The Updated OBRA Regulations: New or Forgotten?

By Steven A. Levenson, MD, CMD

Key Principles

CMS has asserted that the newly updated regulations and guidance are meant to align with “current clinical standards of practice.” So what aspects of current care should be considered a clinical standard of practice, as distinguished from usual and customary but undesirable habits (I Am Med Dir Assoc 2007;8:493–501)?

For one thing, geriatrics is based on key clinical principles and practices that apply to all settings — not just nursing homes. And they apply to all patients and to all professional disciplines — not just to the care of older adults or as a guide for medical practitioners. These principles include (1) a systematic approach to clinical decision making, (2) importance placed on precise cause identification, and (3) a prudent, comprehensive approach.

A Systematic Approach

The principles of clinical reasoning and problem solving are universal and enduring. Geriatrics incorporates a key idea: How you get to a clinical destination is just as critical as the destination itself. The care delivery process (CDP) — which involves the steps of recognition, cause identification, treatment/management, and monitoring — is not discipline specific, and it is not just “clinical” or “medical.” The choice of interventions (the care plan) needs to result from adherence to the CDP, which makes good outcomes more likely. Shortchanging the CDP (e.g., “robotic” care based on unwarranted predispositions or erroneous conclusions) is a common cause of inappropriate treatments and poor outcomes.

Chapter 4 of the CMS Resident Assessment Instrument (RAI) manual discusses the CDP in some detail. Every nursing facility in the United States must have a copy of the RAI manual in order to complete and submit the Minimum Data Set (MDS) for regulatory compliance and for reimbursement. It is vital to dig further into the RAI manual to learn more about key foundations such as the CDP. This highly recommended reading for all nursing home practitioners and staff, as well as surveyors.

Precise Cause Identification

As a physician once wrote, “A fundamental principle in medicine is that if you get the diagnosis wrong, you’ll probably apply the wrong therapy” (WSJ, Apr. 7, 2013, https://on.wsj.com/319XcWh). Precise cause identification, a vital step in the care delivery process, is a key to high quality care.

Over 50 years ago, Lester S. King, MD, discussed how diagnosis — competent cause identification — is not just clinical or medical but everyone’s business (JAMA 1967;202:714–717). The literature, such as the American College of Physicians’ Teaching Clinical Reasoning (Philadelphia: ACP, 2015) and the Competencies Curriculum of AMDA — The Society for Post-Acute and Long-Term Care Medicine reinforce effective cause identification as the foundation for the success of all interventions for all problems and conditions, medical or otherwise.

Capable clinicians may take competent cause identification for granted, but in overall practice it remains quite erratic.

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Given the three-decade-long effort to implement the basic blueprint that was outlined in the 1986 IOM report, why do some old concerns still seem problematic? Have we consistently applied timeless and enduring truths and relevant knowledge, or have we made things too complicated and costly while trying unsuccessfully to reinvent the wheel?

Throughout 2020, and based on the above ideas, this column will explore in detail whether and to what extent we are on the right track after three decades of effort as well as the implications for nursing home residents, Society members, and the entire interdisciplinary team. Along the way, I will offer many specific suggestions for using key principles and practices to meet regulatory requirements.

Dr. Levenson has spent 42 years working as a PALTC physician and medical director in 22 Maryland nursing homes and in helping guide patient care in facilities throughout the country. He has helped lead the drive for improved medical direction and nursing home care nationwide as author of major references in the field and through his work in the educational, quality, and regulatory realms.

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Visiting nursing homes and spending time with residents was his lot in life,” said David Smith, MD, CMD, of his dog Mike. The yellow Labrador retriever was a mainstay at Dr. Smith’s nursing homes for years, and he even attended a conference of AMDA — The Society for Post-Acute and Long-Term Care Medicine in 2012 to promote the Foundation’s Caring Canines calendar. Mike passed away last month at the age of 13-3/4.

Dr. Smith got Mike as a hunting dog when he was just a six- or seven-week-old pup, and he recalled, “I fell in love with him right away.” As it turned out, Mike’s talent wasn’t necessarily for hunting. Dr. Smith observed, “He was just average in the field, but he excelled in the nursing homes with people.”

Mike was especially popular with residents who were outdoors enthusiasts and hunters. “They would ask about him. We would talk about hunting, and they would tell me about hunting dogs they had owned over the years. It gave us a connection,” said Dr. Smith. However, Mike had a gift for connecting with everyone. “A lot of residents knew Mike, but they didn’t know he was my dog,” Dr. Smith said. Sometimes, he would have Mike perform tricks, but mostly “Mike would wander around and visit with people,” he said.

Dr. Smith would use hand signals to direct Mike to residents who needed cheering up. “It would look like he was approaching them on his own, which was much more powerful,” he said. Although Dr. Smith has other pets, including dogs, Mike was special. “As physicians, we are in a continuous state of becoming. Mike grounded me in the moment, and encouraged me to enjoy the present for what it is. I will miss him,” he said.

Caring Pays Tribute to Mike the Dog

David Smith, MD, CMD, and his dog Mike promote the Foundation’s Caring Canines calendar at the Society’s conference in 2012.

Photo courtesy of David Smith, MD, CMD.

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