Subacute Care Bulletin
Nov./Dec.'98

Notes from the Chair Elect & Editor

by Becky Mabry, RRT

Most respiratory therapists providing therapeutic services to patients in subacute and skilled nursing facilities are now facing serious challenges to their ability to provide effective and necessary services to these patients. This is particularly true for those who provide services to the many elderly patients who depend on Medicare for their health care coverage. The recent implementation of the interim Prospective Payment System (PPS) for Medicare Part A SNF services has left many of these patients without adequate coverage for many essential and necessary respiratory therapy services.

In the last issue of the *Bulletin*, the AARC urged all subacute care practitioners to write a letter to their US Senators urging them to pass emergency legislation requiring HCFA to provide the non-therapy ancillaries, including respiratory therapy, a temporary exemption in the PPS payment. The Senate has taken an active lead in pursuing this issue. It is absolutely essential that they receive information from respiratory therapists on the ramifications of PPS.

Specifically, they need to know that respiratory therapists have pioneered effective and important multidisciplinary approaches to patient care in SNFs and subacute care units across the US. In doing so they have improved patient outcomes and provided high quali patient care to many elderly and me ically fragile patients. Many of the patients, especially the ventilat dependent or difficult to wean, a patients whose potential for rehabilit tion may not have been recognized a addressed in a busy and crowded ICU Coordination of rehabilitative servic from respiratory therapy, speech, a physical therapy, along with activ patient education, has allowed the patients to make significant strid toward ever greater degrees of fun tional independence, resulting in low acuity and a reduced utilization of me ical services. This lowers overa patient care costs, while ensuring a overall improvement in the patient quality of life.

Diane Saunders, a respiratory ther pist in Wisconsin, has been kin enough to share with us a letter sh wrote to her Senator. I think it sums u many of the issues wrought by the ne PPS. I urge you to review Diane's le ter, think about your own experience and take an active role in this lobbyin effort. Write your Senators and expre your concerns over the current PP Remind them that without emergen action many elderly patients will be risk and may be forced back into hig er cost acute care settings. ■

From a Letter to Senator Russ Feingold

by Diane Saunders, RRT

Dear Senator Feingold,

I am writing concerning components of the regulations that the Health Care Financing Administration (HCFA) has enacted regarding the interim Prospective Payment System (PPS) for Medicare Part A Skilled Nursing Facility (SNF) services.

I am a respiratory therapist (RT) in Wisconsin working with patients in SNFs throughout southern Wisconsi Until recently (July 1, 1998), HCF required RTs to be "hospital-based" be reimbursed for services they provi ed to Medicare recipients in SNFs. other words, we had to be employe of a "transfer hospital" that had enter into a "transfer hospital agreemen

"Letter to Senator" continued on page

the SNF(s) before we could provide iratory therapy services to these ents.

ince that requirement has now been inded by HCFA, my "transfer hospi- has decided not to continue its respi- y therapy outreach program, effec- December 31, 1998, the day before takes effect for most SNFs in the ıtry. The third party management pany I work through has decided not art its own program.

Much of this letter relates to the ource Utilization Group (RUGS III) gorization scheme devised by HCFA, Minimum Data Set (MDS 2.0), and Resident Assessment Instrument I) manual, which describes how resi- s of SNFs are to be assessed by the ing staffs of SNFs, thereby establish- the patient's RUGS reimbursement gory.

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sion of a wide range of therapeutic modalities to SNF Medicare patients who have been diagnosed during their most recent qualifying hospital stay with one or more cardiopulmonary disorders. The nursing staffs of these facilities have come to rely very heavily on our clinical expertise with this patient population, to the extent that we now provide virtually all of the respiratory therapy needs of Medicare patients in these facilities until such time as we determine that their conditions are no longer "acute" or an "exacerbation" of a chronic condition. Once we determine that the acute stage of a disease (e.g., pneumonia or chronic obstructive pulmonary disease) has been resolved, we turn the respiratory therapy of these patients over to the nursing staff. Our presence in these SNFs has freed the nursing staffs of these facilities to concentrate on their patients' other, usually more routine care, such as PICC lines, IVs, tube feedings, and, of course, medication delivery, which occupies much of their time.

