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Notes from the Chair & Editor

by Becky Mabry, RRT

PPS implementation has posed significant challenges for RTs and will continue to do so for the remainder of 1999 and beyond. The AARC has been, and continues to be, proactive on the legislative front with regard to the provisions for respiratory care under the current PPS system. In addition, funding is available through the AARC Research Program for clinical research that documents the impact of the RT in various health care settings, including subacute care.

Research proposals should feature outcomes-oriented research suitable for publication in a peer-reviewed journal such as *Respiratory Care*. Proposals are accepted for review and those with merit are eligible for AARC research funds. It is very important that peer-reviewed, published data become available on the clinical and cost benefits that can be achieved when RTs participate in subacute and long-term patient care programs.

When faced with severe financial constraints, health care administrators must seek ways of cutting costs. Providers of ancillary care services, such as respiratory therapists, must market themselves to long-term care facility administrators in order to continue or expand participation in subacute respiratory programs. It is important to have objective data to support the contributions of RTs in long-term care.

Section members who work in facilities that are currently part of an integrated delivery system or provider network are well-positioned to adapt to changes driven by both Medicare and managed care. An integrated delivery network typically includes acute care facilities, rehabilitation programs or facilities, and one or more subacute programs (either within the hospital or in affiliated skilled nursing facilities). It may also include home care services and durable medical equipment programs.

RTs who take the initiative can document the improvements in patient care and operating efficiency that are possible in both acute and post-acute care when tools such as therapist driven protocols or respiratory therapy consult services are developed and applied across the continuum of care. I urge those of you in these situations to consider participating in this much-needed research effort. For more information on the AARC Research Program, see "AARC Research Program: How To Apply" in this *Bulletin.*

On another note, I am happy to announce that Henry Horner, RRT, clinical director for GNA Respiratory Care Services in Plymouth, MI, has accepted the challenge of serving as editor of the *Bulletin* for the remainder of the year. We are always seeking guest editors and prospective authors who would like to contribute to the *Bulletin*. Henry will need volunteers who are willing to contribute articles or share ideas for topics. Case studies, editorial opinions, success stories, or shared strategies for post-PPS programs are all welcome.

We can provide the novice author with as much editorial assistance as necessary, so prior writing experience is not required. As Lois Drumheller states so succinctly in her article in this issue, we simply need to "communicate, consult, and educate." This *Bulletin* provides us all with a great opportunity to do just that. ■

In My Opinion: Nursing Staffing Levels in Nursing Homes

by Henry Homer, RRT, Plymouth, MI

The Agency for Health Care Policy and Research recently published a news item about a study on skilled nursing facility (SNF) nursing staff levels from 1991 to 1995.1 Since I have been working in the long-term care sector for some time now, I found this study a bit disconcerting. Most nursing homes between 1991 and 1995 did not take patients with intravenous medication or tube feeding,

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or respiratory patients requiring a high amount of intervention from nursing.

If the nursing combined levels were 24 minutes per eight-hour shift at that time, I would like to see the results of a study done with today's patients per case mix (not facility wide), because most nursing homes now have staffing ratios that differ according to whether the patient is Medicare, Medicaid, or private pay.

What I have observed in nursing homes is that most have a treatment nurse who is responsible for treating patients with decubitus or tube feeding or other time-consuming conditions. The RN or the LPN passes medication to all patients, usually working under a ratio of one nurse to 20 to 30 patients. In addition, they have to do patient assessments and new admits, be available for all emergencies, monitor the CNA's work load, be accountable for all lab work and all orders to the pharmacies from their floor, and find time to sit down and chart. It's a job that I would not want and one that most nurses either could not do or would not want to do. Clearly, it takes a special nurse to work in a nursing home.

Just prior to and after implementation of PPS, some homes did add more nursing staff, but their primary responsibility is to complete the minimum data set (MDS). They have very little patient care responsibilities and should not be counted when figuring the patient to nursing care ratio.

What's the solution? I think nursing homes need to look to the other services for help with patient care. Indeed, this is one of the best reasons to have respiratory therapy in the nursing home because we can help with patient assessment, provide all respiratory care in the home (not only the Medicare Part A patients), assist in emergencies, and try to keep patients from going back to the hospital.

