American Association for Respiratory Care's

Subacute Care Bulletin

September / October 2002

PPS for Long-Term Care Hospitals (LTCH): Summary of Proposed Rules

by Carol C. Dague, BS, RRT

Payment under the proposed system of reimbursement for long-term care hospitals (LTCH) will be made upon discharge from the hospital. The current proposal calls for utilization of the current hospital DRG system; but with modifications to the DRGs by development of LTCH-specific relative weights that will account for the multiple co-morbidities usually seen in LTCH patients.

Under the proposed system, at discharge the LTCH will assign appropriate diagnoses and procedure codes to the patient's stay. The system will allow for coding of one principle diagnosis, up to eight additional diagnoses and up to six procedures performed. This information, along with charges for the stay, will be submitted to Medicare on the UB 92 billing form.

Medicare will enter the information, as well as the age, sex and discharge status of the patient, into its claims processing system. The claim will be screened through the Medicare Code editor, LTCH grouper and Medicare pricer, accounting for hospital-specific adjustments. Once the LTCH DRG and payment amount are determined, the determination will be sent back to the LTCH. The hospital will then have 60 days to review the assignment and submit additional information requesting re-review of the claim. This request is examined by the fiscal intermediary (FI) to determine if a change in the LTC-DRG is appropriate. If the FI agrees that a change should be made, the change is submitted to a Peer Review Organization (PRO). After the 60 day period, the

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Elements of Success: Doing the Right Things Right

by Carol C. Dague, BS, RRT

The simplest definition of quality is inspired by the work of W. Edwards Deming. At its most basic, achieving high quality means "doing the right things right." In health care this means offering a range of services that are safe and effective, and that satisfy a client's needs and wants. In the last issue of the Bulletin, we looked at the role benchmarking plays in the process by examining the critical elements in the 40-plus respiratory care programs operated by Integrated Health Services. In this issue, we continue our exploration into the provision of quality respiratory care services in the subacute care environment by examining best practices in the respiratory care department structure.

Policy and procedure development

There are several ways to complete policy and procedure development for your respiratory care department. First, you can "borrow" policies/procedures from the acute care environment, which may be satisfactory in completing technical aspects of equipment function, therapeutic modality administration and simple administrative policy (dress code, hours of operation, qualifications of staff). You can also purchase, for a hefty price, "pre-fab" policies from any number of organizations or agencies looking to save you time and aggravation. Or, you can sit down with a (large) tablet, pen, word processor and volumes of Clinical Practice Guidelines, and begin the adventure of a lifetime in designing your own policies and procedures - which will define not only WHAT you do within your service, but HOW it is accomplished. Whatever tools you use, the deed must be done, and sooner rather than later, as each day that passes without documented standards of practice places you and your facility at ri

Essential elements of an effective policy or procedure are:

- Policy or procedure statement
- Purpose of policy or procedure
- Scope of coverage (where, when, how policy to be utilized)
- Essential steps or functions
- Statement of known risks or complications
- Assignment of level of risk for infection/universal precautions required
- Who may perform
- Authorization (department director, administrator, medical director)
- Date of original policy
- Date of review or revision
- Signature(s)

Protocol utilization

Subacute respiratory care is the perfect environment for promoting utilization of patient driven protocols. With professional staff shortages looming large and with physician coverage already stretched thin, effective protocol usage helps assure the continuity of quality respiratory care and good clinical outcomes. When used appropriately, protocols will take us from totally ventilator-dependent to tracheal decannulation with one order: "Wean per protocol." In a smooth fashion and a cost effective manner, we reconnect ventilator-dependent or tracheotomized patients with quality of life. Minimally invasive monitoring, few or zero blood gases, swallowing studies and speaking valves are introduced in a natural progression, often taking less time than in acute care, and with success rates approaching 75%-80%. Medical director support and approval of these processes is essential for success. Once in place, the results are stunning.