I have grave concerns about the current provisions for the PPS for Medicare Part A SNF services. HCFA incorrectly accounted for respiratory therapy services as they devised their new system of patient categorization (the RUGS III categories). For payment calculation purposes, HCFA has elected to place respiratory therapy (along with pharmacy, IV therapy, orthotics, and prosthetics, among others) in the non-therapy ancillary category. If these provisions remain in place on January 11, 1999, the respiratory therapy services provided to patients in SNFs around Wisconsin and the rest of the country will, in all likelihood, not be provided by RTs, but by the already overworked, understaffed nursing staffs of most SNFs. THIS MOST LIKELY WILL RESULT IN A DIMINISHED QUALITY OF CARE PROVIDED TO THESE PATIENTS, because, in addition to what the nursing staffs are already doing, they will also be doing our work.

Respiratory care should never have been included as a "non-therapy ancillary." Rather, it should be recognized in the more appropriate category of "therapy." In the multidisciplinary team meetings that all the therapy services (PT, OT, ST, and RT) attend in the SNFs that my company serves, the rehabilitation medicine doctor who runs the meetings considers respiratory therapy to be an integral, inseparable part of the "rehab" or "therapy" team.

Unfortunately, companies such as the one I currently work for will not maintain respiratory outreach programs if the being there. As it stands at this mom I will be unemployed on January 1, 1 for that reason. It may be true that elimination of the transfer hospital ag ment by HCFA will free SNFs to their own RTs to provide respiratory t apy services to SNF patients. But experience in the SNF setting is when the census of the Medicare drops below an arbitrary number se the corporation that owns the SNF - number below which they feel are sp ing "too much" on the cost of labo terms of the nurse-to-patient ratio — corporate-run SNF will send the home, leaving the nurse or nurses on unit to provide for the patients'respir ry therapy needs.

To ensure that patients continue receive the respiratory therapy serv they need, the Senate should req HCFA to create a temporary, 18 month pass-through for the paymen non-therapy ancillary services under SNF PPS. But ultimately, HCFA n rethink its position concerning the le macy of respiratory therapists in SN Over the last six to 12 months, we h been systematically limited by HCFA the Medicare Fiscal Intermediaries a which modalities (and the frequency duration of those modalities) we can vide to Medicare residents in S because HCFA does not believe that piratory therapists have a legitimate in the provision of care to SNF patie This tunnel vision has led HCFA to v RTs as hospital clinicians only, with legitimate role outside the hospital ting. This attitude is only hurting people we serve.

Do people who leave hospitals to admitted to SNFs suddenly become ' ill" and not in need of specialized c NO! In fact, because of PPS and DRGs in the hospital setting, patients routinely discharged by hospitals w they are still very ill. Two of the SNFs I work in routinely admit pati whose "level of acuity" is high, mean that they may require complex mec management and the services of sev disciplines, including nursing, respira therapy, physical therapy, occupati therapy, and/or speech therapy as par their rehabilitation plan of care.

One SNF where I work on a reg basis, for example, frequently adı patients from the University Wisconsin Hospital & Clinics who h tracheotomy tubes in place becaus some respiratory condition. These ty of patients frequently require a hi

"Letter to Senator" continued on pa

l of care, but under PPS they will not the specialized care they need from RT. Instead, they will be receiving r respiratory therapy from over-ked and understaffed nursing staffs.

he whole focus of the multidisciplin- team approach in the SNF setting been the rehabilitation of the patient at the person can return to whatever l of functioning he or she was at just r to the most recent qualifying hospi-tay. Under HCFA's PPS provisions, emphasis on that approach fades y, replaced by a categorization me that lumps all the person's daily (per diem) needs together into one GS III category upon which the reim-ement rate depends.

What I see happening is the following: frequency and duration of the thera-ic modalities that a patient may very nature of HCFA's PPS reimburse-ment scheme, be reduced to that which only minimally affects patient outcomes. Ergo, patients will not receive the care they need to return to their prior level of functioning because each discipline that provides services will, by necessity, have to reduce the frequency and duration of care to account for the fact that its "piece" of the per diem reimbursement "pie" does not adequately cover the necessary services.

