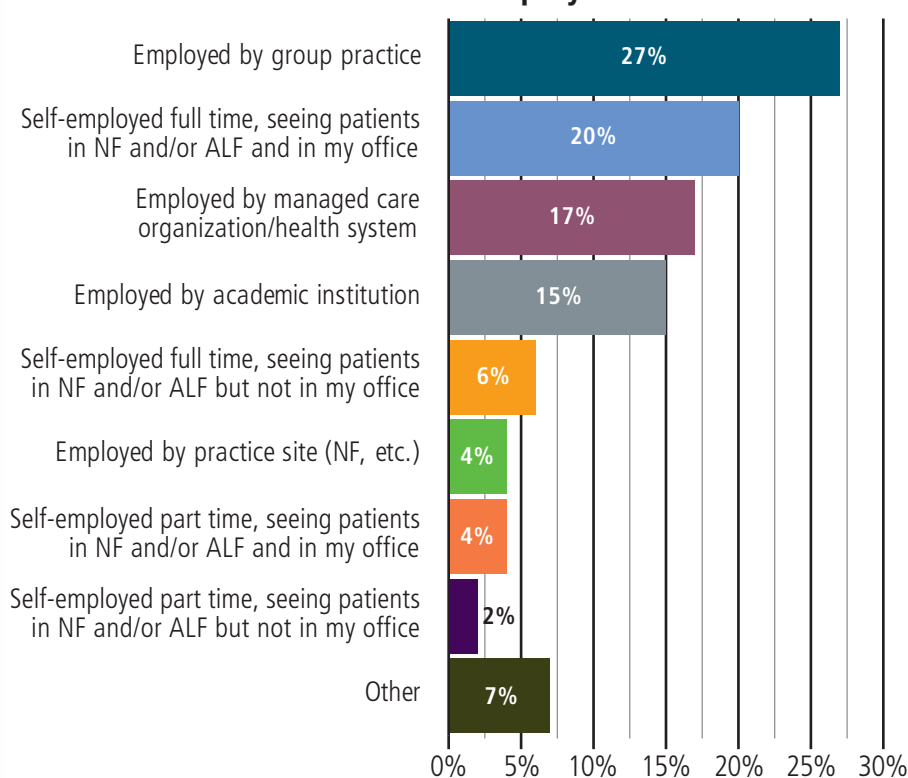


FIGURE 24

Medical Directors — Employment Model



of their professional hours (42%) in the nursing facility (Figure 23).

About a third of their time (36%) is spent in office-based practice. On average, 8% of their time is allocated to “other” activities, including hospice care, academia, and administration.

Employment Model

Medical directors most frequently reported being employed by a group practice (27%) (Figure 24).

One-fifth (20%) said they are self-employed full time and see patients in nursing facilities, assisted living facilities (ALFs), and/or in their office. Seventeen percent indicated that they are employed by a managed care organization and/or health system.

Medical Directors in NFs

The majority of medical directors (54%) said they serve in that capacity in one facility, while 24% said they serve in two facilities. Eighteen percent said they serve in three or more facilities (Figure 25).

Medical Directors Serving as Attending Physicians

Ninety-three percent of medical directors said they also serve as an attending physician in one or more nursing facilities (Figure 26).

More than a quarter of respondents (27%) said they serve in that capacity in only one facility, while 20% said they serve in two facilities. Seven percent said they serve as an attending physician in six or more nursing facilities.

Total Number of Residents Served by Attending Physicians

When medical directors were asked to report the total number of residents they serve at any one time as attending physician (in one or more facilities), they reported an aver-

FIGURE 25

Medical Directors — Number of Nursing Facilities Served as Medical Director

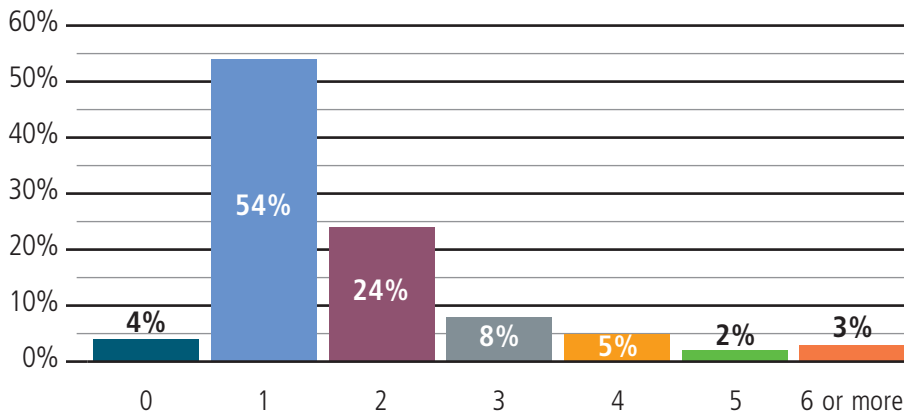
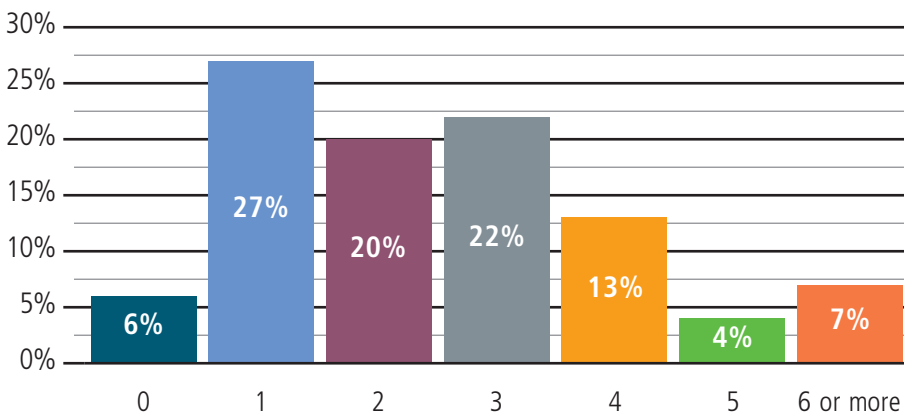


FIGURE 26

Medical Directors — Number of Nursing Facilities Served as Attending Physician



age of 113, with a maximum of 600 (Figure 27).

The majority (68%) said they have responsibility for 100 or fewer residents, while 13% said they serve more than 200 residents as an attending.

The survey asked medical directors to identify the average number of residents cared for by non-medical director physicians in their facility(ies), not counting those physicians who only occasionally care for residents in the facility. Respondents reported an average of 62 residents, with a maximum of 500.

An overwhelming majority of medical directors (87%) reported that their non-medical director colleagues have responsibility for 100 or fewer residents as attending physician, and 9% said these physicians serve between 100 and 200 residents.

Income from NF Practice

The survey asked medical directors to indicate the percentage of their total gross annual income that is derived from the administrative and clinical components of their nursing facility practice. The most frequent response for both components was between 1% and 19%, with 62% of respon-

FIGURE 27

Number of Residents Served as Attending Physician

Residents served	Medical directors	Non-medical director physicians
	Average: 113 Range: 1-600	Average: 62 Range: 1-500
1-100	68%	87%
101-200	20%	9%
201-300	5%	1%
301-400	4%	1%
>400	4%	3%

dents reporting this range for their NF administrative responsibilities and 35% reporting it for their NF clinical responsibilities (Figure 28).

Relatively small percentages reported that 60% or more of their annual gross income is derived from their NF administrative or clinical responsibilities.

Collaboration with Non-Physician Providers

The survey asked medical directors if they work with non-physician providers (NPPs)—including physician assistants (PAs) and advanced practice registered nurses (APRNs) such as nurse practitioners (NPs)—in a formal collaborative arrangement. Sixty-three percent of respondents said they collaborate with at least one APRN (range, 1-35) (Figure 29).

The majority of those (86%) reported working with three or fewer NPs (data not shown).

In comparison, only 19% of respondents said they work with at least one PA in a formal collaborative arrangement.

FIGURE 28

Medical Directors — Income from NF Practice

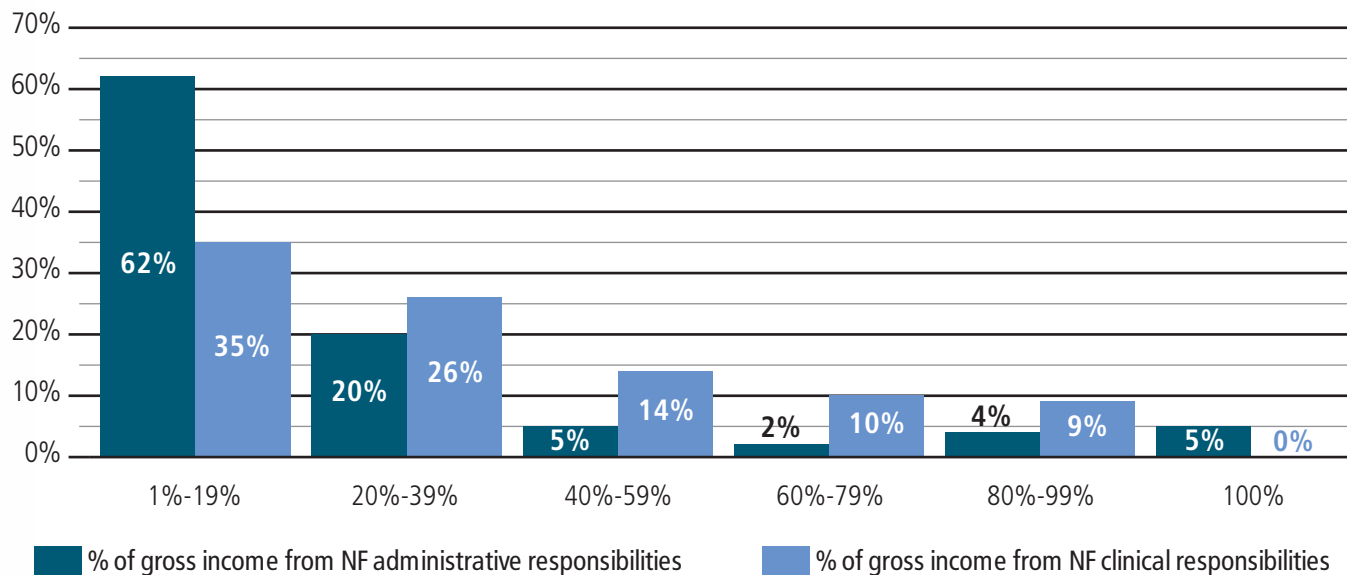
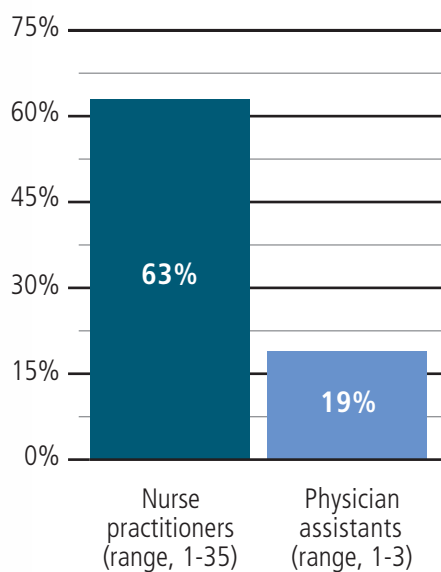


FIGURE 29

Medical Directors — Collaboration with Non-Physician Providers

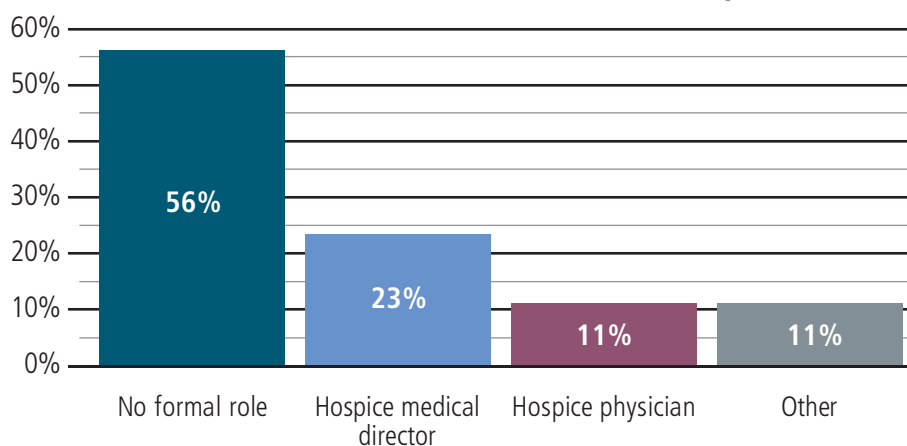


Medical Directors in Hospice

Survey participants were asked about their role in hospice. Forty-five percent indicated some involvement, with 23% serving as hospice medical director, 11% serving as hospice physician, and 11% reporting some other involvement, such as caring for

FIGURE 30

Medical Directors — Involvement in Hospice



residents receiving hospice services though without having a hospice contract (Figure 30).

Medical Directors in ALFs

More than two-fifths of respondents (42%) said they serve as a medical director/advisor in one or more assisted living facilities (Figure 31).

Almost two-thirds (62%) of medical directors who serve in an assisted living facility said the ALF is connected to a nursing facility (data not shown).

The majority of respondents (63%)

said they see assisted living residents within the ALF, either in the patient's personal residence in the facility (46%) or in an on-site office/examination room (17%). Thirty-eight percent of physicians said they see assisted living residents in their offices (Figure 32).

Home Visits

Survey respondents were asked how many community-based patients (those who live at home, either alone or with family or a caregiver) they see in their private residences. More than

FIGURE 31

Medical Directors — Number of ALFs Served as Medical Director/Advisor

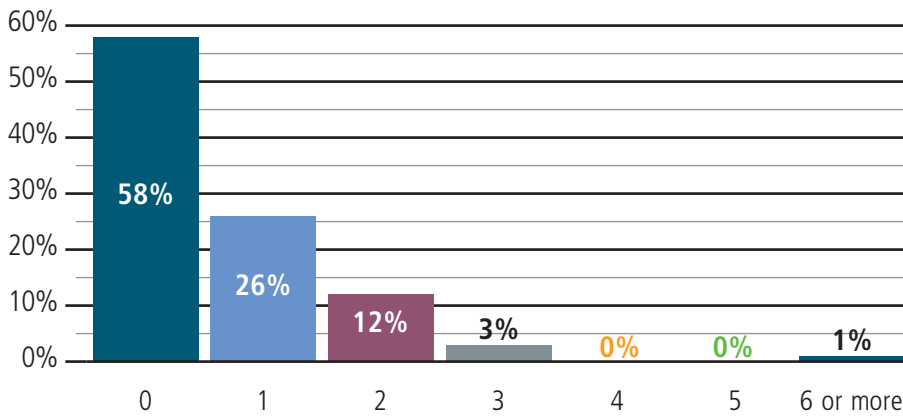


FIGURE 32

Medical Directors — Site of Patient Visits for Assisted Living Residents

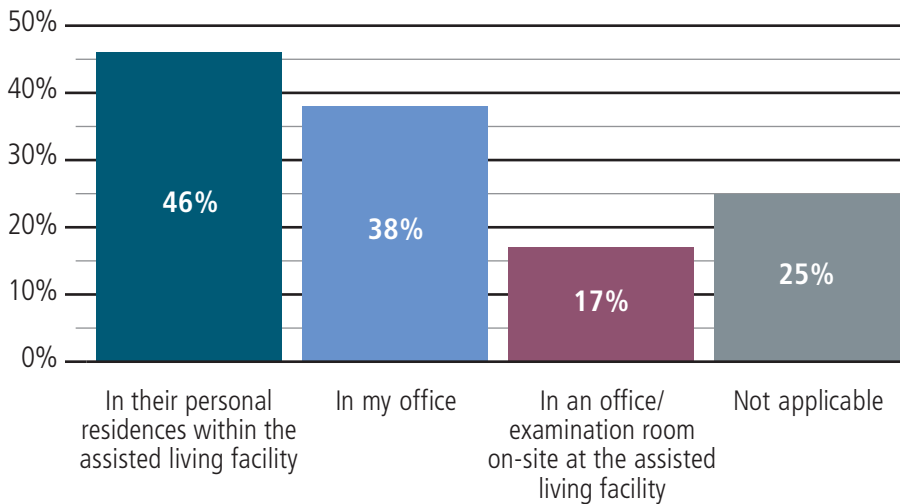


FIGURE 33

Medical Directors — Home Visits by Physicians

Physicians making home visits: 42%

Average number of home visits per month: 7

Range: 1-35

Number of home visits per month

1-10	81%
11-24	15%
≥25	4%

two-fifths of respondents (42%) said they make one or more home visits per month (range, 1-35) (Figure 33).

Of those who provide home visits, the majority (81%) said they make 10 or fewer such visits per month, while a smaller percentage (4%) said they make 25 or more home visits monthly. The average number of home visits per month was seven.

Commentary

The survey results reveal that most medical directors are board certi-

fied and/or credentialed as a certified medical director. As more facilities make quality improvement a priority, the number of physicians seeking the CMD certification is apt to increase. A recently published study suggests that, among other factors such as a high RN staffing ratio, having a certified medical director contributes positively to a nursing facility's quality of care.²

A "typical" medical director could be described as self-employed (either part time or full time), serving as a medical director in one facility, dividing most of his or her time between the nursing home and an office-based practice, and spending a smaller portion of time in hospital practice. The average medical director also typically serves as an attending physician for a large number of residents in the nursing facility(ies) where he or she is medical director and, in some cases, in other facilities as well. While the average number of residents that medical directors serve each month as attending physician is 112, a small percentage reported serving 200 or more nursing facility residents. Medical directors serve as attendings for about twice as many residents as non-medical director physicians, which should be expected since medical directors are typically in the facility more often than most attendings. They often are asked by nursing staff or other clinicians to care for residents because of medical complexity, family wishes, or Medicare Part A coverage, which typically requires more frequent physician visits.

With regard to ALFs, it is common for physicians to report seeing patients in their personal residences or in an office/examination room within the facility. This reflects the growing

role of assisted living in the work life of medical directors, the increasing medical complexity of assisted living residents, the evolution of the medical component of ALFs, and efforts to provide person-centered care that addresses the needs and desires of individual residents. More than half of assisted living medical directors/advisors reported that their facilities are connected to nursing facilities, where they may serve as medical director for the entire campus—for example, in a continuing care retirement community.

While on average medical directors reported spending only a small portion of their time in ALFs, the percentage who reported serving as medical director/advisor in one or more ALFs is noteworthy considering that such facilities are not generally required to have a physician serving in that capacity. This suggests that assisted living administrators and owners increasingly recognize the importance of medical care and management in this environment. While many ALFs were developed as a social model, it quickly became apparent that many residents required medical care for issues such as dementia/cognition problems and polypharmacy. To enable these individuals to remain in ALFs safely, a medical component was deemed necessary. As a result, many ALFs established relationships with physicians, pharmacists, and other clinicians.

The fact that most physicians reported formal collaborative arrangements with non-physician providers demonstrates that collaboration between these professionals is common. NPPs can provide coverage for routine management and assessment, enabling physicians to care for a larger number of residents than they other-

wise could and to spend more time on more complex medical issues.

This is the first year that the *Senior Care Digest Interdisciplinary Report* queried physicians about the percentage of their income derived from their administrative and clinical work in NFs. That the majority of medical directors said their income from NF administrative duties represents less than 20% of their total annual gross income indicates that the role of medical director is nowhere near a full-time job, unless the physician is serving in that capacity in multiple facilities or in one or more very large facilities. A closer look at the survey responses supported this assertion, as two-thirds of medical directors who said that 100% of their annual gross income comes from NF administrative duties reported serving six or more facilities in that capacity.

The number of respondents reporting higher percentages of income from their clinical work probably reflects the varying extent of clinical responsibilities, with some medical directors serving as attending for most or all of the facility's residents and others caring for smaller numbers.

The survey asked medical directors whether they plan to discontinue either their attending physician or medical director role in the coming year, and more than 90% indicated they would not be ending these activities (data not shown). Since there were so few considering a departure from these roles, no definite patterns could be identified. However, their reasons for leaving include semiretirement, insufficient pay, over-regulation, and concerns about medicolegal liability. (See the discussion of medicolegal liability beginning later on this page.)

These data indicate that the vast majority of physicians are satisfied with their nursing facility practice. As one of the medical director panelists for this report stated, *"Practicing in LTC has great flexibility. I also find that my time is appreciated more by my patients in this population, and I get to take my dogs to work every day. And it is a privilege to get to talk about end-of-life issues with patients, some of whom—despite the fact that they are 97 years old—apparently have never contemplated their death or discussed it with their primary care doctor, who is too busy trying to meet patient quotas and keeping the waiting room from getting backed up."*

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Physicians' Medicolegal Liability and Malpractice Insurance

Introduction

Concerns about medicolegal liability continue to be a subject of interest to health care professionals, and physicians have voiced their concerns about liability undercutting their ability and desire to provide nursing home care.¹

The survey asked physicians to report whether they have ever been named in a lawsuit as an attending physician

or a medical director and, if so, to report the outcome of the case(s).

Description of Data

Lawsuits Involving Attending Physicians

One-fourth (24%) of respondents reported having been named as an attending physician in at least one lawsuit concerning a nursing facility resident. Slightly more than half of those (13%) said they have been named in a single suit (**Figure 34**).

Two percent said they have been named in six or more cases. According to the survey responses, the majority of cases were dropped without settlement or were settled out of court. Few cases went to court, and only rarely was a decision rendered against the attending physician.

Lawsuits Involving Medical Directors

Few physicians reported being named in a lawsuit as medical director. In

fact, only 8% said they have been named in a lawsuit in that capacity. The majority of those (5%) said they were named in only one suit; none said they were named in more than four (**Figure 35**).

As with the cases involving attending physicians, most of the suits involving medical directors were dropped without settlement or were settled out of court. According to the survey responses, decisions against the medical director were rare.

Malpractice Insurance Coverage

The survey asked physicians to identify which source(s) of coverage they have for malpractice insurance in their work as either an attending physician or medical director. Most respondents (61%) said their facility covers them as medical director; 23% said their non-NF employer provides coverage for their work in this capacity (**Figure 36**).

Only 7% reported having no malpractice insurance coverage for their medical director responsibilities.

Nearly half of respondents (45%) said their non-NF employer provides coverage for their work as attending physician; another 30% said they personally pay for this coverage. Five percent reported not having malpractice insurance for their NF attending physician responsibilities.

