Subacute Care Bulletin

Jan./Feb. '02

American Association for Respiratory Care

Notes from the Chair

by Carol C. Dague, BS, RRT

It is with great excitement that I accepted the position of chair for the Subacute Care Section of the AARC for 2002. As respiratory care practitioners in the post-acute care segment of the industry, we are in the most dynamic and evolving environment ever. Increasing demand for respiratory care services, the changing regulatory climate, and increased expectation to maintain the highest level of professional integrity have thrust us into the forefront of post-acute care. From the skilled and long-term care segment, to post-acute rehabilitation, to long-term acute care, the respiratory care practitioner is clearly associated with provision of quality health care services.

The section's focus for 2002 will include:

• Increasing awareness of opportunities for respiratory care practitioners in the post-acute care environment.

• Education of respiratory care practitioners in regulatory changes that affect both practice and payment for respiratory care services in the post-acute care environment.

• Exploration of department design and function for efficient, cost-effective delivery of respiratory care services in the post-acute care environment.

• Integration of the post-acute care environment into the respiratory care education process.

• Effective medical direction in the post-acute care environment.

As members of the Subacute Care Section, your input and recommendations will be essential in addressing these areas. I look forward to working with each one of you during the coming year. Please do not hesitate to contact me with suggestions, recommendations, and comments. ■

Are the New Kids Back?

by David Ellis, BA, RRT

When compared to nursing or physical therapy, respiratory therapists have been "the new people on the block" in the subacute care and nursing home business. Many in these other disciplines, who have practiced long-term care well before us, are still asking where we fit into the whole scheme of things in their industry. Since there is so much variability in our role in many facilities, that's certainly understandable. Some use us extensively, while others see no need for RT at all. In one facility, we may be used in the ventilator unit only, while in another we just provide therapeutics on the floors. Others still are glad to have us there because we offer special skills. Some are just glad to see us because we can relieve them of the respiratory therapeutic responsibilities. Most importantly, there are still those that have been uncomfortable relinquishing their traditional nursing home responsibilities to RT.

In the past, there were some creative RTs out there who saw a lucrative future in this market for respiratory care. We took the ball and ran with it. Later, as the financial market changed, RTs were seen as a major cost liability to administrators. As many jobs dried up, they had to find other work. This whole sequence of events reminds me of the "striking while the fire is hot" adage. But we did so while expecting the mentality of the whole nursing home/subacute care industry to change simply because we happened to show up. We proceeded to enter this market so "fast and furious" that these facilities, as well as their financial payer sources, didn't have time to prepare or deal with it.

Rather than moving slowly and methodically into subacute care as a profession, we exploded into the industry and hit the ground running. In some cases we were welcomed, but not always with open arms. By moving so quickly, could we have shot ourselves in the foot? There were views that surfaced such as, "We were here first" "This is our industry" and "RTs were allowed here to enhance care when we needed them, but were not to be so opportunistic or encroaching."

The prospective payment system was new and confusing, causing many nursing home disciplines to review their service roles. It was a matter of financial survival. As fraudulent claims were exposed, some in the government and in the nursing home industry became skeptical about the role of ancillary services and concerned about the bad press received by a few irresponsible respiratory care practitioners or companies that were abusing the system. This has not been fair to those of us who have tried to live up to the AARC Standards of Conduct and the proud distinction of calling ourselves respiratory care practitioners. Nevertheless, we got a bad rap.

Should we blame administrators from disassociating themselves from RT services when the

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practices of a few were under scrutiny from the government? Many facilities, with the looming PPS regulations, absorbed RT care, even though our services, being well-researched, were of such great benefit to this resident population. As a result, little has been done by the Centers for Medicare and Medicaid Services (CMS) to include respiratory care into the fold, except for a few changes in RUG rates. I don't blame the government for posturing on the side of caution when it comes to RT reimbursement. In our state, the Local Medical Review Policy (LMRP) was written to limit the scope of RT care in nursing homes. Some states have LMRPs that are more inclusive.

It has been exciting for RT to see another role away from the pressures of the hospital DRG world. But I encourage all those in this subacute care specialty to step back and ponder the following questions: How do we gracefully become an *integral* part of that community? Do we see ourselves as providing quality therapeutics or enhancing our professional role through resident assessment, therapeutic evaluation, and nurse education? Has PPS been all that bad? (In our facility, the respiratory role certainly outweighed the cost.) Even though the Muse Study has clearly demonstrated the effectiveness of RTs in this community, how do we, as RTs on the front line, become the needed and appropriate subacute care players to the other disciplines, to administrators, and to CMS?

I invite others to contribute their thoughts by agreeing with or challenging the comments put forth in this article. It is not my intent to claim the only view on these matters, but to encourage open debate so that, together, we can arrive at the better common good and continue to provide our special form of compassionate care to those who need it. ■

One of Our Greatest Success Stories

by Kathy Kelley, LPN, subacute coordinator, Banner Health

On March 22, 2001, Kenneth Kauffman, a strong, active farmer in our community and father-in-law to one our staff nurses, was seriously injured in a motor vehicle accident. He sustained multiple extremity fractures, including left intertrochanteric fracture; left femoral shaft fracture; right radius and ulna fractures; left proximal humerus fracture; and ruptured spleen, with splenectomy; as well as fracture-dislocation of his right ankle. After a stay in ICU and acute care, Ken was transferred to our facility on April 3, 2001 to be closer to his family, friends, and home.

