Subacute Care Bulletin
July/August '99

American Association for Respiratory Care

Notes from the Chair

by Becky Mabry

As I write this column in early summer, the AARC is continuing to pursue legislative solutions to the problems that the new prospective payment system (PPS) has created for respiratory therapists working in the skilled nursing and subacute settings. The Association has participated in several meetings with Health Care Financing Administration officials and is working with related groups and organizations to ensure adequate coverage for our services in these settings. This activity has the potential to improve the current subacute care situation, both for respiratory patients and the respiratory therapists who care for them.

In this issue, Patricia Budo, LCSW, NHA, and Patricia King, RN, BSHCS, of Totally Kids Specialty Healthcare in Loma Linda, CA, share their strategies for implementing a successful pediatric subacute program. Their insights into providing care for this special population should prove interesting reading for all concerned.

The subacute section is still in need of guest editors for the *Bulletin*. Anyone interested in participating, either by authoring an article or by serving as guest editor, can contact me at rmabry1056@aol.com. ■

Strategies for Pediatric Subacute Care

by Patricia Budo, LCSW, NHA, and Patricia King, RN, BSHCS

Totally Kids Specialty Healthcare is a free-standing, solely pediatric subacute facility located in Loma Linda, CA. The facility has been providing pediatric subacute care since October, 1994. Totally Kids encourages a multidisciplinary approach to patient care for technology-dependent children, many of whom are ventilator dependent.

The programs focuses on enriching the health and quality of life of technology dependent and medically fragile children of all ages. We strive to meet their needs medically, developmentally, socially, and psychologically, while providing support and education to their families. Totally Kids encourages the greatest possible family involvement and participation in care.

Totally Kids currently serves approximately 40 children ranging in age from six months to 20 years. The majority of these children present with complex medical problems, including multi-system failure, ventilator dependency, tracheostomy dependency, gastrostomy dependency, neurologic insults, post-organ transplants, and metabolic disorders. The facility also serves children whose primary need is for rehabilitation services but who cannot yet tolerate the intensity of an acute rehabilitation program.

Totally Kids provides both transitional and long-term care. Children receiving transitional care are discharged to the family home, to foster homes, or to acute rehabilitation programs. Children receiving long-term care are those who require intensive nursing care and whose families are not able to care for them at home due to a variety of reasons.

Although Totally Kids has contracts with a number of HMOs, the primary funding source for the facility is the California Medicaid program, known as Medi-Cal. The initial Medi-Cal rate was established using the rate for adult subacute programs as a base and adding on projected costs for additional

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requirements related to the pediatric program. It was grossly inadequate to provide services at the level expected by the Department of Health Services (DHS). After nearly three years of effort by Totally Kids, the DHS finally increased the Medi-Cal rate to cover the cost of the program. Extensive education and negotiation is required to arrive at contracted rates that provide adequate reimbursement from third-party payors.

Chief considerations

Over the last five years, we have developed strategies for pediatric subacute care programs that we believe will benefit other clinicians practicing in this new field.

When situating and designing pediatric subacute programs, we believe that it is essential for the pediatric subacute facility be located in close proximity to a pediatric tertiary care center. It is our experience that when a child's condition becomes unstable and readmission to the acute hospital is necessary, the child is most often admitted to an intensive care unit, not the acute care ward. It is critical that such a unit be available within minutes of the facility.

To appropriately serve the medically complex pediatric population, the facility must have easy access to a wide range of pediatric specialists as well. Close proximity to a pediatric tertiary care center makes it easier to access the requisite physician staff. These physicians are often only available through such a center. In addition, the primary referral sources for pediatric subacute facilities such as Totally Kids are the discharge planners and case managers from pediatric tertiary care centers. The facility's proximity to several of these centers facilitates referrals and admissions.

A pediatric subacute program has space issues related to equipment, supplies, resident needs, and family needs. The medical equipment required by each child served in our facility takes significant space. We often find that a room licensed for three children can only accommodate two children and their required equipment. Because Totally Kids has an in-house public school program, we have also had to dedicate space for a classroom.

Pediatric subacute facilities must be prepared to deal with the issue of extended visitation by family members. To meet the needs of families who come from a wide geographic area encompassing Southern California and Nevada, we have established our Kids 4 Ever house. This home, which is located directly behind the facility, is available to families for overnight stays.

To provide appropriate respiratory services in the facility, a properly designed medical gas system is essential. Piped O_2 and medical grade air sources must be available by each bed and in areas where residents will spend the day. Pediatric care places great demands on this system, so sufficient capacity and an easily expandable design are important considerations.