I am seriously concerned that, under PPS, some nursing homes may cut their nursing staff (RN, LPN, and CNA) or utilize caregivers who are not qualified to provide the services of respiratory therapy, occupational therapy, physical therapy, and speech to make up for the shortfall in revenue. Likewise, some patients will not be accepted to a nursing home because of the amount of care they need and the cost of that care. It is the responsibility of all caregivers to write, call, or even visit their senators/congressmen to alert them to the problems that PPS is causing in nursing homes. ■

Reference:

1. Harrington, C,.(1998).Nursing Facility Staffing in the States:1991 to 1995 period. Medical Care Research and Review 55(3), pp. 334-363

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A Respiratory Therapist's Scenario: Before and After PPS

by Lois Drumheller, BS, RRT, Monroeville, PA

As skilled nursing facilities (SNF) begin to operate under the interim prospective payment system (PPS), respiratory therapists must redefine their role in this setting. Some RTs are working under new contractual arrangements with managed therapy companies, while others are employed directly by the SNF. I work under contract with a managed therapy company and believe that respiratory therapists are needed in the post-acute setting. Indeed, our exclusion under PPS has already resulted in poorer care, and the flaws inherent in the system have already been supported by studies using HCFA data. (See the Nov.-Dec. issue of the *Bulletin*, "Study Uses HCFA Data to Show Flaws In SNF PPS Regs.") These flaws also allow us to predict future scenarios and compare them to our current and past experiences. I would like to illustrate these points by relating my own experiences in the SNF setting.

Past experiences in respiratory care

Under Medicare Part A service arrangements made possible by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) RT was allowed to provide ancillary services as part of skilled nursing care using standardized assessment and cost-based reimbursement. RT reimbursement covered under Part A was a valuable source of revenue for nursing homes operating under the transfer agreement. Conventional wisdom in the industry promoted maximizing the Medicare Part Adollars in this lower cost setting. In turn, this appealed to facilities with whom I marketed as a manager.

When negotiating contracts, some facility administrators valued assessment and quality of care over cost reporting at year's end. But with Medicaid as a primary payor source in SNFs, conventional wisdom also could not ignore the possible cost shifting utilizing Medicare Part A dollars. Fiscal relationships were more likely to be valued over marketed clinical guidance or leadership in transdisciplinary plans of care. In "homes" where higher values were placed on quality of care, there seemed to be better communication between a director of therapy and nursing. Still, it should come as no surprise that we, along with other fee-for-service entities such as physical therapy (PT), occupational therapy (OT), and speech/language pathology (SLP), comprised almost half of the SNF payments made for ancillary services, according to a Congressional Budget Office 1995 report.

When I think back on my own management experience, which was often good and bad, I recall an unpleasant situation that some other managers may have also experienced. During the implementation of a plan of care that allowed therapy goals to be reached there were times when our post-hospital Part A services were encouraged to extend beyond their goals.

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Similar types of pressure have existed in other settings for a long time. RTs from the "older days" may recall many treatment modalities that outlived their therapeutic usefulness in acute care settings. As the therapeutic goals were reached, fiscal concerns still drove the census when hospitals were reimbursed under fee for service.

Under OBRA guidelines in the SNF, other influences encouraged over-utilization. This came in the form of RT outreach competitors who aggressively marketed the SNF, promising to "pick up" or transfer more Medicare Part A residents from their larger, integrated networks. As a result, it became apparent that outreach programs could only sustain themselves by employing staff as "casual" or "flex pool" status.

Current experiences

As the first quarter of 1998 ended and OBRA regulations were almost ending, I left management and began working as a licensed RT practitioner.

Under the current PPS, a per diem payment covers routine, ancillary, and capital-related costs. Covered services include all items and services (other than those specifically exempted). I realized that the bundled pricing payment discouraged our services and wondered what a therapist would be able to do under contractual arrangements. This scenario was mimicking a similar situation that had impacted respiratory care during the advent of hospital PPS.

Given the nature of our managed therapy company's contract under PPS, it appeared that I would perform grand oxygen rounds. Attempting to keep my hours short on a daily basis is frustrating, particularly since my time on site should include participation in daily admission meetings, screening new admissions, and occasionally training the nursing staff. Efficiency requires communication with the SNF's case manager and nursing administration, and most importantly, the admissions team and the registered nursing assessment coordinator (RNAC) who must quickly determine the level of skilled services and payment rates. Nursing staffs are overtaxed on a good day.

There have been instances where the SNF was not ready to accept residents with complex respiratory therapy needs. For example, in one case no notice was given to provide RT cross-training for the nursing staff when they accepted a resident with such needs. In this case, durable medical equipment (DME) vitally needed to provide care was absent on site, and an emergency DME order followed this realization. Regardless, nurses were untrained to administer the therapy. Within hours of admission the resident's condition deteriorated, high-flow oxygen was given, and the resident returned to the hospital.