Commentary

Research has found significant regional differences in physicians' degree of anxiety about medicolegal liability. This concern is influenced by prevailing state laws, including the presence or absence of caps on damages, attorney advertising, media coverage of nursing homes, and residents' and families' threats to sue.¹

With malpractice insurance coverage responses totaling well over 100%, it is evident that many physicians have

FIGURE 34

Medical Directors — Involvement in NF Resident Lawsuits as Attending Physician

Please indicate the number of lawsuits concerning a nursing facility resident in which you personally have been named as an attending physician and indicate the outcome of the case(s).

	0	1	2	3	4	5	6 or more
Number of lawsuits in which I have been named as an NF attending physician	73%	13%	5%	2%	0%	2%	2%
Number of active cases	91%	3%	2%	0%	1%	0%	0%
Number of cases dropped without settlement	80%	10%	4%	1%	0%	1%	2%
Number of cases settled out of court	86%	5%	2%	1%	0%	1%	1%
Number of cases that went to court with decision in my favor	90%	2%	3%	0%	0%	0%	0%
Number of cases that went to court with decision against me	93%	1%	0%	1%	0%	0%	0%

FIGURE 35

Medical Directors — Involvement in NF Resident Lawsuits as Medical Director

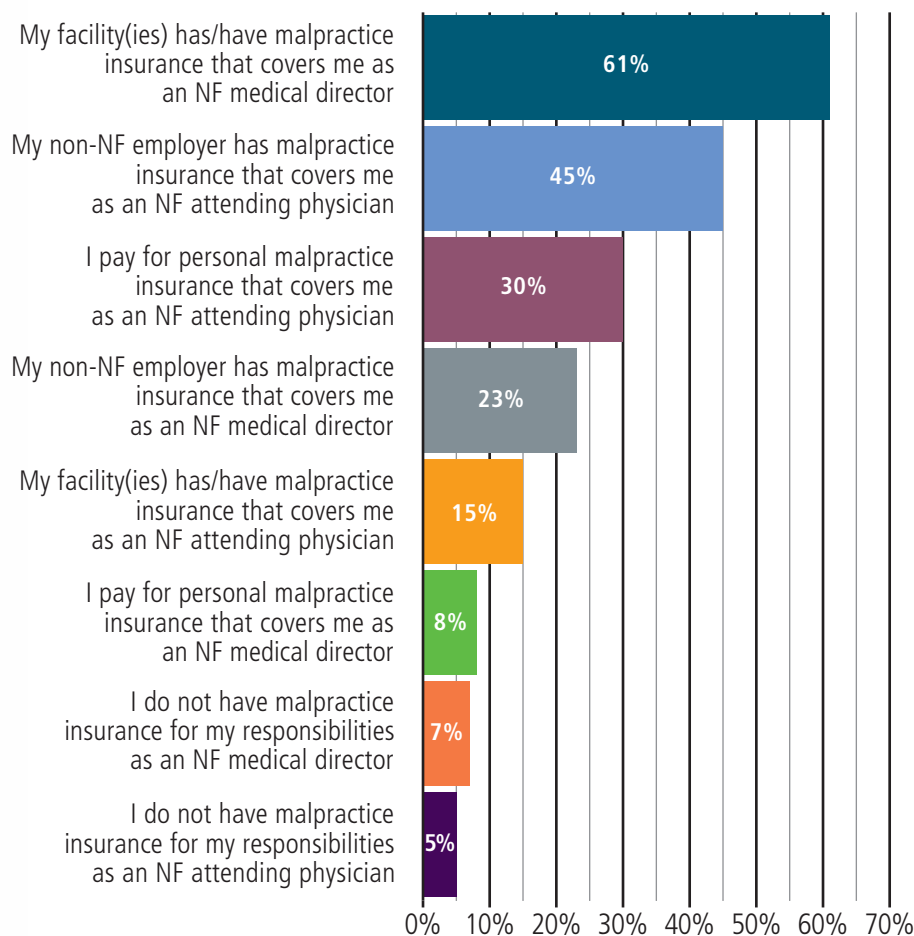
Please indicate the number of lawsuits concerning a nursing facility resident in which you personally have been named as a medical director and indicate the outcome of the case(s).

	0	1	2	3	4	5	6 or more
Number of lawsuits in which I have been named as an NF medical director	89%	5%	1%	1%	1%	0%	0%
Number of active cases	95%	2%	0%	1%	0%	0%	0%
Number of cases dropped without settlement	91%	4%	2%	0%	0%	0%	0%
Number of cases settled out of court	93%	1%	1%	1%	0%	0%	0%
Number of cases that went to court with decision in my favor	95%	0%	0%	1%	0%	0%	0%
Number of cases that went to court with decision against me	94%	0%	0%	0%	2%	0%	0%

FIGURE 36

Medical Directors — Malpractice Insurance Coverage

Which of the following apply regarding your malpractice insurance coverage?



more than one source of coverage. For example, they may be insured by the nursing facility where they serve as medical director and have their own personal malpractice insurance policy. This apparent duplication may be intentional to ensure that they are adequately protected.

The survey responses show that while attending physicians are named in lawsuits more frequently than medical directors, the latter also may be named. Depending on the case and the plaintiff’s attorney, various facility staff—rather than or in addition to the attending—may be named. In some cases, even the administrator, director of nursing, and facility owner are named as individuals.

Some comfort should be gained from the fact that the majority of lawsuits involving survey respondents were dismissed, but even a favorable outcome can be unsettling to the professional(s) named in the suit. Cases resulting in settlement

could represent frivolous lawsuits not based on merit, or they could be a “fishing expedition” in which multiple parties are named in an effort by the plaintiff’s attorney to cover all bases—perhaps prematurely because the attorney does not understand the true issues involved in the case.

Some nursing facilities have made themselves unlikely defendants in malpractice lawsuits by purchasing less insurance or, in some cases, even “going bare” without any insurance.¹

It is difficult to interpret the responses of those participants who reported having no insurance coverage as attending physician and/or medical director. It is possible that they are not currently serving in either of those capacities, are unable to find an insurer willing to cover their clinical and/or administrative responsibilities, are unaware that their facility or employer provides coverage for them—or they knowingly forgo insurance coverage in an attempt to decrease the likelihood of being sued.

This approach has been described, but concern has been raised that it places both the physician and patient at risk.²

References

1. Tucker ME. Liability concerns common in NH practice. *Caring Ages*. 2009;10(2):8.
2. Weinstock FJ. Forgoing malpractice insurance is not the best solution. *Med Economics*. 2009;86:34-35.

Medical Director Commentary



Paul R. Katz, MD, CMD

I would like to compliment the editors of this survey report for exploring the current status of long-term care as well as the numerous challenges faced by practitioners in this field. It's clear from the data that these practitioners care deeply for the work they do and are willing to go the extra mile to provide excellent patient care. While this is not a scientific study and there is some bias in that respondents are members of their professional associations, this report offers some key insights into practices and attitudes of team leaders in this care setting.

The questions regarding the Drug Enforcement Administration (DEA) and controlled substances were of great interest, as this is an ongoing issue of concern in long-term care. It wasn't surprising to see that the majority of respondents from all disciplines agreed that innovative solutions must be developed to meet the needs of both the DEA and nursing facility residents. It also wasn't surprising that 94% of physicians said that the nurse should be considered the physician's agent and that verbal orders ought to be allowed. The American Medical Directors Association (AMDA) has been working closely with other associations and the DEA on this very issue. In fact, we at AMDA recently responded to a notice for solicitation of comments from the DEA about whether any further revisions to its regulations are feasible and warranted. We also worked with other medical associations to develop the "Tip Sheet on Prescribing of Controlled Substances in Long Term Care." Clearly, this issue is of interest to practitioners from all four disciplines, as ensuring that our residents get the medications they need when they need them is a crucial priority. We are passionate about making sure that they don't suffer because of red tape or regulations that keep drugs from them unnecessarily.

Elsewhere, I was pleased to see that one in five physicians is involved in research. However, I suspect that the actual number is even higher. Many medical directors participate in—or even lead—quality improvement studies in their facilities, but they may not define this as research. These studies often don't require strict oversight by an Institutional Review Board, but they can offer important information about the impact of various interventions, processes, and systems on outcomes. We have seen more medical directors getting involved in research studies through the AMDA Foundation's Long Term Care Research Network. I hope that we will see more medical directors taking the lead on facility-based studies. After all, a sizeable number of AMDA members hold faculty appointments and thus have access to the infrastructure necessary to perform research. The key will be to develop research questions that can be translated into quality practice.

It was noteworthy that the majority of medical directors said they have 20 years of experience or less. This suggests that the profession is attracting younger physicians—a trend that must continue if we are to resolve the workforce crisis facing us in long-term care. We need a continuing focus on recruiting and retaining physicians in long-term care, and we will need role models to demonstrate to trainees the uniqueness of this practice environment and its challenges. Helping young physicians understand the professional and personal satisfaction they can gain by working in long-term care is vital. The AMDA Foundation Futures Program has been accomplishing this for years, and we will continue these efforts.



DISCIPLINE-SPECIFIC QUESTIONS

Pharmacists

Demographics

Introduction

The survey asked pharmacists to report their professional memberships and credentials and to identify their practice involvement.

Description of Data

Memberships and Credentials

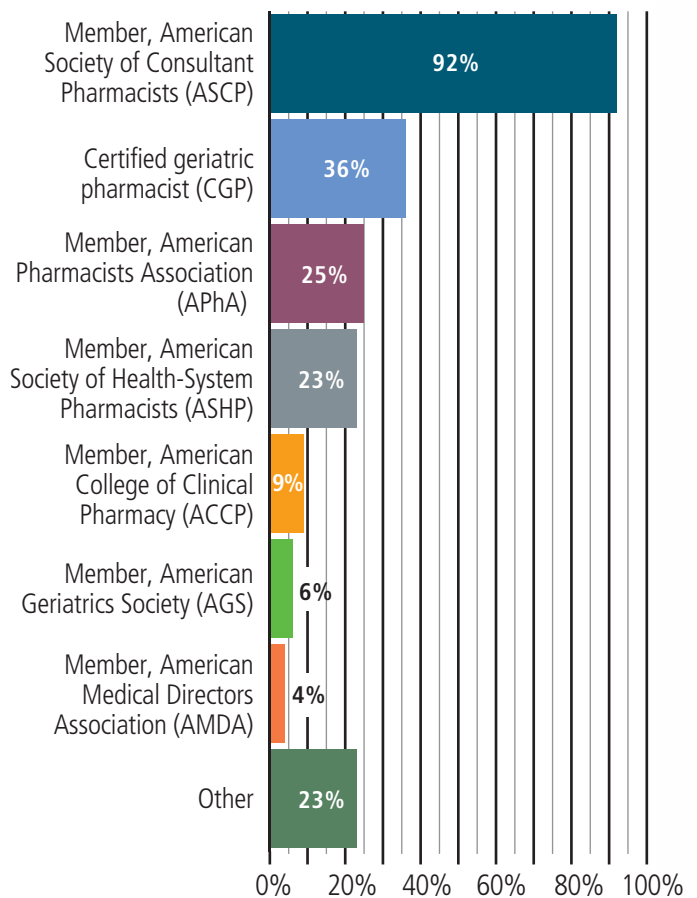
Ninety-two percent of pharmacist respondents reported that they are members of the American Society of Consultant Pharmacists (ASCP), and 25% said they belong to the American Pharmacists Association (APhA) (**Figure 37**).

Approximately one in four respondents (23%) indicated that they have one or more memberships in organizations other than those listed as response options in the survey question. Most commonly, respondents reported membership in a state pharmacy organization and/or national academic organizations or other professional societies. More than a third of respondents (36%) said they have earned the certified geriatric pharmacist (CGP) credential.

The survey asked pharmacists without this board certification to identify from a list of options why they had not become a CGP. Half of these pharmacists (49%) indicated that they plan to take the certification exam in the future. Thirteen percent said they don't see any value in becoming a CGP, and one in four (23%) said it is too expensive. A small percentage of respondents (8%) reported concern that they might not pass the exam (**Figure 38**).

In an open-ended response, pharmacists offered various other reasons for not being a CGP, including a lack of time to prepare for the exam and a belief that it wasn't

FIGURE 37
Pharmacists — Memberships and Credentials



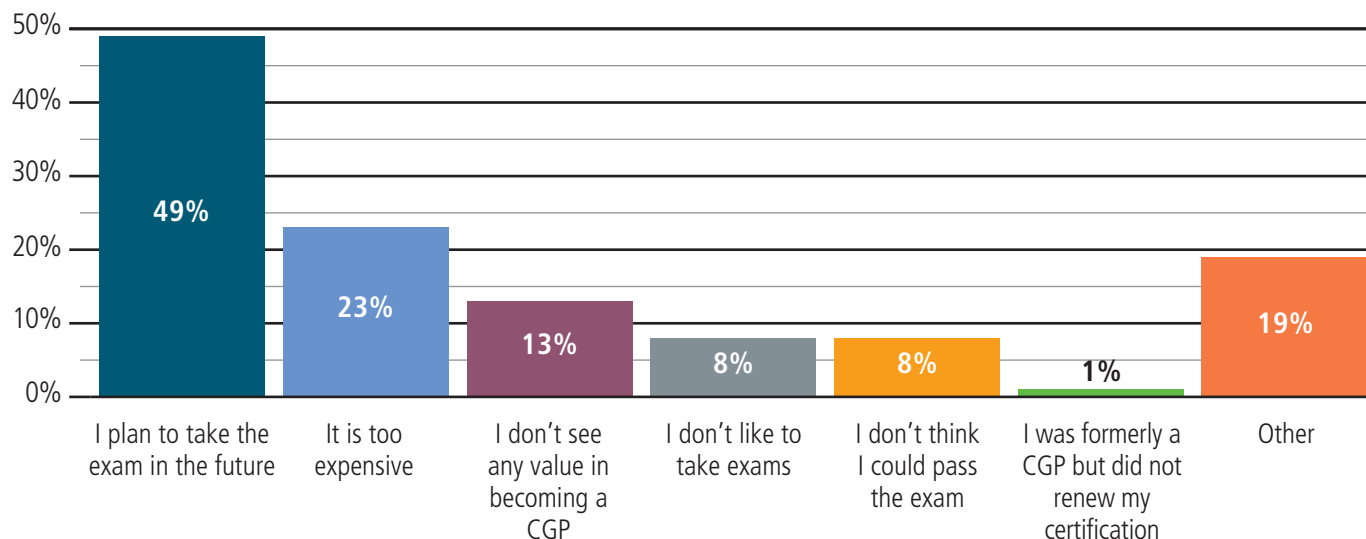
relevant to their job description. Some respondents reported that they are near the end of their career, and therefore such a credential would be unnecessary.

Practice Environment

Two-thirds of pharmacists (68%) said they practice in one or more nursing facilities (NFs), and a third said they practice in assisted living (38%) and/or serve as dispens-

FIGURE 38

Pharmacists — Reasons for Not Being Board-Certified Geriatric Pharmacist



ing pharmacist for a long-term care pharmacy provider (34%) (Figure 39).

Approximately one in four respondents (23%) reported serving as a consultant pharmacist in another residential setting such as a group home. Similar percentages said they serve as a hospital pharmacist (19%) or a community pharmacist (18%).

More than a fifth (22%) reported a practice involvement other than those listed as response options in the survey question. The most frequent of these responses involved management responsibilities such as pharmacy manager or director. Other responses identified employment in a wide range of environments, including managed care, outpatient clinics, and adult day care.

Practice Involvement

Survey respondents were asked to describe the amount of time they spend on various professional functions. On average, 41% of their time is devoted to providing consultant pharmacy services (Figure 40).

About a fifth of pharmacists' time

FIGURE 39

Pharmacists — Practice Environment

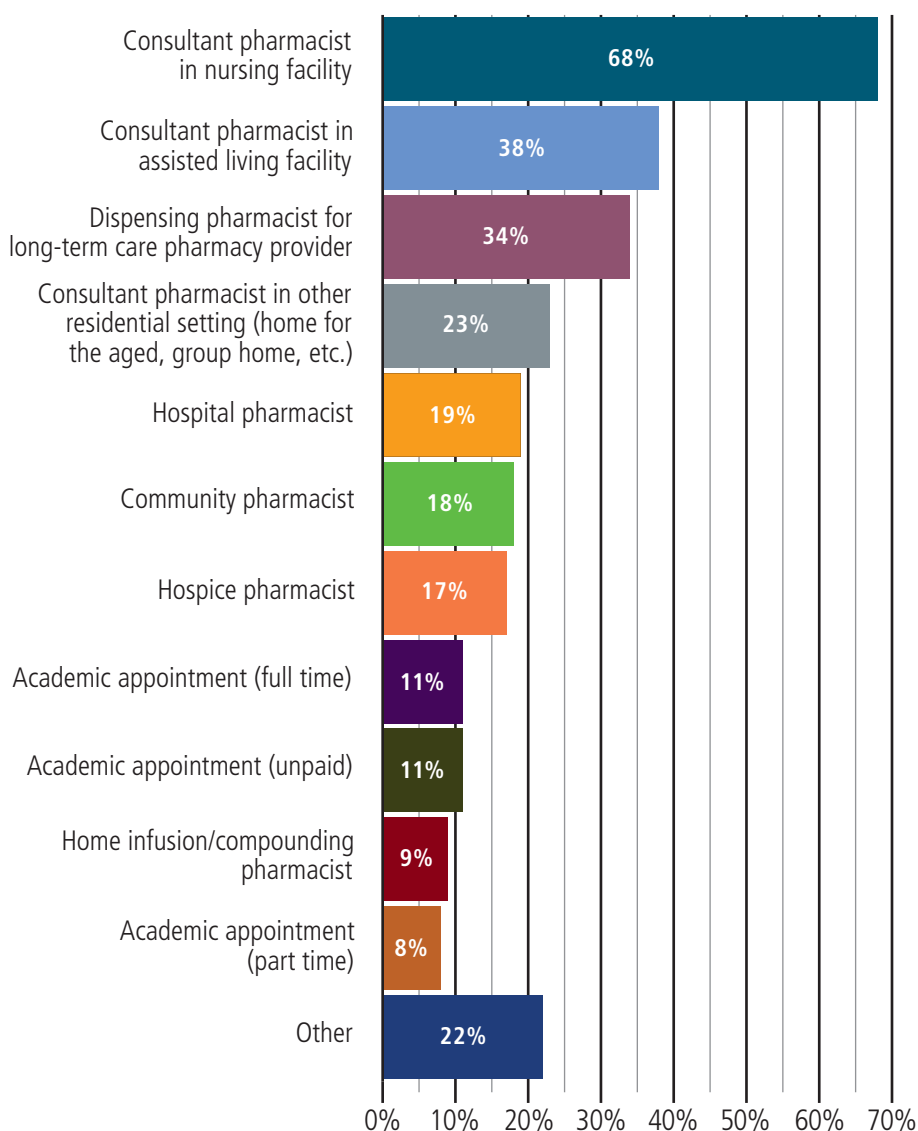
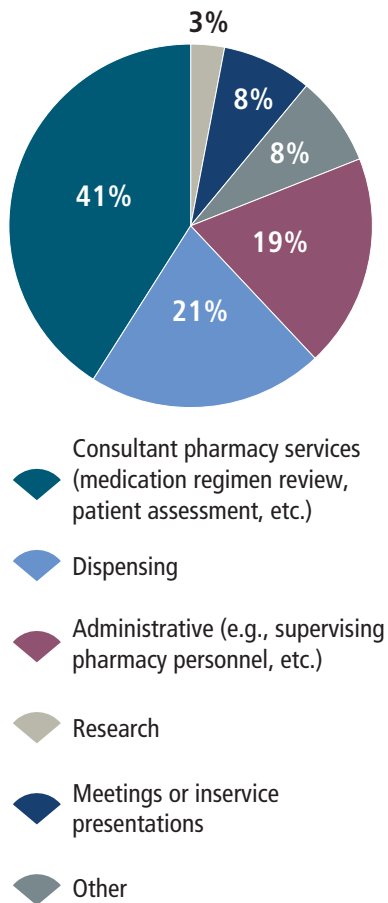


FIGURE 40

Pharmacists — Average Percentage of Time Devoted to Practice Functions



(21%) is spent dispensing medications, and a similar portion (19%) is devoted to administrative responsibilities. A small percentage of their time (8%) is devoted to functions other than those listed as response options in the survey question. Of these, the most commonly identified activities involve teaching and/or precepting pharmacy students.

Facilities Served

A large majority of respondents (72%) said they serve as a consultant pharmacist in one or more nursing facilities (**Figure 41**).

Of those, roughly similar portions serve in one facility (27%), two to four facilities (21%), or five or more facilities (24%). Forty-two percent said they serve as a consultant pharmacist in one or more assisted living facilities (ALFs), with 11% reporting service in six or more facilities.

Payment Model

Pharmacists most frequently said they are paid by a pharmacy provider, whether by salary (30%), by the hour (15%), or by the bed (2%) (**Figure 42**).

They also frequently reported being paid by the facility where they provide services, whether by the hour (15%), by salary (14%), or by the bed (7%). One-sixth of respondents (15%) said they are paid by a hospital.

Commentary

The large percentage of respondents reporting membership in ASCP is to be expected since this organization provided the list of pharmacists invited to participate in the survey. Moreover, ASCP is the only national or international organization dedicated to representing pharmacists who work in long-term care and senior care. The fact that pharmacists also reported membership in other national, state, and local pharmacy groups—as well as organizations representing specialty practice such as diabetes and lipid disorder management—is a reflection of the clinical complexity and sophistication of their practice.

That a significant portion of pharmacists who are not yet geriatric certified plan to take the board exam suggests that there will be increasing numbers of CGPs in the future.

