MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, January 15, 2004
9:15 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Long-term care hospitals: continuing research
-- Sally Kaplan

DR. KAPLAN: Good morning.

The purpose of this presentation is to bring you the results from two qualitative studies of long-term care hospitals.

As you know, qualitative research has limitations. Results cannot be generalized because samples are generally small and opportunistic rather than randomly selected. In addition, informants frequently are not objective. Nevertheless, when used in conjunction with quantitative studies, qualitative research provides context and color to enable policymakers to have a better understanding of an area.

In the first study, NORC and Georgetown conducted 34 interviews with physicians, hospital administrators, nurses, and discharge planners in market areas with and without long-term care hospitals. Interviews focused on treatment and referral patterns of patients requiring a high level of care for an extended period of time. The principal investigators of that study are in the audience if you have questions about the interviews that I am unable to answer.

For second study Dr. Nick Wolter and MedPAC staff visited three cities: Boston, Houston, and New Orleans. Dr. Norbert Goldfield, a physician from 3M who is very familiar with long-term hospitals, accompanied us to Boston and Houston. Pete DeBusk accompanied us to two long-term care hospitals in New Orleans. In all physicians from 10 long-term care hospitals presented profiles of patients in a grand rounds format, providing information about each patient's condition, acute hospital stay, admission to the long-term care hospital, treatment, and discharge.

The results I'm presenting today address the three research questions on the screen. These are three of the five research questions we've consistently asked in this study. These ask about the role of long-term care hospitals, about how patients are treated in areas without long-term care hospitals, and about outcomes.

Long-term care hospitals provide post-acute care in to small number of stable, medically complex patients. Many patients require ventilator little support, have multisystem failure, neuromuscular damage, contagious infections, or complex wounds needing extended care. Long-term care hospitals extensively screen patients. Representatives of these facilities maintain that they select patients who have a prognosis for improvement. They also screen for insurance and reportedly generally do not admit patients without insurance supplemental to Medicare. Medicare is by far the biggest payer for long-term care hospitals. Some long-term care hospitals have contracts with Medicaid, some have contract with commercial insurance. Long-term care hospitals have a feeder system of acute hospitals that refer patients. Acute hospitals benefit from being able to

transfer patients to long-term care hospitals and are a major driver for the growth in these facilities.

Interestingly, on site visits, we were told that physicians frequently are obstacles to transferring patients to long-term care hospitals, either because they do not understand the care long-term care hospitals provide, or they may believe they have to turn over their patients and lose control of their patient's care. Families also can be obstacles if they did not understand the difference between long-term care hospitals and a long-term care facility or nursing home.

Patients in areas without long-term care hospitals are treated in various settings. Some patients stay longer in the acute hospital. They are usually moved from the ICU or the CCU to medical or surgical beds. Usually these patients would be high-cost outlier cases.

Some acute hospitals have created units stepped down from the ICU level of care and these units treat patients similar to long-term care hospital patients. Some SNFs are adequately equipped to handle long-term care type patients. However, it is clear from everything we were told in both studies that fewer of these SNFs exist under the SNF PPS. I'll talk more about SNFs in a moment.

On site visits inpatient rehabilitation facilities were not mentioned as an alternative to long-term care hospitals. However, NORC and Georgetown were told that some IRFs do accept patients similar to those treated in long-term care hospitals.

The biggest disagreement between what we were told on site visits and in the structured interviews concerned whether SNFs are capable of providing care for patients treated in long-term care hospitals. On site visits long-term care hospital representatives were adamant that SNFs could not care for long-term care hospital patients. They pointed to long-term care hospital patients' need for daily active intervention by physicians who are available seven days a week in long-term care hospitals and not routinely involved in SNF patient care. They also pointed to nurse staffing of six to 10 hours per day compared with five hours per day in hospital-based SNFs and three hours per day in freestanding SNFs.

In addition, they told us that most long-term care hospitals have physical, occupational, speech, and respiratory therapists on staff and frequently employ specialist RNs.