When Ken arrived on our unit, he was totally non-weight bearing and had only limited use of his right hand. The left arm and hand were immobilized completely.

Our physical therapists, occupational therapist, and OTA began work immediately. Initially, therapy was limited due to his many injuries; however, Ken was always ready to participate in his treatment. As you might imagine, therapy was often painful and many times grueling. But Ken never complained and always had a thank-you for the staff.

Ken progressed from bed mobility training to gradually being an active participant. After many weeks of intensive physical therapy, we began to see progress that pleased us all, especially Ken.

Ken's respiratory needs, which were handled by RTs Dona Kirkendall and Diana Jenkins, included oxygen at 3l/m, Albuterol neb treatments Qid, IS qid, and frequent saturation checks. He was very dyspneic with any exertion, anxious, and had rhonchi and diminished breath sounds with a very weak cough. By April 6, however, Ken required oxygen only at night. On April l4, he no longer needed oxygen. He was soon dismissed from respiratory services.

The weeks passed and activity slowly increased for Ken. During this time, Steve, one of the staff nurses, spent a great deal of time with Ken, and would even accompany him home on a day pass from time to time to attend birthdays, graduations, and confirmations. I'm convinced he played an important role in Ken's progress, as did family members and friends who visited regularly and without restriction.

As time passed by, Ken went from non-weight bearing status to partial weight bearing status and was graduated to a walker as prescribed. After a period of three months, and a few set backs, such as a P.E and pneumonia, Ken left our facility to celebrate Father's Day at home with a very grateful family. ■

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11030 Ables Lane
Dallas, TX 75229-4593
(972) 243-2272
FAX (972) 484-2720
e-mail: info@aarc.org

Debbie Bunch
Bulletin managing editor

Edwards Printing
Bulletin typesetting

Section Chair
To be appointed

Medical Advisor
Terence Carey, MD
(918) 481-8100

FYI . . .

Tool identifies low-risk residents

Researchers in Missouri have designed a new tool that they believe will allow nursing homes to better determine which patients with lower respiratory infection are at low risk for death and thus may be treated safely without transferring them to a hospital. The study, which was funded in part by the Agency for Healthcare Research and Quality (AHRQ), was published in the November 21 issue of the Journal of the American Medical Association.

The work builds earlier research funded by AHRQ and conducted by the Patient Outcomes Research Team (PORT) on Community-Acquired Pneumonia. PORT developed and validated the Pneumonia Severity Index (PSI), which is used to identify pneumonia patients living in the community who can be treated safely at home. Because the PSI assigns higher risk based on age and other variables common to elderly people, it predisposes most nursing home residents with respiratory conditions to hospitalization, whether or not their condition actually warrants it.

To make the new tool more sensitive to residents of nursing facilities, the researchers gave more weight to variables such as activities of daily living (ADLs), mood decline, and markers of poor nutritional status.

The researchers caution that since all facilities in the study were in central or eastern Missouri, the tool will have to be validated in other states, where factors affecting mortality may be different.

Quality indicators segue into protocols

In the 1990s, the University of Wisconsin-Madison Center for Health Systems Research and Analysis (CHSRA) began developing indicators for the Health Care Financing Administration (HCFA) aimed at assessing nursing home care quality. Now the Centers for Medicare and Medicaid Services (formerly HCFA), is using the indicators as the basis for a second-generation set of quality mechanisms that would apply not only to nursing homes, but also to other settings, such as post-acute care. As part of the new work, CHSRA has developed specific protocols that nursing homes can use to review individual care areas. The protocols detail investigative and follow-up guidelines for each quality indicator.

Psychotropic drug use in nursing homes

Psychotropic drug use in nursing homes is not

as pervasive a problem as critics have claimed. According to a final inspection report released late last year by the Office of the Inspector General (OIG), these drugs are generally being used appropriately. Where problems do exist, they are most often related to inappropriate dosage, chronic use, a lack of documented benefit to the resident, and unnecessary duplicate drug therapy. Lack of adequate documentation for residents' psychotropic drug use was also noted in the report.

The OIG suggests that the Centers for Medicare and Medicaid Services consider educating providers to better document the use of these drugs. The inspection was conducted in response to concerns expressed by the Senate Special Committee on Aging about the use of psychotropic drugs as inappropriate chemical restraints.

Adverse drug reactions common in the elderly

A new study from Canadian researchers has found that about 10% of 283 emergency department visits of people 65 years and older were directly related to an adverse drug reaction, and 30% of the patients had potential adverse drug interactions.

The five most frequently found potential adverse drug interactions noted in the study involved the following medications:

- Furosemide and digoxin potentially leading to electrolyte disturbances and arrhythmia.
- Salicylic acid interfering with the antihypertensive effect of beta-blockers by inhibiting renal prostaglandins.
- Salicylic acid decreasing insulin requirements.
- Enalapril and potassium supplements predisposing electrolyte imbalances and arrhythmia.
- Acetaminophen increasing the anticoagulant effect of warfarin. ■

CD-ROM Addresses End-of-Life Issues

A new CD-ROM developed at Michigan State University is helping people with advanced illnesses address the important issues they face as they approach the end of life.

