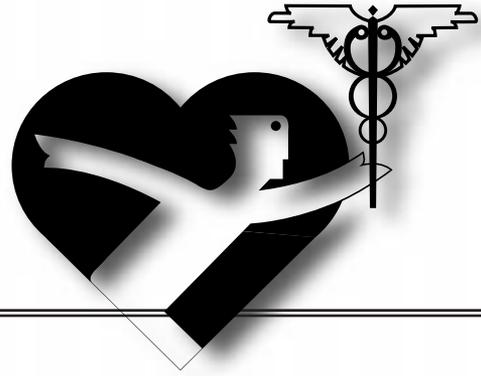


Subacute Care Bulletin

THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

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MONTANA SNFs DENY REIMBURSEMENT FOR RESPIRATORY CARE SERVICES

Last month Subacute Care Section members were mailed a legislative alert about a situation in Montana in which the Medicare intermediary has denied payment of claims for respiratory care services provided in skilled nursing facilities because they were provided by respiratory care practitioners.

The American Association for Respiratory Care is very concerned about this situation and has engaged a Washington law firm with a great deal of experience in health care and Medicare issues to assist us.

We are still seeking your input at this time.

In brief, the circumstances are as follows:

- The Medicare intermediary in Montana has denied reimbursement of respiratory services to several patients in skilled nursing facilities because those services were provided by respiratory care practitioners. They contend that services provided were "routine" nursing services and therefore should have been provided within the fees paid for routine nursing care.
- A letter from the Region VIII Medicare office to the Montana Medicare intermediary states:
"In those cases where we did have sufficient information, we determined that the services, which were billed as requiring the skills of a respiratory therapist, in fact, could have been safely and appropriately performed by qualified nursing staff. In most cases the records did not indicate any acute respiratory involvement of such a nature as to require the skills for a respiratory therapist. As you have indicated in your denials this is the only situation under which Medicare reimbursement for respiratory therapy services would be appropriate in skilled nursing facilities."
- Furthermore, Region VIII has suggested that a national policy be prepared and released to ALL skilled nursing facilities and fiscal intermediaries to define what is appropriate billing for respiratory care services in nursing homes. This frightening situation could affect the practice of respiratory care in SNFs across the country.

We need information from you and other members about denials of respiratory care reimbursement in skilled nursing facilities. We are not interested in denials made because of inadequate documentation, but rather denials

made based on what the Medicare intermediary viewed as inappropriate utilization of respiratory care and respiratory care practitioners.

We simply *must* gather information quickly to stake our claim as providers of skilled respiratory care services in SNFs. There is nothing "routine" about respiratory care, and it is incumbent upon us all to provide the documentation and information needed to confront this issue before this thinking spreads beyond the borders of one state.



HANDLING MEDICARE DENIALS FOR SKILLED NURSING FACILITY (SNF) RESPIRATORY CARE

The situation in Montana calls to mind a question about how one does go about filing an appeal when a Medicare Fiscal Intermediary (FI) denies a SNF Respiratory Therapy, Medicare Part A claim for reimbursement based on medical necessity guidelines.

J. Michael Thompson, BS, RRT, RPFT, and Melvin A. Welch Jr., MPH, RRT, are respiratory care practitioners in California who serve as allied health consultants for Blue Cross of California (BCC), one of the FI's for Medicare. "BCC not only reviews claims from CA, but in fact is the FI for a growing number of Providers around the country", according to Welch. They explained the process available to a Provider who disagrees with an initial FI determination that Respiratory Therapy services were not "medically necessary" in a specific patient:

When a medical necessity denial for reimbursement is received from a FI, the provider has 60 days in which to file a request for an appeal for reconsideration. The BCC reviewers recommend that this request include reference to the specific pages in the medical record where the medical necessity for the respiratory care is established and where it is made clear why the skills of an RCP were necessary. Welch gives the following example of where the medical necessity may be clear, but the need for the skills of the RCP may not be: "The medical record may clearly document a patient has COPD, and even that he/she occasionally is a little short of breath and wheezes. But, if the record also documents the patient is stable from a respiratory perspective, and has a history of home use of MDI's and is again discharged home on MDI's...it gets a little difficult to make the case for an RCP to watch the patient use a hand-held

nebulizer (or MDI for that matter) while in the SNF.” “The RT documentation should make it clear why the RCP was involved” added Thompson.

The appeal or “reconsideration”, as it is known, is an independent reevaluation of the facts and findings regarding a claim by a different individual within the FI’s organization. Some Intermediaries have contracts of another Intermediary to perform reconsideration appeals.

“In California, a denial issued by one Medicare reviewer will be revisited by another reviewer with Blue Cross of California,” said Thompson. He explained that this did not appear to be the case in Montana. In that situation, an individual in Utah reviewed the denials and upheld the Montana Intermediary’s decision.

Providers who do not agree with the outcome of the first level of appeal, may file for a second level. “Within 60 days of a upheld denial based on the reconsideration appeal, a provider may ask for a hearing by an Administrative Law Judge,” said Welch. “In order to qualify for this level of appeal, the dollar amount of the denied services must be more than \$100,” said Thompson. He explained that the hearing before an Administrative Law Judge, allows the patient and/or provider to present the reasons that denial should be reversed.

The first step in filing an appeal for a hearing with the judge is to fill out a HCFA-5011A Form. This form is available from any Social Security office.