FIGURE 41

Pharmacists — Number of Facilities Served as Consultant Pharmacist

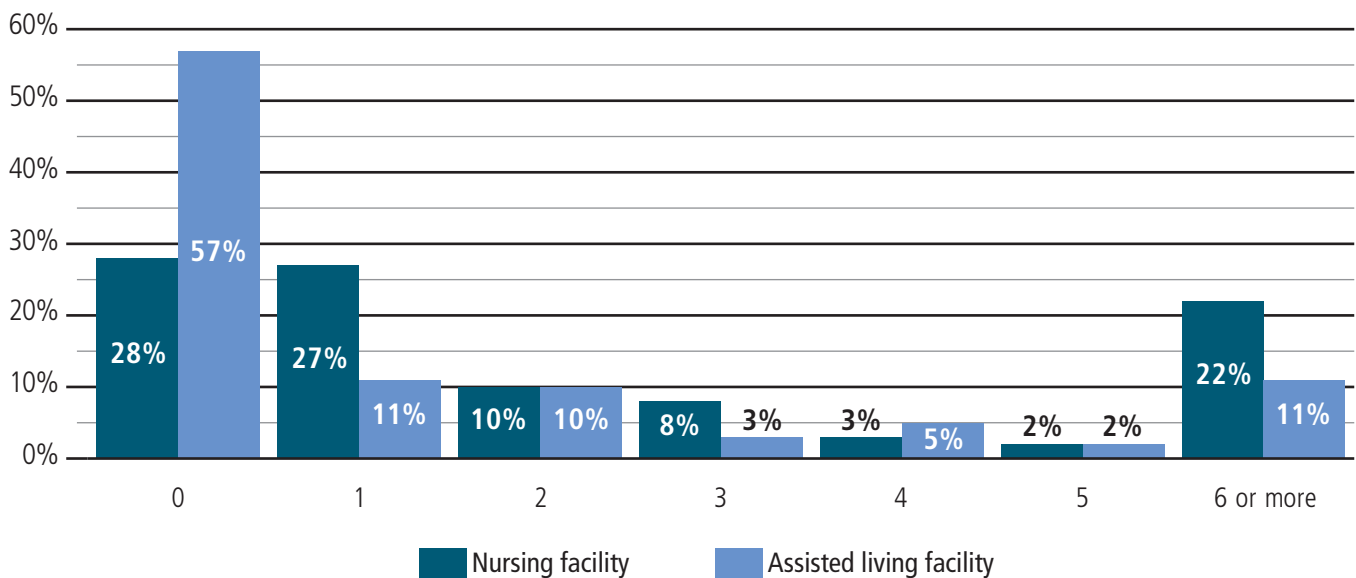
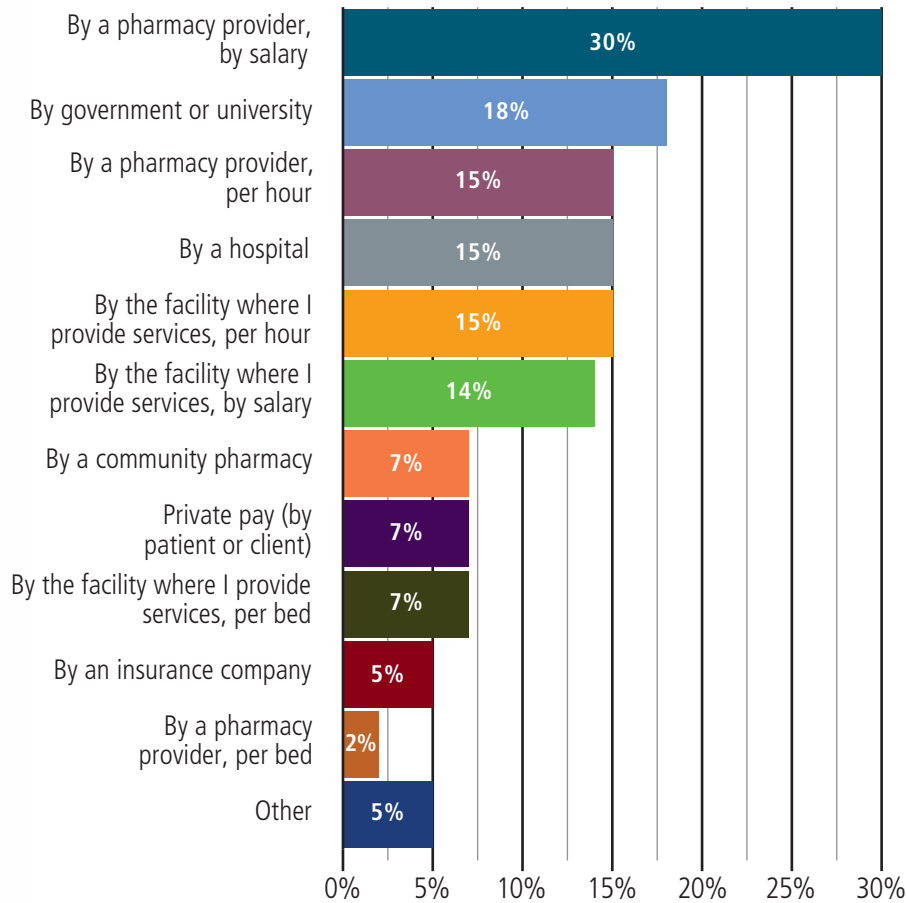


FIGURE 42

Pharmacists — Payment Model



However, it will be interesting to see if these individuals actually make the time and financial commitment to take the exam. Since 2006, the Commission for Certification in Geriatric Pharmacy has been offering the CGP board examination at more than 150 H&R Block secure testing centers across the country, making it readily accessible for nearly all pharmacists. More recently, computer-based testing has become a popular option that makes the exam even more accessible, which could very well increase the number of pharmacists earning the credential.

Growing recognition of the CGP will surely increase incentives for pharmacists to earn this qualification. For example, recently drafted

legislation—the Independence at Home Act of 2009 (S. 1131/H.R. 2560)—proposed “to provide certain high cost Medicare beneficiaries suffering from multiple chronic conditions with access to coordinated, primary care medical services in lower cost treatment settings, such as their residences, under a plan of care developed by a team of qualified and experienced health care professionals....” and it significantly recognized the CGP as the standard for demonstrating knowledge and expertise in geriatric pharmacotherapy. Specific wording in the bill required “monitoring and management of medications by a pharmacist who is certified in geriatric pharmacy by the Commission for Certification in Geriatric

Pharmacy or possesses other comparable certification demonstrating knowledge and expertise in geriatric pharmacotherapy, as well as assistance to participants and their caregivers with respect to selection of a prescription drug plan under Part D that best meets the needs of the participant’s chronic conditions.”¹ While not all provisions of the legislation were included in the final health care reform package, it sets the precedent for increasing recognition of the CGP credential. This and future legislation certainly will increase awareness of the CGP credential among pharmacists, consumers, and other health care professionals as well as provide opportunities for pharmacists to become more involved in monitoring and managing medications.

Pharmacists serving as a consultant in only one nursing facility may be employed by a community pharmacy serving one or two local facilities. In addition, they could be working in a facility’s in-house pharmacy, or perhaps they are self-employed and consulting on a part-time basis. In contrast, those serving in six or more facilities are apt to be full-time consultants, perhaps working for a large long-term care pharmacy provider, with few or no other responsibilities such as dispensing.

The fact that so many pharmacists are serving as consultants in assisted living speaks to their innovative nature, and this will be a trend to watch. While nursing homes are regulated by the federal government, assisted living facilities are regulated by the state in which they are located and thus the federal mandate requiring pharmacist-conducted medication regimen review (MRR) in nursing homes does not apply. Although some states do require MRR in as-

sisted living facilities, it typically is required less frequently than monthly, and, depending on the state, it may be performed by non-pharmacists.² However, the pharmacist's role in assisted living is becoming more formalized. For example, in 2009 Kansas expanded its regulations to require a licensed pharmacist to perform MRR when there is any significant change in a resident's condition as well as quarterly.³

Payment models vary, but it is revealing that only a small percentage of respondents said they are paid per bed. This was once a very popular mode of payment, with pharmacists being paid based on the number of MRRs they performed. The move in recent years to salary or hourly compensation may reflect the fact that MRRs have become more sophisticated, complex, and highly individualized; these other payment methods take into account the time that pharmacists devote to providing their services.

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2. Wizwer P, Simonson W. Complex medication regimens call for help with medication management. *Assisted Living Consult.* 2006;2(6):26-30.
3. Karl Polzer, for the National Center for Assisted Living. Assisted living regulatory review 2010. March 2010. <http://www.ahcancal.org/ncal/resources/Documents/2010AssistedLiving-RegulatoryReview.pdf>. Accessed May 21, 2010.

Senior Care Pharmacy Services

Introduction

“Senior care pharmacy” is a practice that recognizes and addresses the unique health care needs of the senior population. Pharmacists who specialize in senior care have unique knowledge of the medication-related needs of the senior population and typically are involved in providing comprehensive pharmacy services to nursing facility residents and seniors living in environments that provide some level of assistance and support, such as assisted living facilities.

Some innovative pharmacists provide services to seniors and their family caregivers outside a nursing facility via face-to-face visits with patients in their homes or in a “pharmacy office” setting.

To determine how pharmacists feel about and practice in the senior care environment outside the nursing home, the survey asked about their involvement in providing these services.

Description of Data

Provision of Senior Care Pharmacy Services

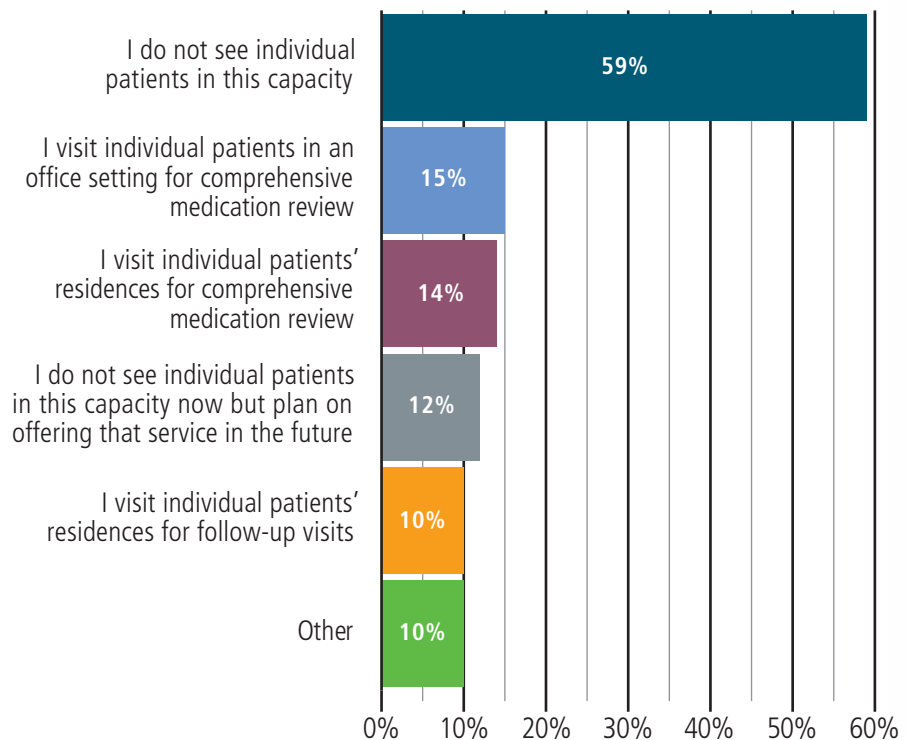
While more than half of respondents (59%) indicated that they currently do not see individual patients as a senior care pharmacist, 12% said they plan to offer senior care services at some point in the future (**Figure 43**).

Fifteen percent of respondents said they conduct patient visits for comprehensive medication review in an office setting. Fourteen percent said they perform such reviews in the patient's residence, and 10% said they provide follow-up visits there.

Payment for Senior

FIGURE 43

Pharmacists — Involvement in Senior Care Pharmacy Practice



Care Pharmacy Services

More than half of pharmacists who provide senior care pharmacy services in environments other than nursing facilities (56%) said they are reimbursed on a private-pay basis, either by the patient (31%) or by the patient’s family or representative (25%) (**Figure 44**).

A third (39%) said they are paid by their employer, and 31% are paid for these services by an insurance company.

Methods to Document Patient Visits/Interventions

The methods used by pharmacists to document their senior care pharmacy patient visits and interventions were similar to those used by pharmacists to make their nursing facility MRR recommendations. However, a greater percentage of respondents said they use laptop computers for their senior care practice than for their nursing facility MRRs (64% versus 40%, respectively) (**Figure 45**). (See the discussion on preparation of MRR beginning on page 50.)

Marketing of Senior Care Pharmacy Services

More than half of respondents (56%) indicated that they don’t market their services, while the remainder reported using a variety of methods—alone or in combination—including group presentations (33%), personal visits to potential referral sources (31%), and print ads (19%) (**Figure 46**).

Commentary

The provision of senior care pharmacy services to individuals living outside a nursing home is a concept that has grown out of the more traditional consultant pharmacist role. It reflects the fact that older individuals face similar drug therapy challenges

FIGURE 44

Pharmacists — Payment Sources for Senior Care Pharmacy Services

How are you paid for the senior care services you provide outside nursing facilities?

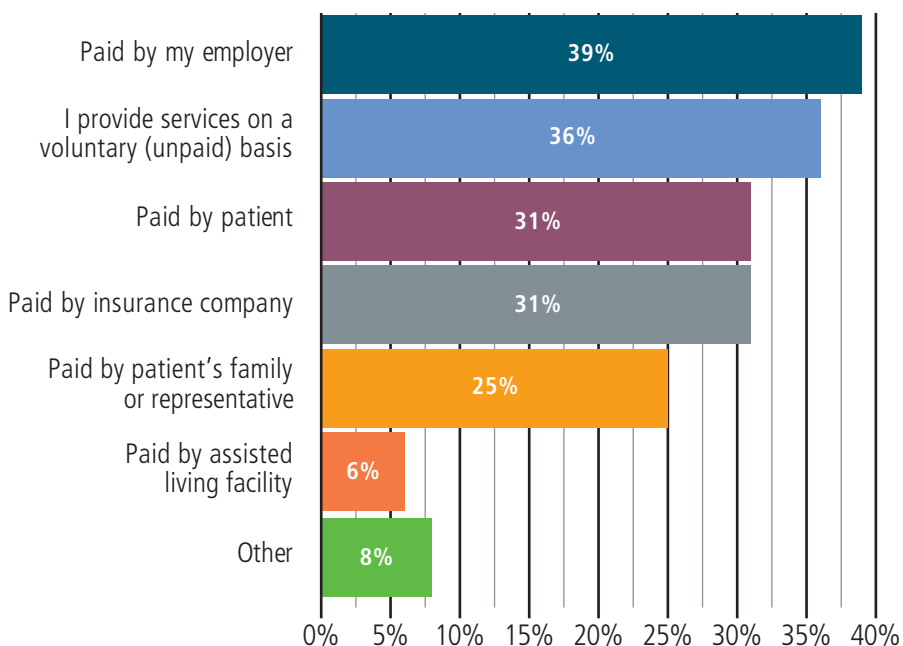


FIGURE 45

Pharmacists — Methods Used to Document Patient Visits/Interventions

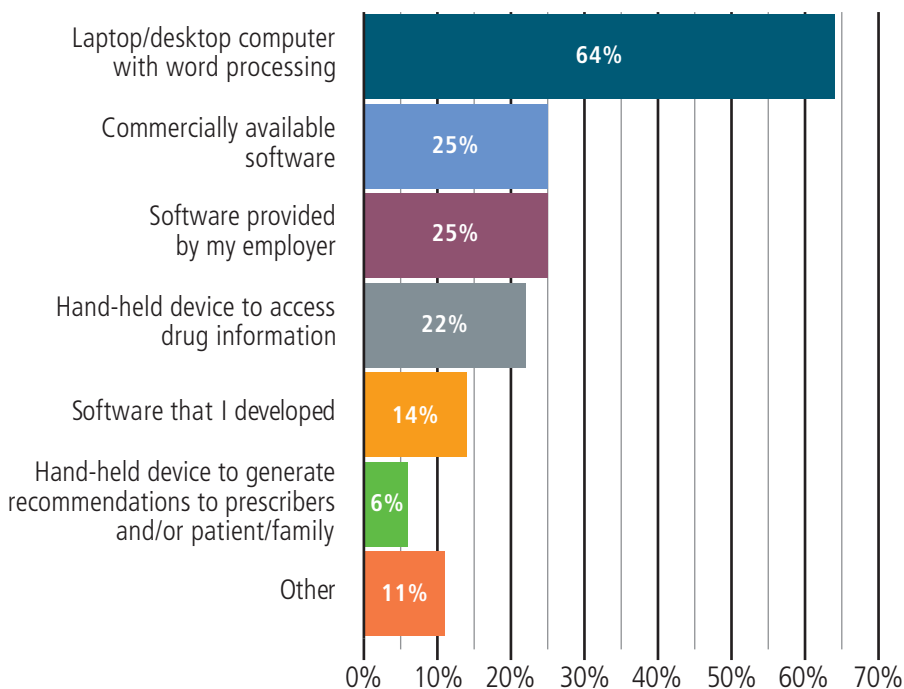
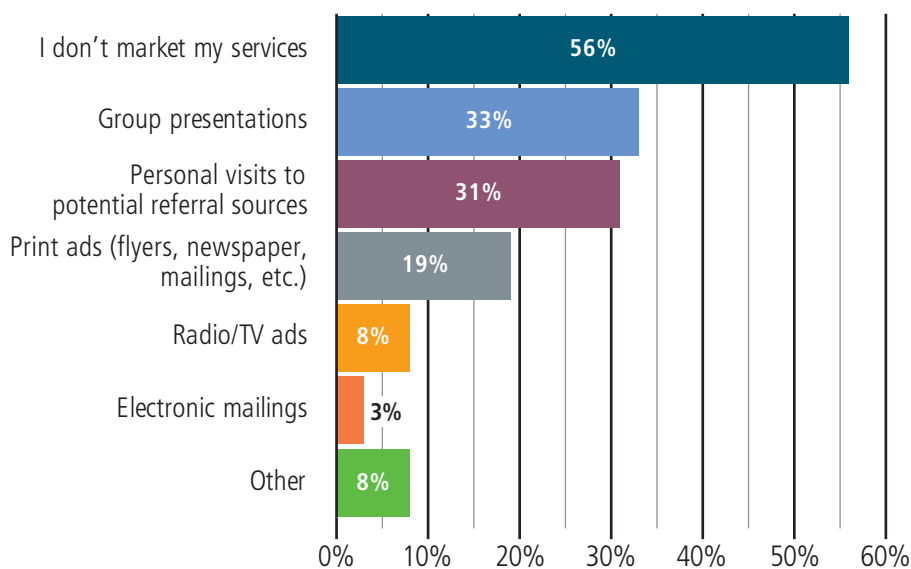


FIGURE 46

Pharmacists — Methods Used to Market Senior Care Pharmacy Services



whether they reside in a nursing facility, a care setting such as assisted living or a continuing care retirement community, or in their own home in the community at large.

The roles and practice environments for consultant and senior care pharmacists today have progressed far beyond what the most optimistic pharmacist would have predicted 20 years ago. Originally, consultant pharmacist services were limited to nursing homes. The most innovative consultants now provide advanced services—including comprehensive medication regimen review, disease management, software development, laboratory services, medication therapy management (MTM), nutrition services, and clinical research—in a number of settings.

The consultant pharmacist's role has evolved from providing basic services such as drug regimen review (now referred to as medication regimen review) in nursing facilities. Today, knowledgeable, experienced senior care pharmacists are increasingly in

demand, partly because of the rapidly growing number of seniors in this country. These seniors are prone to suffer from medication-related problems such as adverse drug events, drug interactions, excessive use of medications, and inappropriate or duplicate drug therapy—all of which can be improved with the intervention of a geriatric medication therapy expert.

Because of the growing number of elderly and the complex nature of their medication regimens and health issues, the practice of consultant and senior care pharmacy must not be restricted to institutional settings such as skilled nursing or assisted living facilities. This is especially true as the concept of "aging in place" grows in popularity and more seniors seek to stay in their own homes with the assistance of family and/or professional caregivers, home care and hospice services, special equipment and home modifications, and so on. The quality care and services provided by consultant and

senior care pharmacists are needed by seniors wherever they reside—including the community at large. Moreover, this need is almost certain to intensify in the coming years as baby boomers age.

It is a credit to pharmacists that so many are providing what could be considered two of the most advanced facets of senior care pharmacy—home visits for medication management and services in office-based senior care pharmacy practices.

We expect that increasing numbers of pharmacists will offer senior care pharmacy services to noninstitutionalized individuals in the future, but the growth of this type of practice will depend largely on the development of a reliable and consistent payment mechanism that recognizes the pharmacist's cognitive services aside from the provision of a drug product.

The identical questions concerning involvement in and reimbursement for senior care pharmacy services were asked in the 2009 *Senior Care Digest* survey, and the responses were quite similar—with the exception of payment for services by an insurance company (31% in 2010 compared to 10% in 2009).¹ Whether this represents a real trend is yet to be determined. Until a reliable payment mechanism such as reimbursement by Medicare or insurance companies is developed, the true impact of senior care pharmacy likely will not be realized since many seniors lack the resources or are unwilling to pay for these services out of pocket.

The lack of marketing by most senior care pharmacists could reflect the fact that senior care pharmacy practice is still in its infancy, or it could be that these pharmacists are

practicing on a part-time basis and are not looking for additional work. Another possibility is that they have enough work without having to advertise. While some pharmacists are making business connections through social networking sites such as LinkedIn and Facebook, it is possible that they don't consider this to be marketing.

It was interesting to see that marketing via group presentations was a popular response. These presentations could be formal programs at senior centers or other organized events such as senior citizen health fairs. Personal visits to potential referral sources could include a wide array of resources, including geriatricians, geriatric care managers, and hospital discharge planners.

Senior care pharmacy practice outside the nursing facility and assisted living environments is a logical extension whereby pharmacists are able to apply their skills in order to reduce the negative impact of medication-related problems and maximize outcomes and quality of life. Awareness and appreciation of senior care pharmacists can be expected to grow as organized initiatives such as ASCP's consumer information Web site, www.seniorcarepharmacist.com, make it possible for seniors and their caregivers to learn about senior care pharmacy and to find a local pharmacist offering these specialized services.

Reference

1. Simonson W, ed. *Senior Care Digest Interdisciplinary Report: A Survey of Long-Term Care Health Professionals*. Managed Care Digest Series® 2009. Bridgewater, NJ: sanofi-aventis U.S. LLC; 2009.

Pharmacist Practice Activities

Introduction

The survey asked pharmacists to indicate their participation and experience in various clinical activities and committees.

Description of Data

Committee Involvement

More than half of respondents (57%) said they are involved in a quality assessment and assurance committee (Figure 47).

Other top responses included involvement in a pharmacy and therapeutics committee (50%), quarterly review committee (48%), and behavior management/psychotropic drug committee (44%).

