Management Bulletin
March/April '02

American Association for Respiratory Care

Word on the Web

In this issue, we feature sound bites from recent discussions on the Management Section listserve involving coding and missed treatments.

Please note that postings have been edited slightly for space and style considerations. And remember, if you have yet to join the listserv, all you have to do to start taking advantage of this valuable membership benefit is visit the Management Section area of AARC Online (www.aarc.org) and follow the directions to sign up.

Coding

Manager #1: Recently, we have developed an asthma protocol in our emergency room. Part of our protocol includes an educational component where the therapist reviews some key points with the patient, including a written asthma action plan. This has been a key component in a number of the benchmarking studies we reviewed.

We have a charge in place for this service, but since there is no CPT code for this we are running into problems when it involves a Medicare patient. The 94799 code is not an option, as we were told by our fiscal department a long time ago that nothing will be reimbursed under this code. I was wondering what others may be doing concerning this issue and if anyone has found a CPT code that works.

Manager #2: I, like many of you, have been told in the past that we should not use 94799-Misc. Procedure. However, during a discussion at the office of our fiscal intermediary regarding pulmonary rehab in August of 2001, we were told that we could in fact use 94799 for the service rendered by a respiratory therapist during a pulmonary rehab session. Specifically, we could charge for the educational component we were providing the patient during that session. We could NOT charge for a pulmonary rehab program, but we could recover some costs in this manner. The FI in our part of Georgia is BC/BS.

Manager #3: You may be able to use 94799 if your FI will except it. I know in Northern and Central Wisconsin our FI will not except it as a valid code.

Manager # 4: Since the advent of APCs we are receiving payments on 94799.

Missed treatments

Manager # 1: Please help me with a small problem I am having comparing my department's performance with like departments (benchmarking):

- Do you track missed treatments (i.e. treatments that were ordered and not administered for whatever reason, except refusal)?
- What percent of legitimate orders are missed by your department?
- What portion of your missed treatments (as defined above) were treatments with medications?

Manager # 2: We track all missed therapy, including refusals. In my 2001 report , 4% of therapies were not delivered. Of the 16,136 potential therapies to be delivered, 15,451 therapies were delivered and 685 therapies were missed. That makes for a 96% compliance rate. Following are the reasons therapies were missed:

- Patient unavailable. (In x-ray, surgery, eating or missing.)
- Patient or family refused.
- Technician triage for ED, ICU or Code Blues.
- RCP in Imaging with Vent Patient.
- Overall treatment workload prevented completion.
- RCP miscommunication/oversight.
- RN didn't do night treatment.
- No documentation or reason given.
- Therapy not communicated by unit clerk or RN.
- Patient symptoms counter-indicated, such as tachycardia, chest pain, etc.
- Nurse requested that treatment not be given.
- Equipment unavailable (out of Flutter devices).
- Miscellaneous.

"Word on the Web" continued on page 2

"Word on the Web" continued from page 1

I have all these reasons numbered and RCPs keep a log of name, date, time, reason and therapy with drug missed. The list is in descending order from greatest to least.

Manager # 3: We do track our missed medication treatments. We do not turn in anything if the patient refuses or is unavailable. We have a Missed Medication Tool form that goes to the pharmacy. It was going to risk management and the data we were receiving did not meet our needs. I have not received any data from the pharmacy yet. We do have criteria for what is considered "missed," such as, how late a missed treatment was.

I cannot give you the exact percentage of missed treatments, but it's probably about 1%. JCAHO is interested in medications missed. We had our survey last year and we were tracking our missed medications; they were very pleased. Our hospital has 250 beds, and we have 2000 employees. It is always good to know the size of the hospital when benchmarking.

Manager #4: I am the JCAHO survey coordinator for my institution, and I have an article from JCAHO that talks about RT and missed therapy. It does indicate that late and refused tx's are to be reported in accordance with your hospital's policy. For example, our policy says we have a 30-minute window on either side of a non-stat therapy. So if a tx is given one hour late, then it is considered a missed therapy and is reported as such. ■

AARC CRCE Changes

The AARC continues to receive a record number of applications for programs seeking approval for Continuing Respiratory Care Education (CRCE). In order to expedite the process of reviewing applications, the AARC will institute two new procedures:

- As of March 1, 2002, all applications must be received in the AARC office at least 60 days before the program is to be presented; you will be notified of the review decision within 30 days after the application is received.
- In order to expedite the review process, the CRCE application form has been simplified.