An economic study jointly commissioned by the American Association for Respiratory Care (AARC) and the National Subacute Care Association (NSCA) and performed by Don Muse, has documented that the database used by HCFA is flawed, and the only way to have accurate data is to do further analysis and study.

ly those with the high acuity levels t routinely see, will not receive approp reimbursement. The quality of, access to, respiratory therapy wil diminished, thus undoubtedly for patients to receive care in the higher acute care hospital setting.

Therefore, I urge you to sponsor leg tion requiring HCFA to address the p of concern I have raised in this l Without legislation to clarify Congr intent regarding PPS, HCFAwill be fr finalize the provisions in the int Prospective Payment System (PPS) Medicare Part A Skilled Nursing Fac (SNF) services discussed in this letter. result will be a significantly reduced q ty of care provided to Medicare patien SNFs and subacute care facilities. ■

tudy Uses HCFA Data to Show Flaws SNF PPS Regs

a study commissioned by the AARC ws that flaws exist in the methodolo-sed to construct the new PPS system SNFs. Muse and Associates, a well-wn Washington-based consulting , used HCFA data compiled from the 4 and 1996 Standard Analytical eficiary Encrypted Public Use Files how that serious gaps are inherent in RUGs III system of reimbursement.

supported by a coalition of long-term and skilled nursing advocacy organi-ons, the study included all persons received respiratory therapy services he inpatient hospital or SNF setting ng 1994 and 1996. Claims for these viduals were extracted and the data ed to identify beneficiaries who ired intense respiratory therapy uti-ion in SNFs (defined as $1,000 in l respiratory therapy services). ailed statistics on the diagnoses, s, utilization, and demographics of intense users were generated, and all were weighted to the full Medicare eficiary population.

he purpose of the study was four-fold:

- examine and outline the HCFA ethodology regarding respiratory erapy
- determine, with the most recent data, e growth, scope, and extent of respi-tory therapy services in Medicare patient settings
- determine if there were significant mbers of Medicare beneficiaries who were intense users of respiratory therapy services
- to speculate on how these intense users might be better served in the SNF PPS system.

The results clearly show that respiratory patients are being shifted from inpatient hospitals to SNFs in large numbers, and that the PPS system–which was largely based on data collected from nursing homes before this shift took place–did not adequately cover their needs. The study showed that respiratory service charges grew by $658 million in SNFs and declined in inpatient hospitals by $417 million between 1994 and 1996.

One if the most revealing aspects of the study was that the data indicated there were no significant differences between SNF and inpatient hospital diagnosis patterns with regards to respiratory therapy services. The top 100 diagnoses accounted for 98.6% of all respiratory services, the top ten accounted for about one-half, and the top five accounted for one-third in both settings. Nor were any differences found between SNF and inpatient hospital diagnoses patterns for intense users of respiratory therapy services.

Beneficiaries with paid claims of more than $1,000 comprised 18% of all Medicare beneficiaries who received respiratory therapy services and accounted for 74% of all Medicare expenditures for respiratory therapy services, again, in both inpatient hospital and SNF settings.

These data effectively confirm what the respiratory community has long pected: the SNF respiratory patient today are the acute care hospital resp tory patients of yesterday. Patients leaving the hospital sicker and quic often landing in a SNF or rehabilita facility in a much more acute condi than ever before. To deny them the s level of quality care afforded in the a care hospital–i.e., respiratory serv delivered by trained, educated, and dentialed respiratory therapists–woul tantamount to discrimination.

The AARC has submitted commen HCFA urging the agency to revisit the PPS issue and to consider carefully data from this study. For more details a the significant findings of this rese visit the government affairs section o AARC website (www.aarc.org). ■

AARC Online brings you the latest in respiratory ca news and information.

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http://www.aarc.org

The AARC recently got a boost in its efforts to support the use of respiratory therapists in SNFs with letters of support sent to the Health Care Financing Administration (HCFA) by three prominent physicians.

