Subacute Care Bulletin
March/April '02

American Association for Respiratory Care

Notes from the Chair: *Thoughts at 31,000 Feet*

by Carol C. Dague, BS, RRT

A little less than two months into my tenure as chair of the Subacute Care Section, and I am curious. A call for speaker and topic proposals for the 2002 AARC International Respiratory Congress has gone unheeded. A survey sent to the section membership via email received sparse attention. I know you're out there. And I know you have made your departments successful by facing challenges head-on. Your patients and their families find you knowledgeable, compassionate and professional. You solve problems every day. Your administrator admires your business acumen. Indeed, you may even be the administrator of a skilled nursing facility or long-term acute care facility.

So, why are you so silent? Your colleagues are anxious to hear your experiences, learn from your challenges and network for success across the entire profession of respiratory care. You have much to share. I challenge you to bring it on. Bring this section to life. ■

Understanding Post-Acute Care

Licensing for health care organizations depends largely on the environment in which the health care services are provided. We are most familiar with the traditional hospital setting consisting of emergency departments, inpatient surgical suites, post-anesthesia recovery areas, intensive and critical care units, onsite diagnostic imaging, onsite laboratory, multiple onsite ancillary services (including respiratory care) and of course, inpatient medical care and treatment. Such hospitals operate under an "Acute" license and survey process.

Providing health care in any setting other than a hospital is done in the "Post-Acute" environment. This multi-faceted environment includes the following:

1. Outpatient Clinics (rehabilitation and/or surgery)
2. Home Care (visiting nursing, DME)
3. Acute Rehabilitation Hospitals (free-standing or hospital-based)
4. Long-Term Acute Care Facilities (LTAC) (free-standing or within a hospital)
5. Skilled and Intermediate Nursing Facilities (SNF) (includes subacute care facilities)
6. Assisted Living Facilities
7. Independent Living Facilities
8. Personal Care Boarding Homes

Each of these areas has a separate licensing and survey process that is specific to the type of patient treated within. Outpatient clinics, home care, acute rehabilitation, LTACs and SNFs also come under the regulation of CMS (Centers for Medicare and Medicaid Services formerly HCFA), and as such are subject to additional surveys from the individual state departments of health.

Additionally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) provides a voluntary (purchased) survey for acute care, home care, outpatient, LTAC and SNF providers, including a specific survey process for subacute care. ■

JCAHO And Subacute Care

Accredited long-term care organizations can seek separate recognition for subacute care programs. In order to achieve JCAHO accreditation for subacute, the organization must comply with the regular long-term care standards and intent statements *as well as* the subacute intent statements.

Subacute program surveys are conducted by surveyors who have expertise and current clinical experience in subacute care. There is a separate fee for conducting the subacute care survey; however, the organization will receive only one score and accreditation decision. The subacute program will receive a separate special award certificate

A subacute program is defined as one which provides inpatient care for people who have had an acute illness or injury. According to JCAHO, subacute care:

- Is rendered immediately, after or instead of acute hospitalization.
- Treats one or more specific, active, complex or unstable medical conditions, or administers one or more technically complex treatments.
- Requires services of an interdisciplinary team whose members are trained to assess and manage specific conditions to perform necessary procedures.

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- Provides care at a more intensive level than that provided in a traditional nursing facility, but less intensive than that provided in acute inpatient hospitals.
- Lasts for a limited time, until a condition is stabilized or until a predetermined course of treatment is completed.

The subacute protocol is used to survey programs providing care to:

- Ventilator-dependent patients
- Closed-head trauma patients, immediately after the acute phase
- Subacute rehabilitation therapy patients
- Patients requiring medically complex treatment; wound healing, IV therapy, pain management, or AIDS treatment, for example

Subacute programs eligible for survey may be either:

- Freestanding, accredited long-term care organizations with subacute programs
- Stand alone subacute programs
- Part of a hospital or skilled nursing facility that is already accredited or is pursuing long-term care accreditation. ■

HHS Study Derails Minimum Staffing Requirements

According to a new study from the Department of Health and Human Services, fully 90% of the nation's nursing homes do not have enough nurses and nurse assistants to provide quality care for patients. That's enough to derail any requirements for minimum staffing ratios in nursing homes, even though such standards would help raise quality care.

The report, which was sent to Congress earlier this year, states that there is "strong and compelling evidence on the relationship between staffing ratios and quality of nursing home care." But it goes on to say that the widely advocated federal requirement for minimum staffing ratios in nursing homes, "is not currently feasible," mainly because it would take $7.6 billion annually – an 8% spending level increase – to achieve the necessary staffing levels. ■

SNFs Facing Severe Manpower Shortages

A new study from the American Health Care Association (AHCA) also outlines the severe shortage of skilled health care professionals currently facing the nation's nursing homes. (See previous article.) During testimony at a recent Congressional hearing on helping displaced workers find jobs, AHCA urged the House Education and Workforce Committee to consider the fact that more than 100,000 health care professionals are urgently needed to help care for the nation's frail, elderly and disabled citizens residing in skilled nursing facilities.