You may download the new form at: www.aarc.org/education/crce_app/instructions.html For any additional information, please contact Teresa Wright, AARC CRCE coordinator, at wright@aarc.org, or (972) 243-2272. ■

JCAHO Launches DSC Program

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has launched a groundbreaking Disease-Specific Care (DSC) Certification Program that it believes is the first of its kind in the country. According to the JCAHO, disease management programs serve patients suffering from specific chronic illnesses — such as asthma, diabetes and congestive heart failure — and identify ways to improve care and health outcomes. These programs also identify at-risk groups and promote early detection, compliance and prevention.

The 2001 Institute of Medicine report, "Crossing the Quality Chasm," recognized that chronic conditions are now the leading cause of morbidity, disability and death; and account for the majority of health care expenditures, with more than 105 million Americans suffering from at least one chronic condition. Asthma, diabetes and congestive heart failure are among the leading chronic diseases affecting Americans and account for nearly $400 billion annually, according to the Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention.

Despite these facts, there have been no consensus-based national standards broadly applied to disease-specific care services and no independent, external quality evaluation process to assess compliance with national standards.

JCAHO's new certification program requires compliance with:

- Consensus-based national standards
- The effective use of established clinical guidelines to manage and optimize care
- The measurement and improvement of health processes, outcomes and perceptions of care

"Disease management service companies, health plans and hospitals are seeking new methods to distinguish levels of care," says Maureen Connors Potter, RN, MSN, executive director of the DSC program. "JCAHO's national program offers an external validation of the quality and outcomes of DSC services. And the improved systems and processes derived from standards compliance contribute to operational efficiencies."

The DSC standards, which are posted on the Joint Commission web site at http://www.jcaho.org/, were developed in consultation with clinical experts from the National Chronic Care Consortium, the Disease Management Association of America, the Disease Management Purchasing Consortium and other leadership organizations.

For more information about DSC certification, call Potter at (630) 792-5256. ■

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Patient Safety Top Priority

The Bush Administration wants to spend $10 million to help hospitals and other care settings develop new and better ways to reduce medical errors. The spending, part of the president's 2003 budget plan, would go for projects aimed at encouraging hospitals and other providers to take advantage of underutilized technology and increasing governmental oversight of medical errors and other incidents that could put patients in harm's way. ■

Leapfrog Group Addresses Quality of Care

Just about everyone within the health care industry has been trying to bring greater consistency to quality of care issues for the better part of the last two decades. Now, the nation's major health care purchasers are weighing in as well, with their own standards-setting organization. Formed just two years ago by a coalition of more than 90 Fortune 500 companies buying health care coverage for over 28 million people, the Leapfrog Group is jumping over traditional think tanks with its first report on fixing the nation's health care system.

The initial set of standards developed by the Group focus on reducing medical errors and call for hospitals to implement a computerized system for placing medication orders, use critical care physicians to manage their ICUs and meet high-volume requirements for six high risk procedures. In order to gauge the frequency of these standards in the nation's hospitals, the group conducted a survey of nearly 500 hospitals in six regions of the country.

While results showed 53% of hospitals met one or more of the standards, not surprisingly, few facilities currently meet them all. Just three percent of hospitals polled had computerized their medication ordering system, although 30% said they plan to do so by 2004. Ten percent of hospitals had intensivists in their ICUs at least eight hours a day, with another 18% planning to use them by 2004.

The results on volume requirements for high-risk procedures— termed "evidence-based hospital referral" by the Group— ran the gamut, from 31% of hospitals meeting the standard for coronary angioplasties to just 12% performing enough coronary artery bypass surgeries. Other high risk procedures measured included abdominal aortic aneurysm repair (21% met the standard), carotid endarterectomy (20% met the standard), esophageal cancer surgeries (15% met the standard) and NICUs (22% met standards for select high-risk deliveries).

