

MAINE STATE LEGISLATURE

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**TASK FORCE ON PAPERWORK REDUCTION
IN NURSING FACILITIES**

**FINAL REPORT TO THE MAINE LEGISLATURE
JANUARY 1997**

Task Force Paperwork Reduction/Nursing Facilities

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January 27, 1997

Dear

The Task Force on Paperwork Reduction in Nursing Facilities created by the Maine Legislature in 1996 has completed its work. You will find the final report attached. The work has been complicated and educational for all of the members. We are pleased with the results we have achieved and look forward to a continuation of the process, should our recommendation be adopted by the Health and Human Services Committee.

We would like to thank the Legislature, the Health and Human Services Committee and Senator Phil Harriman for giving us the opportunity to try and correct some costly problems that existed within nursing facilities across the State. Additionally, thanks go to the hundreds of nurses who worked together to raise the issue in a constructive and collaborative way.

Should you have questions or concerns, please do not hesitate to contact me or any member of the Task Force. I look forward to hearing from you.

Sincerely yours,

Jeanne Delicata, RN,C

pc Health and Human Services Committee
Senator Phil Harriman
Task Force Members

*individualized
copy
to each
member
HHS*

BACKGROUND

In July, 1995, Shelly Lezer, RN (then Director of Nursing Services at the Freeport Nursing Home) contacted Senator Phil Harriman R- Brunswick in an attempt to get some regulatory relief from the ever increasing burden of repetitive paperwork in nursing facilities. The concern expressed at that time was that the paperwork requirements were:

1. costly
2. counterproductive in terms of resident care
3. causing experienced nurses to leave gerontological nursing

Senator Harriman requested that Shelly gather information from other nurses which would demonstrate the scope of the problem. Shelly and a small group of peers designed a questionnaire that would capture the needed information and mailed that questionnaire to 700 gerontological nurses throughout the state in August. Forty three percent of the nurses responded in less than one week.

Of the nurses responding more than half indicated that between 50 and 75% of the required paperwork was redundant; 224 of these nurses estimated that only 25-50% of the paperwork was needed to ensure quality of care; 228 said the time they spent doing paperwork diminished resident care; more than half indicated that they received conflicting information from the regulatory agencies at least quarterly.

The problem was multifaceted and due in large part to the multiple agencies involved in the regulation of these issues. While each of the agencies involved (Bureau of Medical Services, Case Mix Demonstration Project, The Muskie Institute, BEAS, Department of Health and Human Services) had a legitimate need for the information requested, none knew what the others were requesting. The result was confusing to providers and regulators alike. Gathering and documenting the same information in multiple formats was counterproductive and costly. At a time when residents were much more in need of time and services from Registered Nurses they were receiving less attention and their medical records were receiving more.

Results of the questionnaire were conveyed to Senator Harriman who then submitted to the Maine Legislature a bill designed to reduce the amount of paperwork required. The bill did not pass in both houses and an appeal was made to the Legislative Council which endorsed it unanimously! The Human Resources Committee subsequently heard testimony on this bill and in the end directed that a Task Force be created to address the issue of excessive documentation requirements in nursing facilities. Appointments to the Task Force were completed by the middle of May (see attached list of appointees and Department Representatives) and the group met for the first time on May 29, 1996. As directed by the Legislature a chair was elected by the nurse members of the Task Force. The members agreed to meet every other week and did so until the final meeting on January 9, 1997.

GOALS AND OBJECTIVES

The goal of the Legislative Task Force on Paperwork Reduction was to “study the needs of the patient and family, the nursing and professional staff of the nursing facility, the department and other interested parties(and).. shall search for methods of meeting the legitimate needs of all parties in the most efficient , efficacious and collaborative manner possible”.¹

It quickly became apparent that the first objective was to clarify the issue for members of the Task Force. It is fair to say that all members learned a great deal about the workings of all the other entities involved. Once members had a clearer sense of perspective we began the process of determining further objectives. We acknowledged the fact that there were some issues over which we had no control due to federal mandates. There was also acknowledgment of some confusion on the part of providers as to what was a requirement and what was facility practice.

We reviewed documentation requirements by the various regulatory agencies and recommended or implemented changes that will provide documentation to:

- * assure and validate high quality resident care
- * assist in a method for determining medical eligibility
- * demonstrate compliance with State and Federal Regulations.

It was a very complicated process. While the Task Force was meeting, other regulatory changes were taking place, and major changes anticipated with the adoption of the federally mandated resident assessment form (MDS 2.0). We were mindful throughout the process that we must consider the current regulatory framework, as well as the anticipated Federal requirements which had no date certain for becoming effective in the State of Maine.

¹LD 1689 Maine State Legislature

ACCOMPLISHMENTS

Throughout the work of the Task Force, members remained committed to working collaboratively and to understanding the issues from all aspects. As a result we were able to make many changes that will be beneficial to all parties. It is our collective view that regulatory bodies, providers, taxpayers, and, most importantly, the residents for whom we provide services, will benefit from the work we have done. We believe that this work was necessary and the process a good one. The process speaks to cooperation, collaboration and joint problem solving in the long term care arena. As the system continues to change at a rapid pace, it would seem to be a model that could be duplicated in our continued search for an efficient, efficacious and humane health care system. The refinement of this effort could be the beginning of a CQI model across the continuum of care.