Clinical Activities

More than half of respondents said they are involved in medication error reporting/reviewing (56%), the provision of inservice education (48%), and adverse drug reaction monitoring (44%). A third (35%) said they perform MTM for Medicare Part D prescription drug plans (22%) and/or non-Part D payors (13%).

The 5% indicating "other" activities reported a wide variety of functions ranging from involvement in an institutional review board, admissions screening committee, and/or home care committee to anticoagulation therapy monitoring.

Commentary

Not surprisingly, pharmacists reported involvement in a wide variety of clinical and committee activities—many having to do with some aspect of medication management.

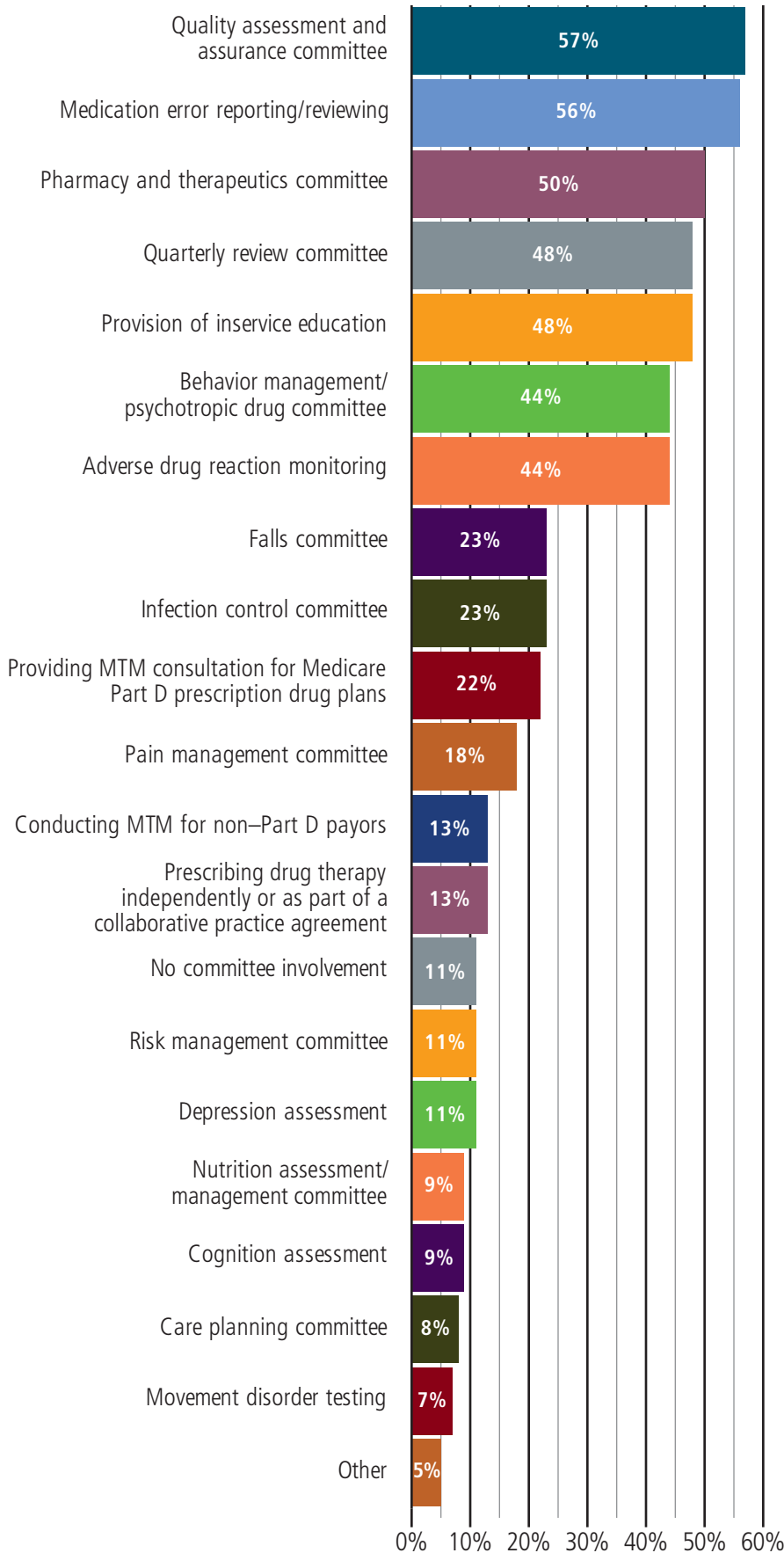
The extent of pharmacists' involvement in such professional activities may be influenced by factors such as their practice environment(s), experience, and roles in the facilities in which they practice. Depending on their contractual agreements with their facilities, involvement in certain committee and clinical activities may or may not be required. At the same time, their involvement in activities above and beyond basic medication regimen review may be influenced by the support and/or encouragement they receive from their employers and leadership and staff at the facilities in which they practice.

The role of pharmacists in MTM, a required component of the Medicare Modernization Act of 2003, will almost certainly increase as the law is fully implemented and enforced. While pharmacists' involvement in MTM appears to be limited to date, future surveys will probably show more practitioners involved in this activity, and to a greater degree.

When comparing pharmacists' involvement in committees and clinical activities between 2007 and 2010 we see little change.¹ This is interesting considering that several state survey F-Tags modified in 2007 potentially would increase pharmacists' involvement in areas such as reduction of unnecessary drugs. However, pharmacists' responses to similar survey questions since 2007 haven't supported this speculation. One possible explanation is that there is a limit to what pharmacists realistically can be expected to do as part of their practice activities. Another possibility is that consultant pharmacy has reached an equilibrium in which pharmacists commonly are

FIGURE 47

Pharmacists — Clinical and Committee Activities



providing a mix of services that meet current practice standards and regulatory requirements in the facilities they serve.

However, even with reports of similar involvement over this period it is probable that the scope, depth, and sophistication of that involvement have been increasing—although this would not be captured by the survey question. For example, in 2007 a pharmacist who reported involvement in the review and reporting of medication errors may have been performing this activity as part of a routine medication regimen review, whereas in 2010 such involvement may be part of a formal, facility-wide initiative to reduce medication errors. Alternatively, it is possible that as a result of the external pressures arising from revision of Appendix PP in the Centers for Medicare and Medicaid Services’ “Guidance to Surveyors for Long Term Care Facilities,” clinical role expansion has been thwarted by the need for consultant pharmacists to perform more basic activities to assist facilities in complying with regulatory requirements.

While consultant pharmacy practice will continue to evolve, it will almost certainly do so at a constant rate unless some new and unforeseen clinical or regulatory requirements are enacted. At the same time, it is important not to underestimate the role of skilled nursing facilities in requesting and offering to pay for more sophisticated clinical pharmacy services. These may include clinical outcomes and processes such as decreased rehospitalizations, medication reconciliation, and increased collaboration with other members of the health care team.

1. Simonson W, ed. *Senior Care Digest Interdisciplinary Report: A Survey of Long-Term Care Health Professionals*. Managed Care Digest Series® 2007. Bridgewater, NJ: sanofi-aventis U.S. LLC; 2007.

Medication Regimen Review

Introduction

Medication regimen review, formerly called drug regimen review, is an evaluation designed to identify potential and actual “irregularities” in drug therapy, including inappropriate combinations of medications, adverse drug reactions and interactions, and/or the use of medications that are no longer needed. MRR also serves to optimize the benefits of treatment by encouraging the most appropriate drug therapy.

Current federal guidelines require that all nursing facility residents

receive an MRR from a licensed pharmacist at least monthly or more frequently depending on the individual’s condition and the risks or adverse consequences related to his or her current medication(s). When irregularities are identified, the pharmacist must report them to the attending physician and the director of nursing (DON), and the physician must acknowledge and respond to the recommendations.¹

To determine how pharmacists perform MRR, the survey asked participants who said they are responsible for performing resident-specific nursing facility MRRs to describe their thoughts about and approach to the process.

Description of Data

Time Needed for Individual MRR

Nearly three-fourths of pharmacists (70%) said they perform MRRs in nursing facilities (data not shown). About half (51%) reported that it takes them an average of 6 to 10 minutes to conduct an individual

MRR for a long-stay resident, but when they were asked how long it takes to perform an MRR for a short-stay resident, the most frequent response—indicated by a third of pharmacists (36%)—was 11 to 15 minutes (**Figure 48**).

MRR for Short-Stay Residents and/or Residents with Acute Change of Condition

More than half of pharmacists (61%) said they receive a request to perform an MRR when a resident is admitted for what will likely be a short stay and/or for a resident with an acute change in condition (**Figure 49**).

A third (39%) said that the request goes directly to the pharmacy provider.

Contact with Residents During MRR Process

Fifty-eight percent of pharmacists said they have contact, either occasional or routine, with residents for the purpose of observation/information gathering as part of their MRR (**Figure 50**).

FIGURE 48

Pharmacists — Average Time Required to Perform an Individual MRR in Nursing Facilities

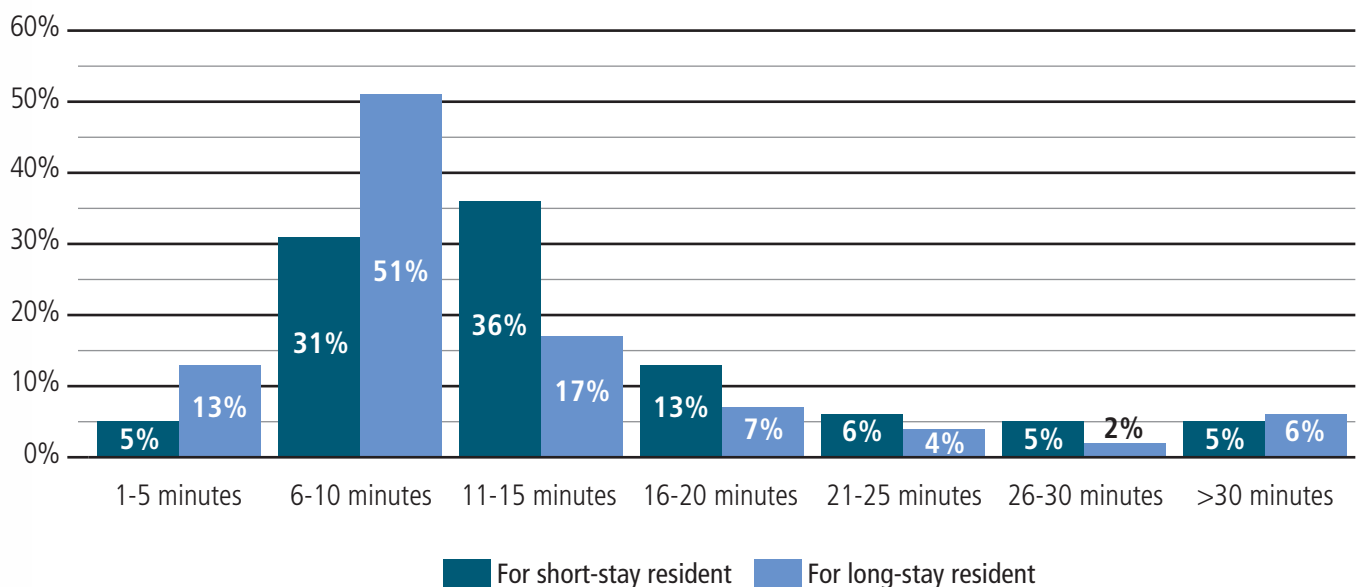


FIGURE 49

Pharmacists — MRR for Short-Stay Residents/Residents with Acute Change of Condition

How are MRR requests for short-stay residents and residents with an acute change of condition handled in your facility?

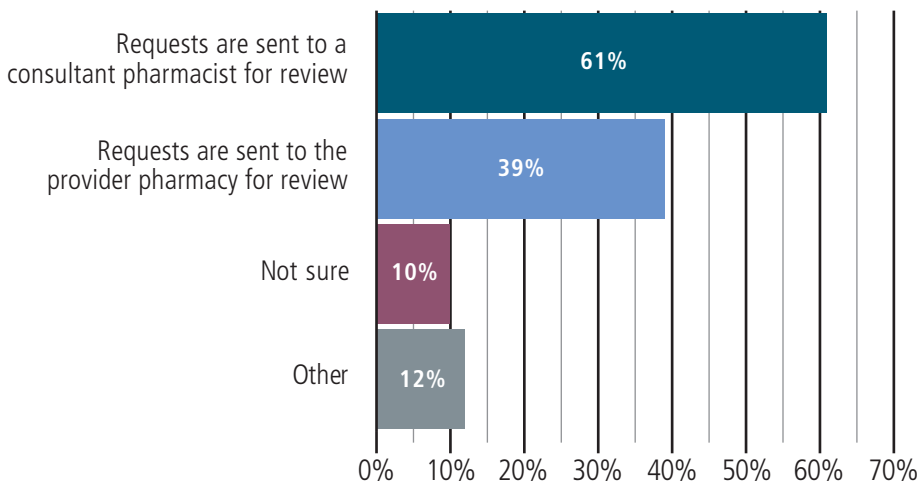
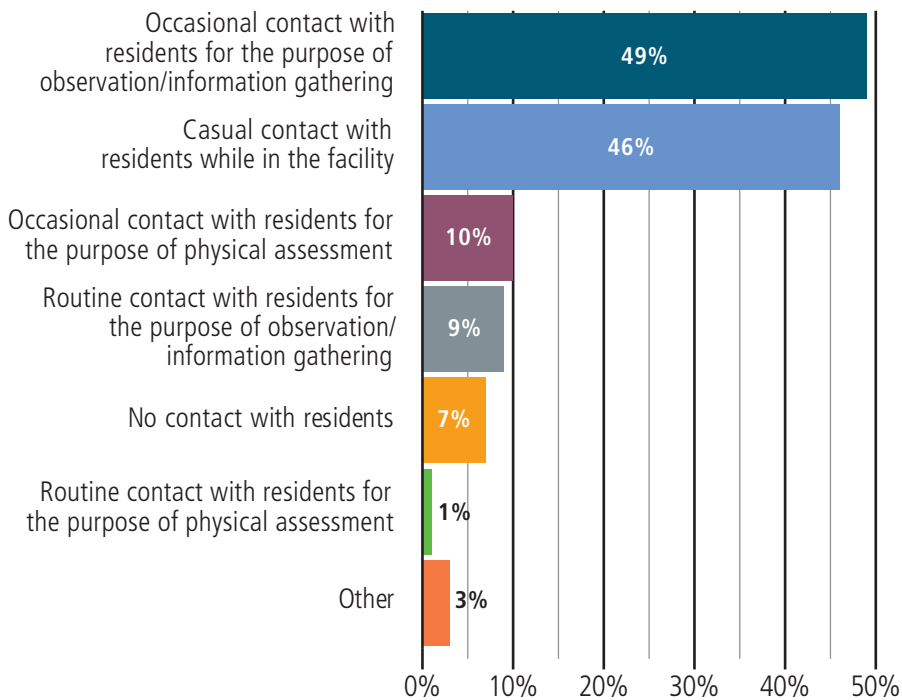


FIGURE 50

Pharmacists — Contact with Residents During MRR



Nearly half of pharmacists (46%) reported casual contact with residents while in the nursing facility. Ten percent said they have occasional contact with residents for the purpose of physical assessment, while 1% said they have routine contact for this purpose. Only 7% said they have no resident contact during the MRR process.

Reasons for Contact with Residents

The survey asked pharmacists to indicate from a list of options the reasons for their contact with residents. They most commonly reported seeing residents on request of facility staff (86%) or when a staff member or another clinician suspects a medication-related problem (69%) (Figure 51).

Nearly half of respondents (48%) said that contact with a resident occurs at the request of the physician, and 4% said they visit all residents routinely. Pharmacists who provided open-ended responses also said they may interact with residents on request of the resident’s family or because they know the resident and are making a casual visit.

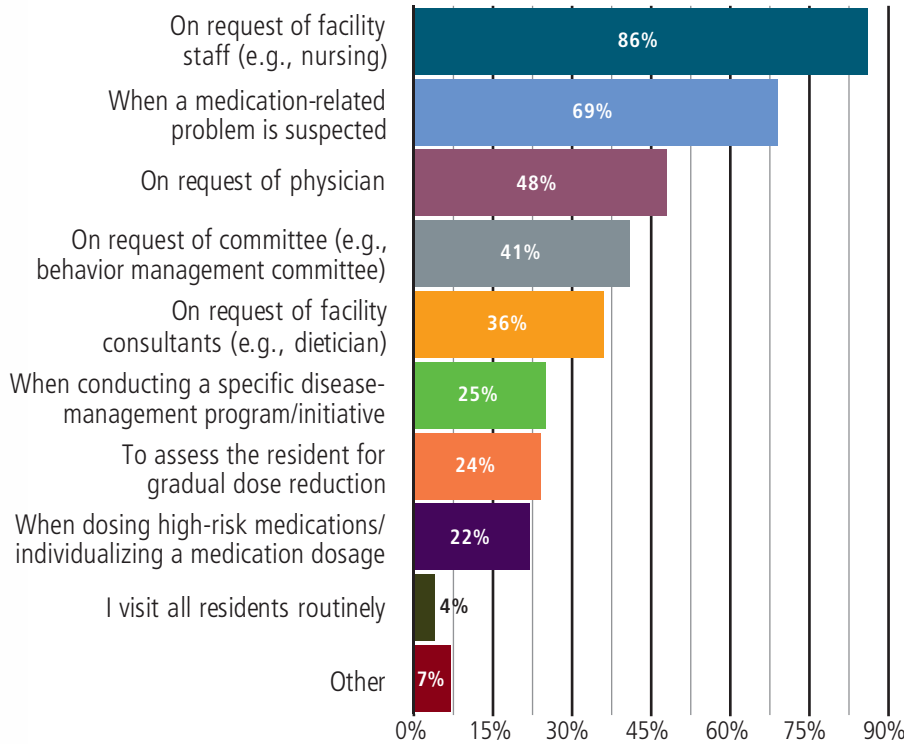
Approach to MRR Data Collection

Respondents said there are certain parts of the patient record they frequently or always use when performing MRR. These include physician orders (including all prescribers) (97%), lab results (96%), and the medication administration record (MAR) (66%) (Figure 52).

Among the data sources respondents said they use infrequently or never as part of the MRR are the care plan (30%), formal meetings with staff to discuss individual residents (29%), the Minimum Data Set (MDS) (27%), and committee reports (23%).

FIGURE 51

Pharmacists — Reasons for Contact with Nursing Facility Residents



Preparation of MRR Recommendations

Similar percentages of pharmacists said they use one or more of the following technologies to develop and/or prepare their MRR recommendations: commercially available consultant pharmacy software (41%), computer with word processing and self-developed macros (40%), or a hand-held device to access drug information and/or generate recommendations (35%) (Figure 53).

Delivery/Communication of MRR Recommendations

Respondents commonly said they use more than one type of delivery method for their MRR recommendations. More than three-fourths of respondents (78%) said they deliver their recommendations to the facility staff in a written or printed format

FIGURE 52

Pharmacists — Frequency of Information Used in the MRR Process

	Always (100%)	Very frequently (80%-99%)	Usually (50%-79%)	Occasionally (20%-49%)	Infrequently (1%-19%)	Never (0%)
Medication administration record	45%	21%	17%	13%	5%	0%
Physician orders (including all prescribers)	86%	11%	1%	1%	0%	0%
Vital signs	34%	22%	23%	15%	5%	1%
Physician progress notes	44%	22%	21%	11%	2%	0%
Nursing notes	24%	21%	29%	23%	3%	0%
Lab results	75%	21%	3%	0%	1%	0%
Assessment records (e.g., AIMS testing)	32%	24%	28%	10%	5%	1%
Consults/reports from specialists	31%	33%	25%	8%	2%	0%
Pharmacy-generated reports (therapeutic interchange notice, drug interaction warning, etc.)	45%	22%	14%	8%	8%	3%
Reports from committees	8%	17%	29%	23%	18%	5%
Discussion with nursing staff	26%	30%	26%	10%	6%	1%
Discussion with consultant staff (e.g., dietician, therapists, etc.)	9%	21%	26%	25%	16%	2%
Formal meetings with staff to discuss individual residents	10%	21%	16%	24%	22%	7%
MDS data	9%	17%	24%	22%	17%	10%
Care plan	7%	17%	18%	28%	23%	7%

FIGURE 53

Pharmacists — Methods Used to Prepare MRR Recommendations

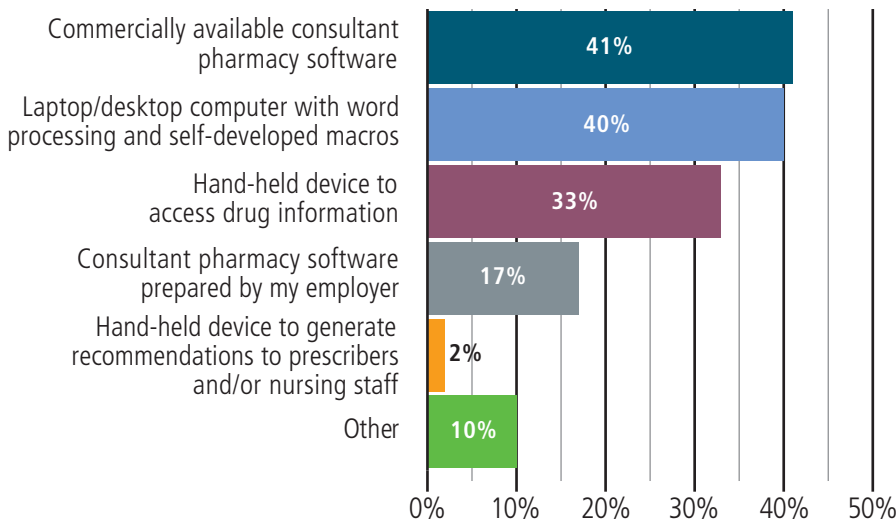
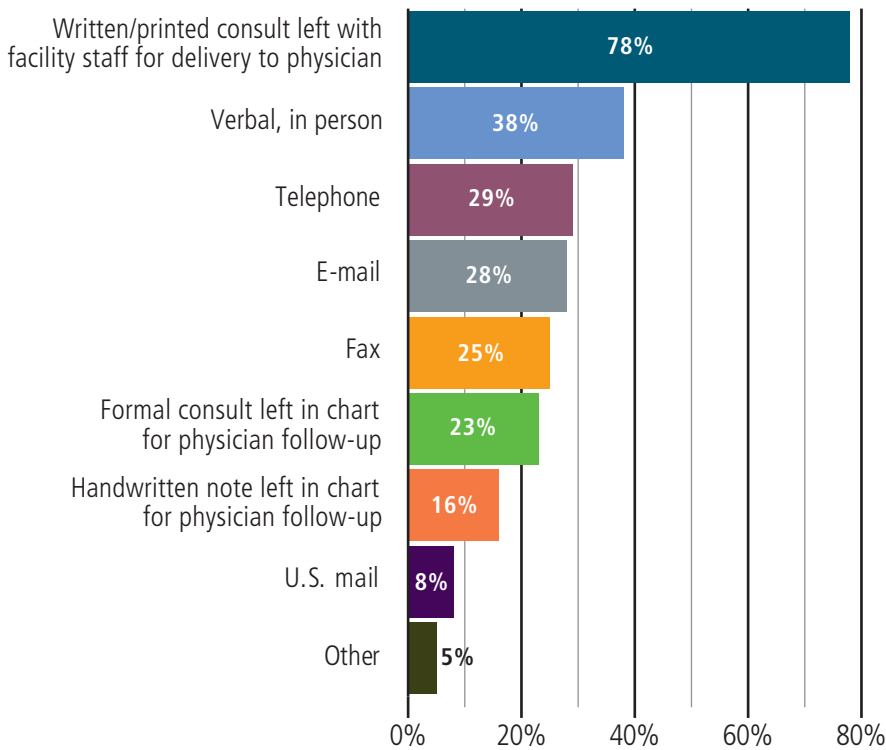


FIGURE 54

Pharmacists — Transmission Methods for MRR Recommendations



for delivery to the physician (Figure 54).