According to the Institute of Medicine, between 44,000 and 98,000 people die each year and many more are injured from preventable mistakes made in hospitals. In addition, approximately one million medication errors occur in hospitals each year. The Leapfrog Group says that implementing its standards could save nearly 60,000 lives and prevent more than 500,000 medication errors annually.

The Leapfrog standards, however, have met with mixed reviews by others in the health care establishment. While the Joint Commission on Accreditation of Healthcare Organizations has jumped on the bandwagon, announcing a formal partnership with Leapfrog, the American Hospital Association and other hospital organizations are favoring patient-safety standards using criteria developed by the consulting firm Protocare. The federal Agency for Healthcare Research and Quality has said the Leapfrog standards lack too much clinical evidence to be recommended for immediate implementation in the nation's hospitals.

Still, the impact that the group and its standards are having on the upper echelons of health care is unmistakable. In a recent article in *Modern Healthcare*, the chief executive officer of the National Quality Forum called the group and its standards, "the wave of the future" in health care.

For more on the Leapfrog standards and other initiatives, visit their web site at: www.leapfroggroup.org. ■

Update on Critical Access Hospitals

More and more small, rural hospitals are taking advantage of the opportunity to be designated as Critical Access Hospitals (CAH) by the Centers for Medicare and Medicaid Services (CMS). According to the most recent data from CMS, the number of these hospitals rose by 69% in 2001, up from 310 in 2000 to 526 last year. Ten more hospitals have achieved CAH status this year. With this designation, hospitals are eligible for a number of financial incentives, and many see the program as a means to achieve fiscal viability.

The latest boost for these hospitals came earlier this year when CMS Administrator Tom Scully announced that CAH hospitals will no longer have to comply with the lengthy Minimum Data Set forms for swing beds. The move came after the American Hospital Association and other groups argued that these forms, designed for care planning in the long-term care setting, were inappropriate for short-term acute settings.

According to government and industry statistics, the Great Plains states continue to lead the way in the establishment of CAH facilities, with 54 in Nebraska, 40 in Kansas, 32 in Iowa, 24 in North Dakota and 23 in South Dakota. The CAH designation was established by the Balanced Budget Act of 1997 and pertains to limited service hospitals designed to provide essential services to rural communities. ■

Nursing Shortage Continues, says Survey

Vacancy rates for registered nurses remain high across the country, says a new report from the American Organization of Nurse Executives (AONE), a group affiliated with the American Hospital Association. According to the latest AONE survey, which polled nurse executives at nearly 700 hospitals, RN vacancy rates range from 14.6% in critical care areas to 6.5% for nurse managers.

The fallout from these vacancies is causing problems throughout hospitals, continues the report. Specifically, 51% of respondents said the shortage of qualified nurses is contributing to emergency department overcrowding, 26% to diversions for more than four hours a week, 69% to higher care delivery costs, 25% to bed closures, 11% to increased waiting time for surgeries and 6% to reduced or eliminated services.

How can hospitals overcome the nursing shortage? The nurse executives suggest increasing salaries and educational opportunities, improving staff satisfaction and input, providing more bonuses and offering flexible scheduling. ■

Bulletin Deadlines

Issue	Date editor must have copy
January/February	December 1
March/April	February 1
May/June	April 1
July/August	June 1
September/October	August 1
November/December	October 1

Mergers and Acquisitions Up Over Third Quarter

After showing a significant decline in the third quarter of last year, the number of health care mergers and acquisitions climbed 33% in the fourth quarter, says the latest report from Irvin Levin Associates. Hospitals led the way in this area, with 24 mergers or acquisitions, up by a third from the third quarter and up 20% over the previous year's figures. Nineteen deals took place in the long-term care market, up from 11 in the third quarter and rehabilitation services had four, up from one in the third quarter. According to Levin, the upwards trend in mergers and acquisitions should continue in 2002, particularly in the long-term care and home health markets. ■

Study Questions JCAHO Accreditation

Hospital accreditation is a poor predictor of the quality of patient outcomes, according to a new study by two University of Michigan School of Public Health researchers.

The study, by John R. Griffith and Jeffrey A. Alexander, shows no relationship between Medicare-based measures of mortality and complications and the scores assigned to hospitals by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The study was published in the January issue of *Quality Management in Health Care*.

