

SUBACUTE CARE IN NURSING HOMES

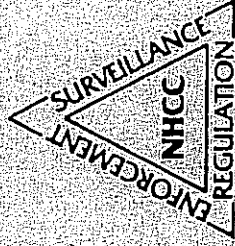
CONSUMER AND PROVIDER PERSPECTIVES

ON BENEFITS AND CONCERNS

RECOMMENDATIONS

FOR OVERSIGHT

written by
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Any errors in the final manuscript is the attributable only to the author.

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EXECUTIVE SUMMARY

INTRODUCTION

The advent of Medicare's Prospective Payment System (PPS), technological advances and the proliferation of managed care has led to great nursing home industry interest in "subacute care." Subacute care in nursing homes is seen as a less expensive alternative to hospitalization and is seen as a new market for nursing home expansion. Since managed care was late in coming to New York State, the drive to subacute care has been limited. It is however, growing.

Subacute Care Is Not Really New

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), defines this level of care as a "goal-oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury, or exacerbation of a disease process. It is rendered immediately after, or instead of, acute hospitalization to treat one or more conditions in the context of a person's underlying long-term conditions and overall situation." Typically, subacute residents are those who no longer need acute care services, but still require a high level of medical and nursing care and treatment for a limited period of time (under 100 days).

Lewin-VHI, in its report to the Health and Human Services Assistant Secretary for Planning and Evaluation, "Subacute Care" Policy Synthesis and Market Area Analysis," concludes that the service provided to the "subacute" patients are "high-end Medicare skilled care, service that some nursing facilities and home care providers have been providing for years under a variety of different names."

Much of what is called subacute are services that have long been offered in nursing homes. However, some of the services that in the past were given to patients in hospitals, prior to the advent of the PPS system when patients stayed in hospitals until they fully recovered, and prior to recent technological advances that allowed such care to be given outside the hospital, are now being provided in some nursing homes.

And, although some of these services were provided in some nursing homes in the past, the number of residents cared for tended to be few. This type of care is now being given to larger numbers of people. Also, some nursing homes that previously hospitalized residents who needed acute care treatment such as IV's for infections will now be caring for them in the facility. This type of care is also called, subacute.

Potential Positive Effects of Subacute Care

1. Less frequent hospitalizations for nursing home residents
2. Attraction of more qualified staff to nursing homes
3. Meeting the continuum of care needs
4. Focus on speedy recovery and preparation for discharge
5. Less costly setting

Potential Negative Effects of Subacute Care

1. Quality will be poor because subacute care is being marketed only as a profit-making tool
2. Quality will suffer because subacute care has proliferated without many guidelines or regulations
3. Present nursing home regulations may be at risk
4. Traditional nursing home resident faces potential problems such as violation of regulations, lack of access, and a lowering of quality of life,

Project Objectives

1. Make recommendations for regulations or guidelines for subacute care in New York State's nursing homes.
2. Educate consumers by producing an educational piece about subacute care in New York State's nursing homes.

Methodology

1. All existing regulations and guidelines developed for subacute care in the country were requested and analyzed.
2. A consumer questionnaire was developed by a qualified, research psychologist with experience in developing questionnaires and interviewing nursing home residents. This questionnaire (see Appendix A) included questions on all the issues raised above as well as questions relating to provider concerns.
3. After analyzing the results of the consumer questionnaires, a similar questionnaire was developed for providers in New York State (see Appendix B). It included concerns raised by respondents to the consumer questionnaire.
4. The findings of both questionnaires were analyzed.

FINDINGS

Consumer Questionnaire

Three hundred seven surveys were mailed to nursing home consumer advocates in

49 states¹, Washington, DC, and Puerto Rico. In each state, surveys were sent to the state ombudsman, one local/regional ombudsman, one member of a consumer group (if available), and one additional advocate (either local/regional or consumer group). With the exception of the state ombudsman, all potential participants were chosen randomly from a nationwide list of consumer advocates.

In a subset of six states (Arizona, California, Ohio, Massachusetts, Florida, and Texas), surveys were sent to all consumer advocates in the state. These states are known to have more well-established managed care or subacute care services.

We had a return rate of over 46 percent and a sample representing 37 states with almost all experienced in visiting nursing homes and responding to complaints.

The results of the questionnaire indicate that subacute care services, or at least the term, "subacute," is new for many of the ombudsmen and consumers advocates across the country. Often a quarter to a half of the respondents were "unsure" of an answer to a question. Some respondents stated that subacute was new in their area or that they were unaware of any subacute facilities. Of those who were confident of their answers, many responded in a very negative fashion. Almost all of those who responded to open-ended questions wrote negative comments.

Types of Services

The most common subacute service named was rehabilitation, followed by wound management. In general, subacute services were quite widespread, with only two services (chemotherapy/radiation and dialysis) named in less than 25% of the areas represented.

Payer Source

Respondents stated that most subacute services are paid for by Medicare, with Medicaid, Commercial Insurance, and private pay also covering a substantial proportion of services. Only managed care was listed as a source of payment by less than half of respondents.

However, in the subset of 6 states with more established managed care or subacute care, the respondents stated that managed care companies were more likely to cover services.

¹New York State was not included. At the time we began this study, subacute was not a force in New York State. Thus, we believed that consumers in New York State would have little knowledge of subacute care.

Potential Benefits of Subacute Care Services

While many of the respondents were unsure of the answers to questions relating to potential benefits, those that did respond reported that the expected benefits of subacute care were realized some of the time, depending upon the resident and the facility. Nearly half of all the respondents believed that subacute care did result in less frequent hospitalizations for residents some or most of the time, while slightly more than half agreed that subacute care was instrumental in shortening hospital stays some or most of the time.

Quality of Subacute Care

Here too, a large percentage of the respondents were unsure about the answers to these questions. Most of the advocates who felt confident of their response report that the quality of care and protection of subacute residents' rights varies among the facilities in their area. Most believed that at least some facilities in their area provided high quality care.

Need for Guidelines or Regulations

Many advocates voiced the need for guidelines or regulations covering subacute care and reported violations of existing nursing home regulations.

Violations

More than a third of the advocates responding reported that nursing home regulations were consistently being violated by subacute care providers in their states. The most common regulation reported to be violated was transfer/discharge, followed by activities.

Need for Stronger Regulations

Nearly a quarter of those who responded believed that there were existing regulations that should be waived or changed for subacute care providers. However, most of these believed that the regulations should be changed by strengthening them in such ways as staffing and assessment to protect subacute residents. In addition, over 40 percent believed that the nursing home regulations now in place should not be changed so that subacute residents would have the same protection as traditional residents. **Thus, over half of all the respondents believe that nursing home regulations should either remain the same or be strengthened.**

Compliance with JCAHO Guidelines

Advocates were asked about provider compliance with JCAHO guidelines related to need for assessment; the need for a qualified interdisciplinary team; and the need for 5 or more hours of nursing.

According to the respondents, there was great variability in compliance with JCAHO guidelines for subacute care. Overall, approximately one third of advocates felt that most providers followed these guidelines. However, an even greater percentage (1/3 to 1/2) were unsure.

Nearly half the advocates who responded felt that staff providing subacute care were no better trained than those providing traditional services.

When Subacute Care is No Longer Needed or When Benefits Run Out

Procedures for providing long term care for residents who no longer need subacute care also seem to vary among facilities. Most advocates reported that these residents do remain in the same facility most or some of the time, although usually in a different bed or wing. Unfortunately, few reported that residents were always prepared for the move.

Impact of Subacute Care on Traditional Residents

Access Issues

Only a small percentage of advocates reported that traditional residents were having trouble finding a nursing home bed. Those that reported problems stated that it was more serious for residents on Medicaid. However, between a quarter and a third of the respondents anticipated future problems.

Quality of Life

Over a quarter of the respondents reported a decline in the quality of life for traditional residents either some or most of the time while 40 percent believed that there was no decline in quality of life.

And, while over 11 percent stated that the facilities offering subacute services in their areas had not become more medicalized, almost 20 percent felt that they had and almost 27 percent more expected this to occur.

Provider Concerns

Advocates report that the most common concern of providers is insufficient

reimbursement. Other concerns include inappropriate regulations; the need for specific regulations or guidelines covering subacute care; and a shortage of qualified staff willing to work in the nursing home setting. Half the respondents agreed with these concerns.

Provider Questionnaire

Six hundred sixty surveys were mailed to all nursing home providers in New York State. We had a response rate of over 37 percent. Our sample was representative of the state. Forty-two percent represented proprietary facilities; 42.5 percent were and over 12 percent were public. More small facilities participated in the study than large ones: 151 (66.2 percent) had 200 residents or less, while 77 (33.8 percent) had more than 200 residents. Ninety-one or 41.7 percent of the respondents were downstate² while 127 or 58.3 percent were upstate facilities. Almost 69 percent offered some subacute services.

Types of Services

Not surprisingly, rehabilitation was offered by most of these respondents. The second most frequently offered service was wound management. The 3 most infrequently offered were: ventilator/respiratory therapy, cardiac rehabilitation and AIDS services. There were significant differences by sponsorship, size, location and case-mix index.

Reasons for Offering Subacute Services

When asked why they decided to offer subacute services, most providers said they offered such services to provide a continuum of care; to respond to changing patient needs and preferences; and because there were higher reimbursement levels. Establishing relationships with managed care companies was less frequently given as a reason. There were significant differences by size and location.

Payer Source

Given the high number of subacute providers offering rehabilitation and wound management, it is not surprising that the overwhelming majority of facilities are reimbursed for subacute care by Medicare. Medicaid and Private Pay are also picking up a substantial percentage of services. Over 38 percent cited managed

²Facilities located in New York City, Long Island, Westchester, or Rockland counties were considered downstate. All other counties were considered to be upstate.

care as a source of payment. Although there were significant differences by sponsorship, size, case-mix index and location, location and case mix index were found to be the determining factors in reimbursement through managed care.