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Add-Ons Should Stay

The skilled nursing industry is asking Congress to reinstate the temporary add-ons allowed to expire under the annual update to the SNF payment rates. While the industry will benefit from a 2.6% increase announced in the Federal Register notice published last summer, the loss of the 16.6% add-on to the nursing component of the RUGs and the 4% add-on to all RUGs will wreak financial havoc in the industry, leading most facilities to lose more than $30 per resident day. The add-ons, say industry representatives, are critical to the industry's ability to continue to care for Medicare and Medicaid beneficiaries. ◆

Workers' Health Takes Center Stage at OSHA

The Occupational Safety and Health Administration is launching a new program aimed at minimizing injury and infection rates among nursing home employees. The surprise inspections of about 1000 facilities around the country will look at:

- Ergonomics issues related to resident handling
- Exposure to infectious materials such as blood
- Exposure to tuberculosis
- Slips, trips, and falls

The program will target facilities that have, for every 100 workers, reported 14 or more injuries or illnesses that resulted in restricted activity or lost work days in 2000. ◆

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ELEMENTS OF SUCCESS: DOING THE RIGHT THINGS RIGHT

CQI activities

As in acute care, our processes in subacute require monitoring for effective outcomes and problem potential. What should be monitored? Identify your high volume-high risk procedures (trach care, tracheal suctioning) and your low volume-high risk procedures (arterial puncture, trach change) as a starting point. Also decide if your measures will be defined by minimally acceptable standards for achieving adequate care or for achieving high standards of excellence - actually, both elements are necessary. As individual issues arise, use them to identify opportunities to improve patient care through outcomes, cost effectiveness or reduction or process streamlining. Continuous quality improvement (CQI) activities should be monitored daily, weekly or monthly, and reported through a formalized institutional program at least quarterly. Documentation must be thorough and supported with valid statistical data.

We will continue our identification of best practices and elements for constructing a successful respiratory care service in the subacute care environment in the next issue. ◆

Joint Commission Announces 2003 National Patient Safety Goals

The Joint Commission on Accreditation of Healthcare Organizations has announced its first set of six National Patient Safety Goals. Health care organizations will be surveyed on the following goals beginning in January:

Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.
- Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active - not passive - communication techniques.

Improve the effectiveness of communication among caregivers.

- Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order.
- Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

Improve the safety of using high-alert medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.

Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

- Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
- Implement a process to mark the surgical site and involve the patient in the marking process.

Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

Improve the effectiveness of clinical alarm systems.

- Implement regular preventive maintenance and testing of alarm systems.
- Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit. ◆

NOVEMBER IS COPD AWARENESS MONTH

Quality Project Gets an Overhaul

If you live in Colorado, Florida, Maryland, Ohio, Rhode Island or Washington state, you've probably already seen ads in your local newspapers publicizing quality measures for local nursing homes through the Nursing Home Quality Initiative operated by the Centers for Medicare and Medicaid Services (CMS).

In anticipation of a nationwide rollout of the program in October, CMS is revamping a couple of the quality measures to ensure the data are more representative of nursing home quality. The measure related to weight loss is being cut from the program entirely and the measures for pressure ulcers and delirium management are being cut in half, with a facility admission profile to account for facilities that admit more residents with special conditions. CMS will compare the measures with and without the profile to see which is more accurate.

For more on the future direction of the Nursing Home Quality Initiative, visit http://www.snfinfo.com/ppsrc/#MDS and click on "Quality Measure Criteria and Selection August 2002." ◆

Vaccinations All Around

All nursing home residents should automatically be vaccinated against influenza and pneumonia, say government officials, and they plan to urge facilities to implement standing orders to make that happen - at least in states that currently allow the care delivery practice.

According to the Centers for Medicare and Medicaid Services (CMS), standing orders programs, which allow nurses and pharmacists to administer the vaccines according to institution- or physician-approved protocols, are the most effective and efficient way to ensure residents are protected from pneumonia and the flu. ◆

HIPPA Regulation Finalized

After several years of debate, a final rule governing the privacy of medical records was published in the Federal Register August 14. The regulation, established by the Health Insurance Portability and Accountability Act, includes the following provisions:

- Patients must give specific authorization before entities covered by this regulation could use or disclose protected information in most non-routine circumstances - such as releasing information to an employer or for use in marketing activities. Doctors, health plans and other covered entities would be required to follow the rule's standards for the use and disclosure of personal health information.
- Covered entities generally will need to provide patients with written notice of their privacy practices and patients' privacy rights. The notice will contain information that could be useful to patients choosing a health plan, doctor or other provider. Patients would generally be asked to sign or otherwise acknowledge receipt of the privacy notice from direct treatment providers.
- Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before sending them marketing materials. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- Specifically, improvements to the final rule strengthen the marketing language to make clear that covered entities cannot use business associate agreements to circumvent the rule's marketing prohibition. The improvement explicitly prohibits pharmacies or other covered entities from selling personal medical information to a business that wants to market its products or services under a business associate agreement.
- Patients generally will be able to access their personal medical records and request changes to correct any errors. In addition, patients generally could request an accounting of non-routine uses and disclosures of their health information.