The authors believe their research suggests a serious need to review the JCAHO system, which assures quality in 95% of U.S. acute care hospitals and is used for Medicare certification and often for state licensure. The JCAHO system, in use for 50 years, almost exclusively uses structural and process measures and does not track newer, more direct performance measures such as the number of deaths or unexpected complications, the hospital's financial strength or its ability to adapt to the latest treatment approaches.

Griffith and Alexander examined Medicare outcomes by comparing JCAHO scores, submitted by JCAHO, against Medicare inpatient data prepared annually for "The 100 Top Hospitals: Benchmarks for Success" study by Solucient LLC.

According to the investigators, Solucient mortality and complications indexing, adjusted for differences in the kinds of patients and cases treated, shows that patients' chances of having serious adverse events, such as death or complications, are about twice as great at the bottom 20% of hospitals as at the top 20% of hospitals. On other measures, the top quintile outperforms the bottom quintile by about one and half times.

Griffith says that the "Balanced Scorecard" theory, increasingly popular among leading companies, suggests a successful organization should achieve in a range of performance areas, including safety, stable financing, efficiency and relations with its customers and workers. Such an organization would also work at the kinds of things JCAHO criteria emphasize, such as staffing in care units and compliance with codes.

"Performance data like Solucient's suggest that America's hospitals need real improvement," continues the investigator. "The differences between best and worst are too big to ignore. Most hospitals make a huge effort to raise their accreditation scores. If they put that energy in a smarter direction, we'd all be better off."

Part of the problem, say the researchers, is lack of public knowledge. JCAHO scores are translated to a "failure count" of the 48 areas studied, and hospitals get a list of "Type I Recommendations" to correct. About one hospital in 12 gets a nearly perfect score, with no recommendations, and only three of 100 get "conditional" accreditation. With so many hospitals receiving similar scores, the system does not encourage competition, say the authors.

The Solucient performance scores, on the other hand, are only used in a "Top 100 Hospitals" program that recognizes only the 100 hospitals that achieve the highest benchmarks, failing to provide ranking information on the more than 5,000 other hospitals studied and ranked annually.

Another problem is understanding exactly what does contribute to high performance. JCAHO criteria are based on a consensus of what seems to work, rather than practices tested against real performance, say the researchers.

"JCAHO scores four dozen separate activities in hospitals, calculates a weighted overall score and makes a final decision to accredit. We expected to see 'good' JCAHO hospitals get 'good' performance scores — be safe, well financed, efficient and progressive. The data show the hospitals with the worst JCAHO scores have as good performance as the group with the best," Griffith says.

The disconnect suggests either something left out or something wrong. "I believe it's something left out," Griffith continues. "It could be problems with the way JCAHO's inspectors assign the scores, but it's more likely the things JCAHO does not measure, particularly employee and doctor learning and enthusiasm." ■

Are Seniors Up to the Task?

The Centers for Medicare and 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 communication 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 disproportionate 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. ■

SNFs Facing Severe Manpower Shortages

A new study from the American Health Care Association (AHCA) outlines the severe shortage of skilled health care professionals currently facing the nation's nursing homes. 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 an 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. ■

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. 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 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. ■

Bar Codes on the Way

According to the American Society of Health System Pharmacists, the Food and Drug Administration is planning to develop a proposal that will call for bar codes on the labels of all drugs and biological products intended for human use. The codes will include product-specific information, such as the National Drug Code number identifying the company's name and the drug's name, strength and package size. The product's lot number and expiration date may be included as well, to make it easier for health care professionals to spot expired and/or recalled drugs.

The FDA proposal fits right into recommendations made by the American Hospital Association (AHA) and other groups. The AHA and six other organizations recently joined forces in a letter to HHS Secretary Tommy Thompson urging support for regulations requiring scannable bar code labeling of human drugs and biological products. In addition to the AHA, supporting the move are VHA, Premier Inc., the Federation of American Hospitals, the National Association of Public Hospitals and Health Systems, the Association of American Medical Colleges and the Catholic Health Association of the United States. ■

Management 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

Would you rather receive a printed newsletter or more timely and more frequent email updates of news and information?

___ Newsletter
___ Email
___ No opinion

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http://aarc.org/sections/section_index.html

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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Additional comments:

_____

_____

_____

_____

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