Separate Sections or Units

Only one third of the facilities offering subacute services reported that they have separate units for subacute residents. Although there were significant differences by size, case-mix index and location, size and case mix index accounted for the differences in having separate units.

Evaluation of Program Success

Two thirds of the respondents reported that they routinely evaluated the success of their program in terms of resident outcomes. There were significant differences by location.

Destination of Residents After Subacute Program

Providers who offered subacute services were asked where the majority of their residents go when they no longer need subacute services. Sixty-five of the 160 respondents checked more than one destination, thus not answering the question for the majority of their residents. Of those who responded correctly choosing only one response for the majority of their residents, an equal number of facilities (45; reported that residents usually went home or that residents remained in the same bed. There were significant differences by sponsorship and size.

Interaction of Subacute Residents and Traditional Residents

Providers were asked if their subacute and traditional residents interact and if they do, how beneficial this interaction was. Almost all the facilities reported that their traditional and subacute residents do interact with one another. Providers varied in their assessment of how beneficial this interaction proved to be for subacute and traditional residents. Just over one half of providers felt that the interaction was very or somewhat beneficial to subacute residents. A slightly higher percentage felt that the interaction was very or somewhat beneficial to traditional residents.

Types of Residents Appropriate for Subacute Care

All respondents, whether they offered subacute services or not, responded to questions about their views on subacute care and existing guidelines for these services.

Most providers saw residents needing rehabilitation as the most appropriate for

subacute care. A large proportion of providers also saw current residents needing more complex services as good subacute candidates. There were significant differences by sponsorship, case-mix index and whether they offered subacute services or not.

Regulations

More than two thirds of the respondents felt that existing nursing home regulations are not appropriate for subacute care providers. Over one-half suggested one or more regulations should be waived or changed.

Reasons For Wanting Changes in Regulations

Transfer and Discharge

Over half of the providers wanted to change the transfer/discharge regulations. These respondents felt that transfer to other beds within the facility, or out of the facility altogether was an inherent feature of providing subacute care.³ These providers felt that regulations restricting these transfers or mandating 30 days notice impeded their ability to provide this type of specialized care in an efficient manner. Others complained that it is difficult to give 30 days notice prior to discharge when a stay is planned is brief.⁴ There were significant differences by case mix index.

Activities, Social Work or Dental Care

The most commonly cited complaint was that regulations mandating services like activities or dental care were geared toward longer-staying residents. There were significant differences by whether the provider offered subacute services or not.

Assessment

A large group of providers felt that the timing and design specified in existing regulations often was not appropriate for short stays.

³This is a major difference from the consumer advocates' responses.

Their responses indicated great concern about moving subacute residents.

⁴This may be a misunderstanding of the regulation. If a resident is in the facility less than 30 days, the 30 day notice is not required.

Agreement With National Guidelines

The overwhelming majority of providers expressed agreement with the subacute care guidelines suggested by the JCAHO. The only guideline that any substantial proportion of providers objected to was the provision of 5.5 to 7 hours of skilled nursing care per resident⁵ per day, although the majority did endorse it. There were significant differences by sponsorship, size, case-mix index and whether the provider offered subacute services or not.

Obstacles to Providing Subacute Services

By far, the most commonly cited obstacle was insufficient reimbursement. Problems in applying existing regulations to subacute care were also cited by more than half of the providers. There were significant differences by sponsorship, size, whether the provider offered subacute services or not and location.

Benefits of Subacute Care

The most commonly cited benefits included increased case mix index, shorter hospital stays, lower health care costs, and less frequent hospitalizations for nursing home residents. One third of the providers cited increased profits or surplus as a benefit of subacute care. There were significant differences by sponsorship, size, whether the provider offered subacute services or not and location.

Responding to Consumer Concerns and Cited Problems

Providers were asked to comment on the concerns raised by at least 25 percent of the consumers responding to the consumer questionnaire discussed above. They were asked for their suggestions to prevent these concerns from becoming problems in New York State.

Not enough trained staff

The largest group of providers responding to this issue felt that increased reimbursement or new sources of funding would allow providers to hire more, better trained staff.

⁵This is not actually a part of JCAHO guidelines. When the questionnaire was sent to a number of nurses and provider representatives, it was suggested to add this because traditional nursing home care requires almost 4 hours per day for most residents. At least 5 hours was considered appropriate.

Violation of existing regulations (particularly transfer/discharge)

The overwhelming majority of providers responding to this issue felt that the best way to avoid this problem in New York State was to change the existing regulations for subacute care residents.

Trouble finding a bed for Medicaid or Traditional residents

Most of the providers responding to this issue (64) did not feel this would be a problem in New York. Many cited a surplus of beds in New York State.

More medical model

In a major divergence from consumer advocate opinion that nursing homes should not be based upon a medical model, most of the providers responding to this issue felt that the shift in long term care to a more medical model was not a problem. Instead, most viewed it as a positive and inevitable change related to changing needs.

Residents not prepared for move to another bed

A number of providers felt that this was not a problem in their facilities, or in New York State in general. They felt that extensive preparation was provided to residents in their facilities, and pointed out that New York State regulations already mandated 30 days notice prior to transfer or discharge⁶.

Decline in traditional residents' quality of life

Many providers strongly disagreed that this could become a problem in New York State, even though many providers agreed that there was a shift to a more medical model (see above).⁷ Many expressed the opinion that all of the efforts of nursing homes and regulators were geared toward enhancing residents' quality of life.

⁶This regulation may soon be changed, if it has not been already. Even though most consumer, advocacy and professional groups have protested this change, this regulation has been proposed for removal by the Department of Health. If this is removed, we may find that this does become more of a problem in New York State. In addition, many of the provider respondents indicate that they want this regulation removed.

⁷Many consumers feel that a shift from a social model to a medical model will lead to a decline in resident quality of life.

RECOMMENDATIONS

Some of the standard regulations should be changed for the short-term resident.

If we define short-term residents as residents who are expected to be in the facility less than 100 days, some of the standard nursing home regulations do not seem to be appropriate or protective.

1. The assessment requirements should be modified.
2. The transfer/discharge requirements should be modified.
3. The activities and dental requirements should be modified.
4. Additional requirements should be mandated in the areas of staffing and setting and meeting goals.

Care for short-term residents need to be guided by specific regulations or guidelines related specifically to their needs.

1. Nursing facilities should be required to **assess** these residents within the first week of the resident's stay.
2. Nursing facilities should be required to **assess** these residents on a frequent basis such as: once a week for the first 2 weeks; once within the next 2 weeks; and once a month for the next 2 months.
3. Nursing facilities should be required to develop, with participation of residents and family, **goals with timelines** for meeting them.
4. Nursing facilities should be required to develop, with participation of residents and family, a **tentative discharge date** for those residents who expect to go back home.
5. Nursing facilities should be required to **provide a more intense number of skilled nursing hours** for these residents than they do for traditional residents. This generally means at least 4 to 5 hours of skilled nursing care per resident per day. This number will be more, depending on the needs of the resident.
6. **Transfer/discharge regulations** must include requirements for written notice of a state health department external resident appeals rights for residents and family when there is a disagreement with the facility regarding inability to meet

goals and ability to benefit from more therapy.⁸ The appeal will determine if the resident still needs subacute care. Enough time must be given to the resident and family to appeal before discharge. Residents must be allowed to remain in the subacute bed and in the facility until the appeal decision is rendered.

These protections must be in place whether the individual's care is reimbursed by Medicare, Medicaid, insurance or by managed care companies.

7. If an appeal determines that the resident still needs subacute care, but all benefits for such care have run out and the resident is not eligible for Medicaid, **the maximum amount that the nursing home may charge is the rate they were previously receiving.**
 8. The **activities** should meet the needs of the short-term resident, just as the regulations require for long-term residents. The timing of assessments should be modified to relate more to the short-term resident by changing the requirement for quarterly assessments. In addition, it would make sense to try to limit the amount of paperwork necessary for this short-term resident since so many of these residents will not be in the facility over 3 months.
 9. Short-term subacute programs should be required to conduct **evaluations of the success of its program in meeting the goals** it sets for its residents. The outcome measures they use and the results must be made public.
- HCFA should fund studies and research into finding appropriate evaluations and outcomes that providers and consumers would find valid and reliable for measuring the success of subacute programs.
10. Physicians who specialize in the specific medical problem being treated must be an active member of the care planning team and be available for care and information. Physicians are expected to see residents frequently, for some as often as weekly.

⁸This protection is now in place in New York State for all nursing home residents who do not want to be discharged through the use of an informal appeal to the State Health Department. We are recommending the same type of appeal for subacute residents who believe they should remain in subacute care. If the Health Department does not have the staff or resources to undertake potential additional appeals, additional staff and resources must be given by the State Legislature, specifically for this purpose.

Regulations for long-term subacute residents should remain the same as for traditional residents.

These residents are receiving long-term care, even if more specialized than traditional care, and they need the same protections as other long-term care residents. In addition, since their care may be more skilled and sophisticated, they need the protection of specific regulations related to their specific care needs.

New Transfer Regulations for Traditional Residents

1. Facilities should be required to assess, prepare residents and evaluate any move of a resident from her/his room.⁹

- (1) **assessment** - both risks and benefits of the move to the resident must be examined and what the impact of a room change will be on the resident.

Things to be considered: the resident's (family's) feelings about the move; the degree of resident's cognitive and sensory impairment; the length of time the resident has lived in the room; the resident's ability to cope with changes; the resident's mood and functioning level; the effect of the move on socialization; the number of times a resident has moved in the past.