Nursing inservices were given when the resident returned to the facility. RT supervised the care provided by nursing and documented daily. The physician who admitted the resident expressed hesitancy regarding admission of future residents with COPD. In spite of this, the physician was very positive regarding the RT intervention. In the facility's pre-admission negotiations with managed care, the case manager obtained time units of care under the rehab services of OT and SLP, all of which the resident was unable to tolerate due to the primary diagnosis of COPD. Since the case manager was not able to negotiate a retroactive order for RT evaluation, the SNF incurred the cost of time on site to prepare the nurses for accepting this resident. In other words, justifiable SNF payment was lost.

In the past, I have trained caregivers for this same type of DME equipment use in home settings, with good results in terms of continuity of care. But with the nursing staff in the SNF setting, all the training, handout materials, and continual follow-up is not as effective. It is my opinion that formal training should be the standard for this type of care. In defining skilled care, the Code of Federal Regulation (CFR) states, "the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of a professional or technical personnel."

It is reasonable to assume that this does not mean inexperienced nursing staffers who simply give their best efforts after an inservice. The CFR could also imply that my time on site was necessary, as I was called in to train staff and to supervise this care. I was correct in asking the physician to order an RT evaluation and recommending a plan of care for the resident with nursing goals to be monitored daily by RT. The doctor agreed. We also agreed that serial documentation should continue until this type of supervised care was no longer needed in the plan, and I documented this well.

But my time on site was not payable to the SNF, as it could have been under managed care arrangements. The negotiated rates allowed five units of care per day for OT and SLP services, but didn't even consider RT. This example serves as a lesson for developing a matrix of services to address the highly complex care of residents usually found within the resource utilization groups (RUGS) with respiratory involvement. I believe we will need to develop and use care plans until outcome studies can support the need to amend a flawed system of reimbursement.

Service trends for RTs

RTs in the SNF should offer services that are based on a knowledge of the PPS. A method where residents can be made ready for a care plan should be driven by a type of clinical pathway that allows the therapist to function as consultant, if indicated. A matrix of service levels would spell out whether the RT intervention should train and follow-up, phase out therapy to the nursing staff, or continually monitor and train the nursing staff at various levels when needed. A matrix of services could be driven by care maps or pathways. However, it should be noted that clinical pathways cannot be interpreted the same way in long-term care facilities as they are in acute care facilities. For this reason, pathways should be developed to address critical elements that occur in the SNF.

For example, if pre-admission RT intervention is absolutely critical to attaining the resident outcome (as in the above example) then it should be labeled as a critical element and tracked to assure outcomes for COPD. Ultimately, this will minimize problems stemming from an improper plan of care and reduce the likelihood that the resident will have to be returned to the hospital. From the time the SNF's case manager works up pre-admission (Medicare or managed care payor), RT might be involved to provide vital information. Consultation can be used with all SNF residents who otherwise would not be seen under OBRA by a professional RT.

To summarize, the RT roles in the SNF setting are:

- Respiratory consultant for the continuum of care (as emphasized by the Joint Commission standards for long-term care)
- RT services with phase-in nursing education on a negotiated basis
- Documentation of care, services to track utilization and outcome (communicate, consult, and educate) ■

Respiratory Consult Service Fits Well With PPS

by Becky Mabry, RRT, and Susan Y. Parsons, BS, RRT, director, respiratory therapy, BMH East, Memphis, TN

The cost issues stemming from the government's new prospective payment system (PPS) for skilled nursing facilities (SNFs) and subacute care can seem insurmountable. Can these issues be overcome without sacrificing quality or patient safety? At Baptist Memorial Healthcare Corporation (BMHCC) in Memphis, TN, RTs are successfully addressing the new PPS by becoming more efficient in the delivery of care.

BMHCC, which is a member of the Baptist System with hospitals in Arkansas, Tennessee, and Mississippi, is an integrated delivery system encompassing BMH East, BMH Germantown Center, BMH Medical Center, Restorative Care Skilled Nursing Facility, BMH Desoto, and BMH Germantown Rehabilitation Center. Prior to PPS, transfer agreements were in place with 20 local nursing facilities. A national subacute respiratory care provider manged the SNF program, utilizing RTs employed by BMH East to provide services to the SNFs. In addition, transitional care units for ventilator patients were available at both BMH Medical Center and BMH East. Now that PPS has eliminated the need for the transfer agreement, BMH in the process of contracting directly with a number of local SNFs to provide respiratory care services and, in some cases, durable medical equipment services.