More than a third of respondents (38%) said they provide their recommendations to the prescriber verbally, in person. Twenty-eight percent transmit their recommendations via e-mail, and 23% leave a formal consult in the chart for physician follow-up.

Prescriber Acceptance Rate of Pharmacist's MRR Recommendations

The majority of pharmacists (54%) reported that prescribers accept 81% to 100% of their recommendations (Figure 55).

A very small percentage (8%) reported an acceptance rate of 40% or less.

Pharmacist's Follow-Up on MRR Recommendations

When pharmacists were asked what action they take when the prescriber does not respond to their MRR recommendations, nearly three-fourths (72%) said they resubmit their recommendations to the prescriber the following month (46% said they resubmit only selected recommendations, and 26% said they resubmit all recommendations) (Figure 56).

Most (64%) said they discuss the matter with the director of nursing (DON), and a third (36%) said they discuss the matter with the medical director.

Frequency of MRR Recommendations

Pharmacists with MRR responsibilities were asked to indicate from a list of potential MRR suggestions which ones they might include in their recommendations, and how frequently. More than two-thirds

FIGURE 55

Pharmacists — Prescriber Acceptance Rate of Pharmacist's MRR Recommendations

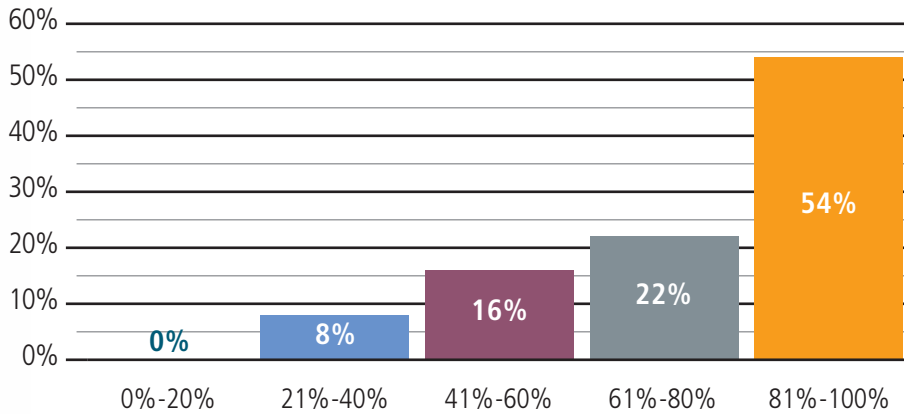
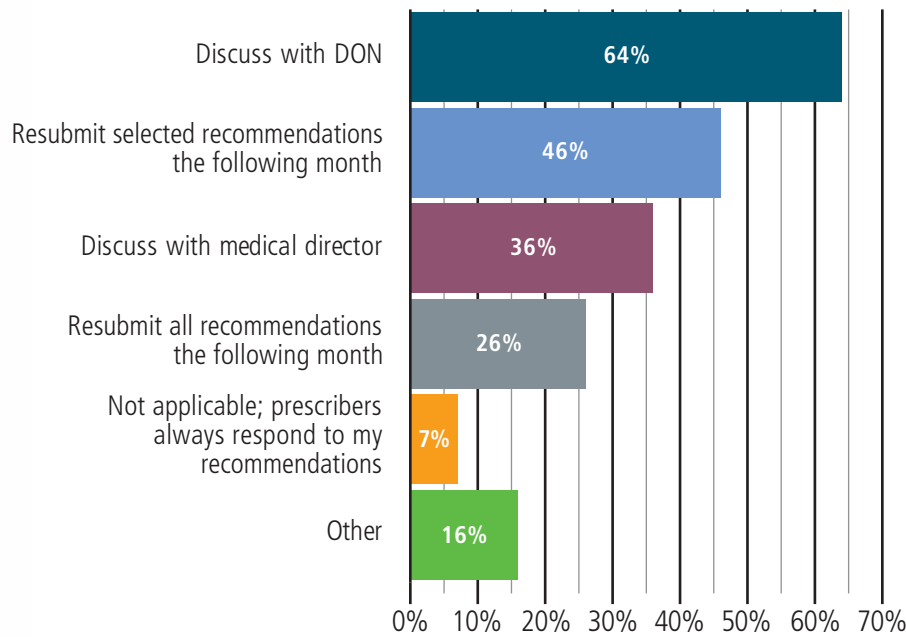


FIGURE 56

Pharmacists — Follow-Up on Unaddressed MRR Recommendations

What action(s) do you typically take when a prescriber does not respond to your MRR recommendations?



said they routinely recommend lab tests according to product labeling (75%), discontinuation of duplicative therapy (72%), clarification of an indication for a prescribed medication (69%), and modification of drug therapy as part of gradual dose reduction of a psychopharmacological medication (68%) (Figure 57).

Pharmacists said their recommendations either rarely or never include alerts about possible drug interactions with dietary supplements or herbal/complementary/alternative medications (40%), discontinuation of therapy to switch to a substitute or formulary product (31%), and alerts to possible drug interactions

with nutrients, vitamins, and minerals (28%).

Influence of Tag F329 on NF Prescribing

Lastly, pharmacists were asked to provide their opinion of how the modified Tag F329 – Unnecessary Drugs has influenced drug prescribing in NFs. The most frequent response was that Tag F329 has had a positive impact on prescribing (52%), with 44% saying it was somewhat improved and 8% saying it was much improved (Figure 58).

Commentary

Many considerations go into the specifics of how pharmacists perform MRR, including individual needs and/or requests of the facility, patient, and prescriber. The survey data cannot be interpreted as a comprehensive snapshot of MRR, but they do provide a revealing look at this process.

Recent revisions to the Centers for Medicare and Medicaid Services (CMS) State Operations Manual—the document that guides surveyors' assessments in nursing facilities—have had considerable impact on the MRR process. For example, revisions to the Investigative Protocol for Tag F329 – Unnecessary Drugs, Tag F428 – Drug Regimen Review, and Tag F309 – Quality of Care, as well as the new Quality Indicator Survey (QIS) being adopted by nursing facility surveyors, have increased the likelihood that surveyors will want or need to interview consultant pharmacists during a survey.

The State Operations Manual contains an extensive list of the consultant pharmacist's activities within the nursing facility. Although regulations specify pharmacists' responsi-

FIGURE 57

Pharmacists — Frequency of MRR Recommendations

	Routinely	Occasionally	Rarely	Never
Recommend lab test to monitor drug therapy per product labeling recommendations	75%	21%	5%	0%
Discontinue therapy to eliminate duplicative therapy	72%	22%	6%	0%
Clarify indication for prescribed medication	69%	24%	7%	0%
Modify drug therapy as part of a gradual dose reduction of psychopharmacological medication	68%	25%	7%	0%
Recommend lab test to monitor drug therapy per State Operations Manual guidance to surveyors	61%	25%	13%	1%
Alert to possible drug interaction with another drug	56%	36%	8%	0%
Recommend lab test to monitor drug therapy regarding a boxed warning	55%	33%	10%	1%
Discontinue therapy due to drug no longer effective or necessary	55%	37%	8%	0%
Modify drug therapy: dosage adjustment	55%	38%	7%	0%
Modify drug therapy based on kidney function	54%	32%	14%	0%
Recommend lab test to monitor drug therapy based on patient-exhibited drug effect	53%	38%	9%	0%
Manage possible drug interaction: suggest monitoring parameters	53%	38%	9%	0%
Modify drug therapy to change medication administration time	47%	38%	14%	1%
Discontinue therapy due to patient exhibiting adverse effect	46%	37%	17%	0%
Modify drug therapy to change frequency of administration	46%	34%	20%	0%
Manage possible drug interaction: discontinue interacting drug	46%	41%	13%	0%
Modify drug therapy to manage an adverse effect of another medication	41%	38%	21%	0%
Discontinue therapy due to duration beyond PI recommendations	39%	43%	17%	1%
Manage possible drug interaction: reduce the dosage of substrate or interacting drug	39%	40%	21%	0%
Discontinue therapy due to desired therapeutic response achieved	38%	44%	18%	0%
Modify drug therapy for an untreated indication	34%	47%	18%	0%
Discontinue therapy due to substitute or switch to a formulary product	32%	37%	26%	5%
Modify drug therapy to augment a partially treated indication	31%	45%	22%	2%
Alert to possible drug interaction with nutrients, vitamins, and minerals	31%	41%	28%	0%
Alert to possible drug interaction with dietary supplements such as herbal, complementary, and alternative medications	24%	36%	39%	1%

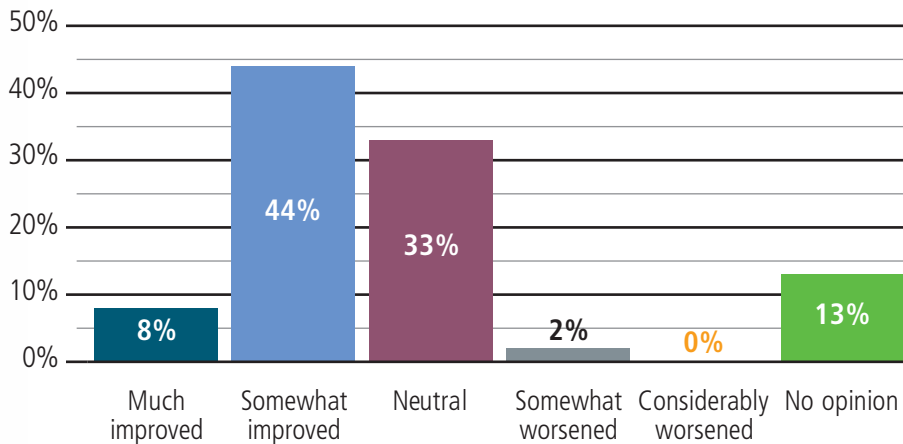
bilities, these practitioners have considerable leeway with respect to how they perform MRR. They may adopt various techniques and approaches to the process, and the survey responses reflect this individuality.

As the data here clearly demonstrate, MRRs for long-stay residents require less time to complete than those for short-stay residents. There may be several reasons for this. For one, the pharmacist is no doubt familiar with

the long-stay resident and his or her medication regimen. This individual may have been following the resident for some time, so he or she may have already made suggestions to prescribers about the resident's therapy.

FIGURE 58

Pharmacists — Influence of Tag F329 – Unnecessary Drugs on Prescribing in NFs



Moreover, long-stay residents are less likely to experience frequent changes in drug therapy, condition, or lab test results. When long-stay residents are relatively stable, the MRR may take just a few minutes to complete.

On the other hand, short-stay residents typically have more acute conditions and complicated drug histories that require careful consideration during transition of care—in this case, from hospital to nursing facility. In addition, these individuals often have more complicated medication needs, such as postsurgical anticoagulation or systemic antibiotic therapy, so the MRR for such residents may take considerably longer and need to be performed more frequently than monthly. In fact, in open-ended responses to the question about MRR for short-term admissions and short-stay residents, many pharmacists said they make weekly visits to the facility. Others indicated that they work in an “in-house” pharmacy located within the nursing facility, which, of course, would make them readily available so MRR could be performed more

frequently than monthly as necessary.

MRR frequency is an important issue for facilities and pharmacists to address because what is often referred to as the monthly MRR really is required at least monthly. Depending on the resident and his or her condition, MRR may need to be performed more frequently. For example, a short-stay resident who is expected to be in the facility for just two weeks might be completely missed by a pharmacist who only comes to the facility once a month; this could result in a survey citation for the facility. The pharmacist is an important team member who works with the facility to ensure that MRRs are current and accurate, both to protect the resident and to comply with state survey requirements.

How and when pharmacists use particular data is apt to change with the advent of new technologies and other influencing factors. For example, some pharmacists do not routinely rely on the MAR for the individual MRRs they perform. From a practical perspective, this could be due to

the fact that the nurse often is using the MAR, so it may be unavailable to pharmacists during their reviews. As the use of health information technology increases the availability of electronic MARs, access to and use of MAR data should increase in MRRs. Likewise, the new MDS 3.0, which promises to be a valuable clinical tool and which involves interviews with residents and families as part of care planning, may be used more frequently by pharmacists than the older MDS 2.0 to monitor the effects of drug therapy.

The survey responses demonstrate that there is no standard way for pharmacists to deliver recommendations to physicians. The most common approach—leaving recommendations with facility staff for delivery to the prescriber—helps ensure timely transmission, since the facility presumably has routine communication with the prescriber. In addition, the facility is better able to track the prescriber’s response (or lack thereof) and make sure that all recommendations are addressed. This is the method of choice reported by more than three-fourths of pharmacists, compared to slightly more than half in the 2009 *Senior Care Digest Interdisciplinary Report*.²

The percentage of pharmacists who said they send their recommendations electronically was similar to that reported in the 2009 *Senior Care Digest Interdisciplinary Report*.² Some pharmacists still use a handwritten note, which could be an entry in the progress notes or perhaps a communication sheet dedicated to pharmacist comments. However, this longstanding method may soon be replaced when electronic medical records are implemented on a widespread basis

throughout the long-term care continuum. Some pharmacists communicate their recommendations in person as circumstances allow, such as when pharmacist and physician visits to the facility coincide, during a scheduled meeting, or perhaps when a complex or sensitive issue calls for a personal discussion.

That pharmacists said most of their MRR recommendations are accepted by the prescriber is testimony to the quality and pertinence of their suggestions. While some pharmacist-generated recommendations are fairly basic—such as requesting that the prescriber document an indication for which a medication was prescribed—others may be more clinically complex, such as requesting that a particular lab test be ordered to monitor for a drug's therapeutic or adverse effect. Still other recommendations could involve suggestions for alternative therapy or various changes or interventions. More than half of pharmacists indicated that their recommendations routinely address 12 of the more than two dozen categories of MRR recommendations. This suggests that MRR recommendations are varied, detailed, and address

the individual needs of each resident. MRR is not a “cookie-cutter” process and to describe it as merely a chart review would be inaccurate.

The survey questioned pharmacists about what they do if the prescriber fails to act upon their MRR recommendations. Their responses suggest that they are diligent about following up and making sure their concerns are addressed. That respondents reported various means of dealing with this situation—such as talking to the DON or medical director—suggests that they will use whatever action will get the best result. While there is no formal “best practice” model for MRR, what does exist is a set of specific guidelines for appropriate drug therapy. These guidelines help drive the nursing home survey process. Surveyors evaluate each resident in an effort to identify the use of unnecessary drugs, defined as those used in excessive dose, for excessive duration, without adequate monitoring, without indications for their use, or in the presence of adverse consequences which indicate that the dose should be reduced or discontinued—or any combination of these reasons.¹ What matters is not precisely how

the pharmacist conducts an MRR but whether the pharmacist's MRR and subsequent recommendations—in conjunction with the efforts of other interdisciplinary team members—can ensure that drug therapy is appropriate for each resident and that medication-related outcomes are optimized. Achievement of that goal is measured by survey findings, and if deficiencies are noted, it may be necessary for the pharmacist to modify his or her approach to the MRR process.

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Consultant Pharmacist Commentary



Rachelle F. Spiro, RPh, FASCP

This year's survey report covers some new and interesting topics. The data are revealing in terms of what practitioners currently are thinking and doing. However, the information makes me wonder how responses might

change as practitioners gain experience with new programs, regulations, and activities. That is why it is important to have reports such as this that track practices and attitudes over time.

For example, as a practitioner with a passion for technology, I was interested to see a question about the use of social networking sites. While the numbers of practitioners actively using sites such as Twitter, LinkedIn, and Facebook are fairly low now, I believe this is because many colleagues are just now discovering these sites and they still have questions and concerns about issues such as privacy. Interestingly, pharmacists reported the highest use of these sites. This didn't surprise me, as these practitioners have a history of being early embracers of new technology. Most pharmacists reported using Facebook. Again, this isn't surprising, as it is probably the easiest social networking site to use. I also suspect that many people are using Facebook for personal purposes to connect with friends and family members. It appears that significant opposition exists for use of social networking sites for patient care applications.

As consultant pharmacists gain more experience with social networking technology, I can envision them interacting with other practitioners and their patients via such sites as a standard of practice. The practitioners who already use these sites—myself included—are finding them to be important ways to share information, market services, and network with colleagues and consumers alike. There must be a cultural shift in health care toward more openness regarding technology, and I see this happening more and more.

The increasing implementation of electronic health records (EHRs) will no doubt have a tremendous impact on how practitioners respond to questions about technology. As more facilities move to EHRs, we will start seeing pharmacist medication regimen review (MRR) integrated into this tool. The MRR is essential to ensure that patients get the medications they need during transitions—such as from the nursing facility to the hospital and back, or from short-stay rehab to home. Strongly integrated MRRs will help improve transitions of care between settings—an issue that has received a great deal of attention in recent years.

Another issue that will change with time involves controlled substances in long-term care. This matter remains controversial and unresolved. The American Society of Consultant Pharmacists (ASCP) currently is working with other professional organizations to address this issue in order to ensure that pain medications are available to patients in a timely manner. We at ASCP advocate recognition of the nurse as an agent of the physician and the ability to transmit the chart order as the prescription to the pharmacy. If this issue is resolved, it likely will affect future survey responses considerably.

Only about three-quarters of pharmacists reported being involved in any aspect of gradual dose reduction in nursing facilities. It will be interesting to see how this number changes following the implementation of MDS 3.0. The new MDS likewise could impact how interdisciplinary leaders respond to questions about research in long-term care. The information that facilities will glean from MDS data will enable more practitioners to conduct quality improvement studies.

I am looking forward to next year's report and following up on some of these questions to see how experience and innovation change answers and attitudes.



DISCIPLINE-SPECIFIC QUESTIONS

Directors of Nursing

Demographics

Introduction

The survey asked directors of nursing (DONs) to report their professional memberships and credentials and to identify their practice environment and related employment history.

Description of Data

Practice Environment

As expected, an overwhelming majority of respondents (91%) identified the nursing facility as their practice environment (**Figure 59**).

Six percent said they serve as a DON in both a nursing facility and an assisted living facility (ALF), while 3% said they practice as a DON or the equivalent (e.g., resident care coordinator, health care coordinator, RN wellness nurse, etc.) in an ALF.

Memberships and Credentials

More than a third of respondents (35%) reported membership in the National Association of Directors of Nursing Administration (NADONA), and 12% said they have earned NADONA's director of nursing administration certification (CDONA) (**Figure 60**).

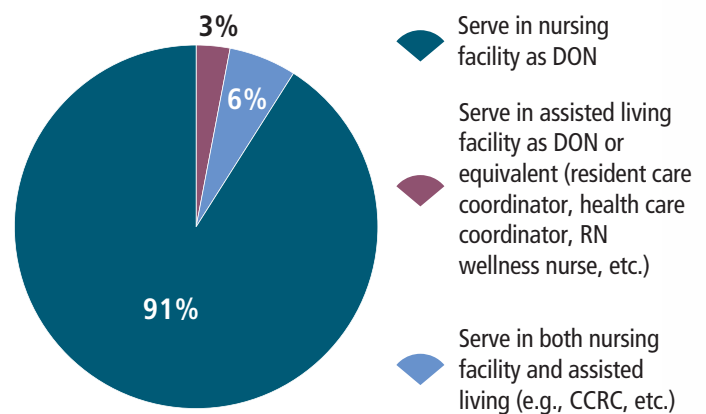
Ten percent said they have received the American Nurses Association (ANA) certificate in gerontology. Nearly half of respondents (48%) said they have neither the membership nor credentials listed as response options in the survey question, while 22% said they maintain a membership and/or credential other than those listed.

Years Served as DON

Two-thirds of DONs (67%) said they have been serving in that capacity for five years or more (**Figure 61**). However, only a third (39%) said they have served as a

FIGURE 59

Directors of Nursing — Practice Environment



DON in their current facility for that entire time (**Figure 62**). Slightly more than half (55%) said they have served as a DON in more than one facility during their career (**Figure 63**).

A third (34%) reported serving in three or more facilities during their career.

Plans for Continuing Career

When asked about their plans to continue their work as a DON, a quarter (24%) of respondents said they plan to work in that capacity for fewer than five years (**Figure 64**).