- (2) **preparation** - preparation of both resident and staff may help to minimize any negative effects.

This should include: a resident specific plan which includes time to meet staff and other residents before move; a pre-move conference with resident (family) and staff; provision of care plan to new staff; designation of one staff member to coordinate and oversee preparation; enabling resident (family) to feel somewhat in control by giving choices in terms of time needed, time and date of move and type of room and unit to relocate to; provide residents (family) with information on how to complain internally, to the Long Term Care Ombudsman Program and to the Department of Health.

- (3) **evaluation** - followup with resident and family regarding the move.

⁹This is especially important if the requirement now in place to give a resident a 30 day notice for a transfer s/he objects to is removed.

This should include: a post-transfer conference with resident and family to evaluate the impact of the move on the resident.

2. Facilities should not be allowed to transfer any resident when it is determined that a transfer is "medically contraindicated." This means that if the assessment determines that the impact of the transfer on the resident's physical, mental and psychosocial well-being will cause new symptoms or exacerbate existing ones beyond a reasonable adjustment period, the transfer may not occur.
3. Facilities should be discouraged from moving residents from a room they have lived in for a long time, if, after assessment and preparation, they still object.

Regulations Must Look Managed Care

Managed care entities do not want to be held accountable for the care received by their members. A recent New York Times article, "H.M.O.'s Using Federal Law to Deflect Malpractice Suits," November 17, 1996, states that HMOs are telling courts across the country that they cannot be held responsible for medical malpractice because HMOs normally cannot make medical decisions about the treatment provided to their members. They say that those determinations are made by providers under contract to the HMO.

Although many HMOs do not want to be held responsible for the care they pay for and manage, it is clear that the reimbursement policies of managed care entities to the providers under contract to them often affects the quality of care delivered.

If the reimbursement is too low, or if the HMO controls the ability of the provider to give tests and treatment, the quality will suffer. Thus, we believe that there should be regulations setting rules for types of reimbursement policies that will not be allowed.

Managed care companies must not be allowed to set up rules that encourage less skilled care such as:

1. gag rules:

The facility must be able to tell the resident and the family what care is needed in their professional judgement even if the managed care company has decided not to pay for the services.

2. capitated rates:

Managed care companies should not be allowed to give sub-capitated rates to nursing homes for the care of its patients. This will encourage facilities to do what hospitals have done, discharge patients before they have met the goals of the program.

Sub-capitation means that facilities will be given a set amount of money to care for each resident. Thus, the nursing home assumes the financial risk for the resident and has an incentive to give less care in order to keep costs under the "cap" or in order to make a profit.

Negotiated rates are more acceptable because the home can discuss the rate it needs to care for the individual and nursing homes will be paid for each day of care. Thus, they have less of an incentive to discharge subacute residents before their care needs are met.

Need For Long-Range Planning Regarding the Continuum of Long-Term Care

Subacute care rose as a separate part of the long-term care continuum because certain events encouraged its proliferation, some of which had nothing to do with the needs of long-term care residents.

We no longer can let events overtake us. There is a crucial need for long-range planning regarding the needs of long-term care patients. We must relate their needs to a planned continuum of care. A number of the concerns about subacute care can only be resolved as we develop and look at the entire continuum of services and think about how subacute care fits into the continuum of long term care.

The very real problems of nursing homes offering subacute care becoming more and more like a hospital and this impact on traditional residents' quality of life demands that we carefully plan for an integrated continuum of long-term care services that will meet the needs of our citizens.

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CHAPTER ONE: **INTRODUCTION**

The advent of Medicare's Prospective Payment System (PPS), technological advances and the proliferation of managed care have led to great nursing home industry interest in "subacute care." Subacute care in nursing homes is seen as a less expensive alternative to hospitalization and as a new market for nursing home expansion.

PPS pressured hospitals to discharge patients as quickly as they could; technological advances made it possible for medically complex services to be provided in non-hospital settings; and managed care companies insisted on the less expensive nursing home health care setting.

Subacute care has become the major emerging trend in nursing homes across the country. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1995) reported that more than 10 percent of the daily census of acute hospital patients could be appropriately cared for in subacute programs. Subacute care is expected to be a \$500 million specialty and to grow 50 percent annually to become a \$10 billion market by the end of the decade.

Since managed care was late in coming to New York State, the drive to subacute care has been limited. It is however, growing.

What is Subacute Care?

JCAHO defines this level of care as "goal-oriented, comprehensive, inpatient care designed for an individual who has had an acute illness, injury, or exacerbation of a disease process. It is rendered immediately after, or instead of, acute hospitalization to treat one or more conditions in the context of a person's underlying long-term conditions and overall situation."

Typically, subacute residents are those who no longer need acute care services, but still require a high level of medical and nursing care and treatment.

Subacute Care Is Not Really New

There has been much discussion about whether subacute care is really a new level

of care. Lewin-VHI, in its report to the Health and Human Services Assistant Secretary for Planning and Evaluation, "Subacute Care: Policy Synthesis and Market Area Analysis," concludes from its review of the literature and interviews that subacute care in practice refers to: patients whose needs fall somewhere between acute hospital care and "traditional" long-term nursing home care. The service provided to these patients are "high-end Medicare skilled care, service that some nursing facilities and home care providers have been providing for years under a variety of different names."

Much of what is called subacute are services that have long been offered in nursing homes. For example, subacute care such as physical therapy after a hip replacement or stroke has long been given in nursing homes under the name, "short-term rehabilitation."

However, some services (e.g., wound management, cardiac rehabilitation and respiratory management) that in the past were given to patients in hospitals, prior to the advent of the PPS system when patients stayed in hospitals until they fully recovered, and prior to recent technological advances that have allowed such care to be given outside the hospital, are now being provided in some nursing homes.

And, although some services such as tracheostomy care and dialysis were provided in some nursing homes in the past, the number of residents cared for tended to be few. This type of care is now being given to larger numbers of people. Also, some nursing homes that previously hospitalized residents who needed acute care treatment such as IV's for infections will now be caring for them in the facility. This type of care is also called, subacute.

Subacute Care Lasts For a Limited Time

Some long-term care services are called subacute because they are more medically complex, e.g., care for those: on ventilators; in a coma; who have AIDS or need dialysis; who have a head injury and can no longer benefit from short term therapy. However, subacute usually means **short-term** care (under 100 days) such as: rehabilitation therapy for people who have had strokes, brain injury, arthritis, hip replacements, spinal injury or amputation; and complex medical treatment for people who have had surgery, have neurological or respiratory problems, need wound care or need terminal care.

Controversy About Subacute Care

Whether subacute services are new or are merely better marketed services that

have always been offered in nursing homes, we need to ask the question: Will the proliferation of subacute services in nursing homes be a boon for patients and residents or will it only be a financial boon for providers?

Proponents of subacute care in nursing homes believe that subacute care will have major care benefits for both subacute patients and the traditional nursing home resident. Others are concerned that subacute care is seen only as a way to increase profit and will negatively impact on nursing home residents.

Potential Positive Effects of Subacute Care

Less Frequent Hospitalizations for Nursing Home Residents

Many advocates of subacute services state that some types of subacute care (e.g., interavenous therapy) can keep traditional nursing home residents in the facility when they get sick or "decline suddenly." Thus, these residents will not have to bear the trauma of being transferred to a hospital.

James Zimmer, M.D., in "Needed: Acute Care in the Nursing Home," Patient Care, states that it is common practice to transfer nursing home residents to the hospital when they become acutely or subacutely ill. Most nursing homes are not geared to providing acute or subacute care that could avoid hospitalization. He discusses the hazards of hospitalizing the elderly:

"Hospitalization place old people at considerable risk of often irreversible decline in functional capacity and this often initiates a cascade to dependency." (p. 66).

Attraction of More Qualified Staff to Nursing Homes

Many advocates of subacute services state that subacute services attract more experienced and qualified staff to nursing homes and that the traditional nursing home resident will benefit because such staff will be available to them as well.

Meeting the Continuum of Care Needs

Many advocates of subacute care believe that this type of care meets the needs of people who no longer need to be hospitalized but are not ready to go home. They believe that this type of patient is better off in a nursing home than in a hospital bed where he/she will not get many activities or social services.

Many advocates of subacute care also state that because hospitals have been encouraged to discharge patients more quickly, many patients do not get needed

medical supervision or rehabilitation services. Subacute care offers such services.

Focus on Speedy Recovery and Preparation for Discharge

Many advocates of subacute care state that subacute care should be encouraged because it focuses on patient education to speed recovery and preparation for discharge and a return to activities of daily living.

Less Costly Setting

Many advocates for subacute care state that subacute care services can save money by reducing costly acute care days reimbursed through the Medicare or Medicaid programs. They believe that subacute care in nursing homes is a more cost-effective service than keeping patients in an acute care hospital. They believe that subacute care offers an innovative, less costly alternative to acute inpatient care.

Potential Negative Effects of Subacute Care

Quality Will Be Poor Because Subacute Care Is Being Marketed Only as A Profit-Making Tool

Many consumers have been concerned that subacute care in nursing homes has been primarily marketed as a profit-making tool. They are concerned that quality will be minimized as profit is maximized. Initial literature touting the new service has focused on the profitability and the ability to attract more private-pay income:

One publisher advertising a new book on subacute care lists "10 Reasons why you need subacute care" and the number 1 reason is to take full advantage of this "newfound source of revenue" (Thompson Publishing Group).

The December 13, 1993 cover of "Modern Healthcare" features a cartoon showing providers (as reindeers with tongues hanging out) standing in front of a santa claus with a bursting bag labeled, "subacute care." The headline states: Hospitals and other providers find the gift of revenue in subacute care.