Welch and Thompson, as allied health consultants for Blue Cross of California, make decisions for reimbursement through Medicare in cases of medical necessity. For Providers who have contracted with BCC, these medical necessity reviews are done by peer review, which the two consultants believe unfortunately may be unique. “For Blue Cross of California, a peer review process is used so that respiratory therapists are reviewing and making decisions on the practices of respiratory therapists, rather than having other health care practitioners making these decisions,” said Thompson. Although there are certainly disagreements over medical necessity even with “peer review”, most would agree that this process is preferable to a non respiratory therapist making the determination about the appropriateness of respiratory care to patients.

Nurses reviewed the cases in Montana.

curing in 47% of patients studied.¹ Indeed, they found that isolation due to communication difficulties was a greater problem than direct airway-related nursing care activities.

Despite the importance to this population, communication is often overlooked until the patient is weaned from the ventilator or becomes a candidate for long term ventilation. In the interim, communication options are both limited and inefficient in meeting the patient’s psychological needs, which can affect the patient’s overall well-being and success in weaning. The ability to communicate can be essential in addressing end-of-life issues and plays a major role in quality of life for long term ventilator patients whose only social outlet may be the ability to communicate. Therefore, achieving the most effective means of communication should be our goal when selecting a communication device.

Non-verbal communication methods that are regularly used for ventilator dependent patients include mouthing words, eye blinking, communication boards, and writing (pen & pencil). These methods are frustrating for both patient and caregivers, as they take considerable skill, effort, and time. Most importantly, these methods do not allow the patient to convey his/her thoughts thoroughly, which can lead to further anxiety.

Talking tracheostomy tubes are a verbal communication option that have been available for many years and are used for those patients who cannot tolerate cuff deflation due to non-compliant lungs, as in severe ARDS. Talking tubes require an outside air source to produce speech, which is achieved by finger-occluding the port of the air source. This, however, may be difficult for very weak patients and impossible for the quadriplegic. Other issues, such as maintenance, humidification of gas source, and cost must be taken into consideration when using these devices as well.

When compliance is not an issue, cuff deflation can be achieved, opening the door to other verbal communication options. Bach and Alba (1990) looked at 104 patients and found that the vast majority with severe respiratory insufficiency and reasonably competent oropharyngeal muscles could be safely and adequately ventilated up to 24-hours a day with their cuffs deflated with appropriate ventilator adjustments.²

“Leak speech” is one method utilizing cuff deflation that has been used on occasion for long term ventilator patients. In this case, the cuff is deflated and the patient forces air out around the tracheostomy tube up through the vocal cords. However, this method requires a great deal of effort and can be fatiguing to the patient. Speech is limited to a few words coordinated with the cycling of the ventilator, with much air lost back through the tracheostomy tube. Length and quality of utterances fall short of the patient’s full capabilities.

One-way speaking valves are an optimal means of communication for ventilator dependent patients. The patented, closed position “no leak” design of the Passy-Muir Speaking Valves has made them the valves of choice for this patient population. The closed position “no leak” means the valves are in a biased closed position at all times except during inspiration, at which time they will open with less than .05 cm H₂O. At the end of inspiration the valves close automatically, restoring a more normal closed respiratory system. In addition, a column of air is created within the tracheostomy



COMMUNICATION FOR VENTILATOR DEPENDENT PATIENTS USING THE PASSY-MUIR TRACHEOSTOMY AND VENTILATOR SPEAKING VALVES

by Sherry Blansfield, RCP, RRT, and David Verreault, RRT

Sherry Blansfield is a Passy-Muir clinical specialist and David Verreault is with Massachusetts General Hospital.

According to Bergbom-Engberg and Haljamaë (1989), the inability to communicate is the main instigator of fear and anxiety in patients during mechanical ventilation, oc-

tube which resists secretions rising up the tube and occluding the valve.

Research-validated benefits of this design include—

- improved voice/speech³
- reduced secretions⁴
- improved swallow with reduced aspiration^{5,6,7}
- restored positive airway pressure (promotes physiologic PEEP, which improves oxygenation and cough)^{4,9}
- faster weaning and decannulation time^{8,9}
- improved infection control and olfaction⁴

There are currently four Passy-Muir Tracheostomy and Ventilator Speaking Valves available, each designed to fit the 15mm hub of any size tracheostomy tube and indicated for in-line ventilator use. The PMV 2000 (clear) and PMV 2001 (purple) Low Profile-Lower Resistance valves, and the PMV 005 (white) valves can be used in-line with flexible, rubber, non-disposable ventilator tubing. The PMV 007 (aqua) valve is designed to fit directly into standard disposable ventilator tubing.

Use of the PMV with ventilator dependent patients requires an understanding of the valve, mechanical ventilation, and respiration. Inappropriate use can result in serious complications. The PMV must be utilized with the tracheostomy tube cuff completely deflated. (If the patient cannot tolerate cuff deflation, the PMV cannot be used and use of a talking tracheostomy tube should be considered.) Prior to cuff deflation, pre-assessment is essential for patient safety and for appropriate ventilator management. Pre-assessment should include cognition, airway patency, swallowing status, work of breathing, secretions, peak inspiratory pressure (PIP), breath sounds (BS), vital signs, and saturation (SaO₂). After cuff deflation, some patients may experience volume loss, as indicated by a decrease in peak inspiratory pressure and subsequent changes in saturations and vital signs. Should PIP decrease, tidal volume (V_T) can be increased to match the PIPs before cuff deflation. Once the PMV is placed in-line, exhaled volumes can be measured by spirometry via the mouth and nose. Accurate exhaled volumes cannot be measured from the ventilator, as exhaled air is redirected through the mouth and nose. The PMV should be placed in-line as close to the tracheostomy tube as comfortably possible to prevent deadspace.