The figures quoted before the committee come from the AHCA analysis of workforce trends, which documents both vacancy and turnover rates in approximately 16,500 nursing homes throughout America. Among the key finding of the AHCA study:

- 106,982 nursing positions are now vacant in nursing homes throughout the United States.
- Of that cumulative number, there are 65,333 vacancies for certified nurse assistants (CNAs), 25,433 vacancies for licensed practical nurses (LPNs) and 16,196 vacancies for registered nurses (RNs).
- The annualized turnover rate for CNAs, LPNs and RNs is 76.1%, 51.5% and 55.5%, respectively.

The new analysis can be accessed at: http://www.ahca.org/research/vacancy-survey_011004.htm. ■

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AARC Section Survey

We want to provide you with the information and service you desire for your specialty section membership. Please take a minute to fill out this small survey and fax it back to: 972-484-6010

Why did you join this specialty section?

___ To receive information about my specialty area of practice.
___ To participate in designing programs and information about my specialty.
___ To network with and learn from others working in my specialty.

How many times a year do you want to receive a newsletter?

___ 6 times a year
___ 4 times a year
___ 2 times a year
—- No opinion

Would you prefer to receive this newsletter by reading it on the website?

___ Yes
___ No
___ No opinion

Nursing Home Chains Emerge from Bankruptcy

The introduction of prospective payment for skilled nursing facilities sent many of the nation's for-profit nursing home chains into a tailspin over the past few years. According to a recent article in *Modern Healthcare* magazine, five of the ten largest firms had ended up in bankruptcy court by January of last year. The good news is, two of those companies have already emerged from the shadows and the other three should be pulling out soon.

Kindred Healthcare, formerly Vencor, emerged from Chapter 11 in April of 2001, followed closely by Genesis Health Ventures in October of last year. The magazine reports that Sun Healthcare Group appears ready to successfully complete its reorganization sometime this spring. That leaves only Integrated Health Services and Mariner Post-Acute Network still struggling to find their way.

Why did these companies fail? The article admits that reimbursement woes had a lot to do with their collapse, but emphasizes that money alone

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didn't bring them down. The bold acquisition strategies pursued by these companies in the go-go '90s are being blamed as well. Under pressure from the investment community, they simply grew too rapidly and were unable to assimilate their new holdings fast enough or repay their loans in a timely manner. By contrast, nursing home companies that didn't attempt to grow as fast didn't end up in bankruptcy court, despite having to deal with the same reimbursement issues.

The reorganized versions of the failed chains appear to be wiser for the experience. For example, Sun owned 369 SNFs and 34 assisted living facilities when it filed for bankruptcy protection. When it emerges this spring, it will operate only about 240 facilities. The companies are also accepting the fact that swings in reimbursement are inevitable, says the article, and are strengthening their infrastructures and integrating operations to improve profitability and compliance with safety and quality standards. ■

FYI . . .

Beverly settles ergonomics case

Beverly Enterprises, Inc., has settled its ergonomics case with the Occupational Safety and Health Administration (OSHA). Under terms of the agreement, the nursing home chain will adopt specific measures aimed at reducing back injuries among employees involved in lifting nursing home residents. The company has also agreed to establish a training program to teach employees how to deal with lifting situations and will purchase mechanical lift equipment to assist in lifting patients.

The case came about after an OSHA review of Beverly's injury and illness records revealed excessive musculoskeletal injuries resulting in extensive lost-work time and restricted work duty among nursing assistants.

MedPAC recommends SNF increases

The Medicare Payment Advisory Commission (MedPAC) is asking Congress to increase 2003 payments to hospital-based skilled nursing facilities. According to a recent article on AHA News, the online newsletter published by the American Hospital Association (AHA), MedPAC is recommending the full market basket update for SNFs, along with a 10% increase until an effective patient classification system is developed. The article says the AHA supports an increase in Medicare SNF rates because hospital-based SNFs incur higher costs due to higher patient acuity levels, shorter lengths of stay and the higher skill mix of staff.

Are seniors up to the task?

The Centers for Medicare & Medicaid Services (CMS) wants to find out if senior citizens have what it takes to play an active role in the care of their health. Earlier this year, the federal agency proposed a survey of 16,000 households aimed at determining whether or not Medicare beneficiaries possess sufficient communications skills, motivation and basic knowledge of their own health care status necessary to participate in medically-related decisions.