The resource, "Completing a Life," is divided into three main content areas:

- Taking Charge: staying active in decisions about health care, family, and everyday living.
- Finding Comfort: easing pain and suffering, and living with dignity at this time of life.
- Reaching Closure: coming to terms with the past, present, and future, and exploring the possibilities for spiritual growth.

A Personal Stories section also features the real-life narratives of people who have confronted terminal illness. To find out more about the CD-ROM, go to: http://www.completingalife.msu.edu. ■

HHS Invests $50 Million to Improve Patient Safety

HHS Secretary Tommy G. Thompson has released $50 million to fund 94 new research grants, contracts, and other projects to reduce medical errors and improve patient safety. The initiative represents the federal government's largest single investment to address the estimated 44,000 to 98,000 patient deaths related to medical errors each year.

The six major categories of awards include:

Supporting Demonstration Projects to Report Medical Errors Data: These activities include 24 projects to study different methods of collecting data on errors or analyzing data that are already collected to identify factors that put patients at risk of medical errors.

Using Computers and Information Technology to Prevent Medical Errors: These activities include 22 projects to develop and test the use of computers and information technology to reduce medical errors, improve patient safety, and improve quality of care.

Understanding the Impact of Working Conditions on Patient Safety: These activities include eight projects to examine how staffing, fatigue, stress, sleep deprivation, and other factors can lead to errors.

Developing Innovative Approaches to Improving Patient Safety: These activities include 23 projects to research and develop innovative approaches to improving patient safety at health care facilities and organizations in geographically diverse locations across the country.

Disseminating Research Results: These activities include seven projects to help educate clinicians and others about the results of patient safety research.

Additional Patient Safety Research Initiatives: The remaining projects will cover other patient safety research activities, including supporting meetings of state and local officials to advance local patient safety initiatives and assessing the feasibility of implementing a patient safety improvement corps. ■

Study Highlights Medication Problems

A new study from the Agency for Healthcare Research and Quality (AHRQ) highlights the problem of inappropriate prescribing in elderly patients in the United States. According to the findings, which were published in a recent issue of *JAMA*, about one fifth of the approximately 32 million elderly Americans not living in nursing homes in 1996 used at least one or more of 33 prescription medicines considered potentially inappropriate. Nearly one million elderly used at least one of 11 medications which a panel of geriatric medicine and pharmacy experts advising the researchers agreed should always be avoided in the elderly. These 11 medications include long-acting benzodiazapines, sedative or hypnotic agents, long-acting oral hypoglycemics, analgesics, antiemetics, and gastrointestinal antispasmodics. ■

Missed Opportunities

Investigators from the Minneapolis Veterans Affairs Medical Center believe health care providers are not making the most of their opportunities to give influenza and pneumococcal vaccinations to their elderly and high-risk patients. In a study published in the December 10 issue of the *Archives of Internal Medicine*, they found that of 1,874 doctors responding to a survey, approximately one in seven generalists and one in four subspecialists failed to very strongly recommend flu shots to their elderly patients. Since more than 60% of all elderly persons receive their flu shots at the doctor's office, they believe that doctors need to do a better job of making the most of the immunization opportunities that occur on a daily basis. ■

Get It on the Web

Want the latest news from the section in the quickest manner possible? Then access the *Bulletin* on the Internet! If you are a section member and an Internet user, you can get your section newsletter a week and a half to two weeks earlier than you would get it in the mail by going to your section homepage at: http://www.aarc.org/sections/section_index.html. You can either read the *Bulletin* online or print out a copy for later.

The AARC is encouraging all section members who use the Internet to opt for the electronic version of the *Bulletin* over the mailed version. Not only will you get the newsletter faster, you will be helping to save the AARC money through reduced printing and mailing costs. These funds can then be applied to other important programs and projects, such as ensuring effective representation for RTs on Capitol Hill.

To change your option to the electronic section *Bulletin*, send an email to: mendoza@aarc.org. ■

JCAHO Accreditation Report

The AARC is currently seeking information on JCAHO accreditation site visits. Please use the following form to share information from your latest site visit with your colleagues in the Association. The information will be posted immediately on the AARC web site at http://www.aarc.org/members_area/resources/jcaho.html and will also be featured in the *Bulletin*.

Accreditation visit you are reporting (choose one):

❏ Home Care
❏ Hospital
❏ Long Term Care
❏ Pathology & Clinical Laboratory Services

Inspection Date:_____

Facility Name: _____

Contact: _____
(Please provide name and e-mail address.)

1. What was the surveyors' focus during your site visit?_____

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2. What areas were cited as being exemplary?

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3. What suggestions were made by the surveyors?

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

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Mail or fax your form to:
William Dubbs, RRT
AARC Associate Executive Director
11030 Ables Lane
Dallas, TX 75229-4593
FAX (972) 484-2720

Additional comments:

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