The PMV can be used in most conventional ventilator modes, including A/C, SIMV, CPAP, and pressure support. Many acute care ventilators have a return demand alarm for exhaled volumes. Microprocessor sensors within the ventilator insist upon air return through the ventilator system or an alarm will sound, as no exhaled airflow is detected. These alarms can be adjusted per physician direction to cease unnecessary alarming.

Low volume demand alarms do not necessarily preclude PMV use, as the valve can be worn during therapies when the alarms can be reset manually by the clinician, allowing the patient the opportunity for periods of verbal communication, socialization, and vocal cord strengthening. When the patient has been successfully weaned or changed to another mode of ventilation, or a different ventilator is used, continuous PMV use can be reassessed.

Two sets of alarms are available on most acute care ventilators, the first being the exhaled volume alarms and the second the pressure alarms. If exhaled volume alarms adjust-

ments are needed, the pressure alarms remain intact and should be properly adjusted (set tighter) to alert the clinician to disconnects or increasing pressures with PMV use. Follow the manufacturer's recommendations for ventilator self-testing, as this may relieve unnecessary alarming (e.g., a short EST should be performed with circuit changes on some acute care ventilators).

The PMV restores physiologic PEEP, which may necessitate a decrease in mechanical PEEP. As each patient differs, so will the adjustments needed for each ventilator differ. The PMV can benefit a wide variety of patients, but caution should be taken with those patients who have known airway obstruction, excessive secretions, and/or non-compliant lungs.

Weaning from mechanical ventilation was a benefit noted earlier that can be of great use for those patients that may be able to wean. Frey & Wood (1991) found improved oxygen saturation and greater tolerance for weaning attempts (56%), eventually leading to independent breathing (33%). They also noted subjective reports from patients, who said that breathing was made easier with the device (44%). The saturations in this study improved with all but one patient, who saturated at 100% before and after valve placement.⁸

With further investigation, the PMV may be considered a valuable augmentative weaning tool. The psychological aspects related to the ability to communicate cannot be discounted and warrant closer attention. Issues such as motivation, anxiety, depression, and isolation greatly diminish what we attempt to achieve physically during weaning.

Decannulation time is decreased with the PMV, thereby decreasing the length of time in the ICU and overall length of stay in the hospital. In a randomized decannulation study, Light, Aten, Fischer, and Chiang (1989) found that the median time for decannulation was 18 days with the PMV and 23 days with standard capping, potentially decreasing hospital length of stay by 5 days.⁹

The benefits to be gained from use of the PMV in-line with the ventilator deserve close attention and should be seriously considered with each ventilator dependent patient, regardless of whether that patient is in the ICU or at home. The savings in hospital costs alone (due to decreased nosocomial infections, aspiration pneumonia, weaning, and decannulation) are an incentive to utilize the PMV, and could potentially save thousands of health care dollars. Most importantly, however, are the increased human dignity and enhanced quality of life that result when ventilator patients are able to tell us what's on their minds.

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MULTIDISCIPLINARY CARE: A "WIN-WIN" FOR PATIENTS & CAREGIVERS

by Linda Rhines, RRT

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Subacute respiratory therapy in a skilled nursing facility (SNF) is intensive rehabilitation therapy. Respiratory care practitioners must be committed to delivering one-on-one patient care with an emphasis on patient education and rehabilitation. In order to deliver successful patient outcomes, however, the RCP must also be willing to function within a multidisciplinary team that is focused on what each discipline is trying to accomplish with each patient. The number one goal is to return the patient to the level of functional independence he or she maintained prior to admission to the referring acute care hospital.

In our SNF-based subacute respiratory programs, RCPs are active participants on the patient care team. The process begins by ensuring that each discipline is actively involved in the initial screen and assessment of each patient on admission. This includes nursing, physical therapy (PT), occupational therapy (OT), speech therapy (ST), and respiratory therapy (RT). On admission, the following process is initiated for each patient:

- Patient needs are assessed and addressed on the initial screen.
- Patient functional status, and short and long term goals, are developed into a care plan and are documented on the initial patient evaluation forms.
- Case manager or physician is briefed.
- All necessary orders to treat the patient are obtained to support the activities outlined in the individualized patient care plan.

All members of the patient care team also share charting. Each discipline has its own section of the care plan and may have goals that are unique, but the data is accessible to all caregivers and every effort is made to coordinate rehabilitation activities to ensure the maximum benefit to the patient.

This can be a challenge for the RCP. Unlike many PTs, OTs, and speech therapists, the RCP may cover up to three or four facilities, depending on respiratory therapy requirements at each facility. Since the patient census at each facility includes fewer patients requiring respiratory therapy, the subacute therapist may find him/herself trying to coordinate visits to several in one day, trying to avoid schedule conflicts with PT, OT, and ST in each.

This travel requirement makes it even more important for the RCP to become an active member of the patient care team. Rather than mechanically following orders, or becoming too involved in the mechanics of a treatment or in maintaining technology in use at the bedside, subacute RCPs must actively use their patient assessment skills to ensure that the care they provide fits in with the overall plan of care. This means consulting with allied disciplines to determine if the respiratory care plan outlined for the patient requires adjustment. Will the patient be able to participate in therapy? Can he/she follow commands? What is his/her attention span? Does he/she have an effective cough? Can he/she follow cueing technique? What is his/her level of cognitive function? Can he/she sit up? What are the goals established by speech, OT, and PT? Is the patient progressing in attaining those goals? The list goes on.

