Despite Retirement Worries, Survey Finds That 45% of Hospital Employees Still Don’t Participate in Employers’ Retirement Plans

I don’t know what last winter was like at your facility, but at Carolinas Medical Center, an 847-bed teaching hospital in Charlotte, NC, we got hammered again. We even achieved an all-time high as far as ventilators per day. It was a busy season, but fortunately our department started a program that really helped out.

The AARC defines a chronic ventilator-dependent patient as “one who receives mechanical ventilator support for at least six hours of each 24-hour period and has been receiving mechanical ventilation for 30 days or more.”

A couple of years ago we began looking at the medical needs of our adult ventilator patients and their lengths-of-stay. We discovered that a subset of the population had either plateaued in their recovery phase or had co-morbid conditions which caused them to require mechanical ventilation longer than the average acute care patient. When we were finished gathering data we discovered that these patients’ average lengths-of-stay were over two months!

We also discovered that taking care of these patients was quite costly when compared to the average acute care ventilator patient, and that the average reimbursement did not exceed the average costs of hospital care. We had therefore confirmed what the AARC had already discovered—that hospitals are stuck with 46% of the cost of care for these patients.

We began to consider the suitability of these long-term patients for admission to alternate care facilities. Help was needed from our professionals in discharge planning, the department of patient and family services (DPFS). We presented the above information to DPFS, and they were convinced that a strategy to address these patients’ discharge planning requirements was needed.

As a result, we selected three facilities and invited them to visit us. Each gave a presentation detailing medical admission criteria, respiratory therapy services, complex medical services, and rehabilitation and wound care programs. Payor sources and clinical information needed at time of admission were also discussed.

We found that the medical criteria for admission at these three facilities were similar and that they only differed in the degree of services provided. A representative from our department (myself) was invited to attend weekly discharge planning meetings in order to identify patients suitable for referral. After several weeks of identifying candidates for a subacute ventilator unit, several physicians were approached. Our attempts were met with a mixed response. Some physicians readily agreed; they could see how the referral could provide effective care at a lower cost. Other physicians were skeptical and needed more information.

We then approached the physicians who gave referrals and recruited them as medical ambassadors for the program. Along with our medical director, they gave formal presentations to key physician groups. Simultaneously, I began to give similar presentations to nurses in the ventilator step-down units. The goal was to fully inform as many members of

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the discharge planning team as possible. I cannot overemphasize the importance of this step.

Physicians became more receptive and more referrals were given. Nurses often became the first to suggest a subacute referral, and as a result, I was invited to conduct a weekly surveillance to see if patients met medical criteria for admission. When a patient met criteria, the discharge planning team decided whether the physician should be approached for a referral. If the physician agreed that a referral should be made, he was encouraged to talk with the patient or the patient’s family to get their buy-in and to seek agreement. Medical social workers also talked with the family to answer any questions or concerns they had, and encouraged visits to the new facility. When all parties agreed to the referral, the rest of the referral process was handled by a placement coordinator who checked on financial information, form completion, and bed availability.

The first year, 1996, was fairly successful in that we had a total of 11 referrals. We continued to track progress on functional capability and participation in activities of daily living, ventilator weaning, decannulation, and the eventual discharge destination. The initial results were encouraging, but we could not draw any conclusions with such a small number of patients.

In order to get more referrals, earlier identification of this type of patient was needed. This meant that patients would need to be screened while they were still in the intensive care unit. Additional inservices were given to each intensive care unit and units. Some patients were discharged to subacute care directly from the intensive care unit. As a result, during 1997, 31 ventilator patients were successfully discharged to subacute care.

How did the program help us last winter? As a result of the program, nearly 3,000 days of inpatient charges were avoided. This meant that last winter, we averaged seven fewer adult ventilator patient days per day. Over $10 million of inpatient charges have been avoided, resulting in cost-savings to our hospital and more effective utilization of our respiratory care staff.

Despite Retirement Worries, Survey Finds That 45% of Hospital Employees Still Don’t Participate in Employers’ Retirement Plans

An independent survey of more than 200 hospital human resource executives has found that nearly half of all hospital employees are failing to maximize financial benefits at work by not taking full advantage of retirement plans that typically include employer contributions.

The research was conducted by the HSM Group Ltd., Scottsdale, AZ, on behalf of Chicago-based AHAInsurance Resource Inc. (AHA-IRI), a wholly owned subsidiary of the American Hospital Association (AHA). The survey went out to about 1,500 human resource executives,
Antireflux therapy improves asthma symptoms but not lung function

The treatment of gastroesophageal reflux (GER) disease in asthmatics may reduce asthma symptoms and reduce the need for asthma medication but has minimal or no effect on lung function, say researchers from the University of Calgary in Alberta, Canada, who reviewed 171 peer-reviewed studies involving 326 patients. The study was published in the July issue of CHEST, the journal of the American College of Chest Physicians.