The advertisement for a conference held in March, 1995 by Global Business Research on "Emerging Issues in Subacute Care" headlines what providers will learn with the sentence, "Learn to profit in the growing \$1 + billion subacute care market."

Consumers are concerned that if the appeal of subacute care is the prospect of converting a \$100 a day bed to a \$300 a day bed to make a \$200 profit and to switch payers from Medicaid to Medicare, managed care and private insurance, quality will suffer.

Quality Will Suffer Because Subacute Care Has Proliferated Without Many Guidelines or Regulations

Although two major health care accreditation bodies, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF), began using survey protocols for facilities that provide subacute care in 1995, few states have instituted required guidelines or regulations specifically related to subacute care.

Regulations Across the Country

Only 6 states have any guidelines or regulations¹⁰ and few of these are comprehensive:

Michigan has separate rules only for nursing homes that treat residents with TB.

Five other states have looked at this issue more deeply. North Carolina does not have separate regulations or guidelines for subacute care, but, similar to New York State, does have separate rules for services for residents who have a brain injury; who are HIV positive; and who are ventilator dependent. In addition, this state has regulations for delivering intensive (15 hours per week) rehabilitation services relating to physician coverage and participation, assessment, care planning, discharge, physical requirements and staffing requirements.

New Hampshire has conducted a study on subacute care and has made a number of recommendations. In a report released on May 17, 1996, a subcommittee of the New Hampshire Health Services Planning and Review Board lists specific details of what it believes should be key components of a nursing facility based subacute program to differentiate it from skilled nursing care.

Louisiana is considering developing and adopting a subacute criteria for nursing homes based upon criteria now being used for long term hospital admissions. This criteria relates to intensity of need and services provided.

¹⁰Information from every state and the District of Columbia was gathered by sending letters requesting such information and through a number of follow-up phone calls.

Illinois has a demonstration program for subacute care in nursing homes and hospitals that requires specific regulations relating to licensure, definition, physician services, nursing care, assessment, discharge planning, diagnostic support services, and agreements with hospitals.

California has the most comprehensive set of rules for all subacute services. These rules relate to admission requirements, nursing services, treatments, licensure, contract with the health department, past compliance history, staffing requirements, staff experience, and inservice training.

Past Quality Issues

Given that so few states are focusing on the need for regulations or guidelines relating to subacute care, consumers are concerned that this absence of adequate state or federal regulatory oversight may allow significant opportunities for abuse that consumers have witnessed before in nursing homes.

In an October 1992 report, the House Committee on Government Operations found extensive fraud and abuse in the virtually unregulated head injury rehabilitation industry (House Comm. On Gov't Operations, Fraud and Abuse in the Head Injury Rehabilitation Industry. H. R. Rep. No. 1059, 102nd Cong., 2nd Sess. 3, 1992). The committee found that the lack of adequate oversight led to a national pattern of patient abuse. The subcommittee noted, "There are obviously enormous profits to be made in an industry that is held to standards that address long-term maintenance care needs for a geriatric population, yet advertise and charge for services that suggest much more costly staffing and therapy regimes. (id. at 5).

Consumers are concerned that these abuses will be repeated in the subacute area.

Managed Care

As more and more of subacute care is paid for by managed care entities, the type of reimbursement may have an effect on the quality of care. Consumers are concerned that if nursing homes are paid a capitated rate (a set amount of money agreed on in advance) for each service they will have an incentive to limit care to either make sure they do not spend more than the agreed upon amount or to try to make a profit.

Present Nursing Home Regulations May Be At Risk

Generally, subacute programs in nursing homes are subject to the same regulations governing traditional nursing home programs. Some providers are already requesting waivers of these nursing home regulations for their subacute units; e.g. transfer and discharge; activities; assessment.

Traditional Nursing Home Resident Faces Potential Problems

Violation of Regulations

There is concern within the consumer community that some regulations relating to traditional nursing home residents may be violated inappropriately because of the desire to offer subacute care. For example, in the push to market subacute care, there is the fear that some providers may be violating transfer and discharge rights as they move traditional residents and replace them with subacute residents.

Access Issues

The proliferation of subacute care may lead to access problems for traditional nursing home residents. Given the profit potential of subacute residents, many nursing homes may want to admit as many of these residents as possible. This may leave less room for the traditional resident. Consumers are concerned that these traditional nursing home residents will have no place to go.

Quality of Life Issues

Subacute care may make the nursing home seem more like a hospital and even less like a home for the traditional nursing home resident.

Reasons for Conducting This Study

The lack of information on subacute care, and the concern over the potential negative effects led to our decision to conduct this study. Additionally, we conducted this study to begin to educate consumers about subacute care.

We wanted to find out if subacute care, in the opinion of consumer advocates across the country, has had a positive or negative effect on subacute patients and traditional nursing home residents. We were interested in how the advocates felt about the effect of subacute care in their areas. In addition, we wanted to find out from subacute providers and potential subacute providers in New York State what they believed the obstacles were to providing subacute care and to ask them to react to potential concerns raised by many of the consumer advocates across the country.

With this information, we want to suggest guidelines and/or regulations for subacute care in New York State nursing homes.

Project Objectives

1. Make recommendations for regulations or guidelines for subacute care in New York State's nursing homes.
2. Educate consumers by producing an educational piece about subacute care in New York State's nursing homes.

Methodology

1. All existing regulations and guidelines developed for subacute care in the country were requested and analyzed.
2. A consumer questionnaire was developed by a qualified, research psychologist with experience in developing questionnaires and interviewing nursing home residents. This questionnaire (see Appendix A) included questions on all the issues raised above as well as questions relating to provider concerns.
3. After analyzing the results of the consumer questionnaires, a similar questionnaire was developed for providers in New York State (see Appendix B). It included concerns raised by respondents to the consumer questionnaire.
4. The findings of both questionnaires were analyzed.

CHAPTER TWO: **CONSUMER QUESTIONNAIRE**

Drafts of the consumer questionnaire were sent to a number of representatives of consumer organizations and ombudsmen for review. Their comments and information from a pilot study were incorporated into the final draft.

Sample

Three hundred seven surveys (307) were mailed to nursing home consumer advocates in 49 states¹¹, Washington, DC, and Puerto Rico. In each state, surveys were sent to the state ombudsman, one local/regional ombudsman, one member of a consumer group (if available), and one additional advocate (either local/regional or consumer group). With the exception of the state ombudsman, all potential participants were chosen randomly from a nationwide list of consumer advocates.

In a subset of six states (Arizona, California, Ohio, Massachusetts, Florida, and Texas), surveys were sent to all consumer advocates in the state. These states are known to have more well-established managed care or subacute care services. As discussed below, responses from these states differed significantly from the other states in a number of instances.

Rate of Response Was 46.5 Percent

We had a high rate of return. Of 301¹² mailed and delivered questionnaires, 140 were returned, for a response rate of 46.5%.

Ten of the respondents who had indicated that they would be willing to be interviewed by telephone for more details were called for further information because the investigator believed more information was needed. Information from these interviews were incorporated into the comment sections of the findings.

¹¹New York State was not included. At the time we began this study, subacute was not a force in New York State. Thus, we believed that consumers in New York State would have little knowledge of subacute care.

¹²We actually mailed 307 but 5 were returned because of incorrect name or address and 1 was returned because the recipient was deceased.

Demographics of the Sample

Our sample was representative of a large number of the states and included people who had much experience in visiting nursing homes and responding to complaints.

The final sample represented advocates from 37 states who had been working in the field for an average of 7.6 years (Standard Deviation 5.42 years), with a range of less than 1 year to 25 years.

The majority of respondents were local/regional ombudsman (77: 66.4%), followed by state ombudsman (30: 25.9%) , and citizen advocacy groups (8: 6.9%).

Almost all reported visiting nursing homes (114: 99.1%) and responding to complaints from residents (110: 96.5%).

Table 1: Sample Characteristics

CHARACTERISTIC	NUMBER OR PERCENT
Number of states represented	37
Average length of time spent in field	7.6 years
Range of time spent in field	1 year to 25 years
Percent of state ombudsman	25.9
Percent of local ombudsman	66.4
Percent of citizen groups	6.9
Percent who visit nursing homes	99.1
Percent who take complaints	96.5

CHAPTER THREE:
RESULTS OF CONSUMER RESPONSES¹³

Ability to Respond and General Tone

The results of the questionnaire indicate that subacute care services, or at least the term, "subacute," is new for many of the ombudsmen and consumer advocates across the country. Often a quarter to a half of the respondents were "unsure" of an answer to a question. Some respondents stated that subacute was new in their area or that they were unaware of any subacute facilities. However, many of the consumers who know about subacute services responded in a very negative fashion. Almost all of those who responded to open-ended questions wrote negative comments. Few of those who had positive things to say about the introduction of subacute services into the nursing home answered the open-ended questions.

Types of Services

The advocates were asked what types of services were available in their states.

The most common subacute service named was rehabilitation, followed by wound management. In general, subacute services were quite widespread, with only two services (chemotherapy/radiation and dialysis) named in less than 25% of the areas represented.

It is interesting to note that the responses from our subset of 6 states with more established managed care or subacute care (Arizona, California, Florida, Ohio, Massachusetts, and Texas) differed significantly from these results. These respondents stated that ventilator/respiratory therapy was offered more frequently in these states.

¹³Of the 140 returned questionnaires, 24 were dropped from the analyses because of a number of reasons: 1 coded all responses "unsure;" 11 said they did not have access to the information requested; 9 stated that there was no subacute care in her/his area; 1 has already participated in the pilot study; and 2 were completed by state regulators. Thus, 116 completed questionnaires were used for the analyses discussed in this report.