Drs. George Burton, Neil MacIntyre, and Tom Petty wrote the letters at AARC request to assist the Association in getting expert opinion to HCFA about the need to have RTs involved in respiratory patient care in this setting. Full-text version of the letters are available on AARC Online (www.aarc.org) in the Professional Resources area, but here are a few pertinent excerpts for your perusal:

"My concerns about the proposed (PPS) regulation are two-fold. First, I am concerned that the MDS-II, which is the engine that drives the RUGs-III groupers, is badly flawed in that it gives short shrift to the complex needs of patients suffering from heart and lung diseases. Secondly, I believe that financial pressures brought about by the PPS will encourage the practice of respiratory therapy by individuals with little or no competence to do so." – Dr. George Burton

"The properly trained RT is uniquely suited for this role. Their educational process focuses on cardiorespiratory physiology and the management of cardiorespiratory diseases. They alone among the allied health professions have the necessary skills to both assess patients with respiratory conditions and then apply appropriate therapies range from inhalational treatmer use of life support systems." – MacIntyre

"The commonplace on-the-jo ing of otherwise qualified health fessionals is simply inadequate with the details and complexities ern respiratory therapy, including such as mechanical ventilators, pulmonary function testing eq and the use of potent pharm agents which are ordered by a physicians. Thus, I urge that t "training" be specific to formaliz ing, pursuant to certification of tion in respiratory therapy, and a ate licensure." – Dr. Tom Petty

FSRC Takes Proactive Approach to SNF PPS in Florida

There's been a lot of hand-wringing over the fate of respiratory therapy under PPS. The AARC has taken an active stance on the issue and continues to work toward a viable solution with the Health Care Financing Administration (HCFA) and other national groups and organizations. But there is much that can be done on the state and local levels as well. The Florida Society for Respiratory Care (FSRC) is a case in point. Last August, the FSRC sent a letter to more than 600 nursing home administrators in an effort to educate decision makers about the value and necessity of respiratory therapists in this setting.

The letter, signed by FSRC President David Rappa, BS, RRT, provides nursing home administrators with specific information about the utilization of respiratory therapists in their facilities. In a press release announcing this proactive step, Rappa said he felt it was important to point out to administrators that respiratory therapists, because of their extensive education, training, and versatility in the health care profession, can actually be the least expensive licensed therapy service in a facility.

The FSRC document lists 16 specific modalities in which respiratory therapy can be utilized effectively and efficiently in SNFs:

1. Provide cost containment services by reviewing monthly use of equipment and modalities.
2. Provide blanket services throughout the facility to all residents at a fixed cost regardless of payer source.
3. Create therapy-driven protocols to provide the most prudent, cost-effective care.
4. Market a Cardiopulmonary Intervention Program at the facility to area discharge planners and pulmonary specialists to recruit residents.
5. Police local medical review policies (LMRPs) from intermediaries to assure proper support in documentation, to assure claim payment, and to locate alternate areas of reimbursement.
6. Utilization of an outcome data base tool to market to HMO's and PPO's for coverage of services.
7. Maintain a Quality Program that attracts physicians and customers.
8. Support MDS nurse with resident assessment.
9. Relieve nursing staff of all respiratory therapy duties.
10. Assist with JCAHO and state survey support preparation and compliance.
11. Provide in-services, education, and patient-care training modules.
12. Comply with state laws for delivery of respiratory therapy.
13. Gain a marketing edge on competitors.
14. Utilize respiratory therapists to initiate treatment to minimize liability.
15. Process documentation structured to assure claim payment.
16. Assure compliance with CDC Infection Control Guidelines.

The letter also outlines several factors that will, and should, play a role in any facility's decision on whether or not to utilize respiratory therapists unde

- **Four of top ten diagnoses are tory diagnoses:** Based on HCF charge percentages for 1997, fo top ten diagnoses being disch SNFs were respiratory diagnose monia, chronic obstructive pu disease, congestive heart dise aspiration/suctioning. Three PPS groups include respirat vices, and three of the four cl tion groups of the Prospective System – medically complex, u acuity, and special care – inc utilization of respiratory servic
- **Utilization of services/quality is crucial:** Recognizing the "tru treat" based on service uti becomes paramount. Resider high utilization of services r treated cost-effectively and toward lower utilization of ser avoid high cost of care after the period ends. Conversely, any c is excessive in duration, frequ modality will generate excessive the facility. Care for all resident fore, must be prudent in nature, ly from the non-skilled caregive
- **Avoiding loss of residents regression/readmission:** To r needs associated with this new ment, therapy services should blanket services for residents, less of payer source, to avoid residents from regression or avo mission that may result in n

"FSRC" continued

penalties. Since respiratory residents are the most expensive patients to treat in the hospital setting and represent a large percentage of residents discharged to SNFs, many HMOs and PPOs are now offering specific coverage for respiratory therapy services in SNFs or home health to limit readmission. In addition, nursing facilities are now directly accountable for ensuring that and necessary (per HCFA's interim final rule released May 12, 1998). If care is not found to be prudent, the FIs may retain payment up to 20% of claims submitted.