The multidisciplinary approach also requires RCPs to play a more active role in coordinating care. The subacute therapist must ask how the activities of other disciplines impact the care delivered by the RCP. For example, if PT or OT has strenuous therapy planned, or if the patient is not progressing in these areas, is the plan for ventilator weaning realistic or should it be adapted to fit the current situation? If speech is working on communication for the ventilator patient, will assistance from the RCP be necessary, or should ventilator settings be adjusted to provide more support? Like the other members of the interdisciplinary team, the RCP in the SNF-based subacute program must constantly assess the patient in terms of how he/she is functioning with respect to the care plan for short and long term goals. This means being flexible in developing and modifying patient care plans to accommodate each patient's individual response to therapy.

Once the patient has progressed and respiratory status has improved, the RCP must assess the patient to determine if a routine level of care can be established. Is the respiratory portion of patient rehabilitation complete, and has the patient achieved the goals? If so, the RCP then communicates this information to nursing via the patient care plan, and nursing assumes responsibility for routine care. (In the skilled nursing facility, respiratory care is considered a skilled service; once routine care is established, nursing takes over.) However, the RCP may still participate in education of family or home caregiver prior to discharge.

While we have had several success stories using the multidisciplinary approach described above, two very special patient histories highlight the benefit to the patient when this team approach is employed.

Patient: G.S. — Admitted 12/26/95, Discharged 3/7/96

An 83-year-old female (G.S.), was admitted after observation and evaluation at the acute care hospital by the nursing and Vencare respiratory team. She suffered from acute respiratory distress, congestive heart failure, acute hypokalemia, and bilateral infiltrates. Upon admission to Anza's subacute unit, the patient was ventilator dependent, had a tracheostomy and g-tube feeding, and was moderate to maximum assist in several functional abilities (i.e., rolling over, supine to sit, sit to stand, body mechanics, and non-ambulatory). G.S. could only communicate via written messages. Through intense training and trials with the help of speech therapy and the Vencare RCP, she later progressed to using a Passy-Muir Speaking Valve. She passed an MBS (modified barium swallow study), and was ultimately discharged to her daughter's home without a ventilator, oxygen, or g-tube, and ambulating with a cane, transferring independently, and communicating verbally.

Patient: K.H. — Admitted 12/4/95, Discharged 1/17/96

A 29-year-old male (K.H.), suffered a severe head injury after a biking accident (he was wearing his helmet!). K.H. underwent a right posterior temporal craniotomy and afterwards was ventilator dependent, had a tracheostomy, and g-tube feeding. K.H. was admitted to Anza's subacute unit after observation and assessment at the acute care hospital by our nursing and Vencare respiratory evaluation team. Upon admission, K.H. was evaluated by our interdisciplinary team. He required a minimum assist of 1-2 persons for all PT skills (bed mobility, sitting, head and trunk control, and transfers). He was without functional communications skills and continued to be ventilator dependent. Nursing and the Vencare RCP began immediate monitoring and managing of the ventilator, while PT and ST began treatments, including training in and the use of a Passy-Muir Speaking Valve. K.H. showed signs of progress within a few weeks of treatment and was rapidly weaned from the ventilator. He was also able to manage oral intake and tolerate PT activities with much less assistance, and was making functional gains significant enough to allow discharge to an acute rehabilitation center for continuation of his rehab goals. K.H. recently returned to Anza for a visit (4/96). He walked in without assistance or any assistive device, talked with everyone, and personally thanked the Anza staff for their part in his remarkable recovery.

T-E-A-M

In our experience, subacute care for the RCP, other members of the multidisciplinary patient care team, and the patient really reflects and reinforces the following management principle:

- Together
- Everyone
- Achieves
- More

BI-LEVEL VENTILATION IN SKILLED NURSING AND SUBACUTE FACILITIES

by Bob McCoy, RRT, RCP

Bob McCoy is executive director of the Minnesota Society for Respiratory Care.

Non-invasive bi-level ventilation is becoming more popular in the subacute setting to prevent or correct respiratory insufficiency and/or failure. This new method of augmented ventilation is gaining acceptance due to its ease of application, low work of breathing for the patient, and a lower cost of equipment needed to provide the service.

Typically, non-invasive bi-level ventilation (NIV) is used to treat COPD, restricted lung disease, and neuromuscular disease. Each of these diseases presents a similar symptom that can be treated with NIV. As a patient begins to hypoventilate, secretions accumulate which cause CO₂ to increase and O₂ to decrease. Prior to the acceptance of NIV, these patients were treated with frequent IPPB, incentive spirometry, and deep breathing and coughing. This was time consuming and fatiguing for both the patient and therapist, and often only delayed the initiation of intubation and ventilation. Now, NIV can be started quickly and comfortably, and begins to break the failure cycle within 12 hours, preventing a more costly and complicated treatment routine.

Skilled nursing facilities

In a SNF, a patient that is presenting respiratory insufficiency leading to respiratory failure can be evaluated by a clinician using good assessment skills. Breath sounds, respiratory rate, heart rate, blood pressure, skin color, and overall appearance are a good first step in determining the severity of the situation. Oximetry and blood gases are useful, yet not critical for the initiation of NIV. Once the clinician has determined that the patient would benefit from NIV, the physician is contacted to order the therapy. If staff and equipment are not available in-house, a DME is contacted for the set up of the equipment and routine monitoring and service.

Prior to the routine use of NIV, a patient that presented a respiratory failure situation in a SNF was treated with oxygen and basic respiratory therapy. If the situation did not improve, he/she would be transferred to the hospital for more aggressive care. Often these situations would get out of control quickly, requiring emergency response and transportation. The patient could go into respiratory arrest and require critical care ventilation and a long weaning process.