Regularly used medical equipment in our facility includes apnea monitors, oxygen saturation monitors, feeding pumps, IV pumps, and ventilators. Comprehensive plans to manage the equipment and ensure proper testing and maintenance are critical. Respiratory therapists are essential to equipment requirements planning. The respiratory therapist is an integral part of the patient care team.

Key relationships

Totally Kids Specialty Healthcare has developed effective working relationships with local agencies serving children with disabilities, with child protective services agencies, and with our state and local legislators. All of these relationships have been critical to our success as a pediatric subacute facility.

Agencies serving children with disabilities serve as a major referral source for children served in the facility. They also play a significant role in providing support to families and in coordinating resident discharges. One of the agencies we work with also supported the facility financially by providing supplemental funding during the period when the Medi-Cal rate failed to cover the cost of all required services and by providing funds to cover start-up costs.

The pediatric subacute program in California exists only because state and local legislators took the initiative to establish the program when the DHS was unwilling to act. Legislators have also been critical in our efforts to secure an adequate Medi-Cal rate. As a result of our efforts to educate and involve legislators, they now view the program as a positive approach to reducing health care costs for the State of California.

Marketing the program

"Wow, we thought you only did long-term care!" We hear this comment over and over again from pediatric nurses, case managers, and physicians who have just found out about the full scope of services provided by our pediatric subacute facility. Indeed, we usually find an initial mindset among our referral sources that pediatric subacute care is actually SNF care.

Education holds the key to changing those mindsets and increasing

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appropriate referrals. We have successfully educated our referral sources by:

- Providing tours and luncheons at our facility
- Requiring case managers and marketing staff to take active roles in local meetings advocating for continuity of care
- Taking the show on the road
- Sponsoring booths at pediatric-related symposiums
- Getting published

Acquiring a contract is the ultimate goal of all marketing activities. All marketing and community relations activities should support this goal. We have adopted the following marketing strategies, which are beginning to pay off with increased census and higher reimbursement rates:

- Get accredited!
- Educate the front line case managers
- Go straight to the top
- Talk to the medical directors of third party payors

Chronic intensive care

One important way to educate these sources and others is to ensure that they correctly understand the term, "subacute care." We have found that the word "subacute" can be misleading, as it implies a lower level of care than that delivered by the acute care hospital. Actually, the subacute arena requires intensive monitoring and the ability to provide urgent, acute intervention when necessary. That's why children who are transferred from our facility to the acute hospital are admitted to the intensive care unit for intensive intervention; acute care intervention has already been provided in the subacute facility.

Totally Kids has developed a strong interdisciplinary team to provide this intervention, and required staffing hours per patient day often exceed those required in an adult subacute facility. Totally Kids currently staffs as follows:

RN/LVN: 6.5 hrs. ppd.
CNA: 5.0 hrs. ppd.
RCP: 2.5 hrs. ppd.

Interdisciplinary shift reports are used to ensure continuity of care and monitoring. The program includes clinical ladders and staff benefits to enhance employment and professional growth.

Hybrid training

In order for staff to maintain a high level of care, extensive orientation and an ongoing education program are a must. Staff education programs should be designed to encourage professional growth and critical thinking skills. The ultimate bedside caregiver is one who uses critical care skills in the context of home health. Mentorship of employees and open communication reinforces respect for the bedside caregiver. This is especially important in the pediatric subacute setting due to the many unique clinical disciplines whose skills are essential to program success.

Protocols and standards

Protocols and standards provide caregivers with a supportive, as opposed to punitive, framework in which to provide indicated medical, nursing, and respiratory care. Staff development and participation in quality improvement projects enhances outcomes measurements.

In our facility, bedside staff rotate into quality improvement projects to ensure that such projects support the ability of staff to provide care. These projects are designed for optimal care, not optimal protection of the facility.

Determining the population your facility can serve is essential. This is governed to some extent by subacute regulation admission criteria. At Totally Kids, an interdisciplinary admission team reviews all referrals to evaluate appropriateness for admission to our facility. Criteria to be considered in this process are:

- Child's needs
- Parent's needs
- Cost of care
- Physician availability

United we stand

At Totally Kids Specialty Healthcare, we have found that dedication to providing the best possible care for these children has united the staff and allowed for significant participation by all disciplines – especially the respiratory therapist. ■

FYI . . .