Table 2: Types of Services

<u>Service</u>	<u>Number of times listed</u>	<u>Percentage</u>
Rehabilitation	108	95.6
Wound management	95	84.1
Post-surgery recovery	93	82.3
Intravenous therapy	91	80.5
Ventilator/respiratory therapy	89	78.8
Low-intensity rehabilitation	79	69.9
Tracheostomy	69	61.1
AIDS services	57	50.4
Traumatic brain injury	53	46.9
Acute care for existing residents	49	43.4
Dialysis	23	20.5
Chemotherapy/radiation therapy	13	11.5

Payer Source

Respondents stated that most subacute services are paid for by Medicare, with Medicaid, commercial insurance, and private pay also covering a substantial proportion of services. Only managed care was listed as a source of payment by less than half of respondents.

However, in the subset of 6 states with more established managed care or subacute care, the respondents stated that managed care companies were more likely to cover services.

Table 3: Payer Source

<u>Payer</u>	<u>Number endorsed (percentage)</u>
Medicare	93 (84.5%)
Private pay	75 (68.2)
Medicaid	56 (52.7)
Commercial Insurance	58 (52.7)
Managed Care	31 (28.2)

Potential Benefits of Subacute Care Services

"I feel that the patient receives adequate care in a setting where they are comfortable (the nursing home), and at a much lower cost to Medicare or insurance, or Medicaid. Smaller facilities can provide a more intimate environment."

"In my opinion subacute care should remain in hospitals. I fear unqualified and untrained nursing home staff will be required to provide care beyond their capacity to do so."

Advocates were asked about potential benefits of subacute care. While many were unsure of the answers to these questions, those that responded reported that the expected benefits of subacute care were realized some of the time, depending upon the resident and the facility.¹⁴ Nearly half of all respondents believed that subacute care did result in less frequent hospitalizations for residents some or most of the time, while slightly more than half agreed that subacute care was instrumental in shortening hospital stays some or most of the time. The services named most frequently, in open-ended responses, as contributors to shorter hospital stays were rehabilitation (9); wound care (7); ventilator (5); IV (5); and dialysis (2).

Nearly half of respondents believed that residents were better off in the nursing home than in a hospital because of a less clinical atmosphere (47: 42.0%), and greater access to activities and social stimulation (56: 50.0%). A smaller proportion of advocates believed that residents were better off remaining in the hospital where more sophisticated medical care is available (32: 28.6%).

Respondents were mixed in their opinions on the positive impact of subacute care services on staffing. The largest proportion of advocates reported that more qualified staff were attracted to nursing homes offering subacute care some or most of the time. However, nearly a third believed that staffing was not enhanced, and a similar proportion were unsure. Of those who did believe staffing improved, most were unsure of the cause (53: 48.2%). Others endorsed a number of possible reasons, including: more on-the-job training (26: 23.6%); more interesting work (20: 18.2%); more stringent educational criteria (18: 16.4%); and higher pay scales (16: 14.5%).

¹⁴The fact that so many advocates were unsure about the answers seems to indicate that subacute care is so new that even people who regularly visit nursing homes may not have enough information.

The majority of advocates reported that traditional residents did have access to additional skilled services. However, few felt that residents benefited in other ways from staffing changes.

Advocates from the subset of states where managed care and subacute care were more established were more likely to report that subacute care attracted more highly trained staff.

Table 4: Potential Benefits of Subacute Care

<u>Potential Benefit</u>	<u>Most of the Time</u>	<u>Some of the Time</u>	<u>No</u>	<u>Unsure*</u>
Less frequent hospitalizations for nursing home residents	12(10.7%)	36(32.1)	19(17.0)	45(40.2)
Shorter hospital stays	23(21.3)	39(36.1)	3(2.8)	43(39.8)
Attraction of more qualified staff	12(11.5)	33(31.7)	29(27.9)	30(28.8)
Traditional residents have access to skilled services	18(16.8)	43(40.2)	16(15.0)	30(28.0)
Traditional residents benefit from staffing changes in other ways	6(5.8)	17(16.3)	34(32.7)	47(45.2)

*Numbers will not always add up to 116 because of missing answers to specific questions.

In open-ended responses, 3 advocates identified an additional benefit of subacute care: shorter nursing home stays, allowing residents to return home. Others

reported that traditional residents could benefit from the availability of physical therapy in-house (2) and from enhanced medical care (2).

Quality of Subacute Care

"Some are very good, others are marginal."

"Care is mostly very good."

Here too, a large percentage of the respondents were "unsure" about the answers to these questions. Most advocates who responded report that the quality of care and protection of subacute residents' rights varies among the facilities in their area. Most believed that at least some facilities in their area provided high quality care. Open-ended responses revealed a broad range of opinions. Some advocates (6) believed that subacute units in their areas were no different than traditional units despite higher reimbursement and level of patient need. Others felt that care varied widely by facility (4) or by the type of service offered (2). Of those who offered specific opinions about the quality of care across facilities, 11 reported poor care, 5 believed care was adequate, and 4 felt care was good. Several respondents felt that they could not offer an informed opinion because too few facilities in their areas offered subacute care (3) or subacute care was still too new (2).

Table 5: Quality of Care

	<u>Most of the time</u>	<u>Some of the time</u>	<u>No</u>	<u>Unsure</u>
Nursing homes provide high quality subacute care	21(18.8%)	43(38.4)	14(12.5)	34(30.4)

**Comments from advocates who believe that nursing homes provide quality care
some or most of the time:**

I would have to presume, given the quality of care in this
catchment area, the statewide quality is good.

I can only comment on my area, which seems very progressive from my non-
medical viewpoint.

Care is very good.

Some advocates felt that the care varies by facility:

Some subacute units provide a higher level of care than others, but the quality is there in all the hospital units; most hospital-based do OK.

The care is very uneven.

Some advocates believe that subacute units are really no different from regular units:

We see little difference in staffing and training.

It's all marketing at this point. "Subacute" has replaced "Dementia Units".

From what I see, it's nursing home care for more money. Some do a better job; in a lot of instances the subacute care delivery is what we have known to be Medicare skilled service that any skilled facility could have delivered.

Subacute translates into "Medicare" unit in our state.

Those advocates that believed that the subacute units in their areas did not deliver quality care (14) raised strong objections:

All subacute units are having difficulties.

The units go from poor to very bad.

The nursing homes do not give the quality of care needed for anyone. The staffing here is so low they can't do quality care.

We receive many complaints that the therapy is insufficient in quantity and quality, that the therapy is done by technicians under the direction of therapists and non-therapists.

Some facilities have people who are untrained doing a skilled service.

Some nursing homes start subacute programs without proper preparation.

The homes offering subacute care are no better at answering call bells, or responding to the consumer.

Advocates also varied in their descriptions of the adequacy of the physical plants and physician coverage. While few reported that physical plants or physician coverage were inadequate in all facilities, many felt that only some facilities provided an adequate environment and physician care for subacute residents.

**Table 6: Quality of Physical Plants
and Physician Coverage**

	<u>Yes, most</u>	<u>Yes, some</u>	<u>No</u>	<u>Unsure</u>
Mds in appropriate specialties available	25(22.3%)	32(28.6)	12(10.7)	43(38.4)
Physical plants meet needs	16(14.2)	48(42.5)	20(17.7)	29(25.7)

Respondents that stated that the physical plants of most or some of the nursing homes in their area meet the needs of the subacute residents (16) believed that the homes in their areas that had remodeled to make sure that they had designated areas appropriate for subacute residents, had higher medical equipment and staffing rates.

Respondents who believe that most of the homes in their area did not meet the needs of the subacute residents (20) raised a number of important issues. They stated that in their areas no modifications had been made to the homes or that there was poor physical architectural planning with layout, lack of lounge areas and small nursing stations. Some stated that most of the facilities were old and did not meet minimum requirements. Some believed that there was a lack of space for necessary equipment and privacy and that some were understaffed or had inappropriately trained staff.

Need for Guidelines or Regulations

"I have begun to receive complaints from these areas, and no one can tell me which rules to follow. Nursing homes are not doing well with their current residents, this prospect is horrifying."

Many advocates voiced the need for guidelines or regulations covering subacute care:

In my state there are no written guidelines. There is only a general statement that subacute care can be offered as long as a nursing home is adequately providing services. We have specific guidelines for all other levels of care but none on a level as important as this one!

We need a licensing designation and regulations for subacute.

There is a need for closer supervision by insurance and government agencies.

Violations of Nursing Home Regulations

While many respondents were unsure if violations had occurred, more than a third of the advocates (40: 36.0%) responding reported that nursing home regulations were consistently being violated by subacute care providers in their states (23 or 20.7% said there were no violations and 48 or 43.2% were unsure). The most common regulation reported to be violated was transfer/discharge, followed by activities. A smaller percentage (10: 8.8%) reported that existing regulations were being waived for facilities providing subacute care (43: 37.7% said no and 61: 53.5% were unsure). Again, the most common regulations said to be waived were transfer/discharge and activities.

Respondents from the subset of 6 states differed significantly on this question. They stated that transfer regulations were waived more often while activities regulations were violated less.

Table 7: Violations and Waiving of Regulations

<u>Violations consistently violated</u>		
<u>yes</u>	<u>no</u>	<u>unsure</u>
40 (36.0%)	23 (20.7%)	48 (43.2%)
<u>Violated</u>		
<u>Regulation</u>	<u>Number reporting (percent)</u>	
Transfer/Discharge	43 (85.0%)	
Activities	10 (25.0%)	
Assessment	8 (20.9%)	
Social Work	8 (20.0%)	
Dental	7 (17.5%)	
<u>Waived</u>		
Transfer/Discharge	5 (50.0%)	
Activities	3 (30.0%)	
Assessment	2 (20.0%)	
Social Work	3 (30.0%)	
Dental	2 (20.0%)	

A few respondents named other violated or waived regulations:

RN coverage
 Facility structure
 Dietary
 Quality of care
 Physician visits - physicians were not actually seeing residents

Some comments made:

Providers want to get rid of the resident's right to stay in the subacute unit.