With the use of NIV, the SNF is able to eliminate unscheduled emergency care, patient management, and possible loss of a customer. The insurance provider benefits from the elimination of a hospital stay, emergency services, and cost of complications associated with critical care. The patient benefits from the elimination of pain and suffering associated with a respiratory crises and critical care. Good therapy that provides good patient care at lower costs is a strong marketing tool in the competitive extended care facility market.

Subacute facilities

In the subacute facility, there are more options for the re-

sponse to and treatment of respiratory failure. Skilled clinicians and sophisticated equipment are available to treat most respiratory emergencies. However, respiratory failure presents the same symptoms in any location and the diseases are similar, although in the subacute setting, the patient is less stable than in the SNF, and therefore more likely to deteriorate with complications of the disease.

Patient assessment tools are readily available in a subacute setting, yet are not necessary to initiate NIV in all circumstances. Again, clinical assessment using observation skills can be used to begin therapy. Objective tools such as ABGs, oximetry, spirometry, and other devices help to determine the severity of the situation and can be used for tracking outcomes.

NIV has become the first step in responding to a respiratory failure situation. In this controlled situation, the patient, family, and the physician can discuss the treatment course and options. Patients become involved in the treatment of their disease and usually become more compliant as a result, which is important in the success of a mask application. The mask is fitted, the NIV device is set, and the patient is educated on breathing techniques and how to work with the therapy. Once the respiratory failure cycle is broken and the patient begins to feel better, the therapy can be discontinued quickly and easily without a long weaning protocol. The next time the patient begins to develop respiratory failure symptoms, reinitiating the therapy is a simple process because the patient knows what to expect and is more likely to be compliant with the therapy. Using NIV in the subacute setting is also a good proving ground for the therapy, which can continue in the home once the patient is discharged, thus eliminating or minimizing emergency visits that might occur with future respiratory failure symptoms.

The benefits to a subacute facility with NIV are outlined in Tables 1 and 2—

Intubation	NIV
Usually a critical situation	Early intervention, controlled environment
Requires skilled clinician to intubate	RT to do mask placement
Sedation required	Low work of breathing, comfortable
Airway needs to be stabilized, taped	Mask can be removed as necessary
Routine vent and alarm checks	Minimal alarms necessary
Routine suctioning	Patient coughs and clears secretions
Routine blood gases	Routine patient assessment
Weaning protocol	Patient removes mask for short periods
Extubation protocol	Remove mask
Post extubation procedures; possible tracheal damage and infection	Minimal post mask complications
3-10 days on ventilator	1-2 days on ventilator
	Intubation is always an option if necessary

Table 1: Characteristics of intubation versus NIV

Intubation	NIV
\$20,000 ventilator	\$6,000 ventilator
Higher supply costs (humidification & suctioning)	Lower supply costs
Critical care staff to patient ratio of 1:1	Staff to patient ratio of 3+:1

Table 2: Cost comparisons of intubation and NIV

Conclusion

Many SNF and subacute facilities are moving to NIV as a first step in treating respiratory insufficiencies and respiratory failure because of the ease of use, the reduced costs, and the improved outcomes. NIV using simple bi-level ventilators is safe and effective and a good alternative to other forms of therapy to treat respiratory failure.



COMPREHENSIVE DOCUMENTATION OF RESPIRATORY CARE SERVICES IN ALTERNATE CARE SITES

by Brian Stitzinger, RRT

Brian Stitzinger is general manager at Mariner Health Medical Services in Dallas, TX.

RCPs have learned the appropriate technical aspects of respiratory equipment and the appropriate methods to deliver treatment modalities. They have the ability to interpret data and documentation requirements for reimbursement. Now it is time for them to learn how to integrate respiratory care with other disciplines at alternate care sites such as skilled and subacute care facilities. Continued dialogue and interaction within our profession and with other disciplines will assist respiratory care in becoming a member of the multidisciplinary teams involved in medical management and/or rehabilitation in these facilities.

What does all this have to do with documentation? Documentation is one way respiratory care practitioners can justify the medical necessity of their profession and its role in patient care to other disciplines. Documentation is also the method that merges patient care with reimbursement and legal consequences, training and education issues, and progress and outcomes data. Unfortunately, it is also an area where clinicians like RCPs occasionally come up short.

A short review of our history in skilled nursing/subacute care helps explain why. In many respects, we entered the skilled/subacute care arena more as a means to supplement respiratory care department revenues, allocate resources to different cost centers, and gather contracts to increase bed totals than as a means to enhance patient care in skilled sites. Indeed, the one week program aimed at instructing respiratory care managers in the charting and reimbursement techniques for Part A SNF care is common. As a result, skilled RT services and subacute care have become synonymous with Medicare's transfer agreement and any facility that has a patient with pneumonia.

Yet, not everyone or every facility is qualified to provide this type of care in this setting. As a profession, we have moved nicely into hospitals within hospitals, the transitional care units, and specialty hospitals. But further progress will require us to justify and quantify our services, going beyond the regulations that Medicare requires for orders and documentation. As reimbursement starts to change, the

goal is to *integrate* respiratory care into the continuum of care and *demonstrate* our profession's role in the care of these patients.

How does documentation add to our ability to reach that goal and why is documentation important? A greater focus on patient care and, ultimately, outcomes of patient care, is critical to respiratory care's ability to compete in an era of changing reimbursement. Outcomes will be noted by our documentation of therapy and care planning. Data collection that reflects the RCP's role in the patient's care and progress (e.g., showing decreased length of stay due to respiratory services) is vital. Patient assessment techniques should go beyond the norm of auscultation, pulse rate, and cough. A multidisciplinary approach to patient care that incorporates RCPs as team members is achieved through interaction with other disciplines and comprehensive documentation. This integration should be reflected in our documentation, which should be made available not just to other RCPs, but to all care providers along the continuum.