Through the work of this Task Force the following changes were made in documentation requirements:

Principles of Reimbursement

Many issues that are regulated by Licensing and Certification were duplicated in the Principles of Reimbursement for Nursing Facilities. This required facility staff to review multiple documents in order to remain in regulatory compliance. In addition, each time one of these areas changed multiple documents had to go through the costly rule making process. All areas of duplication have now been removed from the Principles of Reimbursement.

Unresolved conditions report

This is a summary report of ongoing clinical issues compiled from the resident assessments (MDS+) sent to the Muskie Institute each month. Any identified errors, including typographical errors, required re-accomplishment of the entire resident assessment. Working with High Tech Software, the Task Force requested the ability to track such issues before transmission to the Muskie Institute. This has been accomplished and will save resources for both providers and the Muskie Institute.

Schedule for completion of the Resident Assessment (MDS+)

Maine was not following the national schedule for the completion of the resident assessment (MDS+), but rather required them to be completed on a more frequent basis. The major reason for this was that Maine is a Case Mix reimbursement state. The Task Force determined that there was no compelling financial reason to continue completing multiple assessments for each resident and that requirement was changed. Maine now follows the national assessment schedule.

MDS+ as a sole source of information

The information located on a resident assessment (MDS+) has been required to be validated in other areas of the resident record in order to be considered "true". Task force members have agreed that the initial MDS+ should not require validation of ALL information in the record as this information can be obtained from the resident, family, or other care providers. Subsequent MDS+s would require more areas of validation.

Triggers and RAPS

RAPS (resident assessment protocols) "are problem oriented frameworks for additional assessment based on problem identification items (triggered conditions)."² There are currently 18 identified RAPS with an additional four under development. They are , in practice, a detailed recipe for care planning.

There has been much concern and confusion over what the requirements are for "working" the RAPS. Most facilities have adopted lengthy , commercially available forms in an effort to address issues that have arisen at time of survey relative to whether or not the RAPS have been "worked" Licensing and Certification has respond to this issue via Task Force discussions. It will now be acceptable for the interdisciplinary team to write a summary statement indicating why the decision to proceed or not proceed with care planning was made. There is no regulatory requirement for the use of any particular form or format.

Survey issues

Facilities have been required to transfer data from facility staffing schedules to a state specified form , which was a lengthy, time consuming and redundant process. Licensing and Certification has now agreed that copies of facility schedules will be accepted.

There were other survey issues that we were unable to resolve because they are Federal requirements. Several of the Task Force Members are participating in a Federal work group that is attempting to re-design some of the very issues that we have raised in Maine (paperwork requirements for short stay admissions, federal forms at survey, data gathering at survey, etc.). Other issues that are federal requirements (medication review, monthly progress notes) were also outside of the scope of our work.

Care Planning

Care plans remain lengthy and poorly utilized by many team members.. The Task Force recommends a care plan format that is usable and meaningful to all team members. . In that spirit we have developed a format that is being tested in the pilot project discussed

² Long Term Care Resident Assessment Instrument User's Manual version 2.0 October 1995 page 4-1

below. The format being tested has the potential to significantly reduce duplication and redundant documentation. It is the concept that is endorsed by this Task Force pending final results of the pilot program. Facilities would have the option of adopting the concept at that time.

The Pilot Demonstration Project

The Task Force members have agreed in concept to a new mechanism for documenting and validating resident care that meets the goals and objectives of this project. Three facilities (Southridge Living Center in Biddeford, Auburn Nursing Home in Auburn, and The Barron Center in Portland) are currently piloting the system. The pilot will be in progress from January 1 until March 31, 1997. All levels of nursing home beds are involved and all regulatory bodies will continue to work together on this . At the successful conclusion of the project all interested parties will be offered the opportunity to learn the new concept. Early reports from the participating facilities indicate that it is working well. This new way of dealing with documentation should be effective, efficient and easily used by all.

RECOMMENDATIONS

The Members of the Task Force on Paperwork Reduction in Nursing Facilities believe that the work they have done was necessary and will have a positive effect on consumers. The reduction in duplicative paperwork will allow us to spend our time and resources in a more cost effective and rational manner. The collaborative work that providers and regulators have done has increased our ability to see the larger issues and make recommendations for improvements at all levels of the system. The individual changes that were made and will continue to be made as a result of our work are, of course, important. We believe strongly that the more far reaching accomplishment was in the process of collaborating and joint problem solving. All parties were in the same room at the same time discussing issues that effected all of our consumers. We developed a mutual understanding of the bigger issues. We have learned a great deal about all areas of health care regulation.

The issues that lead to the creation of this Task Force are not going to disappear unless there are changes in the way we communicate and collaborate in the field of health care. If we can improve services and reduce duplication of effort surely we will be conserving resources that are scarce. All members of the Task Force are committed to cost effective high quality care in the most appropriate setting for our consumers. We believe that the efforts of the Task Force should continue in some way. Extending this effort across the continuum could assist emerging areas of the health care system in avoiding the same problems that we have begun to resolve.

We respectfully suggest that the work of this Task Force could be the basis of something larger. Health care providers and regulators working together to identify and solve problems would be a more CQI/TQM approach than the inspection model we currently have. We would ask that the Task Force continue for one year for purposes of developing a CQI/TQM model to problem solve across the continuum of care. Given the success of this Task Force we would request that providers and regulators continue to work together on this project.

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*Replaced Shelly Lezer who relocated to
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Corrected Member List
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February 1997

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