Some nursing homes do not inform the subacute resident that they do not have to leave the bed they are in when

they no longer need subacute care but still need nursing home care.

Some nursing homes transfer Medicaid residents out of the home if they no longer need subacute care and a Medicaid bed is not available.

Need to Strengthen or Change Existing Regulations

"The laws are good and we should not waive any laws in effect. We need all the protection we can get for all frail people."

Nearly a quarter of those who responded (22: 22.7%) believed that there were existing regulations that should be waived or changed for subacute care providers. However, most of these believed that the regulations should be changed by strengthening them in such ways as staffing and assessment to protect subacute residents. In addition, over 40 percent believed that they should not be changed (48: 43.6%) so that subacute residents would have the same protection as traditional residents. **Thus, 62 or 53.4 percent of all the respondents believe that regulations should either remain the same or be strengthened.**

Specific suggestions were: strengthening various existing regulations (3); adding new regulations related to increased staffing and assessment requirements (9); and protecting residents from being discharged after Medicare coverage is exhausted (2). Other respondents suggested changing the scope or time frame of existing regulations to accommodate the shorter stays of subacute residents, and one suggested allowing subacute facilities to share resources with affiliated hospitals rather than duplicating services.

Reasons given by those who believed that the regulations must be strengthened for subacute care:

Some subacute facilities are using Medicare benefits up and then dumping folks.

When the insurance/private pay client is terminated from services, the insurance rate is being used to bill the private patient during search for alternate bed. This is not right.

Subacute residents' medical needs are more severe, residents are at higher risk.

Some nursing homes extract promises from entrants from hospitals that they will leave when their Medicare (subacute) therapy is complete and that they will not change to Medicaid.

Reasons advocates gave for not changing nursing home regulations for subacute residents:

All the regulations play a vital part in one's quality of life. Although the stay may be shorter than a traditional nursing home resident, all of the subacute resident's needs should be met.

Different regulations within same facility would confuse things; subacute care is often the beginning of short or long term stay at facility (nursing home).

All residents in nursing homes should be subject to same provisions no matter what individual care plans are utilized.

Some advocates believed that regulations should be adjusted to meet the special needs of the subacute resident:

Nursing home regulations are more a social model than a medical model.

Due to short stay in subacute unit, a short form for assessment should be used.

The 30 day notice should be lessened; people enter subacute units knowing it is for a short time.

Discharge planning needs to begin at admission. The length of time to complete initial assessment and care plan is way too long for short stay subacute resident.

When residents are in for a short time activities are not as essential as they are in a long term care setting.

Table 8: Regulations that should be changed*

<u>Regulation</u>	<u>Number endorsing (percentage)</u>
Transfer/Discharge	11 (44.0%)
Assessment	9 (36.0)
Activities	8 (32.0)
Social Work	5 (20.0)
Dental	5 (20.0)

*A majority (14) of these respondents believed that these regulations should be strengthened.

Table 9: Regulations that should NOT be changed

Social work	36 (69.2%)
Assessment	35 (67.3)
Transfer/Discharge	34 (65.4)
Dental	33 (63.5)
Activities	32 (61.5)

Compliance with JCAHO Guidelines

Advocates were asked about provider compliance with JCAHO guidelines related to need for assessment; the need for a qualified interdisciplinary team; and the need for 5 or more hours of nursing.

According to the respondents, there was great variability in compliance with JCAHO guidelines for subacute care. Overall, approximately one third of advocates felt that most providers followed these guidelines. However, an even greater percentage (1/3 to 1/2) were unsure.

According to respondents from our subset of 6 states, residents were more likely to be assessed at least once weekly.

Table 10: Following JCAHO Guidelines

<u>JCAHO Recommendation</u>	<u>Most do</u>	<u>Some do</u>	<u>Most do not</u>	<u>Unsure</u>
Interdisciplinary team	33(29.7%)	34(30.6)	17(15.3)	27(24.3)
Weekly assessment	31(28.2)	17(15.5)	17(15.5)	45(40.9)
Five or more hours of nursing, with physician, lab and pharmacy	21(19.3)	13(11.9)	25(22.0)	51(46.8)

Nearly half the advocates who responded (50: 43.9%) felt that staff providing subacute care were no better trained than those providing traditional services (33: 28.9% said no; 31: 27.2% were unsure). Of those who believed staff were more highly trained, 69.7% (23) reported that Rns received special training, 45.5% (15) that LPNs received training, and 45.5% (15) that aides received special training.

When Subacute Care is No Longer Needed or When Benefits Run Out

"Residents lose out."

"They can stay in the facility as a traditional resident or they are asked to leave."

Procedures for providing long term care for residents who no longer need subacute care also seem to vary among facilities. Most advocates reported that these residents do remain in the same facility most or some of the time, although usually in a different bed or wing.

Unfortunately, few reported that residents were always prepared for the move. In open ended responses, most respondents (41) described a system in which residents who exhausted their subacute care benefits could choose between transfer to another bed in a traditional unit, transfer to another facility, discharge home, or paying privately for the higher level of service. In some areas, residents

could remain in the same bed or facility if they were eligible for other coverage, such as Medicaid or commercial insurance (10). In two areas, respondents stated that residents were generally sent back to the hospital to reactivate their Medicare coverage. Only three advocates reported that residents in their area could petition to extend their subacute coverage. Eight advocates reported that residents whose subacute benefits expired simply did not get needed services.

Responses from our subset of 6 states differed significantly from the responses of the total sample. Residents no longer needing subacute care were less likely to be able to remain in the same facility if they continued to require long term care than in other states.

Comments from advocates who were concerned about what happens when insurance coverage for subacute care runs out:

Therapy stops, but private pays will find a bed.

There is less care.

Residents are transferred or discharged.

They get home care coverage.

Private pay or out in most cases.

They are not given an option to remain in unit once Medicare is exhausted, even though beds are Medicaid certified. Medicaid recipients are told to leave. Residents are advised that private pay rates are used to continue the care - rates range from \$130-\$450/day.

They are forced to pay privately or transferred to a lower level of care prematurely.

They are moved to a regular care bed/wing/ward.

Pay source is the key here.

They are hospitalized.

If they are Medicaid eligible and the bed is so certified, they might get to stay in the bed. Most problems occur when the home's subacute unit is not dually certified and residents are forced to move.

They are informed they can appeal decision - and then secondary payment (private/ins./Medicaid) begins.

Generally, they receive it if it is determined the patient cannot be maintained in a lower level.

The resident still receives the subacute care if he/she remains in the facility.

Table 11: Destination When Subacute Care Is No Longer Needed or Benefits Have Run Out

<u>Destination</u>	<u>Most of the Time</u>	<u>Some of the Time</u>	<u>No</u>	<u>Unsure</u>
Residents can remain in the same facility for long term care	49(43.0)	47(41.2)	3(2.6)	15(13.2)
IF YES:				
Transferred to another bed	55(59.1)	28(30.1)	3(3.2)	7(7.5)
Prepared for the move?	25(27.5)	32(35.2)	20(22.0)	14(15.4)
IF NO:				
Prepared for the move?	4(10.5)	12(31.6)	16(42.1)	6(15.8)

Impact of Subacute Care on Traditional Residents

Consumers were asked about the impact of subacute care services on the traditional nursing home resident.

One respondent raised an interesting issue related to designated areas being next to traditional units: she stated that in her area, most of the subacute units are next to other traditional long term care units and that this causes some problems. Since there is a lot of activity on subacute care units the hustle/bustle effect sometimes

"ripples" to other units. This is a problem particularly for residents with cognitive deficits.

Access Issues

Only a small percentage of advocates reported that traditional residents were having trouble finding a nursing home bed. Those that reported problems stated that it was more serious for residents on Medicaid. However, between a quarter and a third of the respondents anticipated future problems.

Some comments:

It appears that facilities are filling their Medicare certified beds with subacute care residents rather than individuals who would be possible long term Medicaid residents.

Some nursing homes are seeking to de-license Medicaid approved beds to convert to subacute. There is already a shortage of Medicaid beds in this community.

Nursing homes got a certificate of need with the promise to provide long term care. Now we have a cap on beds and a cap on long term home care. Now nursing homes are converting beds approved for long term care to short term use, exacerbating the shortage of long term care services in this state, especially for poor and middle income.

The system is not working for the poor and under-served.

We are concerned that many long term care beds, especially in the inner city, have been sold to hospitals and other providers and converted to subacute. This may limit the availability of quality services to the longer term residents.

Quality of Life

"Nursing homes must decide. Do they want to care and give rehabilitation for elderly or do they want to become miniature hospitals."

While, 40 percent believed that there was no decline in quality of life, over a quarter of the respondents reported a decline in the quality of life for traditional residents either some or most of the time.

And, while over 11 percent stated that the facilities offering subacute services in their areas had not become more medicalized, almost 20 percent felt that they had and almost 27 percent more expected this to occur.

Quality of life problems described in open-ended responses included inadequate staffing or staff attention (9), shifting physical plant resources to subacute residents (5), and a more medical atmosphere (2).

