



Adult Acute Care

Bulletin

Sept./Oct.'98

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

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FYI...

Respiratory Care Department Starts Subacute Ventilator Referral Program

by Michael Scotton, BA, RRT, clinical specialist, department of respiratory care, Carolinas Medical Center, Charlotte, NC

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." ¹ 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 ser-

vices (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 as a result, more patients were identified before transfer to step-down 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 mechanical ventilation and 4,000 days of inpatient care were avoided. This meant that last winter, we averaged seven fewer adult ventilator patients 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.

Continued success and growth of the program will depend on timely referrals and appropriate communication between all members of the discharge planning team. We have demonstrated that respiratory therapists can be effective members of the team. Even though our department started the program and continues to monitor its effectiveness, the process is multidisciplinary in scope.

We can make similar contributions in other areas, particularly in chronic respiratory disease management. I would like to hear from colleagues who have similar programs or are respiratory disease managers. Please feel free to contact me to discuss this program in greater detail. Perhaps we can learn from each other. ■

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Reference

1. A Study of Chronic Ventilator Patients in the Hospital (AARC, 1991)

Adult Acute Care Bulletin

is published by the
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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 AHA Insurance 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,

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including members of the American Society of Healthcare Human Resource Administrators (ASHHRA).

The results showed that:

- Although 86% of employees are eligible to participate in their employers’ retirement savings program, only 55% do —far short of respondents’ average goal of 80% participation.
- Non-participants are losing out on money offered by their employers, since 82% of hospitals contribute to their sponsored retirement plans.
- Survey respondents believe that only 25% of employees are saving enough to live comfortably in retirement, even though 86% of respondents said their organizations have educational programs to help employees understand their retirement income needs.

These results are consistent with nationwide trends indicating that a significant part of the U.S. workforce may not have adequate retirement income. The Security Administration, U.S. Department of Labor, estimates that only 46% of workers are vested in private sector retirement plans, which means that more than 50 million Americans lack any kind of pension. This issue has become such an urgent priority that lawmakers from

both parties spoke recently at the National Summit on Retirement Savings in Washington, D.C.

“This study provides valuable benchmark data on the scope of retirement plan issues in health care organizations,” says Dixie L. Arthur, president of AHA-IRI. “When considering the high rate of non-participation, we must consider the reasons why health care employees are not taking advantage of the plans offered them. Perhaps they feel they cannot afford to contribute to a retirement plan. Or technical language and industry jargon make it difficult for them to understand the benefits. Maybe their employers haven’t taken the appropriate steps to ensure that all employees are adequately aware of their savings opportunities.

Studies in the private sector indicate that effective employee educational programs on savings and investment can boost participation rates. For example, one survey of 1,251 employers released last year found that participation rates for 401(k) plans among eligible employees are more than 13% higher when employees are offered financial education programs.

“The AHA-IRI survey data shows that 91% of hospital employee education programs involve discussions with retirement services representa-

tives and 72% use written materials. However, only 54% of the respondents provide formal seminars as a means to educate their employees,” says Sharon Dillon Robinson, Dean of VALIC’s Center for Retirement Education. “Hospitals need to be more proactive in continually educating employees on the advantages of retirement planning. A well-designed educational program that incorporates simple terms that employees can relate to and understand is paramount in increasing the level of plan participation.”

Other survey findings included:

Health insurance is the most important benefit to employees, followed closely by retirement plans.

A majority (64%) of organizations offer defined contribution plans, while 49% offer defined benefit plans.

The most reliable source for information about finances and taxes is the organization’s retirement plan provider.

When presented with various statements regarding factors that may impact retirement savings, respondents most strongly agreed that health care costs during retirement are a major concern for employees.

(Source: AHA Press Release)■

FYI . . .

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 anti-reflux 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

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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 inflamma-

tion 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.

Docs wary of clinical practice guidelines

Clinical practice guidelines have been touted as a way to maintain or improve quality of care while contain-

ing costs. But the physicians who must buy-into these guidelines for them to be effective are becoming more and more suspicious that quality is being sacrificed for the bottom line.

A survey of 62 primary care physicians in Southern California that was conducted in 1992 and 1994 by researchers from Cedars-Sinai Health Systems in Los Angeles found that the number of doctors who distrust these tools is growing. In 1992, 71.2% of the respondents said treatment guidelines were motivated by cost concerns. By 1994, that number was up to 91.6%. Conversely, 85.3% of physicians in the first survey thought guidelines were instituted to improve quality. Just 67.2% were similarly convinced two years later. (*J Gen Intern Med* 1998;13:324-326)

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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