Documentation should include –

- Patient assessment that includes the initial and serial reevaluations. Assess with every treatment.
- Patient education, which includes educating both the patient and other team members.
- Care plans/care maps that change to reflect goals and progress. Understand and coordinate care plans with other team members. Care maps allow practitioners to plan goal-directed therapy on a daily basis and allow for outcomes data.
- Coordination of care and interaction with nurses, physicians, or rehabilitation personnel. Document all communication.
- Diagnostic results of labs and tests. Follow up with physicians for future tests and document your conversation.
- Complete weekly and discharge summaries.
- Ability to perform chart audits to ensure compliance and completeness. Comprehensive and complete charts allow for utilization reviews. Make sure that therapy is medically justified and reasonable.

Proper and complete documentation legitimizes the RCP's role in patient care to other disciplines. In today's world, this is vital for reimbursement, ethics, patient rights, and patient outcomes. Such documentation needs to be available, and its presentation should be meaningful and useful to other disciplines.

RCPs can provide valuable information on the patient's condition and progress that is applicable throughout the continuum of care, from acute hospital to subacute and skilled facilities to home health. The commitment that RCPs bring to alternate care sites will be reflected in comprehensive and quality documentation.

PEDIATRIC SUBACUTE CARE: WHY A BROADER DEFINITION IS NECESSARY

*by Ronald M. Perkin, MD, MA, Daved van Stralen, MD,
Tammy Young, MSN, NP, and Tony Hilton, RN, MPH, CCRN*

Most definitions of subacute care, including the one issued by the Joint Commission on Accreditation of Healthcare Organizations, characterize the setting as one that provides goal-oriented treatment through an interdisciplinary team approach to someone who has had an acute illness, injury, or exacerbation of a disease process. Unfortunately, many of these definitions (including the JCAHO's) limit the provision of these services to inpatient situations and suggest that while the level of care provided there is more intensive than that delivered in the traditional nursing facility, it must be less intensive than that delivered in the acute care hospital. High technology monitoring or complex diagnostic procedures are generally considered outside of the subacute facility's realm of practice as well.

As our experience with subacute care grows, however, some argue that such definitions are far too restrictive. Nowhere are those voices being heard louder than in the area of pediatric subacute care, where patients often are treated outside of a facility, *do* have high technology needs, and must have access to intensive services.

In reality, pediatric subacute care (like its adult counterpart) is identifiable less as a *place* or *site* of care than as a *level* of care characterized by several distinctive and cost-effective features. Through its goal-oriented, team approach, pediatric subacute care aims to minimize acute exacerbations and works to move the patient to a lower level of care in a timely manner. These "levels of care," however, can encompass a constellation of settings, including inpatient services, medical day care, home care, and others.

The shift to subacute care (for appropriate pediatric and adult patients alike) is expected to have a significant impact on respiratory care practitioners, and the reasons are many. First, pulmonary disease represents a major chronic condition. Second, pulmonary patients are frequent users of acute care services. Third, many patients with extended lengths of stay in acute care have a primary or secondary pulmonary condition. And fourth, ventilator-dependent or pulmonary-compromised patients comprise the majority of long-term pulmonary patients. Consequently, RCPs will be in demand in these facilities.

As RCPs make this transition, however, they must realize that the specific site of care should not be decisive in determining whether or not subacute services will be delivered, especially when treating children. Indeed, many of the sickest children are already being treated at home, rather than in an inpatient program, and not just to satisfy a cost-conscious managed care industry pushing for shorter and shorter inpatient stays; this trend also reflects a deeply held belief that home is where children thrive best. Any definition of subacute care that does not include the idea of "alternative settings" surely fails to meet their needs.

**Visit AARC on the Internet—
<http://www.aarc.org>**

**THE UNIFORM REPORTING MANUAL
FOR SUBACUTE AND LONG TERM CARE
RESPIRATORY CARE SERVICES**

by William H. Dubbs, MHA, RRT

William Dubbs is AARC director of management services.

Increasingly, subacute, skilled nursing, rehabilitation, and other health care facilities which provide substantial respiratory care services are competing in a managed care environment. Ensuring staffing efficiency, monitoring utilization data, and benchmarking with similar organizations will be critical in assuring success. To assist managers in these areas, the AARC is currently developing a Respiratory Care Uniform Reporting Manual for subacute and long term care.

This manual will provide managers and facilities with a tool that they can use to track trends in utilization of respiratory care services, determine personnel requirements, and measure demand for and intensity of service. Most importantly, it will provide a foundation for benchmarking performance indicators within the industry.

The manual will contain respiratory care procedures commonly performed in subacute and long term care. Each procedure will be defined and assigned time standards. The manual will also contain appendices to increase its utility to the user. For example, one appendix will guide the user through the computation of workload measurements. Another will provide methodology for establishing valid standard times for procedures not covered in the manual.

To provide a framework for the project, a small panel of experts has been selected from the AARC membership. This group is being assisted by consultants representing the major communities of interest. Together, the small panel and consultants have established methodology and guided the project. Specifically, the panel will assure the validity of the data upon which time standards are based, identify procedures for inclusion in the manual, and ensure that the manual is as "user friendly" as possible.