Table 12: Impact on Traditional Resident

<u>Impact on traditional resident</u>	<u>Expect</u>		<u>Problems</u>	<u>No</u>	<u>Unsure</u>
	<u>Yes</u>				
Trouble finding bed for traditional resident	20(18.3%)	26(23.9)	42(38.5)	21(19.3)	
Trouble finding bed for Medicaid resident	28(25.5)	33(30.0)	31(28.2)	18(16.4)	
More medical model	31(27.7)	22(19.6)	13(11.6)	46(41.1)	
	<u>Most of time</u>	<u>Some of Time</u>			
Quality of life declined	2(1.8)	27(23.9)	46(40.7)	38(33.6)	

Advocates who believed that subacute care units had a negative effect on traditional residents raised the following issues:

Less attention is given to needs; there is an assumption that they are more independent and need less of everything.

Staff is loaded on subacute units to the detriment of others.

Aides tell Medicaid or traditional residents they are too busy to help them.

There is a medical regiment instead of a home like atmosphere.

Capital improvements are made only on subacute wings.

Subacute care has taken up beds that formerly were used for nursing home care.

Units such as Alzheimer are closing to open subacute units.

Traditional nursing home residents are being moved to 4 bed wards to give semi and private rooms to skilled residents.

Traditional residents see how beautiful it is on the subacute units and wonder why their area is not as nice.

Provider Concerns

Advocates report that the most common concern of providers is insufficient reimbursement (55: 57.9%). Other concerns include inappropriate regulations (33: 34.7%); the need for specific regulations or guidelines covering subacute care (33: 34.7); and a shortage of qualified staff willing to work in the nursing home setting (35: 36.8%). Half the respondents agreed with these concerns (47: 51.1%), while 17 (18.5%) disagreed and 28 (30.4%) were unsure.

Advocates in our subset of 6 states were more likely than expected to agree with provider concerns.

Some comments:

Nursing homes feel hospitals have an unfair advantage in providing sub-acute care because of the use of DRG (Diagnostic Related Groups) exempt rate. Nursing homes feel they could provide some care for less money than hospitals if nursing home reimbursement were raised.

The majority of the homes are for-profit and corporation owned. Stockholders want profit not benefits for employees/residents.

The nursing home needs to pay staff more.

Reimbursement is sufficient for a reasonable profit.

My state has one of the highest profit margins in the nation.

The costs are overinflated.

General Comments

As stated earlier, most of the written comments were negative about subacute care. In fact, there was at least one negative comment from each of the states represented in the sample. Of course, we do not know what those who were positive about subacute care might have written, as they chose not to write any comments.

Many of the respondents who did write, had experiences with subacute care that indicate they believe it is merely a way to make profits:

I believe it is an attempt to break the Medicaid discrimination statute and to increase profits.

Large out-of-state corporations are entering our state to position themselves for managed care markets.

Most long term care facilities are concentrating on Medicare or subacute residents because of the higher level of pay.

Administrators feel it's a gold mine.

CHAPTER FOUR:

PROVIDER QUESTIONNAIRES

Drafts of this questionnaire were sent to a number of consumers, providers and provider associations. Many of their comments were incorporated into the final draft.

Sample

Six hundred sixty (660) surveys were mailed to all nursing home providers in New York State. Of these 3 were returned because the facility was no longer operating or was no longer a nursing home.

Rate of Response Was 37.3 Percent

We had a high rate of return. A total of 245 facilities responded to the survey, for a response rate of 37.3%. Although providers were asked to participate even if they did not offer subacute services, 11 responded saying they would not participate because they did not offer subacute care, or returned surveys with too little information to include. This yielded a final sample of 234 useable surveys.

Providers were asked to write down their name and telephone number if they were willing to be called for an in-depth interview. Ten (10) percent of those who agreed to be interviewed were called (i.e., 10 providers, randomly selected from different geographical locations). This information became part of the section detailing comments from providers.

Demographics of the Sample

Our sample was representative of the state. One hundred of the respondents (45.2 percent) represented proprietary facilities; 94 voluntary (42.5 percent) and 27 public (12.2 percent).

More small facilities participated in the study than large ones: 151 (66.2 percent) had 200 residents or less, while 77 (33.8 percent) had more than 200 residents (mean = 189.7 beds with a range of 7 to 889).

Ninety-one (91) or 41.7 percent of the respondents were downstate¹⁵ while 127 or 58.3 percent were upstate facilities.

¹⁵Facilities located in New York City, Long Island, Westchester, or Rockland counties were considered downstate. All other counties were considered to be upstate.

One hundred and sixty one (161) of the respondents, 68.8 percent, offered some subacute services. Their number of subacute beds ranged from 2 to 242 with an average of 22.8 beds.

Table 13: Sample Characteristics: Sponsorship

Sponsorship*	Proprietary	Voluntary	Public
Number	100	94	27
Percent	45.2	42.5	12.2

* 7 facilities did not report sponsorship

Table 14: Sample Characteristics: Size and Location

SIZE*		LOCATION*	
	Over 200	Under 200	Upstate
Number	77	151	127
Percent	33.8	66.2	58.3

*16 did not give report location; 6 did not report size

Table 15: Sample Characteristics: CMI and Number of Subacute Beds

Case Mix Index*		Number of Subacute Beds	
Range	Average	Range	Average
.61 - 1.71	1.17	2 - 242	22.8

* 29 facilities did not report CMI

CHAPTER FIVE:
RESULTS OF PROVIDER QUESTIONNAIRES

Analyses were first conducted on the responses given by all respondents. Then we looked for significant differences by sponsorship, size, location, case mix index and whether the respondents offered subacute services or not. Because downstate facilities were more likely to be large and have case mix indexes above the state average, logistic regression was used whenever a factor was related to location (upstate, downstate) and one or both of the other factors (size and CMI) to determine the strongest predictor.

Types of Services

Many types of services were offered by those respondents who said they offered some type of subacute service (161 facilities). The types of services providers in New York State stated that they offer are similar to services offered in other parts of the country, according to the consumer respondents. Thus, rehabilitation was offered by most of these respondents (93.2 percent). The second most frequently offered service was wound management (80.7 percent). The number (57.8 percent) stating they offer acute care for their traditional residents were higher than that reported by advocates in other parts of the country (43.4 percent). The 3 most infrequently offered were: ventilator/respiratory therapy, cardiac rehabilitation and AIDS services.

Table 16: Subacute Services Provided

SUBACUTE SERVICE PROVIDED	# OF FACILITIES	% OF FACILITIES
Rehabilitation	150	93.2
Wound Management	130	80.7
Tracheostomy	115	71.4
Intravenous Therapy	93	57.8
Care for existing residents acute illness	93	57.8
Post-surgery recovery	89	55.3
Peritoneal Dialysis	42	26.1
Traumatic Brain Injury	39	24.2
Ventilator/Respiratory Therapy	28	17.4
Cardiac Rehabilitation	26	16.1
AIDS Services	18	11.2

Providers were asked about any other services provided in their facilities that they considered subacute care. The following services were reported: TPN (3); Terminal care/Hospice: (3); Hemodialysis (1); Suctioning (1); Nasal Gastric Tubes (1); Enteral Tubes (1); Complex medical care (1); Psychiatric residents (1); Dementia (1); Ostomy care (1); and Coumadine therapy (1).

Significant Differences By Sponsorship

For the most part, facilities did not differ in the services offered based on sponsorship. However, public facilities were more likely to offer AIDS care, while proprietary facilities were less likely to provide this service (chi square = 7.65; $p < .02$). Voluntary facilities were more likely to offer post-surgical recovery while public facilities were less likely to provide this service (chi square = 5.92; $p < .05$).

Significant Differences By Size

Facilities were divided into large (more than 200 beds) and small (200 beds or less)

based upon the average number of beds in the sample (189). Larger facilities were more likely to offer subacute services than smaller ones (chi square = 20.52; $p < .0001$). Larger facilities were also more likely to offer IV therapy (chi square = 6.13; $p < .01$) and tracheostomy care (chi square = 7.58; $p < .006$).

Significant Differences By Case Mix Index

The case mix index of the participating facilities ranged from .61 to 1.71, with an average of 1.17. Providers offering subacute services were more likely to have a high CMI (chi square = 4.74; $p < .03$)

Providers were divided into high (above 1.16) and low (1.16 and below) case mix index based upon the average index for New York State. Those facilities with a high case mix offered a number of subacute services including wound care (chi square = 12.19; $p < .000$); post surgery recovery (chi square = 4.77; $p < .03$); acute care for existing residents (chi square = 9.02; $p < .003$); traumatic brain injury (chi square = 11.44; $p < .001$); IV therapy (chi square = 9.09; $p < .003$); and tracheostomy (chi square = 6.01; $p < .01$).

Significant Differences By Location

As we look at these differences it is important to note that downstate facilities were more likely to be large (over 200 beds; chi square = 42.05, $p < .0001$) and more likely to have a case mix index above the state average of 1.16 (chi square = 12.94, $p < .0001$).

Downstate facilities were more likely to offer subacute services (chi square = 4.30, $p < .04$), and were more likely to offer the following specific subacute services: ventilator (chi square = 3.65, $p < .056$); tracheostomy (chi square = 6.61, $p < .01$); and IV therapy (chi square = 5.86, $p < .02$).

Reasons for Offering Subacute Services

When asked why they decided to offer subacute services, most providers said they offered such services to provide a continuum of care (71.9 percent); to respond to changing patient needs and preferences (70.6 percent); and because there were higher reimbursement levels (55.6 percent). Establishing relationships with managed care companies was less frequently given as a reason (23.8 percent).