PPS means longer hospital stays for some

Elderly patients with complex medical needs who would have been transferred to an appropriate skilled nursing or subacute facility last year are lingering in acute care hospitals this year because payments under the government's new prospective payment system are too low to cover their care in a post-acute setting. In a recent article in the *Wall Street Journal*, the following accounts illustrated the problem:

- A patient in Seattle who had had a below the knee amputation was sent to a skilled nursing facility for six days. The facility had to cover the cost of his prosthetic device – $3,750. Total reimbursement for the stay (including coverage for the device) under PPS amounted to $1,830.
- A Wisconsin nursing home closed its ventilator care unit to new patients after PPS went into effect because daily payment for these patients amounted to just $170. True costs are two or three times that amount. Local hospitals now have to transfer their ventilator patients to a facility 100 miles away.
- Two hospitals in the same Delaware system used to have between 25 and 30 Medicare patients awaiting transfer to a skilled nursing facility at any one time, and they usually waited for no more than a day or two before being placed. Since PPS that number has skyrocketed to 80 and the wait for placement can take weeks.
- A Washington state hospital found that the only way it could convince a nursing home to take a patient on an expensive antibiotic was to agree to pay for the antibiotic itself. Reimbursement rates under PPS would not have been sufficient for the nursing home to pay for the drug. (Wall Street Journal)

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Personal accounts support legislative reforms

The American Health Care Association (AHCA) is supporting the Medicare Rehabilitation Benefit Improvement Act of 1999, introduced in Congress by Reps. Richard Burr (R-NC), Ben Cardin (D-MD), Jim McCrery (R-LA), and Frank Pallone (D-PA) last spring. The bill would give qualified Medicare beneficiaries needed relief from the $1,500 per year cap on therapy services, a positive step toward providing beneficiaries access to rehabilitative therapy.

As part of its promotion of this legislation, AHCA released the following accounts of actual patients who are suffering under the current $1,500 cap:

- A.S. is an 87-year old female who was admitted to an Alzheimer's Care unit on February 3, 1998. On December 29, 1998, she suffered a severe stroke that left her with significant right-sided weakness, inability to speak, inability to walk, swallowing difficulties, and a total loss of her independence. She required total assistance to get in/out of the bed and wheelchair, bathe, dress, use the toilet, drink, walk, and move about the unit in her wheelchair, and was unable to effectively make her needs known. Physical, occupational and speech therapies started in January of 1999. A.S. received approximately four weeks of therapy and was making progress – i.e., regaining self-feeding, speaking, and walking skills, and some ability to do simple things for herself. Just as she was on the verge of functional recovery, she was discharged from all therapy services as her Medicare B funding was used up. There was no funding available to her to continue receiving services that would allow her to return to the highest level of independent functioning possible.
- F. is an active 81-year old resident who underwent orthopedic surgery. Post-surgery complications resulted in a below-knee amputation. Following the amputation, F. underwent therapy to prepare for a prosthetic fitting. The cost of this therapy is $1,500 a month, and F. met his cap in the first 30 days. F. is now struggling to find alternative means to pay for this vital therapy.
- T.C. had a stroke years ago. She has a problem with obesity and had frequent falls due to being unable to stand more than several seconds. She's alert, aware, and tries to be communicative, but can't tell staff when she needs to sit down. Her legs just buckle. Physical therapy was working on getting her to stand for lengths of time. They had her up to two minutes standing, and she could now tell the nurses that she was going to sit. Speech therapy was working on word separation, slowing, and getting her to articulate. T.C. met her cap on January 28th. She will be without therapy for the rest of the year.
- E. suffered a stoke last year and now has some dementia as well as dysphasia. She was receiving physical therapy and was walking up to 75 feet with a rolling walker. She met her cap on February 4th. E. cannot walk without supervision and a walker. She can no longer support her own weight, and she doesn't leave her room except when staff wheel her to recreational activities. (American Health Care Association)

Nursing home stakeholders agree

Despite appearances to the contrary, nursing home advocates, administrators, regulators, ombudsmen, and nursing service directors agree on the three most important yardsticks for measuring how good a job the nation's nursing homes are doing. According to a new study sponsored by the Agency for Health Care Policy and Research (AHCPR) these five nursing home "stakeholder" groups believe quality of care, quality of life, and residents' rights are the most important aspects among a group of 17 indicators typically used to measure nursing home quality.

The study, which was conducted at the University of California, San Francisco's School of Nursing, found that 89% of the stakeholders ranked quality of care among the three top categories, nearly 88% placed quality of life there, and about 75% put residents' rights among the top three.

Although the stakeholders agreed on the three most important categories for measuring quality, however, they differed in how they thought each should be ranked. Nursing home advocates and nursing directors tended to give quality of care the highest ranking, whereas administrators and state licensing and certification survey agency training coordinators were more likely to pick quality of life as the most important category. State nursing home ombudsmen generally chose residents' rights as the most important. (American Journal of Medical Quality, May-June 1999) ■