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| TO: | Becky Phillips, DODD |
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| FROM: | OPRA |
|  |  |
| DATE: | March 25, 2016 |
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| RE: | Comments - Ohio Department of Developmental Disabilities ("ODODD") Proposed Administrative Rule 5123:2-9-39 Waiver Nursing Services  |
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Thank you for the opportunity to provide input on proposed rule 5123:2-9-39, Waiver Nursing Services. We are extremely supportive of the concept, but submit the following comments and questions for your consideration.

We had been working under the impression that nursing services were going to be transitioned into the IO waiver in 2 phases. The first phase was going to be the implementation of nursing services for individuals transitioning from the TDD waiver. The second phase would be the opening up of nursing to all IO recipients (based on assessed need). The proposed rule does not make any distinction. Therefore our comments reflect our current understanding that this rule is broader than a TDD transition and effects all IO recipients.

We want to thank you for including DD waiver providers as qualified providers for the purposes of providing this service. Initial discussions included the concept of Medicare Certification, which would have been both cost and time prohibitive for a significant number of agency providers. This change allows agencies to add nursing to their service package via the waiver application process – a *much* simpler and more cost effective process.

(B)(19) “Waiver nursing services” means services provided to an individual who requires the skills of a registered nurse or a licensed practical nurse working at the direction of a registered nurse.

*Comment*: OBN 4723-4-08 3) (d) Standards for applying the nursing process as a *licensed practical nurse*, allows for providing basic nursing care as directed by a registered nurse, advance practice registered nurse, or licensed physician, dentist, optometrist, chiropractor or podiatrist. An LPN can work under the direction of any of the listed practitioners and carry out their orders without the oversight of an RN. Why the limitation in scope of practice?

(B)(19)(d) Registered nurse consultations…..including but not limited to, those performed by registered nurses for the sole purpose of directing licensed practical nurses in the performance of waiver nursing services or directing personal care aides…

*Comment*: By law, an RN must direct an LPN in certain situations. This is mandated in law but not funded in this rule. We are opposed to additional unfunded mandates.

*Comment*: Section (B)(19) provides that waiver nursing services are services that require the skills of a RN or LPN working at the direction of a RN.  The current rule, 5123:2-9-59(A)(12), states this as well, but also provides that “[w]aiver nursing services may include personal care aide services when provided incidental to waiver nursing services performed during the authorized waiver nursing services visit.”  This language is not present in the proposed rule.  However, (G)(2) of the proposed rule (at the end) notes that “homemaker personal care may be reimbursed as waiver nursing services when provided incidental to waiver nursing services performed during an authorized waiver nursing services visit.”  We are not sure if this language is supposed to align with what was removed/not present in the definition of waiver nursing services at (B)(19)?  Or does this just include tasks completed by a RN or LPN?

(C)(3) Nursing tasks and activities that shall be performed only by a registered nurse include, but are not limited to:

(a) Intravenous insertion, removal or discontinuation;

(b) Intravenous medication administration;

(c) Programming of a pump to deliver medication including, but not limited to, epidural, subcutaneous, and intravenous (except routine doses of insulin through a programmed pump);

(d) Insertion or initiation of infusion therapies;

(e) Central line dressing changes; and

(f) Blood product administration

*Comment*: The LPN’s scope of practice defines what can be done in regard to IV’s. Some of the above (c, d, e and f) are redundant as to what is legally restricted. However, an LPN acting within their scope of practice (who is licensed M-IV) can discontinue an IV that terminates in a peripheral vein if the catheter is less than 3 inches long, can administer some medications after initiation by an RN and can start a peripheral IV that is heplocked. Again, we are questioning why DODD would want limit the scope of LPN practice. There are a few instances in this rule where this occurs, I have limited our comments to 2 examples. We would be happy to discuss this in more detail. In some instances, the use of LPN’s would be a more cost effective way to deliver services. OBN 4723-17-03 Intravenous therapy procedures, outlines what is permissible.

(D) (3) Service Authorization: When reviewing a service authorization request, the department shall determine whether the waiver nursing services for which authorization is requested are medically necessary unless the requested services have been determined by the Ohio Department of Medicaid not to be medically necessary within a twelve-month period immediately proceeding the service authorization request, in which case a medical necessity review under this paragraph shall not be required. The department shall determine the services to be medically necessary if the services:

*Comment*: We had several comments on this provision. No one understands what it means. If ODM found the services not to be necessary, then DODD will stand with ODM’s decision and there is no further progress for the individual until 12 months is up? Or DODD will ignore ODM and proceed with a different process? This provision needs to be clarified.