Table 17: Reason for Offering Subacute Services

REASON FOR OFFERING SUBACUTE	# CITING REASON	% CITING REASON
To provide a continuum of care to patients	115	71.9
To respond to changing patient needs and preferences	113	70.6
Higher reimbursement levels than traditional services	89	55.6
To establish close working relationships with managed care companies	38	23.8

Other reasons cited by smaller numbers of facilities were as follows: to maintain bed occupancy (4); to respond to a changing market (3); to respond to community need (3); to give hospice services (2); to provide rehabilitation/discharge opportunities for local or affiliated hospitals (2); to work toward managed care (1); it is exciting for staff (1); to decrease hospital admissions for our patients (1); to learn about another business (1).

Significant Differences By Size

Larger facilities were more likely to cite establishing close relationships with managed care companies as a reason for offering subacute services (chi = 9.93; $p < .003$).

Significant Differences By Location

Downstate facilities were more likely to list developing a closer relationship with managed care companies as a reason for offering subacute services (chi square = 8.87, $p < .003$)¹⁶

Logistic analysis was used to determine the relative importance of size and location. This analysis indicated that location was the determining factor.

¹⁶As we will see below, large, downstate facilities also tended to get more reimbursement from managed care companies.

Payer Source

Given the high number of subacute providers offering rehabilitation and wound management, it is not surprising that the overwhelming majority of facilities are reimbursed for subacute care by Medicare. Medicaid and Private Pay are also picking up a substantial percentage of services.

Table 18: Payer Source

PAYOR	# FACILITIES CITING PAYER	% CITING PAYOR
Medicare	151	93.8
Medicaid	119	73.9
Private Pay	110	68.3
Commercial Insurance	76	47.2
Managed Care	62	38.5
Unsure of payor	2	1.2

Significant Differences By Sponsorship

Both public and voluntary facilities were less likely to accept managed care reimbursement for subacute services, while proprietary facilities were more likely (chi square = 6.05; $p < .05$).

Significant Differences By Size

Larger facilities were more likely to report receiving managed care reimbursement for subacute services (chi square = 8.93; $p < .003$).

Significant Differences By Case Mix Index

Facilities with a higher CMI were more likely to receive managed care reimbursement for subacute services (chi square = 7.79; $p < .005$).

Significant Differences By Location

Managed care seems to be more important for downstate than upstate facilities. Downstate facilities received more reimbursement from managed care for subacute services (chi square = 17.90, $p < .0001$).

Logistic regression was used to determine the relative importance of size, location and case mix index in predicting provider differences. Location and case mix index are the determining factors in reimbursement through managed care.

Separate Sections or Units

Only one third of the facilities offering subacute services (53; 33.3 percent) have separate units for subacute residents.

Significant Differences By Size

Larger facilities were more likely to have separate subacute units (chi square = 8.83; $p < .003$).

Significant Differences By Case Mix Index

Higher CMI providers were more likely to have separate units for subacute care (chi square = 4.15; $p < .04$).

Significant Differences By Location

Downstate facilities were more likely to have separate subacute units (chi square = 6.62, $p < .01$).

When the logistic regression was used, size and case mix index were the major determinants of the differences in having separate units.

Evaluation of Program Success

Two thirds (100; 62.9 percent) of the respondents reported that they routinely evaluated the success of their program in terms of resident outcomes. However, although asked, no provider gave an example of what type of evaluation was used.

Significant Differences By Location

Downstate facilities were more likely to evaluate their success in terms of resident

outcomes (chi square = 4.90, $p < .03$).

Destination of Residents After Subacute Program

Providers who offered subacute services were asked where the majority of their residents go when they no longer need subacute services. Sixty-five of the 160 respondents checked more than one destination, thus not answering the question for the majority of their residents. The table below shows the responses of all 160 respondents. Most of the residents returned home or remained in the same bed.

Table 19: Destinations for Residents After Subacute Services

DESTINATION FOR RESIDENTS AFTER SUBACUTE SERVICES	# FACILITIES CITING	% FACILITIES CITING
Return home	103	64.4
Remain in same bed	90	56.3
Moved to another unit in same facility	29	18.1
Moved to an adult home	19	11.9
Moved to another nursing home	4	2.5

Of those who responded correctly choosing only one response for the majority of their residents, an equal number of facilities (45; 19.2%) reported that residents usually went home or that residents remained in the same bed.

It is interesting that only a small number of these facilities (3) reported that they move the majority of their residents to another unit in the facility when the resident no longer needs subacute care; 1 facility reported that the majority of their residents went to another nursing home; and 1 reported that the majority went to an adult home.

Significant Differences By Sponsorship

Public facilities were more likely to report that residents were moved to another unit once subacute care was no longer needed,

while voluntary facilities were less likely to report that they move residents to another unit (chi square = 9.54; $p < .008$).

Significant Differences By Size

Larger facilities were more likely to report that residents were moved to another unit when subacute care was no longer needed (chi square = 11.30; $p < .001$)

Interaction of Subacute Residents and Traditional Residents

Providers were asked if their subacute and traditional residents interact and if they do, how beneficial this interaction was. Almost all the facilities (156; 98.1 %) reported that their traditional and subacute residents do interact with one another. Providers varied in their assessment of how beneficial this interaction proved to be for subacute and traditional residents. Just over one half of providers felt that the interaction was very or somewhat beneficial to subacute residents (18.6 % and 38.5%) with 39.1% unsure and 3.8% somewhat harmful. A slightly higher percentage felt that the interaction was very or somewhat beneficial to traditional residents (19.4 % and 43.2%) with 34.8% unsure and 2.6% somewhat harmful. No providers felt that interaction was very harmful to either group of residents.

Table 20: Benefits of Interaction

Beneficial to subacute residents:

very beneficial	18.6 percent
somewhat beneficial	38.5 percent
somewhat harmful	3.8 percent
extremely harmful	0
not sure	39.1 percent

Beneficial to traditional residents:

very beneficial	19.4 percent
somewhat beneficial	43.2 percent
somewhat harmful	2.6 percent
extremely harmful	0
unsure	34.8 percent

Significant Differences By Sponsorship

Providers from proprietary facilities felt that interaction was more beneficial to both traditional and subacute residents than either voluntary or public providers, while public providers reported the least benefit to either group of residents (traditional residents: $F=4.95$, $p<.008$; subacute residents: $F=4.99$; $p<.008$).

Significant Differences By Size

Providers from smaller facilities felt that interaction was more beneficial to traditional residents than larger providers ($F=2.01$; $p<.05$). There were no differences in opinion by facility size on benefits to subacute patients.

Types of Residents Appropriate for Subacute Care

All respondents, whether they offered subacute services or not, responded to questions about their views on subacute care and existing guidelines for these services.

Most providers saw residents needing rehabilitation as the most appropriate for subacute care. A large proportion of providers also saw current residents needing more complex services as good subacute candidates. This may explain the difference between such services reported by advocates across the country and New York State providers. New York State providers reported offering these types of services more.

Table 21: Appropriate Residents

TYPE OF PATIENT	# CITING	% CITING
Short term rehabilitation	209	89.7
Current residents needing more complex care	172	73.8
Some rehabilitation followed by long term care	165	70.8
Complex chronic care	151	64.8

Other types of patients considered appropriate for subacute care by a smaller

number of respondents were: medically complex short stay/medical patients not needing hospital level of care (7); IV/chemotherapy/antibodies (3); post surgical (2); younger population: Cerebral Palsy, Muscular Dystrophy; residents with special needs e.g., tube-feeding, dialysis aftercare, isolation cases (1); residents with chronic diseases (1); terminal/comfort care (1); patients in the community with a prior hospital stay that may prevent hospitalization (1).

Significant Differences By Sponsorship

When asked which patients they believed were appropriate for subacute care, voluntary providers were more likely to endorse short term rehabilitation, while proprietary providers were less likely (chi square = 11.06; $p < .004$).

Significant Differences By Case Mix Index

Facilities with higher case mix indexes were more likely to feel that short-term rehab patients were appropriate for subacute (chi square = 5.95; $p < .02$).

Significant Differences Between Facilities Offering Subacute Services and Those Who Do Not

When asked which patients they believed were appropriate for subacute care, providers who offered subacute services were more likely to choose several types of patients including short term rehabilitation (chi square = 29.19; $p < .0001$); current residents needing more complex care (chi square = 4.74; $p < .03$); and rehabilitation followed by long term care (chi square = 13.98; $p < .0001$).

Regulations

"We should allow facility and medical professionals to use their professional judgment (within accepted standards), and do not overregulate."

More than two thirds of the respondents (155; 69.8 percent) felt that existing nursing home regulations are not appropriate for subacute care providers. Over one-half suggested one or more regulations should be waived or changed.

Table 22: Regulatory Change

REGULATION TO BE CHANGED OR WAIVED	# CITING	% CITING
Transfer/Discharge	80	51.9
Dental	77	50.0
Assessment	75	48.7
Activities	70	45.5
Social work	28	18.2

Reasons For Wanting Changes in Regulations

Transfer and Discharge

"Transfer/discharge regulations make it difficult if not impossible to legitimately transfer a patient to a non subacute unit when services are no longer necessary for them. The subacute bed is needed for a new patient."

Over half (51.9 percent) of the providers wanted to change the transfer/discharge regulations. Problems related to regulations surrounding transfer and discharge were cited by 14 providers in open-ended responses. These respondents felt that transfer to other beds within the facility, or out of the facility altogether was an inherent feature of providing subacute care.¹⁷ These providers felt that regulations restricting these transfers or mandating 30 days notice impeded their ability to provide this type of specialized care in an efficient manner. Others complained that it is difficult to give 30 days notice prior to discharge when a planned stay is brief.

Significant Differences By Case Mix Index

Facilities with a high case mix index were even more likely to feel that regulations regarding transfer and discharge should be waived or changed (chi square = 4.49 $p < .03$).

¹⁷This is a major difference from the consumer advocates' responses. Their responses indicated great concern about moving subacute residents.