Commentary

It is not surprising that most of those who reported working as a DON or the equivalent in an ALF also serve as DON in a nursing facility. This probably represents an environment such as a continuing care retirement community (CCRC) that provides multiple levels of care in a single campus-like setting. The survey produced similar

FIGURE 60

Directors of Nursing — Memberships and Credentials

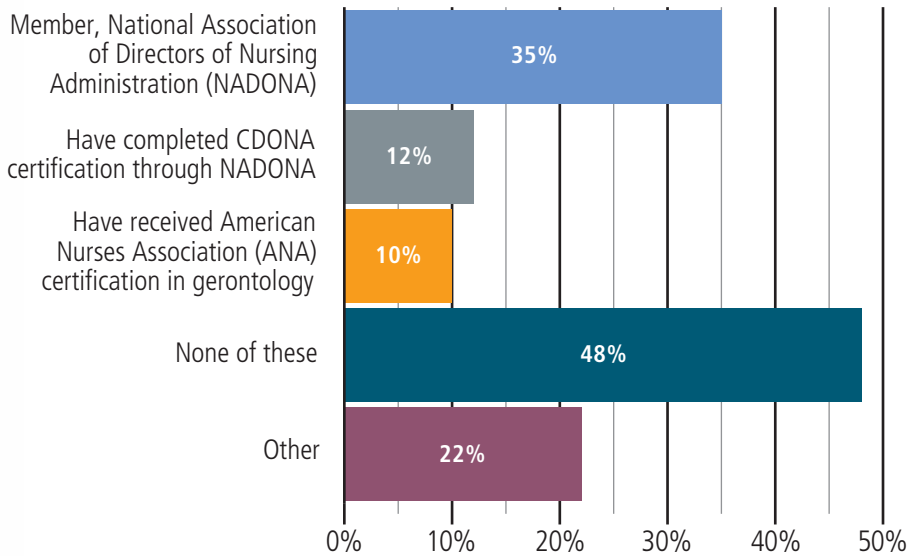


FIGURE 61

Directors of Nursing — Number of Years Served as DON

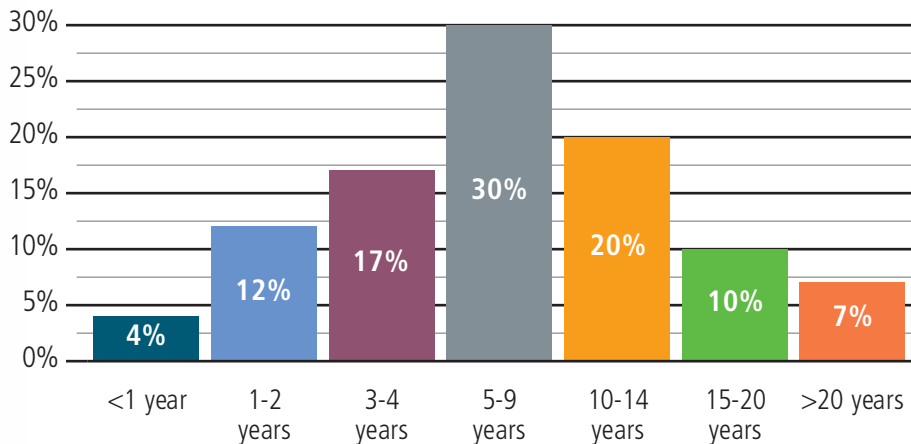
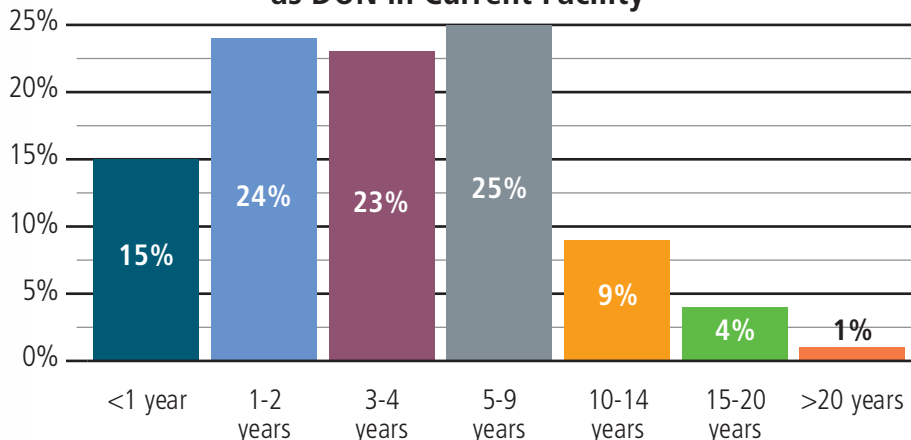


FIGURE 62

Directors of Nursing — Number of Years Served as DON in Current Facility



responses to the same question last year,¹ suggesting that as ALFs and CCRCs become more prevalent, nursing facility DONs are being asked to step into that role in other settings.

About a third of respondents reported membership in NADONA; some of them also have received CDONA or ANA certification in gerontology. A significant portion of these individuals are members of national organizations such as the ANA or the American Association of Nurse Assessment Coordinators, state nursing associations, and/or they possess one or more certifications, including hospice and palliative care, wound care, rehabilitative nursing, subacute care, legal nurse consulting, or Eden Associate certification. As nurses increasingly are involved in leadership roles on specialty teams—such as wound care, risk management, or culture change—it is understandable that DONs are seeking specialized certifications to hone their skills in those areas.

When survey respondents were asked what organizations they belong to aside from those listed in the survey question, half reported no activity in any national or state associations and/or no additional credentials. In an attempt to understand this bimodal pattern, a more detailed analysis was performed to determine which factors might predict DONs' professional involvement. A trend emerged: Those who are members of NADONA tended to have more experience as a DON. This suggests that as DONs become more experienced, they increasingly recognize the importance of this professional affiliation and migrate toward NADONA membership. It also may indicate that members of NADONA

FIGURE 63

Directors of Nursing — Number of Facilities Served as DON During Career

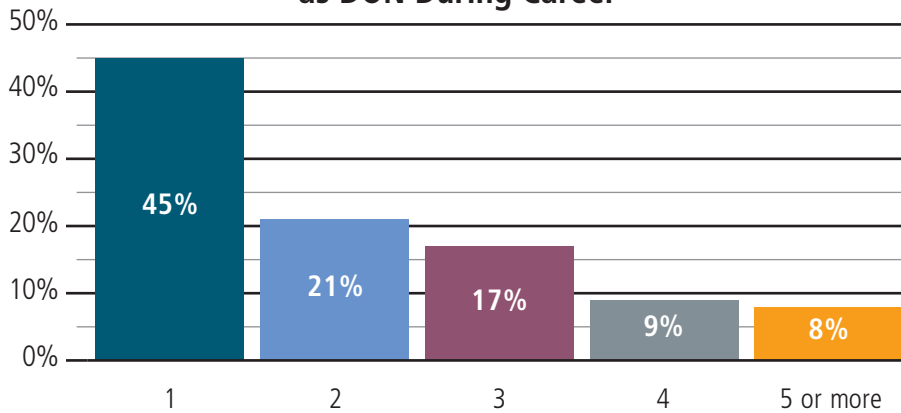
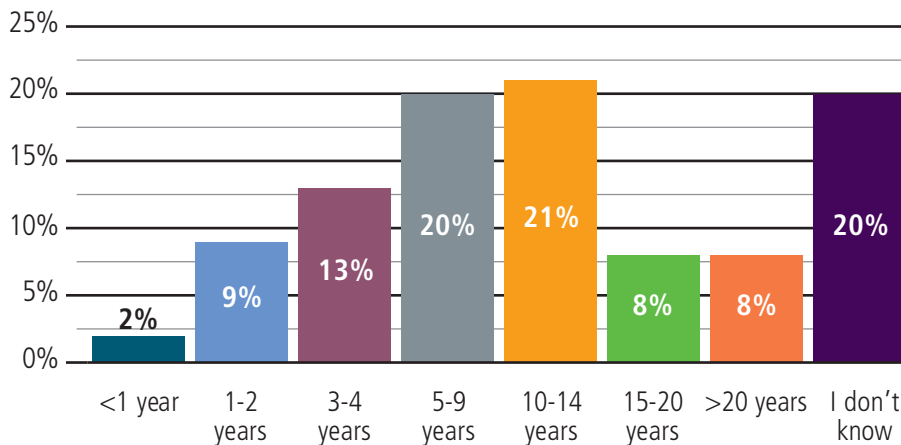


FIGURE 64

Directors of Nursing — Plans to Continue Work as a DON

How much longer do you plan to work as a DON?



are more likely than nonmembers to remain employed as DONs (data not shown).

There is no doubt that DONs' professional plates are full. They work long days in their facilities and often bring work home. They face innumerable challenges as they attempt to balance their work responsibilities and personal/family time. Understandably, they may feel they have little or no time for involvement in activities other than those directly related to their work. In addition, they may not get their employers' support to join

professional organizations and/or attend organization meetings. Yet, as seen in other professions, involvement in professional organizations exposes individuals to resources, new ideas, innovative solutions, and useful tools. Such involvement also provides opportunities for networking and socializing with colleagues and for obtaining nursing continuing education credits. Moreover, it may improve job performance and satisfaction. Failure of such a large portion of DONs to become involved in professional associations such as NADONA is a significant issue that

should be addressed in the coming years. As the population ages, staffing shortages will continue to be an issue, and as more—and sicker—patients enter long-term care, facilities will increasingly rely on DONs as team leaders. This being the case, perhaps facilities will be more supportive of professional education and involvement on the part of their DONs.

The majority of the DON workforce is experienced and plans to remain employed in that capacity for at least five years. And while some DONs have moved around, most have remained in long-term care. These data suggest that a shortage of DONs isn't expected to be a problem in the near future, but unless those DONs who plan to leave the profession within five years are replaced, a shortage could develop in the future.

Reference

1. Simonson W, ed. *Senior Care Digest Interdisciplinary Report: A Survey of Long-Term Care Health Professionals*. Managed Care Digest Series® 2009. Bridgewater, NJ: sanofi-aventis U.S. LLC; 2009.

Staffing Issues, Hiring/Retention, and Health Insurance

Introduction

The survey asked DONs to provide information about staffing and turnover rate in their facilities. In addition, they were asked about barriers and incentives that impact hiring and retention, such as health insurance.

FIGURE 65

Directors of Nursing — Average Number of Nursing Staff Positions

	FTE positions	# of open positions
RNs	11.5	0.7
LPNs/LVNs	20.2	1.2
Nurse aides/assistants	57.2	3.7
Medication aides	2.2	0.3
Total	91.1	5.9

Description of Data

Facility Staffing

When asked to indicate their nursing staff levels, DONs reported an average of 11.5 full-time equivalent (FTE) RN staff positions in their facilities, with an average of 0.7 positions currently unfilled (Figure 65).

DONs also reported an average of 57.2 FTE nurse aide/assistant positions, with an average of 3.7 positions currently unfilled.

Nursing Turnover Rate

When asked to comment on the 2009 nursing turnover rate in their facilities, DONs reported rates as low as 0% and as high as 86% (data not shown). However, the majority (76%) reported a turnover rate of 10% or less, with an average of 9.6% (Figure 66).

Half of DONs (47%) indicated that their facility's RN turnover rate was lower in 2009 than in 2008, compared to 26% who reported that this rate has remained steady. Twelve percent reported that the turnover rate was higher in 2009 than in 2008 (Figure 67).

FIGURE 66

Directors of Nursing — Nursing Turnover Rate in 2009

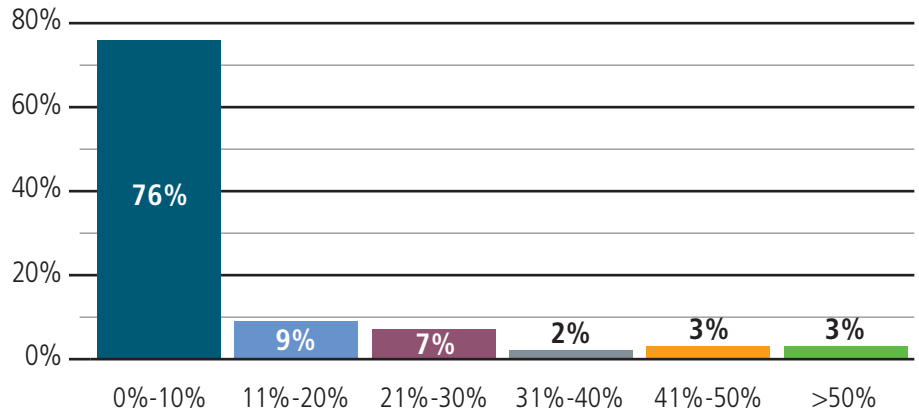


FIGURE 67

Directors of Nursing — Facility RN Turnover Rate

How did your 2009 RN turnover rate compare with your 2008 RN turnover rate?

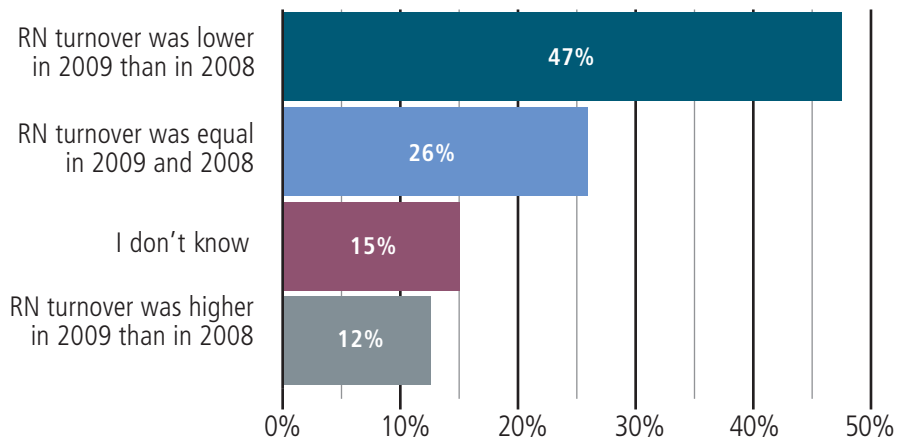
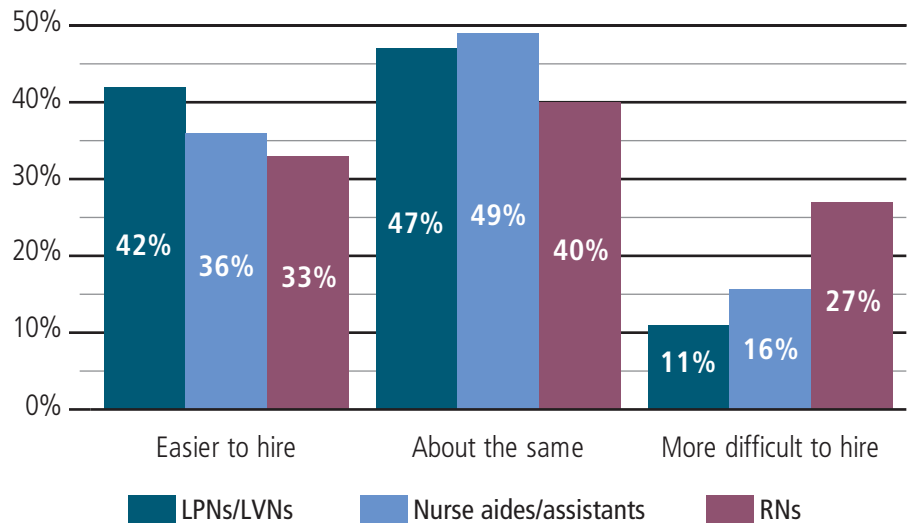


FIGURE 68

Directors of Nursing — Ease of Staff Hiring

Please compare ease of hiring new staff this year versus last year.



Ease of Hiring

When DONs were presented with a question about staff hiring, roughly equal percentages reported that it was “easier to hire” or “about the same” in each category (LPNs/LVNs, aides, RNs) in 2009 compared to the previous year. A smaller number said that hiring was more difficult in 2009 than in 2008, including 27% of DONs who indicated that hiring of RNs was more difficult in 2009 (Figure 68).

Challenges to Hiring and Retention

The survey asked participants to indicate the extent to which they agree with several items that represent possible challenges or obstacles to hiring and retaining professional nursing staff. The two items that received the greatest agreement were the facility’s ability to offer competitive wages (51%) and child care (44%) (Figure 69).

On the other hand, a majority of respondents disagreed that the ability to offer adequate vacation time (59%), the ability of staff to find transportation to the facility (58%), and the ability to offer adequate sick leave (54%) are challenges to attracting and retaining professional nursing staff.

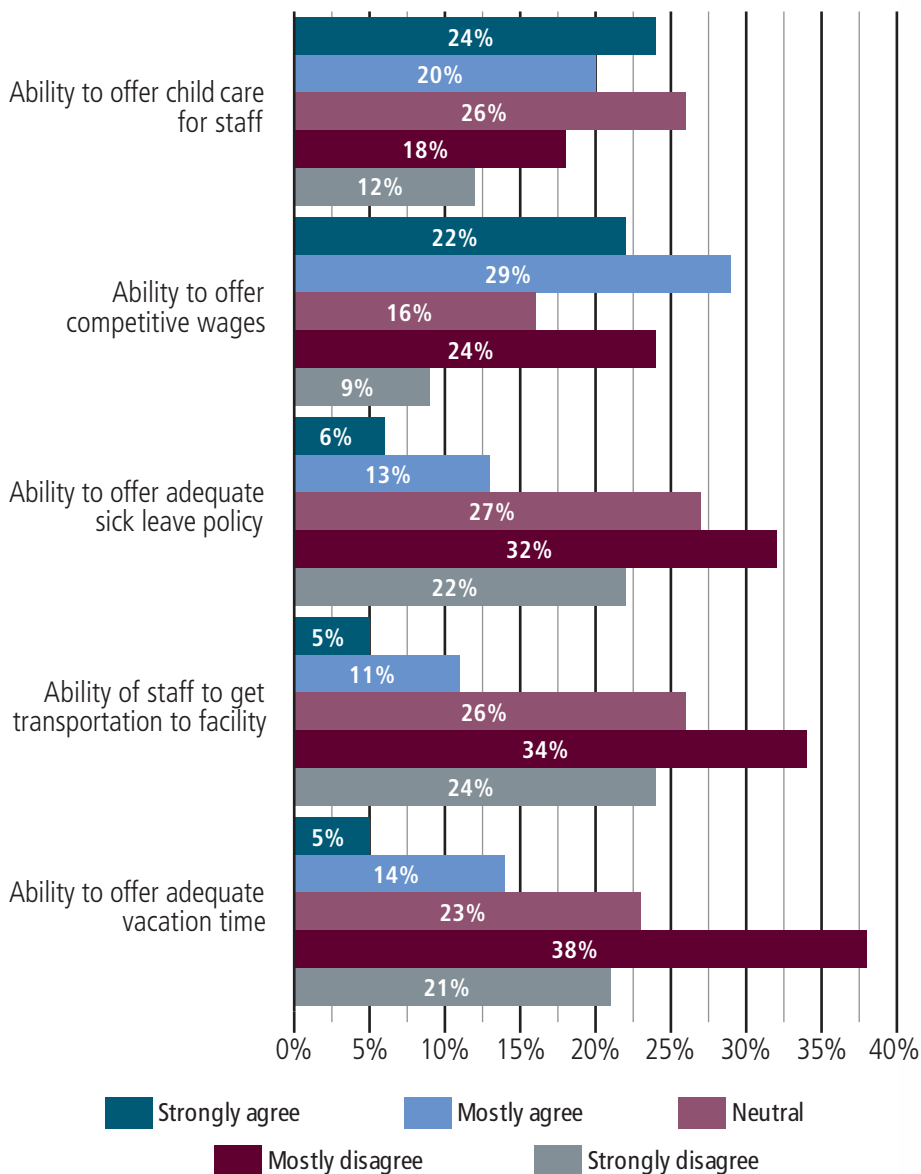
Health Insurance for Facility Staff

The survey asked DONs to indicate whether their facilities provide health insurance coverage for employees and their families. A large majority of respondents reported that their facilities cover a portion of health insurance costs for full-time employees (LPNs/LVNs, 83%; RNs, 81%; nurse aides/assistants, 79%; DONs, 74%). Far fewer respondents said their facilities pay a portion of health insurance

FIGURE 69

Directors of Nursing — Challenges to Hiring and Retention of Nursing Staff

Please indicate the extent to which you agree or disagree that the following items represent challenges to your facility’s ability to hire and retain professional nursing staff (RN, LPN, or LVN).



costs for part-time employees (RN, 43%; LPN/LVN, 41%; nurse aides/assistants, 39%) (Figure 70).

Seventeen percent of survey respondents said their facilities provide fully paid health insurance for DONs, while 7% or less said their facilities provide fully paid health insurance

for other full-time nursing staff (RN, LPN/LVN, nurse aides/assistants). A mere 1% of respondents said part-time staff receive this benefit.

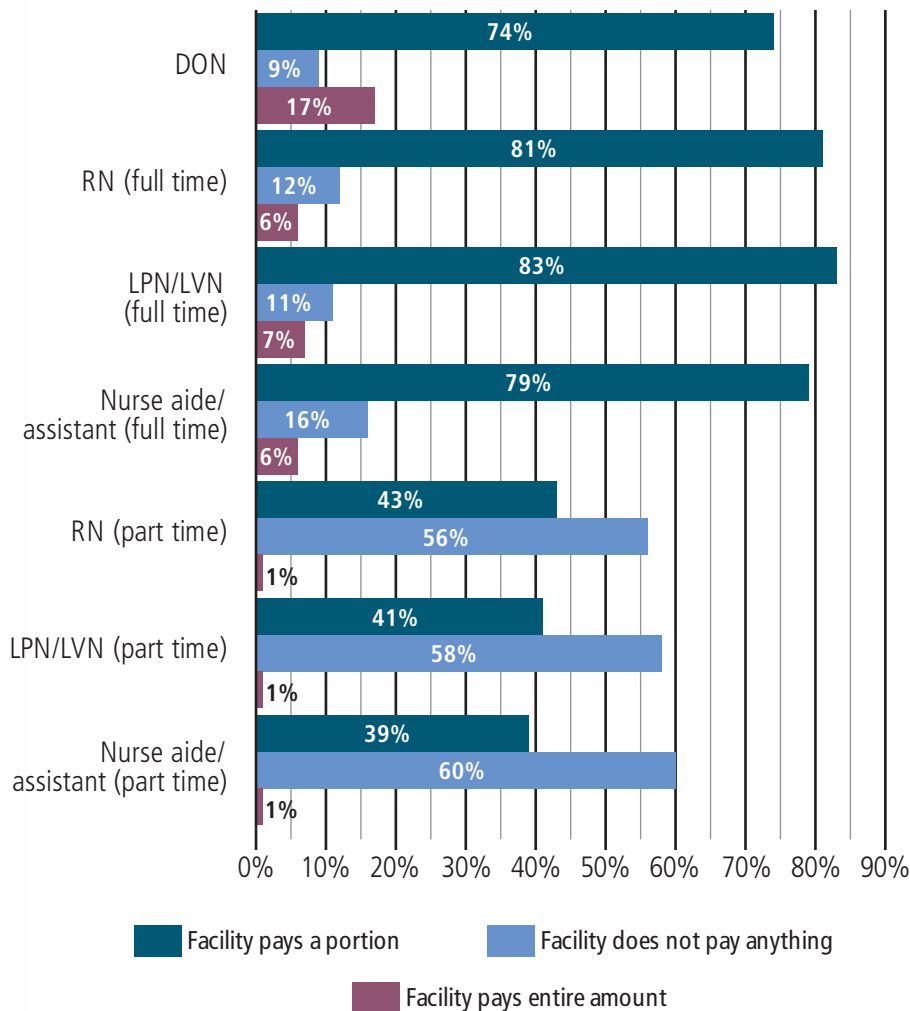
Health Insurance for Family Members of Facility Staff

When DONs were asked if their facilities provide health insurance for

FIGURE 70

Directors of Nursing — Facility-Provided Health Insurance for Staff

To what degree does your facility pay for health insurance for employees in the following staff categories?



family members of employees, their responses showed a similar pattern: The majority said their facilities pay a portion of health insurance costs for family members of full-time staff (LPNs/LVNs, 64%; nurse aides/assistants, 63%; DONs, 60%). A notable exception, however, is RNs. Only 33% of DONs said their facilities pay a portion of health insurance costs for family members of full-time RNs (Figure 71).