*Comment*: We have many questions about the meaning and implementation of the “service authorization” language under division (D).   In particular, under (D)(2), it states that “waiver nursing services shall be authorized only when an individual’s needs cannot be met through medication administration and nursing delegation. . . .”  So, if the services can be completed under medication administration and delegation, then it cannot be a “waiver nursing service.”  How will this work?  Also, under (D)(3), DODD will be determining whether waiver nursing services are medically necessary.  This is contrary to any practice conducted by DODD today.  Is a physician at DODD going to be making this determination?  Additionally, in making the determination of medical necessity, the factors to consider include whether the services are “the most efficient, effective, and lowest cost alternative that, when combined with non-waiver services, ensure the health and welfare of the individual receiving the services” and “*are not otherwise available through other resources*.”  See (D)(3)(c)-(d) (emphasis added).  What other resources?  Medicaid card? Private duty nursing?  We have many questions about how this will work.  For instance, if the service must first be utilized by the individual’s Medicaid card and it is medically necessary under the Card, then how would it not be medically necessary under Waiver nursing?

(E)(2) Waiver nursing services shall not be provided to an individual during the same time the individual is receiving adult day support, adult family living, adult foster care, residential respite being provided in an intermediate care facility for individuals with intellectual disabilities, or voc habilitation.

*Comment*: Is the exclusion of nursing in these settings (with the exception if ICF’s) due to the DRA? We believe that some individuals with nursing needs would be able to remain in and or participate in their preferred settings longer if these services were available. Can you explain the exclusion?

(E)(6) In all instances, when a treating physician gives verbal orders to the registered nurse or licensed practical nurse working at the direction of a registered nurse, the nurse shall record, in writing, the physician’s orders, the date and time the orders were given, and the nurse shall subsequently secure documentation of the verbal orders signed and dated by the treating physician.

*Comment*: What is the expected time frame for getting verbal orders signed?

(F) Documentation of Services

*Comment*: Most of these requirements make sense.  However, (F)(1)(j) includes a description and details of the services delivered, including the individual’s response to “each medication”. . . . A response to each medication?  That seems a bit much, especially for long-standing medications (like cholesterol meds or something like that), where you can’t really document an immediate response to a medication.

*General comments*:

What is the process when there is disagreement? For instance, when a physician’s order is contrary to ODM or DODD determination? Or when a physician’s order is contrary to ISP authorization? What is the responsibility of the provider in these instances?

Agencies are having difficulty envisioning what staffing patterns will be for someone who previously had a full day/shift of nursing under the TDD. Will they continue to have continual shift nursing support? Or if some tasks can be completed by certified/delegated staff - will there be a mix of DSP and nursing hours in a day since waiver nursing will only be authorized when an individual’s needs cannot be met through med admin and nursing delegation? This could be very complicated and extremely difficult to staff.

The TDD currently has a 60 day re-assessment provision that is a billable service. This appears to be gone. Has it been deleted, or as a separate line service is this to be billed elsewhere?

Nurses are required by law to receive/transcribe physician’s orders for G-tubes and insulin. There is no mechanism to bill for this, making it another unfunded mandate.

We have appreciated the opportunity to work with DODD staff on this rule during past few months. We are very supportive of the addition of nursing services to the IO waiver and believe that this will allow more individuals to live in community settings.

We understand that the waiver is the payer of last resort and that all other options must be exhausted before an individual can receive IO nursing. That being said, we do have concerns about the management of this service and the lack of continuity of care this model provides.

There are a lot of moving parts in this model of service. It will take a great deal of time for the provider agencies to track services/supports, manage the paperwork, handle staffing challenges and ensure quality. This is another program that will take time and effort on the part of agencies, without any related reimbursement.

Home care nurses are often assigned and re-assigned. Therefore, an individual may receive care from many home care nurses, even in a one month period. There is no reimbursement mechanism for the waiver agency nurse to coordinate services with the Home care nurse or to coordinate services within their own agency. The optimum service model would provide for care coordination in which **one** nurse coordinates and oversees all the medical services that an individual receives. This allows for clear, concise and consistent transfer of information to other health care providers, family members, guardians and agency staff. This model would reduce duplication of effort, reduce the opportunity for errors and result in the most cost efficient service delivery system. We welcome the opportunity to discuss how nursing services can be streamlined and provide for the best possible quality of care.

Thank you for the opportunity to comment.