Part of the system's success in working with local SNFs lies in the Respiratory Consult Service at BMH East, which has been well received and produced significant improvement in respiratory care department efficiency. The consult service will be modified to extend service to the contracted SNFs and to the BMH Restorative Care Facility.

The advantages of providing the consult service to the SNFs include offering the services of RTs who are highly trained in patient assessment to assist in MDS assessments and documentation. The implementation of protocols helps make RTs accountable for productivity and proper documentation. This is a key factor in managing workflow and reimbursement under PPS. It is anticipated that the participation of the RT will accelerate the pace of therapy to reach the goals outlined in the patient care plan and encourage discontinuation of unnecessary, ineffective, or inappropriate care.

Indeed, protocols and the Respiratory Care Consult Service at BMH East have already resulted in a reduction in the misallocation of procedures such as IPPB, heated mist, O2 therapy, and postural drainage, and an increase in procedures thought to be more effective, such as metered dose inhalers (MDI). This has resulted in a significant reduction in the overall number of procedures, which went from 402,498 in 1997 to 389,305 in 1998. (See chart.) Reductions occurred with increased patient census and the prediction of greater physician demand for respiratory care procedures.

Procedures	FY96	FY97	FY 98
IPPB	34,951	33,192	29,879
MDI	1,536	3,122	4,663
Heated Mist	1,610	553	454
Post Drainage & Percussion	5,989	4,462	3,780
High Flow O2	6,268	3606	3,485
O2 PRN	2,400	1,299	1,097
Pulse Oximeter	11,308	4,746	4,313
Totals	52,754	46,234	43,358

A respiratory consult service for subacute care must include RTs who are knowledgeable in both patient assessment and the newly-introduced Minimum Data Set (MDS) and Resource Utilization Groups (RUGS) classification system for Medicare reimbursement under PPS. The service should provide:

Individualized plan of treatment to meet the patient's needs and diagnosis
- Daily assessment by the RT
- Timely changes in therapy to meet the patient's needs
- Daily progress notes
- RTs who can initiate, monitor, and adjust frequency of treatments such as IPPB, humidification, postural drainage and percussion, and ventilator weaning
- RTs who can discontinue therapies as appropriate in timely manner
- RTs who can maintain respiratory care orders in compliance with national clinical practice guidelines
- RTs who can participate in discharge planning, treatment, and patient education ■

AARC Releases New CPGs

The January 1999 issue of Respiratory Care contains four new AARC CPGs:

1. Removal of the Endotracheal Tube
2. Single-Breath Carbon Monoxide Diffusing Capacity, 1999 Update
3. Suctioning of the Patient in the Home
4. Selection of Device, Administration of Bronchodilator, and Evaluation of Response to Therapy in Mechanically Ventilated Patients.

An AARC Clinical Practice Guideline (CPG) is a systematically developed statement to help the practitioner deliver appropriate respiratory care in specific clinical circumstances. Practice guidelines are common in many disciplines and are developed for a variety of reasons. The AARC CPGs exist for the noblest of reasons – to improve the quality of respiratory care administered to patients.

The variability in clinical practice from one hospital to another is well known, and these variations have come under increasing scrutiny over the years. In response to this, the AARC published its first five CPGs in 1991 and has continued to take a leadership role in the development of clinical practice guidelines to improve the appropriateness of respiratory care practice throughout the country. The Association currently has XX available CPGs. You can order them from the AARC by calling 972/243-2272 or download them from our website at www.aarc.org. ■

AARC Research Program: *How To Apply*

In 1996, the AARC earmarked $1,000,000 for a research program to fund projects aimed at determining the relationships between clinical interventions by respiratory therapists and the outcomes of care. The primary purpose of the program is to sponsor research initiatives that can document the clinical and economic impact of respiratory therapists in the delivery of health care. Clinical trials and effectiveness research to determine how clinical interventions by respiratory therapists affect the overall health of patients, including physiologic indicators and quality of life, will be considered for funding.

The AARC requires submission of a "Research Plan Abstract" form prior to the submission of a complete application. These abstracts will be used to plan the proposal review process. The abstract is not binding on the AARC or the applicant. The AARC will forward application packages to those submitting abstracts that propose projects that support the AARC's research agenda. The AARC will notify the applicant if a full application is not warranted.