Regarding patients requiring ventilator support long-term care hospital representatives told us that only patients who were stable but with little ability to be weaned were the type of patients SNFs could treat. However, in the structured interviews NORC and Georgetown were told that SNFs were the principal alternative to long-term care hospitals. They were told that some SNFs are adequately equipped to handle ventilator-dependent patients or others requiring a high level of care. These SNFs offer a level and intensity of care that some respondents thought comparable to that offered by long-term care hospitals.

NORC and Georgetown did more digging on this issue. In one market at least three SNFs provide care to ventilator-dependent patients. For example, one of these SNFs specializes in

respiratory care and over half of its patients require ventilator support. Most of these patients have other complications such as major wounds, COPD, or multisystem failure. About one-third of these ventilator-dependent patients are undergoing active or semi-active attempts to wean them from the ventilator.

This SNF has a pulmonologist medical director who rounds with the nursing and respiratory staff. There are two respiratory therapists onsite 24/7 and a respiratory care director at the SNF every day. A primary care physician makes rounds twice a week at this SNF.

One thing everyone agreed about was that SNFs capable of caring for costly patients are much less common since the SNF PPS was implemented. As you know, the SNF PPS overpays for rehabilitation patients but respiratory therapy does not count towards rehab in SNFs. It counts as an ancillary just like drugs and the SNF PPS does not cover the cost of ancillaries accurately.

NORC and Georgetown found mixed opinions about long-term care hospital outcomes. Some respondents reported that long-term care hospitals provided a valuable service to patients who needed extended acute care. Others told researchers that long-term care hospitals could be overused when they admitted patients with little chance of recovery. Still others reported that long-term care hospitals postpone a timely discussion of end-of-life issues.

In standard outcome measures long-term care hospitals report wide variation on a hospital-to-hospital basis. On site visits, we were told that 10 to 33 percent of patients die in the long-term care hospitals and 35 to 90 percent of patients are weaned from the ventilator.

Regarding patient satisfaction, patients and families appear to appreciate the amenities at long-term care hospitals. Frequently there are private lives and/or rooms with windows.

As far as the next step in this research is concerned at the March meeting we plan to present results from two types of analyses, more multivariate analyses and policy analysis. The policy analysis will be designed to identify ways to better define long-term care hospitals and the patients appropriate for them.

I'm happy to take your questions or comments.

DR. REISCHAUER: Thank you, Sally.

MR. DURENBERGER: This will just be a brief comment without a question in it. As somebody who was concerned about this in the beginning, I'm really very, very impressed with the scope and the depth and the variety of approaches that are being taken here. And I'm totally impressed by the fact that Pete and Nick are going to go out and be part of it, and obviously looking forward to some of their reaction as you start moving towards the policy design and so forth.

But this is just so impressive to see this kind of a broad gauge support where we're not just looking at it from the standpoint of this institution with this name versus that one. But I sense that behind that you're really looking at the issues of patient care, and the family involvement, and the role of

professionals, and some of those other kinds of issues which are really important for this particular population.

DR. REISCHAUER: I think we'd all like to associate ourselves with that comment.

MS. DePARLE: That's what I was going to say, too. And I think you very well describe the limitations of site visits and more anecdotal research. At the same time I think it's vitally important that we get out of our offices and see what's changing and how these different providers are actually operating in the marketplace and serving beneficiaries.

Nick and Pete, thank you on behalf of everybody else for taking the time. I'll volunteer to go out with you. I've been to I think one in Philadelphia but it's been four or five years ago and I think I could use some updating, too. I think it's great work on the part of the staff.

DR. WOLTER: The one thing I would just say is to agree with that. This is a complex topic. I did not know much about LTCHs prior to these visits. And having gone up the site visits but not been part of the structured interviews, I was really impressed with how you all put this information together. So an excellent job.

MR. HACKBARTH: Any others?

Okay, thank you, Sally.