- **Capturing reimbursement from many payers:** Our government, via these changes and the advent of Medicare +Choice, is capitating care costs to treat the aging population and creating a shift of all residents to alter-

future will be based on their a control costs and capture re ment from as many payers as Note also that Medicare criteria erage remains unchanged (HC 12, Section 230) – i.e., whoev most qualified to deliver the should be providing the servi eligible for coverage. ■

HCFA Works on MDS for Post Acute Care

One of the primary concerns that subacute care providers have had about the government's new prospective payment system is the fact that the Minimum Data Set (MDS) resident assessment instrument (RAI) utilized to categorize patients into reimbursement levels does not adequately account for the medically intense services provided to their patients. If a new government initiative has its way, however, these concerns may be short-lived. Last summer, the Health Care Financing Administration (HCFA) began developing a new RAI called the "Minimum Data Set for Post-Acute Care" (MDS-PAC) that promises to better address the needs of subacute providers.

According to HCFA, the main objectives of the pilot project, which is being conducted under contract with the Hebrew Rehabilitation Center for the Aged (HRCA) in Boston, MA, are to develop an MDS-based module consisting of core screening and assessment items, to revise existing Resident Assessment Protocols (RAPs) to include content appropriate for this population, and to develop RAPs that address new clinical problems, if warranted.

Says HCFA project officer, Sue Nonemaker, RN, MS, "We are trying to be responsive to changes in the population cared for in facilities certified under the long-term care requirements, and to give clinicians an instrument that better meets their needs in assessing this population."

She says the federal agency decided to embark on the project to address the concerns of clinicians caring for s patients who, for years, have bee to be waived from RAI requ "The burden of conducting an as won't be waived through use of t PAC, but then clinicians have pr formly agreed that an assessment sary. They just want it to be re their patients'needs." She feels t PAC will achieve that goal. "Whi is currently implementing a SNF tem based on the MDS version anticipate that eventually the SN will transition to use of the MDS

HCFA estimates that the pro take 18 months to complete, and to have a version of the MDS-PA sometime in early 1999. ■

Specialty Practitioner of the Year: Joseph Bernardo, RRT, RPFT, NHA

Joseph Bernardo, RRT, RPFT, NHA, has made a tremendous impact on the provision of respiratory therapy services in skilled nursing facilities in his Fort Lauderdale, FL community over the past year. While many other therapists were forecasting doom and gloom resulting from the government's new prospective payment system, Joe went on the offensive, first by improving his own knowledge of the skilled nursing industry by going back to school to obtain his license in nursing home administration, then taking that knowledge and applying it to respiratory therapy services.

Despite PPS, he was able to obtain three contracts with area subacute care facilities, convincing them that respiratory therapy should remain an integral part of their operations. The results speak for themselves: length of stay on respiratory therapy services at these facilities has been cut in half compared to other facilities, while positive patient outcomes have been maintained. Productivity has risen from 70% to 80% or better.

Since approval for addition has been hard to come by since announced, Joe initially achiev outstanding objectives with a staff. The success seen at the thre ties, however, recently led to app additional FTEs. Now word of th itive outcomes is spreading thr the community as well, and a fou ing home has expressed interest ing the service.

Congratulations, Joe, on bein our Specialty Practitioner of the

New Product Suggestions

As you know, new product development is an important component of the services that any association provides its members. But where do these new products originate?

Quite often they originate with you. You and your staff encounter problems and needs everyday. Perhaps you require an educational product on a procedure or disease. Or maybe you need a manual to help you manage certain components of your department.

Tell us what products or services the AARC can develop that will help you perform your job. We will research your suggestion, and if it is viable, produce it and make it available to the profession.

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- Describe who will use this proc
- Tell why you believe potential u buy this product
- List your name, member num specialty section/committee

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