Research agenda

1. To determine the outcomes of care provided by respiratory therapists with expanded roles and scope of practice in various settings (acute care, subacute care, outpatient care, long-term care, and home care).
2. To determine the outcomes of systems for delivering respiratory care services in various settings.

   In pursuing this agenda, investigators may evaluate and compare the roles, effectiveness, and efficiency of respiratory therapists and other providers of respiratory care in various settings. Initiatives to explore both the clinical and economic impact of respiratory therapists in traditional and expanded roles in health care will be considered.

Research fund guidelines

1. Project hypothesis includes measurement of the value of respiratory therapists in a health care setting.
2. Research methodology is:
   - prospective in design
   - randomizes assignments into control and experimental groups
   - sizes of control and experimental groups are sufficient to detect significant differences in primary outcome measure (power analysis)
3. Researchers identified have:
   - experience in performing similar medical studies
   - published such a study in a specific journal
   - identified assistance of a statistician
   - involved RTs where feasible
4. Funding requests have:
   - reasonable allocations of indirect staff costs
   - limited percentage of expenses in capital or travel
   - defined project deliverables at each stage of funding
5. Because of the potential conflict of interest and to assure credibility of research results with external parties (third party payors, policy makers, etc.), the AARC will not fund researc in which the principal investigator employed by an organization tha stands to realize financial gain from th outcome of the study.

Failure to meet the above criteria doe not necessarily bar the proposal fro acceptance. The proposal may still b accepted if the researcher can adequatel address the issue to the satisfaction of th panel.

Priority projects

For abstracts received after 8/1/97, th panel will give priority to research propos als in the following care settings:

- Home health
- Outpatient clinics and physician office
- Long-term care
- Managed care
- Integrated delivery systems
- Other settings outside inpatient area within acute care hospitals

Projects in acute care hospitals will b considered only if sufficiently differe than grants approved to date.

Research Plan Abstract

Individuals who intend to apply fo funding are encouraged to first submit completed "Research Plan Abstract". Yo can access the Research Plan Abstract o the AARC web site at http://www.aar org/awards/program.html or call th AARC at (972) 243-2272 for a copy. Ma completed Abstracts to: AARC Researc Program, c/o AARC Executive Offic 11030 Ables Lane, Dallas, TX 7522 Application receipt dates each yea February 1; June 1; October 1. ■

Writing Your Congressman Can Pay Off

The AARC is always urging its members to write their congressmen and senators about issues that are impacting the profession. But do these letters do any good? Consider the case of AARC member Bill Roberts, who both wrote and called Senator Tom Daschle (D-SD) about the need to assure the competency of caregivers providing respiratory therapy in skilled nursing facilities. Members of Sen. Daschle's health staff not only saw a definite need to address the issue, they called for a meeting with the Health Care Financing Administration (HCFA) to discuss the matter and invited AARC representatives to attend.

In discussing the issue of competency requirements for caregivers providing respiratory therapy, the AARC's primary question to HCFA was, "How can you guarantee quality respiratory therapy will be administered in SNFs when some facilities have a financial incentive under PPS to use inappropriate personnel to deliver that care?"

The AARC urged HCFA to establish requirements for SNFs that would ensure that facilities hire appropriate, qualified personnel to deliver respiratory care to their patients. Noting that it is difficult for HCFAto make any changes in competency requirements without further legislative authority, the federal agency suggested that it may be time to push for the introduction of legislation that would require nursing home staff to meet com petency requirements in order to provid respiratory therapy services in SNFs – a idea that the AARC fully supports and ha been advocating for some time.

The moral of this story? One letter ca make a difference, so please send you own letters to your senators and congres men expressing your concern about assu ing the competency of caregivers provid ing respiratory therapy in SNFs. ■

Review of CPGs

The AARC Clinical Practice Guidelines Steering Committee would like your help in revising the Clinical Practice Guidelines (CPGs). We need the respiratory community to identify specific areas of the CPGs for revision. Note that the CPGs are evidence based; therefore, please identify areas for revision, provide suggestions for revision, and cite peer-reviewed literature to support those suggestions.

Please e-mail your specific comments to the chair of the Steering Committee, Dean Hess, PhD, RRT, FAARC, at dhess@partners.org or fax them to 617/724-4495.

You will find copies of all the CPGs published by the AARC at: http://www.rcjournal.com/online resources/cpgs/cpg index.html

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