To validate the contents of the manual, 187 clinical experts, each representing a facility that matches the size and geographic distribution of the population of Medicare-approved free-standing and hospital-based SNFs that provide respiratory care services, are participating in this project. They are responding to a series of surveys that will let the panel know if the procedures included in the manual are commonly performed, if there are commonly performed procedures that were omitted from the manual, and what time standards should be assigned to each procedure.

The project is now in the survey phase, and the manual should be available before the end of the year. Questions about this project may be directed to Bill Dubbs in the AARC Executive Office at 11030 Ables Lane, Dallas, TX 75229, (972) 243-2272, FAX (972) 484-2720.

**Deadlines for submitting copy
for publication in the *Bulletin***

Spring Issue: February 1
Summer Issue: May 1

Fall Issue: August 1
Winter Issue: October 1

**1998 CONGRESS ON INTEGRATED
HEALTH CARE MANAGEMENT**

Mark your calendars now for the Second Annual Congress on Integrated Health Care Management. The June issue of *AARC Times* highlighted several of the presentations from the first Congress, which was held in March 1997, and next year's event promises to be equally informative. Join other health care managers from each of the allied health disciplines in the second Congress, to be held February 5-8, 1998 in Dallas, TX, and take advantage of this opportunity to expand your management skills in a multidisciplinary environment.

The program begins with the keynote address, "Thriving on Change." Multiple concurrent sessions, as well as the general sessions include: "Exploring Discipline Issues," "Building Effective Relationships," "Achieving Clinical Integration," and "Achieving Balance in Life." The Congress provides multiple opportunities for networking in a retreat atmosphere at the Dallas Lakes Hilton. More information on the Congress program may be obtained by calling CLMA at (610) 995-9580 or (202) 543-7971.



**ARCF SILENT AUCTION OFFERS UNPARALLELED
OPPORTUNITY FOR RC MANAGERS**

Attention RCPs! If you're planning to attend the AARC's 43rd International Respiratory Congress this December 6-9 in New Orleans there's a new attraction you won't want to miss. In an effort to raise funds for important projects aimed at improving quality of care for patients and positioning the RCP for success in our changing health care system, the American Respiratory Care Foundation is sponsoring the profession's first-ever Silent Auction.

Thanks to the generous support of the respiratory care industry and others in the respiratory community, the auction will feature items ranging from Las Vegas casino/hotel nights and ski lift passes to Disneyland vacations. Medical equipment to be auctioned off includes items such as capnographs, ventilators, and an oxygen system. You may also want to take advantage of the many New Orleans packages available, including fine dining, cruises, and voodoo tours. Since opening bids on all items have been set at just 25% of estimated retail value, it's a great way to take advantage of a good deal for yourself and/or your department while supporting your profession at the same time.

The auction will run throughout the four-day meeting and all AARC members and officially registered attendees at the meeting are invited to come by Auction Headquarters as often as they like to place and/or raise bids. A preliminary catalog of items published in the October issue of *AARC Times* tells how the bidding process works, and a final catalog with an updated items list will be available onsite. So take a minute to see what's available, then come and join in the fun.

FYI . . .

Editor's Note: FYI... is a regular feature of the Subacute Care Section Bulletin devoted to short news items that may be of interest to members of the section.

Statistics explain the rush to prospective payment for post-acute providers

If you're still wondering why the federal government is in such a rush to come up with a prospective payment system to govern home care and other post-acute care providers, consider the following statistics from the April issue of *Hospitals & Health Networks*—

- The number of Medicare-certified home health agencies increased from 5,700 in 1990 to 9,800 in 1996.
- About 3/5 of the nation's hospitals now operate home health agencies of their own.
- The percentage of Medicare beneficiaries using home care services nearly doubled during the past seven years, from 5.6% to 10.1%.
- Since 1990, the average number of home visits per patient per year jumped by 43, from 33 to 76.
- Spending on home care services climbed from \$3 billion in 1990 to \$16 billion in 1996.
- Total post-acute outlays have grown from \$8.3 billion in 1990 to more than \$30 billion today, and now represent about 1/6 of all Medicare expenses. (Source: *Hospitals & Health Networks*, 4/97)

Memory-impaired patients benefit from new pager designed especially for them

Businessmen and teenagers aren't the only ones who can benefit from the latest in paging technology. A new device called the NeuroPage is helping people with head injuries, strokes, and brain hemorrhages deal with activities of daily living as well.

The compact pager, which can be worn on a belt, sends programmed reminders to patients via an audible alarm or vibration accompanied by a text message, helping them to remember to take medications, keep appointments, turn off appliances, and accomplish other activities that would otherwise be forgotten. Developed by a neuropsychologist and a California engineer, the device was tested by researchers at Cambridge University on 15 people with significant memory problems, most of whom had been unable to work or live on their own.

All of the study participants improved their ability to perform daily tasks, and several showed "a dramatic improvement, from virtually total failure to total success." After

three months, some of the patients had established their own routines and no longer needed to use the device. Others planned to keep their pagers handy long term.

One advantage the pager has over other electronic reminding systems such as small computers or watch alarms, say researchers, is fact that it is considered not just an acceptable, but also a desirable, device in today's culture. "It is not embarrassing for most users and, indeed, would seem to convey prestige," they say. The study was published in the *Journal of Neurology, Neurosurgery, and Psychiatry*. (Source: Reuters Health eLine, 7/2/97)

Medicare HMOs reap undue rewards, says Florida study

The federal government's push to enroll more and more elderly people in Medicare HMOs may be doing more harm than good to the financial status of the system, say results from a new study of enrollment trends among seniors. Researchers from the University of Miami School of Medicine have found that many elderly people in south Florida who are enrolled in Medicare HMOs switch back to the traditional plan once they become seriously ill and need extensive medical care—then switch again when their health is restored.