Only 8% of DONs said their family members receive health insurance

that is fully paid by the facility. Three percent of DONs said that family members of full-time LPNs/LVNs and full- or part-time nurse aides/assistants receive fully paid health insurance from the facility, and just 1% or less of DONs said that family members of RNs (either full time or part time) or part-time LPNs/LVNs receive such benefits.

Commentary

In recent years, much attention has been focused on the national nurs-

ing shortage and its implications for nursing facilities. While the availability of qualified nurses is bound to be a long-term issue, survey responses suggest that the crisis actually is easing somewhat. Half of DONs indicated that their facility's nursing turnover rate improved in 2009 over 2008, compared to only a third who cited improvement between 2008 and 2007.¹ However, although turnover rates appear to be decreasing, the percentage of DONs who said it was easier to hire RNs this year than last year was similar to the percentage who said it was about the same.

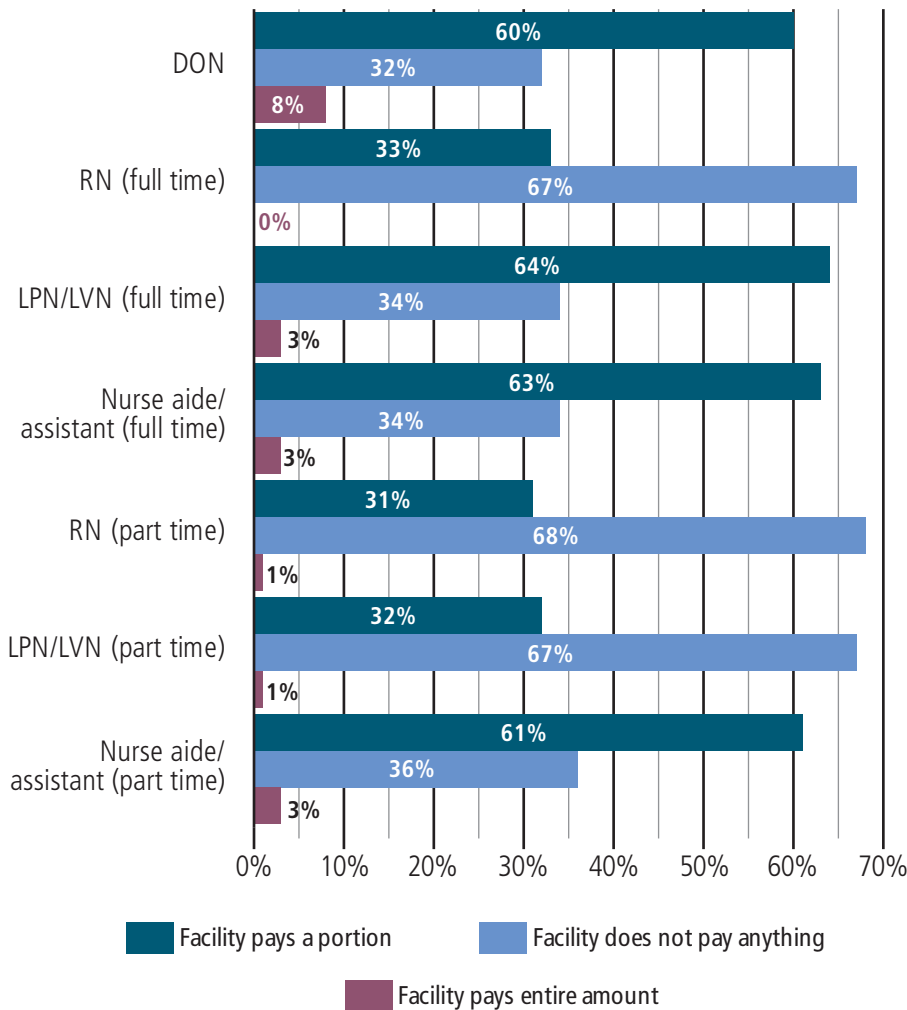
Responses to the question about RN turnover varied tremendously and are undoubtedly affected by many factors, including facility size and approach to staff retention. A facility with a small nursing staff would have a higher absolute turnover rate if it were to lose just one nurse than a larger facility would have losing several nurses. Yet in either case it would behoove the facility to make a concerted effort to reduce RN turnover because of the direct and indirect costs of replacing clinical staff. These costs include assuring adequate patient coverage, administrative processing, interviewing new applicants, and training and orientation. In general, estimates of the cost of replacing an RN vary widely but range from \$5,000 to \$35,000.²

One cannot conclude from these data that the chronic long-term care nursing shortage is over, but the positive trend observed here could reflect the nation's economic climate. If the economy is causing nurses and aides to stay in their positions longer, or even to reenter the profession after leaving or retiring, this could signify at least a partial—if temporary—remedy to the ongoing shortage.

FIGURE 71

Directors of Nursing — Facility-Provided Health Insurance for Family Members

To what degree does your facility pay for health insurance for family members of employees in the following staff categories?



As one DON serving on this report’s editorial advisory panel said, “I’m not surprised about the decreasing turnover rate. This is at least in part due to the sagging economy. Employers are evaluating what staff and programs they have and what they can do without, and employees [are] being more responsible—they are aware that they can easily be replaced.”

DONs submitted numerous responses about staffing and retention, indicating that this continues to be a key issue. While these comments reflect a wide range of opinions, some themes

emerged—including the widespread belief that the economy has increased the availability of nursing professionals and aides due to closures of businesses and cutbacks in the acute care setting. A few DONs noted that they actually have a waiting list of potential nursing staff and that the increased numbers of applicants have enabled facilities to be more selective in their hiring. However, some DONs said that even though LPNs and RNs are more readily available, they often lack the skills needed for long-term care practice.

DONs frequently mentioned that a challenge in hiring aides is their inability to pass background screening and provide good references. They also indicated that many applicants for aide positions have a poor work ethic and lack a personal commitment to meeting the challenges presented by the long-term care environment. A number of DONs suggested that some of these problems can be mitigated somewhat by in-house certified nursing assistant training programs.

While DONs reported that their ability to offer competitive wages is their most significant challenge to hiring and retention, they provided additional comments suggesting that another challenge is their ability to offer adequate benefits—particularly health insurance. They frequently pointed out that unionized employees receive health benefits through their unions rather than the facility, but nonunionized staff must meet the criteria for full-time employment (typically 32 hours per week) to receive health benefits. Additionally, several comments pointed out that rapidly increasing health insurance costs are causing facilities to cut back on coverage and increase employees’ financial burden.

Facilities are doing what they can to attract and retain staff, and the nursing profession is working to increase the number of qualified nursing staff as exemplified by The Center for Nursing Excellence in Long-Term Care™—whose mission is to advance the quality of care and quality of life for residents and patients in skilled nursing facilities through strengthening the professional practice of registered nurses. Organized initiatives such as this one will be a valuable tool to increase nursing

skills and the ability of nurses to provide quality, skilled care in long-term care settings.²

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Five-Star Quality Rating System

Introduction

In 2008, the Centers for Medicare and Medicaid Services (CMS) created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas where they might want to ask questions.

This quality rating system, which is featured in the CMS Nursing Home Compare Web site, assigns each nursing home a rating of between one and five stars. Nursing homes with five stars are judged to be much above average in quality, while nursing homes with one star are considered to be much below average. Each nursing home receives an overall rating as well as a separate rating in each of three areas: health inspections, staffing, and facility quality measures.¹

The survey asked DONs to indicate their level of agreement with a series of comments about the Five-Star system.

Description of Data

Opinion of Five-Star Quality Rating System

The greatest percentage of DONs (76%) agreed that the Five-Star Quality Rating System should be revised (55% strongly agreed; 21% mostly agreed) (**Figure 72**).

Similar percentages agreed that the system causes confusion for consumers selecting a nursing facility (32% strongly agreed; 30% mostly agreed). A comparable percentage (57% overall) indicated that they thoroughly understand the system. Relatively small numbers of DONs agreed that the system is having a positive impact in areas such as staff morale (17%) and census (11%). Fifteen percent of DONs agreed that it is an excellent system, with just 2% expressing strong agreement.

Current and Perceived Five-Star Rating

The survey asked DONs to report their facility's current rating and what they think it should be. Regardless of the facility's current rating, no DONs felt that it should be less than three stars (**Figure 73**).

The following commentary section provides a more detailed analysis of how DONs feel about their facilities' rating and the system.

Commentary

According to CMS, the health inspection portion of the Five-Star Quality Rating System contains information from the last three years of on-site inspections, including both standard surveys and complaint surveys. The most recent survey findings are weighted more than those from the prior two years. The staffing rating is based on information about the average number of

hours of care provided to each resident daily by nursing staff, taking into consideration differences in the level of care needed by residents in various nursing homes. The quality measure (QM) rating is determined by information from 10 physical and clinical measures for nursing facility residents, such as the prevalence of pressure sores or changes in a resident's mobility. This information is collected by the nursing facility for all residents. The QMs provide information about how well nursing homes are caring for their residents' physical and clinical needs.¹

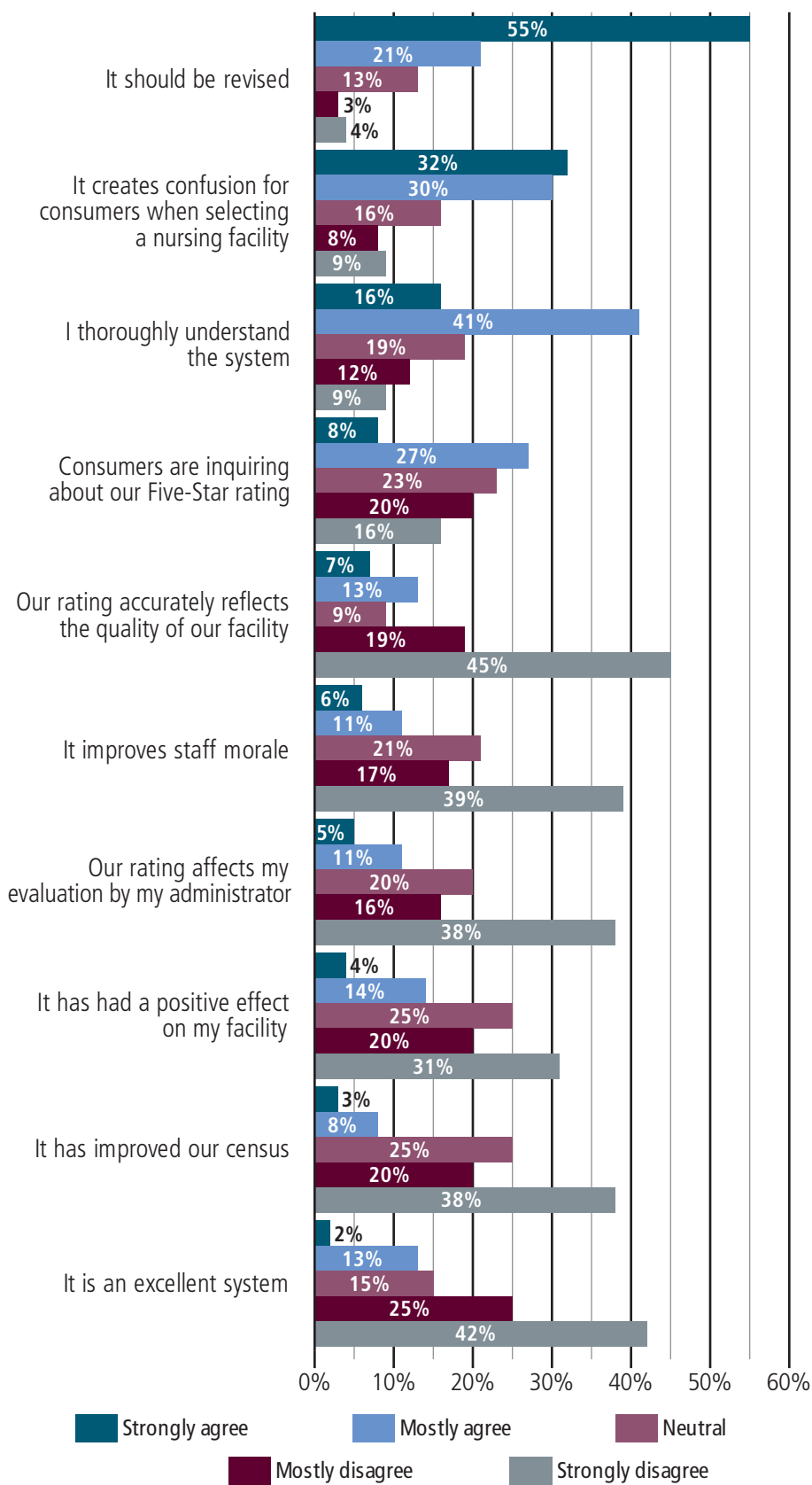
That a large number of DONs said they understand the Five-Star system but think it causes confusion and should be revised suggests that there is room for improvement. Other responses bolstering this concern include the general lack of agreement that the facility's census or staff morale have improved as a result of the system.

Many DONs provided additional comments on the Five-Star Quality Rating System. They generally voiced dissatisfaction and frequently suggested that nurse staffing is weighted too heavily; the data used are old—and perhaps incorrect; and the system does not reflect the quality of patient care provided by the facility or the “customer satisfaction” voiced by residents or their family members. A number of DONs expressed concern that since the system assigns ratings on a curve, only a limited number of facilities will be able to earn the top rating at any given point. One DON suggested that she is aware of facilities with high ratings that, in her opinion, don't deserve them—and facilities with low ones that don't deserve those either. Another DON stated, “*I strongly disagree with this*

FIGURE 72

Directors of Nursing — Opinion of the Five-Star Quality Rating System

To what extent do you agree or disagree with the following statements regarding the CMS Five-Star Quality Rating System?



system in general. The average consumer can't possibly understand what exactly is involved in operating a facility on a day-to-day basis."

There appears to be a direct link between a DON's facility rating and what the DON thinks of the rating system. Essentially all of the DONs reporting a five-star rating strongly agreed that the system is "excellent." At the same time, nearly three-quarters of those whose facilities received a rating of three or fewer stars strongly *disagreed* that the system is excellent. Not surprisingly, two-thirds of DONs who strongly agreed that the system should be revised come from facilities with a rating of no more than three stars.

A similar trend emerged when we examined the relationship between the facility's current rating and what the DON thought the rating should be. Ninety-six percent of those whose facilities had a rating of only one star felt that their facility should have received three or more stars; 95% with a three-star rating thought it should be higher—and three-quarters of those with a current four-star rating thought it should be five!

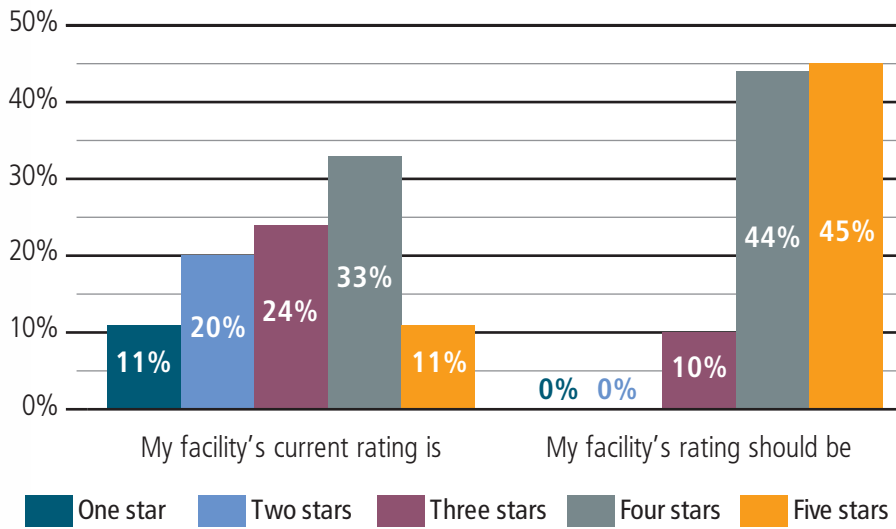
Based on these data, it's impossible to draw an objective conclusion about the effectiveness of the Five-Star Quality Rating System. The survey responses seem to be tainted—however unintentionally—by the rating currently held by the DON's facility.

While DONs' responses strongly suggest that the system is far from perfect, it appears that CMS concurs to some degree. The agency has emphasized that no rating system can address all of the considerations that go into a decision about which nursing home may be best for a particular person. CMS encourages consumers

FIGURE 73

Directors of Nursing — Current versus Desired Five-Star Rating

What is your facility's current Five-Star rating and what do you think it should be?



to visit facilities; to talk to practitioners, residents, families, and others; and to make decisions based on the personal needs and preferences of their loved one. It further advises consumers to use the Nursing Home Compare Web site only in conjunction with other sources of information, including materials from state or local organizations such as advocacy groups and the state Ombudsman program.¹

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Director of Nursing Commentary



Sherrie Dornberger, RNC, CDONA, FACDONA

The 2010-2011 *Senior Care Digest Interdisciplinary Report* addresses some very hot issues in long-term care. As I read through it, I didn't see many surprises. And that is a good thing. This suggests we have our finger firmly

on the pulse of our care setting and we as professionals communicate regularly with our colleagues from other disciplines. This is an important validation of the teamwork and quality care that make long-term care such a rewarding practice setting.

The data shed light on the nurse staffing shortage that has reached near crisis proportions in recent years. It was encouraging to see that 76% of DONs reported a nursing turnover rate of 10% or less. I believe this is partly a reflection of the creative and consistent efforts of DONs and other team leaders to create a positive work environment. These efforts include recognition and bonuses for attendance and longevity, mentoring and career support, and other initiatives. However, we can't ignore the likelihood that this brighter staffing picture is due partly to the nation's economic troubles, which have led many people to think twice about leaving jobs and prompted others to reenter the workforce. At our facility, we now receive 30 or more résumés for a position that would have attracted only a handful of applicants a few years ago. I personally know of several nurses who have gone back into the field because their spouse has lost a job. Not surprisingly, when construction is down, nurses come back into the field. I daresay that long-term care isn't the only setting benefiting from this trend.

Whatever the reason, there is no denying that this is good news for us. It decreases agency use, which both reduces costs and enables more consistent staffing—leading to improved quality. I suspect this is the start of an ongoing trend. Nearly half of DONs said that RN turnover was lower in 2009 than in

2008. It will be interesting to see if this percentage rises in next year's report.

Elsewhere, I'm not surprised to see that DONs are lukewarm about the new Five-Star Quality Rating System for nursing facilities. More than half strongly agree that the system should be revised, and another 21% mostly agree. Only 4% strongly disagree that revisions are necessary. It's a common concern that facilities that were deficiency-free in the past are being denied a five-star rating because of a recent small deficiency that stands out and unfairly mars an otherwise excellent reputation. There also are fears that some facilities have received higher ratings than are warranted because they manage to look better than they actually are.

I suspect that people's opinions of the system are dependent on the rating they received. My guess is that DONs at five-star facilities appreciate the system more than those whose facilities received lower ratings. Consider that while only 11% of respondents reported that their facility received five stars, 45% said they should have received the top rating. And while about one-third of DONs said their facility currently has a one- or two-star rating, none said their facility deserved it. Clearly, as with any new program as ambitious as this one, it will need to be tweaked. We will be watching closely to see what changes CMS makes to the Five-Star Quality Rating System and how DONs in future survey reports respond to those changes.



DISCIPLINE-SPECIFIC QUESTIONS

Nurse Practitioners

Demographics

Introduction

Nurse practitioners (NPs) are advanced practice nurses who provide high-quality health care services addressing a wide range of health problems. They have a unique approach that stresses both care and cure. Besides clinical care, NPs focus on health promotion, disease prevention, health education, and counseling. They help patients make appropriate health and lifestyle choices.

NPs have provided health care for more than 45 years. The first NPs were educated at the University of Colorado in 1965. Programs soon spread across the United States. As of 2010, there were about 135,000 practicing NPs. Close to 8,000 new NPs are prepared each year at more than 325 colleges and universities.¹

The survey asked NPs to identify their credentials, employment/payment models, and practice activities.

Description of Data

Professional Credentials

Most respondents (63%) said they possess the geriatric nurse practitioner (GNP) credential (**Figure 74**).

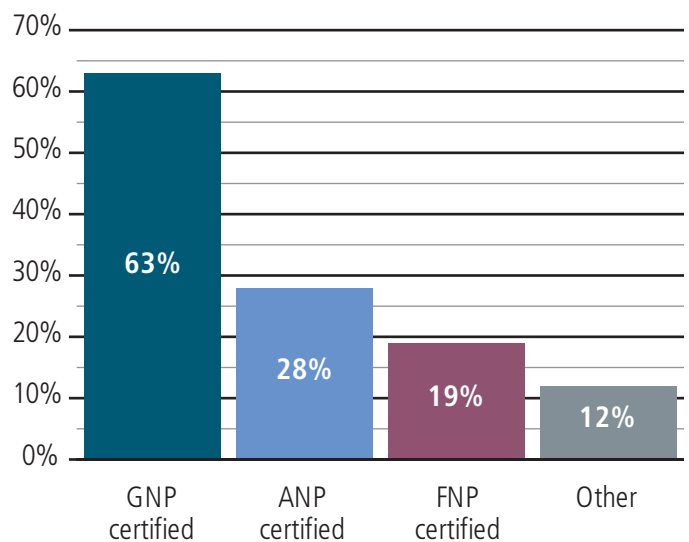
Twenty-eight percent are adult nurse practitioner (ANP) certified, while 19% said they are family nurse practitioner (FNP) certified. The aggregate responses exceed 100% because some NPs hold multiple certifications. Some respondents identified other credentials, including geriatric clinical nurse specialist; certified wound, ostomy, and continence nurse; and hospice certification.