Researchers note that the association between GER and asthma has been reported in the literature for the past 35 years, and symptomatic GER is known to be about four to five times more prevalent in patients with asthma than in other patient groups. Hiatal hernia and esophagitis are also more prevalent in asthmatics.

The analysis of the combined data showed that among asthma patients with GER who were treated with antireflux therapy:

- asthma symptoms improved in 69%
- asthma medication dose was reduced in 62%
- evening peak expiratory flow improved in 25%
- spirometry (in any of the placebo controlled studies) did not improve.

(Source: ACCP Press Release)

“Healthy” smokers have early signs of heart disease

Cigarette smoking causes subtle damage to blood vessels, signaling an early stage of heart disease that worsens as smoking continues, say researchers from the University of California at Los Angeles School of Medicine.

The study involved 33 healthy individuals without chest pain, shortness of breath, artery blockage, or any other evidence of coronary heart disease. Sixteen were long-term smokers whose years of smoking ranged from 11 to 39 years, and 17 were nonsmokers.

Each participant was injected with N-13 ammonia, a radioactive substance that allows researchers to visualize blood flow, and had a PET scan while resting. This was followed 45 minutes later by a cold pressor test in which the left hand was immersed in
icy slush for 45 seconds. Then a second shot of N-13 ammonia was given and the exposure to the ice water continued for another minute as the PET scan recorded blood flow through the heart. Finally, to determine blood vessel dilation, each person received a four-minute infusion of the drug dipyridamole, which increases blood flow to the heart, followed by another injection of N-13 ammonia and further PET scanning.

Results showed that the blood vessels of smokers do not respond as well as those of nonsmokers when the heart needs more blood flow during physical exertion. Smokers averaged about 14% less blood flow to the heart than nonsmokers during the cold pressor testing, and blood flow was impaired even in smokers whose arteries were not obstructed by fat-filled plaque. However, an abnormal blood flow in response to the cold pressor test did correlate with a low ratio of “good” cholesterol to “bad” cholesterol. HDL, or “good” cholesterol, is thought to clear the fatty substances from artery walls. The LDL, or “bad” cholesterol, enters the artery walls and contributes to the creation of the obstructions that impede blood flow to the heart.

The study was published in the July 13 issue of Circulation: Journal of the American Heart Association. (Source: AHA Press Release)

Impaired breathing may raise stroke risk—but marriage could lower it

High blood pressure, prior stroke, and having an irregular heartbeat are all well-established risk factors for stroke. Now Australian researchers have added another risk factor to that list: impaired breathing. Their study of the hospital and death records of 2,805 men and women over the age of 60 found that those whose peak expiratory flow was most impaired by chronic bronchitis had a 77% higher risk for having a stroke when compared to those whose breathing was the least impaired.

“The relationship between impaired peak expiratory flow and ischemic stroke has not, to our knowledge, been previously reported,” say the authors. “A suggested link between inflammation and atherosclerosis is very topical, especially with recent research on the link between respiratory infection and heart disease. Our data allows the possibility of speculation and extrapolation, but more specific research needs to be done on this link.”

Another interesting finding in the study was that marriage may protect against stroke. Investigators found that people who were married had a 30% lower risk of stroke, and married women, in particular, had a 46% lower risk.

The study was published in the June issue of Stroke: Journal of the American Heart Association. (Source: AHA Press Release)

Private meetings with JCAHO may not be so private

One of the biggest changes that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) made when it revamped its accreditation process a few years ago was opening up the process to rank and file hospital employees by actively soliciting their opinions on the delivery of care and other issues. Now anyone on staff can ask for a meeting with surveyors to address specific concerns. Very democratic, right?

Wrong, say some labor groups. Sure, hospital employees can have a private meeting with surveyors to discuss problem areas, but only if they don’t mind having their bosses know about it. According to an article in the July 20 issue of Hospitals & Health Networks, the JCAHO can’t guarantee anonymity for those who raise concerns, and more likely than not, managers are going to find out that such a meeting took place.

JCAHO president Dennis O’Leary is quoted in the article, “Although hospital management might not be (on hand), it would probably become known as to who went in privately to talk to surveyors.” He also noted that surveyors are required to relay employee concerns to standards compliance.

Increasing use of mechanical ventilation documents increasing asthma severity

A British study of mechanical ventilation rates among asthmatics supports the premise that the disease is increasing in severity.

Investigators who compared mechanical ventilation records at one hospital for the periods 1973-1983 and 1986-1992 found a significant increase in the use of mechanical ventilation in asthma patients in the latter period. The group also found an increase in the speed of onset of the asthma exacerbation leading to ventilation and a reduction in the time between admission to the hospital and the initiation of ventilation in the later time period.

On a positive note, both morbidity and mortality rates for asthma declined during the second time frame, due, the researchers say, to improved asthma care in general. (Respir Med 1998;92:716-721)

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