

Stakeholder Feedback Regarding Revisions to Private Duty Nursing Policy

P. Cook

Provided various comments related to the following question, "Absent other technologies, under what circumstance(s) would a client need the continuous presence of an RN to provide: a CPAP/Bi-PAP; Pulse Ox; Oxygen Administration; or Jtube or Gtube feeding service as opposed to an intermittent nursing visit?"

1. CPAP issues: I suspect the documentation is lacking for evidence based skilled needs for kids. I expect that these beneficiaries need a lot more support such as pulmonary assessments, medications, nutrition etc. What I heard was one topic on the oral suctioning for Certified Nursing Aides though the licensure does not allow them to have assessment role. I have advocated for years we need have more LPN trained folks to be the home care assistants over the CNA. It would again bring the CNA have a career path and specialty for ped's home care, respiratory etc.
2. My question is why don't we use experienced respiratory therapists for these clients if the only the real care need is the CPAP technology.
3. I heard from the community this is more a night care issue than 24 hr. care. Nights are hard to staff plus attract high quality people.
4. For our adults, such as ALS etc., that could be a tool over a ventilator. We have the same issues- what are the collateral needs during this time frame? Could we honor adults at home with night services over LTC. Again, things change rapidly and could lead to major risk issues for the agency and state. I find it challenging to find skilled nursing facility to house adults who need this level of care and have to appeal for help with the HBU unit at times. My suggestion is this is a case by case approval instead of blanket statement. I also agree the Pediatric Tool stakeholders did a lot work on this issue and we need true financial costs that spurred this conversation.
5. (Pulse ox etc.) This should only be in conjunction with a disease process that low oxygen would cause great harm. This is same as above- each case has to be assessed and reassessed in real time. What are our real costs and what created the discussion? I cannot image a relevantly stable, chronically ill child needing RN supervision if an oxygen alarm could be used if change occurs such as low oxygen. Now if the same said child had exacerbation of illness or new pulmonary issue then a short term plan could be enacted quickly which could help a hospitalization avoided. What I kept hearing is the children being talked about are very involved cases as examples and would not have only one skill.
6. If/then conversation is not a bad idea but again if we train up the CNA staff to LPN level for being able to react to situation in a linear method instead of drama. There are several triage methodologies that could be reviewed for quality issues. Having this on a tablet so that the person in the home could be quickly instructed would help to decrease the risk issue. Using face-time for the nurse to see the client could also help with assessment. Having folks call 911 repeatedly like we are seeing in assisted livings for falls is an example that this industry

creates due to low skill sets. Do we have current, documentation of inappropriate ER use for children in the pulse ox only category? One person said her child had multiple seizures so that would be a complicated issue.

7. (Jtube/GTube) This is another issue that would rarely be a situation without any other factors. Where is the documentation that this is the only service? If a RN has to be there for 24 hr care then the child is getting continuous feeding for other reasons. There is a difference between assessing complicated case versus providing skin care for exacerbations, changing the tube etc. Our adults rarely are maintained that way for 24/7 feedings. I agree with the lady speaking though I will stay with increasing our CNA population to be in different career path.

A. Ibarra

As a non-clinical person, my contribution is from an outsider perspective and may seem overly naive, but there seems to be a huge contradiction in categories depending on who is responsible for the care.

If a parent is responsible [in the absence of the continuous presence of an RN] they can't be reimbursed for skilled care, but they have no choice to perform it [the task] and when the parent is a paid CNA every little task is looked at in a microscope to ensure they are paid for as little as possible.

It sounds like if a home health agency is getting paid they are able to look at everything and raise it to the level of skilled care and not delegate because of liability.

If care is being provided by a waiver the CNA tasks are just expected as a component of the waiver service, delegation is encouraged and the person doesn't even get the chance to also utilize skilled care in many instances.

I love that we are emphasizing keeping people out of institutions and I think this is a great conversation to really look where Colorado is putting its financial backing to walk that walk.