Reports outline problems with Medicare+Choice

Two new reports from The Commonwealth Fund reveal that Medicare+Choice enrollees paid nearly 50% more in out-of-pocket costs for their health care in 2001 than they did in 1999, and those in poor health had even greater cost increases. Enrollees faced increased premiums and cost-sharing burdens and reduced coverage of prescription drugs during the three-year period.

Both reports, say their authors, point to weaknesses in the Medicare program that have a dispro portionate impact on the sickest beneficiaries, who are also more likely to have low incomes. "Increasing payments to health plans alone will not solve the problems of the Medicare program," says Karen Davis, president of The Commonwealth Fund. "We should consider modernizing Medicare's basic benefit package to meet the health care needs of our growing population of older Americans in the 21st century."

The Commonwealth Fund is a private foundation supporting independent research on health and social issues. ■

Depression May Lower Disease-Fighting Abilities in the Elderly

Previous research has estimated that 15%-57% of older adults experience some form of chronic depression at some time during their later years. Now a new study from investigators at Johns Hopkins and Ohio State University suggests this may compromise their ability to fight off infections and cancers.

According to a report on the research in a recent issue of the *Journal of Abnormal Psychology*, even chronic, sub-clinical mild depression may suppress an older person's immune system. The 18-month prospective study involved 22 older adults who suffered from chronic depression and 56 who didn't. Forty of the participants were caring for spouses with dementia and 38 others were not caregivers. The non-depressed group included 25 caregivers and 31 non-caregivers, while the depressed group included 15 caregivers and seven non-caregivers. Females accounted for 64% in both the depressed and non-depressed groups. The depressed and non-depressed groups were compared for their ability to generate enough white blood cells to fight off an infectious agent.

No significant difference was found for risk of depression according to marital status, education or income levels. All the depressed participants reported clinically relevant depressive symptoms at the beginning of the study and 18 months later, but fewer than half of these participants met formal diagnostic criteria for depression.

This information, along with previous research findings, suggests that depressive symptoms can exacerbate and accelerate the immunological declines that typically accompany aging. "Changes in the immune response, including dysregulation of the proinflammatory cytokines and endocrine functions has been associated with depression as well as aging, especially in adults over 60," say the authors. They also note that other factors in addition to aging can have a role in lowering older adults' immunity. For example, lack of social support has been reported as a risk factor for depression.

The researchers postulate that age-related changes in cell-mediated immunity caused by mild depression is linked to the increased risk and severity of infections and cancer found in older adults. They believe these findings suggest that detection and treatment of even mild depression may be crucial for better health in older adults, since the prevalence of mild depression is high in this age group. ■

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?_____

_____

_____

_____

2. What areas were cited as being exemplary?

_____

_____

_____

3. What suggestions were made by the surveyors?

_____

_____

_____

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

_____

_____

_____

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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Subacute Care Section Survey

A strong Subacute Care Section of the AARC will provide good support and information to its members. In an effort to provide appropriate information and programming in the future, we need some basic information about our members, where they work, and what they do. Please take a few moments to complete this brief survey and return it to Carol Dague, 1324 Maywood Lane, Greensburg, PA 5601.

Name_____
Facility_____
Address_____
City_____State_____Zip_____
Phone_____Email_____

1. What type of facility best describes your workplace?
__Hospital-based subacute or skilled unit
__Free-standing subacute or skilled unit
__Hospital-based long-term acute care (LTAC)
__Free-standing LTAC
__Hospital-based inpatient rehabilitation unit
__Free-standing inpatient rehabilitation unit

2. What services do you provide in your facility? (check all that apply)
__Ventilator management-weaning activities
__Ventilator management-chronic and long-term care
__Consult services using protocols
__Consult services without protocols
__Respiratory therapeutic modalities
    __Medication nebulizers
    __MDIs
    __Incentive spirometry
    __Chest physiotherapy and/or bronchial drainage
    __Other (please list)_____
__Diagnostic studies
    __ABGs __Puncture/draw __Analysis onsite
    __Bedside spirometry
    __Metabolic studies
    __Other (please list)_____
__Care planning activities
__MDS preparation
__Discharge planning/case management
__Patient assessment prior to admission
__Committee participation (please list)_____
__Nursing training/orientation/competency assessment
__Respiratory therapy training as a clinical affiliation or preceptor site
__Other (please list)_____

3. Everyone has successes that they are proud of within their facility. What are some accomplishments that you have participated in (i.e., cost reduction, public relations and community education, clinical practice, outcomes data, etc.)?
_____
_____
_____
_____

4. Are you willing to be interviewed in order to share your success stories in our Subacute Care Bulletin? __Yes __No

5. How do the Local Medical Review Policies or Practice Acts of your state affect the practice of respiratory care within your facility?
_____
_____
_____
_____

6. What areas of challenge do you have or what additional information do you need to be more successful within the subacute care environment?
_____
_____
_____
_____

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