The regulation will go into effect for most entities on April 14, 2003. ◆

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PPS FOR LONG-TERM CARE HOSPITALS (LTCH): SUMMARY OF PROPOSED RULES

hospital will not be allowed to appeal or adjust the claim in any way.

The proposed payment system is intended to be budget-neutral. The per-discharge DRG payment amounts will be updated annually. These payment rates will include both inpatient operating and capital-related costs of care, including routine and ancillary costs. They will not include the cost of bad debts.

The LTCH prospective payment will be considered payment in full for all inpatient hospital services. Medicare will not pay any supplier other than the LTCH for services furnished to a Medicare beneficiary who is an inpatient of the LTCH. The only exceptions are those services that are currently not included as inpatient hospital services (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, psychologist or anesthetist services). As with other prospective payment systems currently in place, LTC hospitals may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's cost of furnishing the services is greater than the amount paid under the PPS system. Medicare is proposing to make additional payment to LTCHs for discharges meeting specified criteria as cost outliers (cases that have unusually high costs). In addition, there are specific policies regarding very short-stay discharges, short-stay outliers, and interrupted stays.

As with the hospital PPS, the LTCH PPS will require that the LTCH have an agreement with a peer review organization (PRO) in order to review the medical necessity, reasonableness and appropriateness of admissions and discharges and of inpatient care for which outlier payment is sought. In addition, the PRO would review the validity of the hospital's diagnostic and procedural information, and the completeness, adequacy and quality of the services furnished.

Payment under the proposed system is based on each patient's principal and secondary diagnoses and major procedures performed, as documented by physicians in the medical record, the LTCH PPS will require physicians to complete an acknowledgement to that effect. Payment may be denied if the Centers for Medicare and Medicaid Services determines (based on information provided by the PRO) that a hospital has misrepresented admissions, discharges or billing information.

The proposed system will have a five year transition period from cost-based reimbursement to prospective payment. The proposed system is scheduled to begin with a cost reporting period on or after October 1, 2002, and all hospitals will be expected to begin PPS by October 2003. There will be no specific area wage adjustments or geographic adjustments to the payment levels.

As of this writing in mid-July, the final rule was scheduled to be published before the end of the summer. ◆

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What's Weight Got To Do With It?

A new study from Spanish investigators has found that COPD patients with low body weight exhibit more muscle atrophy and worse exercise capacity than those with a normal body mass index (BMI) - even when suffering from similar degrees of lung function impairment.

According to the researchers, who published their findings in the second August issue of the American Journal of Respiratory and Critical Care Medicine, skeletal muscle cell death and atrophy were increased in seven COPD patients with low BMI when compared to three other groups: eight normal weight COPD patients, eight healthy volunteers and six sedentary volunteers.

The researchers also discovered that exercise capacity in the underweight patients was better correlated with their BMI than with the degree of their airflow restriction. ◆

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The High Cost of Prescription Drugs

Many senior citizens are failing to take their medications as prescribed, but it doesn't have anything to do with their ability to remember the correct dosing. According to a new survey from the Kaiser Family Foundation and the Commonwealth Fund, nearly a quarter of all seniors are skipping doses or failing to fill prescriptions because the drugs cost more than they can afford.

The survey found about one in four seniors spends $100 a month or more on prescriptions, and even in states with the highest rates of prescription drug coverage, about one in five lacks prescription drug benefits. Many low income seniors also decline to apply for Medicaid programs that might help, believing Medicaid is only for welfare recipients and could affect their other benefits, or because they can't figure out how to fill out the forms involved.

The survey was conducted among more than 10,000 people age 65 and older in eight states. ◆

Don't Let Them Smoke!

An Iowa nursing home has learned the hard way that allowing residents to smoke while using oxygen puts not only the residents, but the home itself, in harm's way. The facility is facing stiff fines related to the death of a resident on oxygen who caught himself on fire after lighting up without first donning the nonflammable apron required by the CDC for anyone who smokes while using oxygen. Adding insult to injury, an investigation into the death found workers in the facility gave him the pack of cigarettes and also allegedly smoked within five feet of the man and his oxygen supply earlier that day.

State and federal regulations both prohibit smoking in nursing home rooms where oxygen is being used. ◆