The study, which was published in the July 17 issue of the *New England Journal of Medicine*, was accompanied by an editorial suggesting that Medicare HMOs are reaping undue rewards from this trend. Since Medicare HMOs enroll more than their share of the healthier Medicare population but have premiums that are pegged to the average cost of the fee-for-service system, which cares for most of the sick patients, says Executive Editor Marcia Angell, they are "doubly rewarded."

Even if Congress makes good on promises to reduce the reimbursement for HMOs from its current 95% of the average cost of providing medical care for an elderly person to 90%, says Angell, it may not be enough to even out the differences that currently exist. A recent government study showing that the costs of caring for Medicare patients in an HMO were 12% higher than those in the traditional, fee-for-service plan raises further concerns about discrepancies between the two forms of coverage. (Source: Reuters, 7/16/97)

Coming soon to an organization near you: ORYX is on the way

ORYX: The Next Evolution in Accreditation may sound like a title for the latest holiday blockbuster, but health care organizations are soon to find out differently. In keeping with its ongoing efforts to redefine the accreditation process, the Joint Commission on Accreditation of Healthcare Organizations will soon be requiring all organizations

to provide objective feedback about their performance to the Joint Commission that can be used “internally to support performance improvement activities and externally to demonstrate accountability to the public and other purchasers, payers, and stakeholders.” The Joint Commission plans to integrate the data into its triennial onsite survey process, allowing for what it has termed a more “credible, objective, consistent, and useful” survey.

Long term care facilities will be the first to come under the new requirements, followed shortly thereafter by hospitals. By the end of December, all accredited long term care organizations are going to be asked to—

- choose a performance measurement system from among 60 such systems that have been approved by the Joint Commission and;
- select at least two clinical indicators from that system that relate to at least 20% of their patient population

—then report both to the JCAHO. Organizations must begin submitting data to the Joint Commission no later than the first quarter of 1999, and continue to submit data on a quarterly basis thereafter. For more information on the ORYX initiative, visit the Joint Commission’s website at <http://www.jcaho.com>. (Source: JCAHO)

Doctoral student receives grant to study subacute care

Shu-Chuan Jennifer Yeh, a doctoral student at the Medical College of Virginia in Richmond, was recently selected to receive one of six Health Care Financing Administration Dissertation Fellowship Grants of up to \$20,000 each to support dissertation research in the area of subacute care. Specifically, Yeh will use trend analysis to measure the recent growth of subacute care in skilled nursing facilities and develop hypotheses to explain the level of subacute care provided in SNFs. (Source: *HCEA Health Watch*, 6/97)

New guide designed to assist organizations in preparing for ORYX

The Joint Commission on Accreditation of Healthcare Organizations has published a new guide called *Using Outcomes to Improve Performance in Long Term Care and Subacute Care Settings* that is being billed as “a roadmap for organizations striving to improve resident outcomes and the quality of services.” The guide is designed to assist organizations in preparing for the ORYX initiative, which will require all accredited long term care organizations to choose a performance measurement system and at least two clinical indicators from that system by the end of December. (See previous article.) The book includes concepts and methods aimed at helping long term care and subacute organizations—

- establish outcomes-based performance improvement programs.
- design outcomes measurement projects.
- collect and manage outcomes data.
- measure and assess outcomes.
- assess and improve key processes.
- communicate findings to internal and external customers.

To order the guide (\$45), call the Joint Commission’s Customer Service Center at (630) 792-5800 and use order code LTC-300. (Source: JCAHO)

Marianna Kern Grachek appointed executive director of Long Term Care Accreditation Services at the JCAHO

Marianna Kern Grachek, RN, MSN, NHA, is the new executive director of Long Term Care Accreditation Services at the Joint Commission on Accreditation of Healthcare Organizations. A 20-year veteran of the long term care field, Grachek was previously the Joint Commission’s associate director for Long Term Care Accreditation Services. In her new position she will oversee all accreditation activities related to long term care services, including the development of standards and survey processes. (Source: JCAHO)

Book reviewer wanted!

Respiratory Care Journal needs an individual with an interest in subacute care to review a recently published book on subacute care by Laura Hyatt, president of Hyatt Associates in Los Angeles, CA. *Subacute Care—Redefining Healthcare*, is a 230-page book outlining the subacute care industry and its development over the past decade. If you are interested in taking on this assignment, contact Kris Williams in the AARC Office, (972) 243-2272, FAX (972) 484-2720.

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JCAHO ACCREDITATION VISIT REPORT FORM

The following survey form is provided to enable the reporting of recent JCAHO accreditation site visits. Compiled results will be published regularly through select section newsletters and the *AARC Times*. Please return your completed survey to:

William H. Dubbs, MHA, RRT
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11030 Ables Lane
Dallas, TX 75229-4593
Phone # (972) 243-2272 Fax # (972) 484-2720

Name: _____

Facility: _____

Address: _____

Phone: _____

If you are willing to discuss your accreditation visit with others check this box and this information will be added to a list that is available to AARC members. If you do not check the box your response will remain anonymous.

Inspection Date: _____

Please check the type of accreditation visit you are reporting:

Pathology & Clinical Laboratory Services

Home Care

Hospitals

Long Term Care

What was the surveyors' focus during your last site visit?

What areas were cited as being exemplary?

What suggestions were made by the surveyors?

What changes have you made to improve compliance with the guidelines?

Please offer any additional comments about the site visit that will be helpful to others. (use additional sheet if necessary)

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