Number of Years as NP

When survey participants were asked how long they have been a nurse practitioner, approximately half (47%) said less than 10 years (**Figure 75**).

FIGURE 74

Nurse Practitioners — Professional Credentials



One-fourth (24%) have been an NP for four years or less, and 14% have been in practice for more than 20 years.

Practice Environment

The majority of respondents (76%) reported that they are involved in nursing facility (NF) practice (**Figure 76**).

A smaller number of respondents said they work in an assisted living facility (ALF) (31%) or an office-based practice (19%). The aggregate responses exceed 100% because some NPs practice in more than one environment.

Number of NF Practice Sites

Forty-seven percent of those practicing in NFs said they serve in one facility, and 13% said they serve in five or more facilities per month (**Figure 77**).

Employment Model

The survey asked NPs to identify from a list of options their personal employment model. The most frequent re-

FIGURE 75

Nurse Practitioners — Number of Years as NP

How long have you been a nurse practitioner?

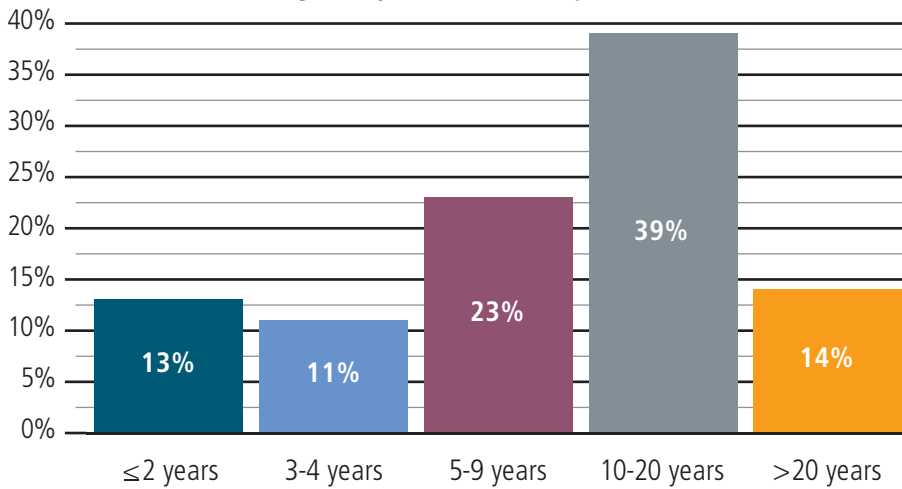


FIGURE 76

Nurse Practitioners — Practice Environment

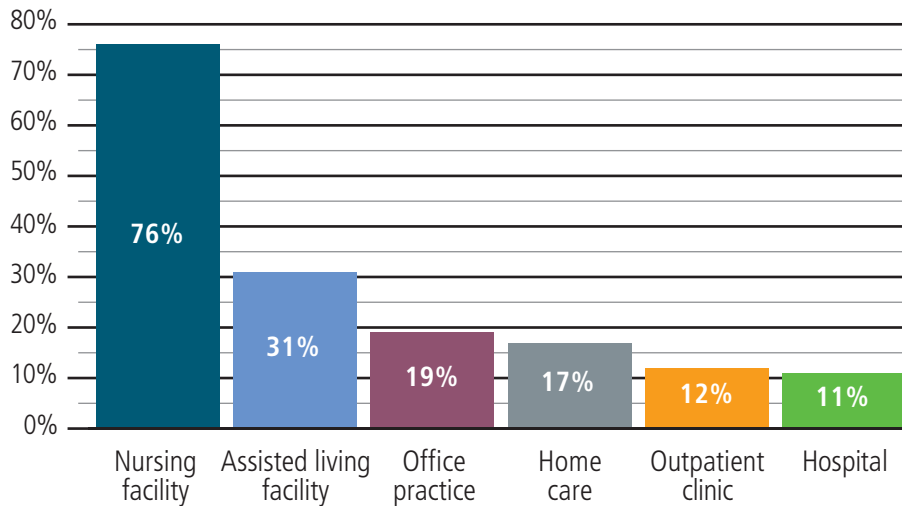
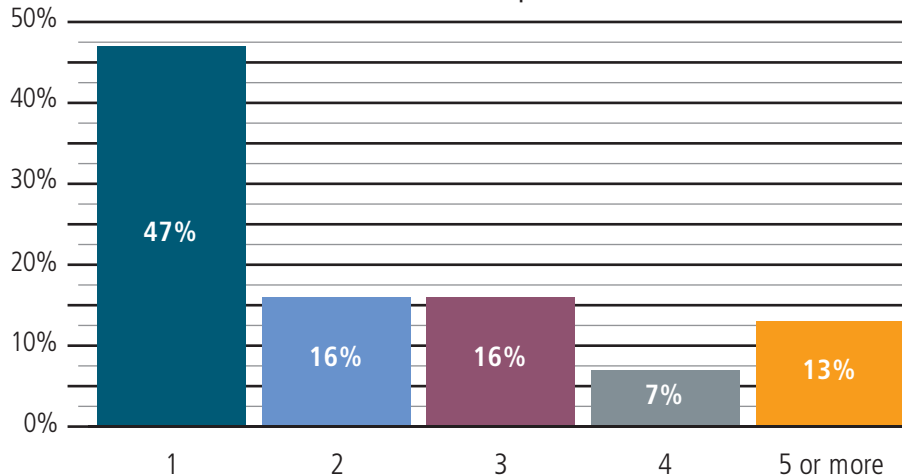


FIGURE 77

Nurse Practitioners — Number of NF Practice Sites

On average, in how many different nursing facilities do you practice each month as a nurse practitioner?



sponses were employment by a managed care organization/health plan (24%) or a physician group (18%) (Figure 78).

Equal percentages said they are employed by a university/academia or are self-employed (13% each). Eleven percent of respondents reported an employment model other than those listed as response options in the survey question, including working for a single physician, hospice/palliative care, or a nonprofit geriatric care agency.

Payment Model

Three-fourths of respondents (74%) said they receive a salary and 17% said they receive hourly compensation. Seven percent reported an incentive-based payment model (Figure 79).

Twelve percent reported a payment model other than those listed as response options in the survey question. These include billing insurance or Medicare directly and being paid per patient visit.

Commentary

Since the survey targeted geriatric NPs, it is no surprise that most respondents possess the GNP credential.

Employment by a physician group was the most frequent NP employment model reported in the 2007, 2008, and 2009 editions of the *Senior Care Digest Interdisciplinary Report*,²⁻⁴ so it was interesting that the most commonly reported model in 2010 is employment by a managed care organization. Whereas the number of NPs reporting this employment model increased from 17% in 2007 to 24% in the 2010 report,² the number reporting employment by a physician group decreased over the same period—

FIGURE 78

Nurse Practitioners — Employment Model

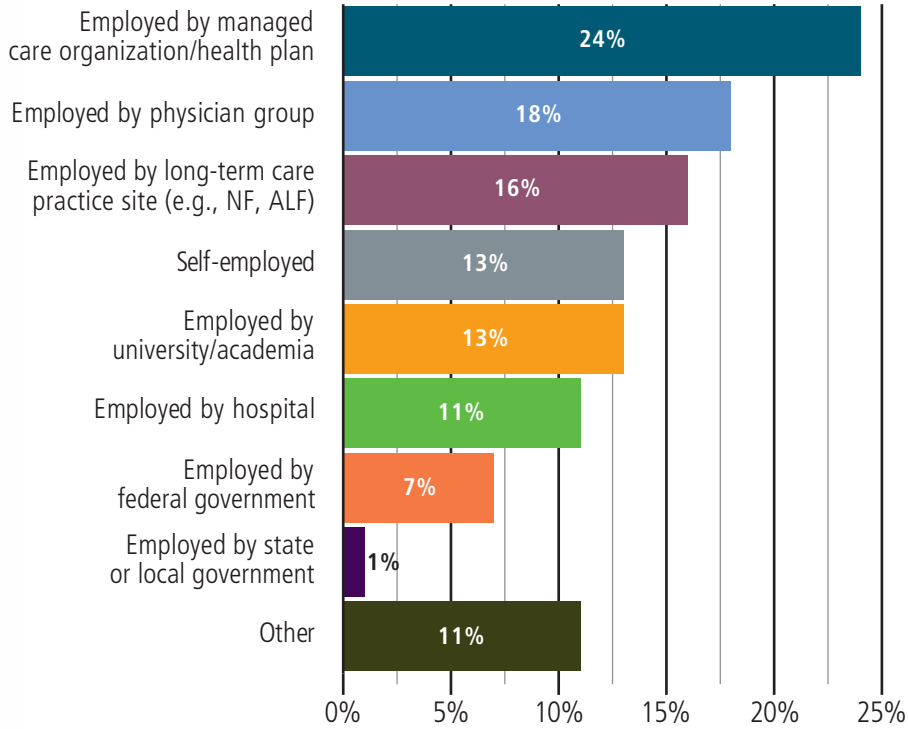
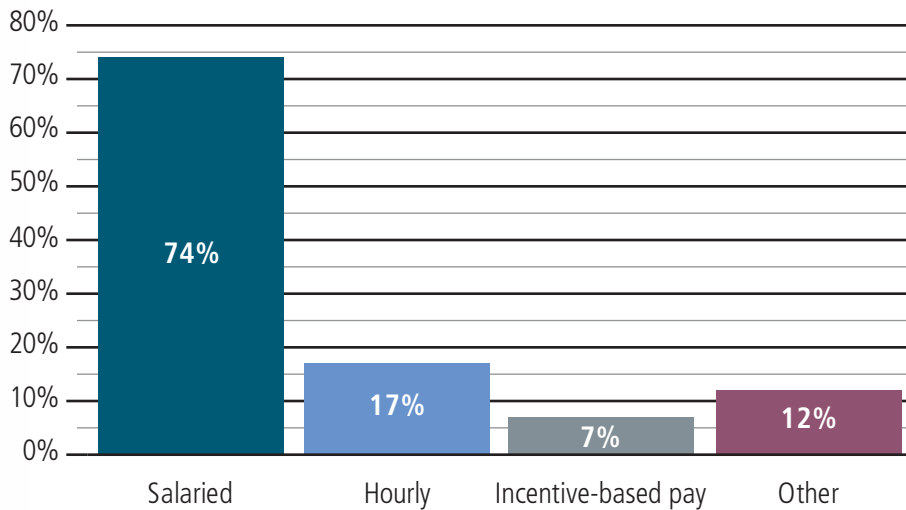


FIGURE 79

Nurse Practitioners — Payment Model



from 29% in 2007 to 25% in 2008 and 2009, to just 18% in 2010.²⁻⁴ While the survey is not powered for statistical significance, this trend may well reflect managed care's recognition of the cost-effectiveness and quality of care that NPs can provide.

Half of NPs serve in multiple long-term care facilities, which suggests employment by a practice that specializes in or has a significant focus on long-term care. In these specialty practices, some NPs may care exclusively for institutionalized residents in nursing facilities, assisted living facilities, or possibly other long-term care environments.

That a quarter of all respondents said they have served as an NP for four years or less may reflect the rapidly growing NP workforce and the sharp increase in the number of NP graduates—from fewer than 6,000 in 2009⁴ to 8,000 in 2010.¹ It is probable that these NPs will continue their involvement in various practice settings—including long-term care—because of opportunities to become involved in collaborative practice agreements, to practice with more autonomy, and to expand their role in the wake of comprehensive health care reform. These expanded opportunities, combined with the wide array of practice environments and employment models reported by NPs, suggest a formula that will result in high job satisfaction and professional longevity for NPs in the coming years.

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DNP Degree

Introduction

By 2015, graduate nursing education programs are expected to have made the transition to the doctor of nursing practice (DNP) degree as the entry-level requirement for advanced practice nurses, including nurse practitioners.

A discussion paper from the American Academy of Nurse Practitioners states that the rationale for this change focuses on several issues, including the observation that only a few health care disciplines—advanced practice nursing being among them—prepare their practitioners at the master's rather than doctoral level.¹

The survey asked nurse practitioners to share their opinion of the DNP degree and its potential impact on new NP graduates.

Description of Data

NPs most frequently agreed that the DNP degree should qualify a nursing faculty member for university promotion and tenure (59%) (**Figure 80**).

A similar percentage (56%) agreed that the DNP will create additional confusion within their profession. Half (51%) agreed that the DNP is the preferred doctorate for advanced practice nursing, with one in four expressing a neutral opinion. A third (34%) felt that all current NPs should be granted the DNP degree based on their experience. Smaller percentages agreed that the DNP will increase NP payment for services provided (20%) and improve physician respect for NPs (19%), while more than half of respondents voiced disagreement with these statements (55% and 57%, respectively).

Commentary

In analyzing the data on this issue, it should be noted that many NPs aren't yet familiar with the DNP degree and its significance to the profession and/or nursing education. While the responses provide a valuable perspective, we expect opinions will change as we approach 2015 and the adoption of the DNP for all NP educational programs—and as more NPs gain a better understanding of the degree.

In this survey, NP responses indicate lukewarm support at best for the mandatory DNP degree. Many respondents expressed the belief that it may cause confusion within the nursing profession. That so many respondents support granting the DNP degree to all current NPs based on their practice experience no doubt points to their concerns that the DNP degree will diminish the professional

standing of practicing NPs with only a master's degree. Another concern could be the implication with respect to salary, although only a small percentage of respondents said that having the DNP degree will increase earnings for NPs. However, according to a 2009 survey of salary conducted by *ADVANCE for Nurse Practitioners* magazine, NPs with the DNP degree earned \$7,688 more than those with a master's degree.² So NPs familiar with this issue might have genuine concerns about salary.

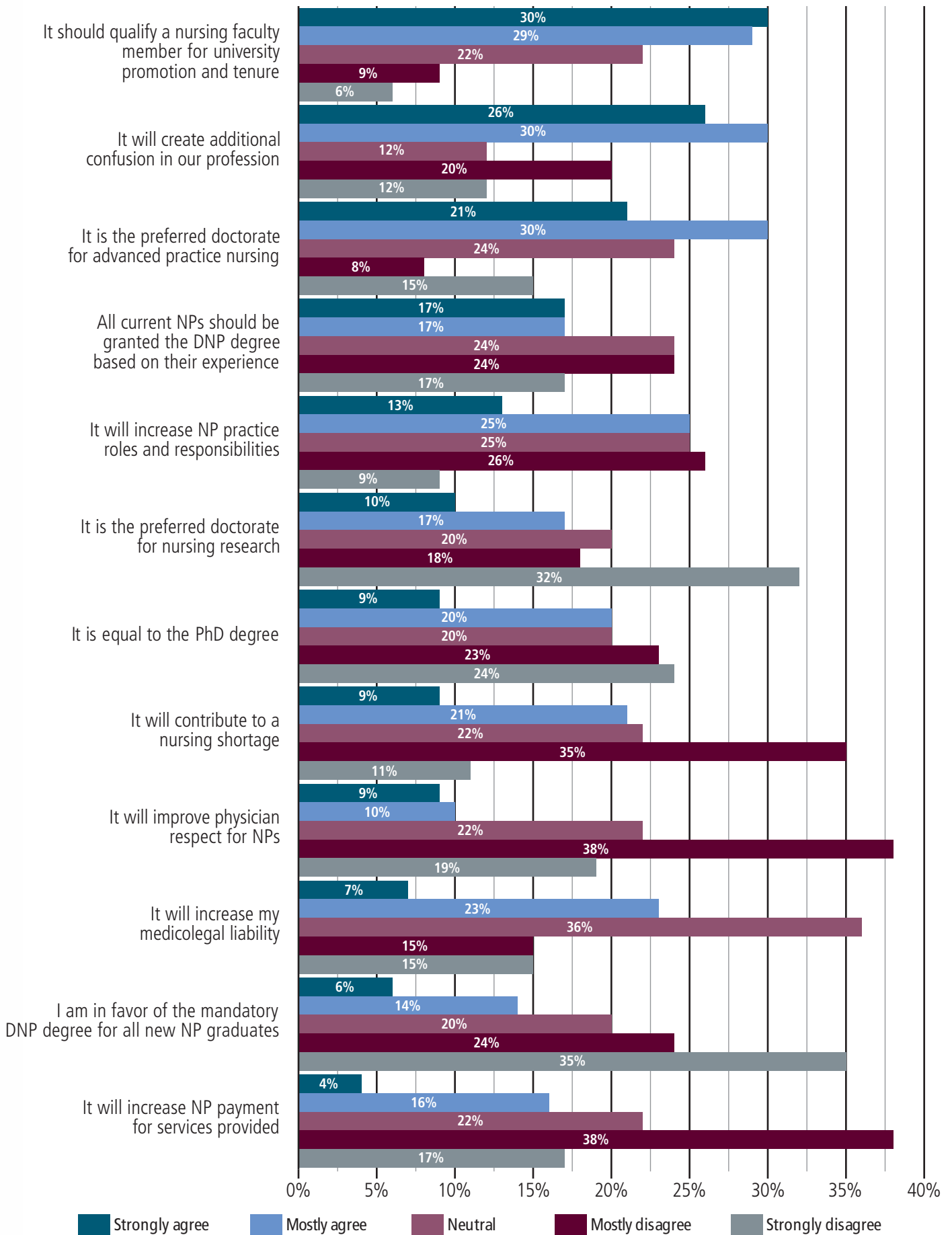
Fewer NPs agreed that the DNP degree will increase physicians' respect for NPs than those who think it will increase their professional responsibilities and professional medicolegal liability. This is somewhat counterintuitive since it would be reasonable to suggest that with increased responsibilities and corresponding medicolegal risk comes greater respect.

Overall, the responses appear to indicate that NPs understand the difference between the DNP (a practice-oriented degree) and the PhD (a research-oriented degree) in nursing. Undoubtedly, some DNPs will choose to enter academia, and four times as many respondents agreed than disagreed that nursing faculty with the DNP degree should qualify for academic promotion and tenure.

In some ways, the transition of the terminal clinical nursing degree to the DNP is reminiscent of the transition of the terminal practice degree in pharmacy to the doctor of pharmacy degree (PharmD) in the 1980s. This transition initially was accompanied by confusion and concern, but pharmacists and other practitioners eventually grew to support, recognize, and even embrace the PharmD. Today, PharmD faculty

FIGURE 80

Nurse Practitioners — Opinion of DNP Degree and Its Potential Impact on New Graduates



members routinely receive academic promotion and tenure and serve as full professors and deans. Pharmacists without the PharmD degree were not grandfathered to receive the advanced degree, but they have been able to remain competitive with their doctorate-trained colleagues. With the parallels that exist between the DNP and the PharmD, the transition to the DNP may be expected to follow a path similar to that of the PharmD—that is, initial fears and concerns will give way to acceptance and recognition.

In spite of some NPs' concerns, the DNP program is a reality that they cannot ignore or deny. Currently, 120 DNP programs are enrolling students at nursing schools nationwide, and an additional 161 DNP programs are in the planning stages.² Schools nationwide that have initiated the DNP program are reporting sizable and competitive student enrollment. Employers are quickly recognizing the unique contribution these expert nurses bring to the practice arena, and the demand for DNP-prepared nurses continues to grow.

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Nurse Practitioner Commentary



Evelyn G. Duffy, DNP, G/ANP-BC, FAANP

I'm pleased to say that this report confirmed a great deal of what we already suspected about nurse practitioners (NPs) in long-term care. We're seeing more NPs practicing in long-term care, and I've noticed a similar trend in the large practice where I work. There is still a physician shortage in this care setting, and more practices are hiring NPs to provide clinical care.

As the survey was conducted in the first half of 2010, it really didn't reflect the entire impact of the economy on NP employment and demographics. Interestingly, when the economy is down, the number of people going back to school seems to increase. I teach in an NP graduate program, and we have more students than ever. We've observed similar enrollment spikes during previous economic downturns. I'm also seeing more part-time NPs seeking full-time employment—often to compensate for a spouse's job loss. Fortunately, it is easier to find work as a geriatric NP than it is to find employment in many other fields. With the burgeoning older adult population, there is more demand for practitioners who have expertise in this area.

I was surprised that there is still resistance to the doctor of nursing practice (DNP) degree. While most NPs seem to be optimistic about this change, it was interesting to see that more than half of the survey respondents believe it will create confusion in our profession and 30% agree it will contribute to a nursing shortage. At the same time, I was amazed to find that nearly a quarter of respondents disagree that this is the preferred doctorate for advanced practice nursing. In my experience there is growing enthusiasm for the degree. I myself chose it specifically and I'm pleased that it has enabled me to balance academia with active practice. I also find that other NPs are embracing and pursuing this degree.

It would be interesting to learn whether those NPs who are most positive about the DNP are employed by organizations that motivate and/or support their NPs to pursue this advanced degree. Many large systems are encouraging their NPs to go back to school for the DNP by offering promotions or providing other incentives. Understandably, it may take longer for NPs who don't have such encouragement or support to embrace the DNP. How quickly the DNP will become required for entry into practice is not clear, but many of the concerns expressed today mirror those expressed when the entry into practice required a master's degree rather than a certificate.

I was pleased to see that NPs and physicians agreed on clinical issues, such as the use of bisphosphonates to manage osteoporosis. This suggests that we are communicating and consistently sharing best practices, protocols, and practice guidelines. It is important for physicians and NPs to be on the same page clinically, so I am glad to see this validated. However, there is still considerable disagreement when it comes to policy and administrative issues. It will be revealing to see if this report triggers conversations on these issues and if next year's report reflects any progress.

The value of reports such as this that track trends over time cannot be overstated. They give us an opportunity to see how changes—such as new regulations, treatment innovations, and technological developments—impact practices and attitudes. They also help us determine where we are making progress and what issues need our ongoing attention. This is key because we all share a commitment to constantly improving quality and making long-term care a setting where patients thrive and practitioners are proud of the work they do every day.

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