Too Much Perfection: Over-prescriptive Regulation

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On November 2nd I was privileged to share a conversation among a group of nurses trying to provide the best care they can to the aging residents for whom they are responsible. The discussion soon led me to an understanding of the limitations of licensure and how that can negatively impact caregiving.

The takeaway was that a more flexible approach could allow providers to deliver better patient care at lower cost with less staff. For staff, it would make their work more meaningful. Better care, lower cost, less staff, more meaningful work. Why wouldn't everyone want that… especially now?

Adverse Regulation.

With the strains on today's workforce, given the challenges of finding talented, qualified workers, the discussion was highly topical. The regulators wring their hands in sympathy, but there is little they can do to help in a reactive regulatory context in which there is zero tolerance for deviation or imperfection. We need to move from a prescriptive-compliance culture toward an adaptable-responsive approach. We can do this.

Although the state in question was California, I have no doubt that similar challenges to good care arise in the regulations of many states. One topic was the delivery of medications and

the various levels of licensure required ranging from medication technicians, to certified nursing assistants, to licensed vocational nurses, to registered nurses. Four levels of qualification, each prescribing what a person so licensed is permitted to do and what not.

Med Management.

Now consider the patients. Those in independent living are, for the most part, able to prepare their own prescribed medications and to take them at the prescribed time, generally without failure. That changes as people lose acuity.

The patients' needs fall along a continuum. They are not discreetly delineated as are the licensure directives. Moreover, a gifted person with a lower level of licensure, working under a higher qualified teacher, can provide services competently that are otherwise above what's permitted.

Dispensing.

This distribution of meds begins with how they are dispensed. Picture an employee standing by a med cart with a matrix of paper dispensing cups in front. Preparing meds for dispensing is a boring meticulous chore requiring careful concentration and error-free accomplishment. A chore like that is prone to error no matter who does the dispensing.

It's clearly a chore that can readily be automated with fewer errors than with manual cup filling. There are systems to automate the monotony of dispensing, but people still are most often involved. That may be a result of minimum staffing ratio prescriptions. It may be that existing automated solutions are too costly, too complicated, or unproven.

Still, machines do well with repetitive tasks that humans do less well. This is a related opportunity for improvement. Regulations and litigating attorneys demand perfection, but humans are not at their best performing repetitive, demanding, boring tasks perfectly.

Challenge to Automation.

Eventually, that litigation exposure may justify the investment in systems like my personal favorite, the OnSiteRx dispensing machine. For now, providers often think that pharmacies should make that investment, while pharmacies see no reason to do so. Moreover, the purveyors of these automated solutions have not done well at letting potential purchasers know of their products.

There are also automated "take-your-meds" reminder systems that are generally so simplistic that they don't work in practice. A low functioning patient, hearing a machine or smartphone or smartwatch say "take your meds," is unlikely to heed the voice. At some point, human intervention is needed to ensure compliance with medication routines.

Patient-Centered.

A friend of mine had a mild stroke, after which her children directed that her meds be handled by staff. My friend noted that she felt she could still handle that routine, but nevertheless her children's caring enough to have staff bring her meds made her feel loved. It also made her feel safe and secure. There are many sides to patient care, some of them less obvious, but often more important, than others.

Some patients are able to ingest their own medications, while others need the medications placed in their mouths ready for swallowing. Additionally, some medications require more sensitivity than others. For instance, insulin requires careful management, and more in some cases than others.

This is where the prescriptive nature of reactive regulation gets in the way of what would otherwise be the best care. Consider a time when the higher qualified licensed staff person is unavailable. It might be that a diabetic patient needs a blood sugar test but the patient can't manage to self-prick a finger. If the available staff is prohibited from helping draw that drop of blood, the patient care suffers. That's contrary to commonsense and contrary to the likely regulatory intent.

There are many similar incidents that can arise in the course of a day in a community that provides care for a wide range of patients with varying self-care, self-administration

capabilities. The result is higher cost for poorer care. We need proactive regulation to allow staff to better meet patient needs. That may come with some nominal risk, but it's impossible to avoid all risk.

Trusted Providers.

How can we make the industry-regulator relationship more constructive and better suited to the needs of the patients? We can note at the outset that not all providers are the same. Many providers are exemplary and do an excellent job of caring for patients without any intervention to demand that they do this or that in this way or that way.

We might, therefore, start with a concept of trusted providers. Some providers can earn trusted status and would then need little, or no, oversight unless a change in performance emerges. That would free authorities to concentrate more closely on improving the performance of substandard providers. By adopting such a principled, proactive approach, we can improve outcomes and, as a by-product, give underperforming providers an incentive to improve themselves beyond contenting themselves with minimal compliance.

A Better Approach.

Care should optimize patient well-being. Such a principled approach is contrary to zero-tolerance, reactive enforcement. It will take a change in mindset to change today's rules-based, prescriptive model to a more sensible model.

Convening a deliberative group of all interested parties and bringing them together to listen to each other and learn from each other can develop a more proactive approach. They can together craft a more meaningful approach. It might take a year or two to achieve, but we can do better than what now hampers care providers.

What is difficult is that:

1. It would require from government a very high level of deliberative talent to chair, facilitate, and lead the effort;

2. It would require moving beyond special interest machinations to find the common good; and
3. It would give an aspirational opportunity to providers to prove themselves trustworthy.

This can be done. Without going into detail, there was such a reform effort for a highly regulated industry in New York State. It freed that industry from regulatory shackles and allowed an era of growth with consumer serving innovations.

The meeting of nurses on November 2nd demonstrated how urgent it is that we improve regulatory oversight. Improvement will help both the industry and the consumers it serves.

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